UNAIDS 2026

Sustaining HIV Community-led Responses: **Technical guidelines for costing and budgeting**

Contents

Executive Summary

Costing and budgeting are not one-off technical tasks. They are tools within a broader learning cycle that enables CLOs to plan, implement, evaluate and adapt their interventions.

Community-led responses (CLRs) are a vital pillar of the HIV response and central to achieving national and global targets, including the 30-80-60 commitments outlined in the 2021 Political Declaration on HIV and AIDS. These guidelines provide practical, step-by-step methods for costing and budgeting community-led responses (CLRs), tailored to the unique features of CLRs. They are designed for use by community-led organizations (CLOs), their partners, national governments, policy-makers, donors, and researchers involved in planning, implementing, financing or evaluating CLRs that address HIV.

Despite the growing recognition of CLRs, evidence regarding their costs remains limited and little practical guidance exists on how to generate robust, transparent estimates. Unique features of CLRs including the high reliance on donated goods and services, including volunteer time; multi-dimensional service delivery; and contributions from many stakeholders. These guidelines address that gap by offering tailored approaches that reflect the full value of community-led efforts.

The guidelines were developed through literature reviews, expert consultations, and piloting in diverse settings—including Sierra Leone, Togo, Zimbabwe and the Philippines. This process ensured that the tools are grounded in real-world experience and responsive to the needs of CLOs operating in varied contexts.

Costing and budgeting as a learning cycle

Costing and budgeting are not one-off technical tasks. They are tools within a broader learning cycle that enables CLOs to plan, implement, evaluate and adapt their interventions. For example, a CLO may conduct a costing exercise to understand the full cost of peer-led HIV testing, use the results to refine their budget, implement changes, mobilize resources to ensure fair pay for their peers and then re-cost to assess improvements in efficiency and reach.

Valuing social impact and community contributions

Costing and budgeting must consider not only economic efficiency but also the social value of CLRs—such as expanding equity, reach and responsiveness to community needs. Many community-led models rely on in-kind contributions and unpaid labour. These must be appropriately valued to reflect the true cost of service delivery and to support fair pay, sustainability and resource mobilization. It is equally important to measure and document these community contributions, which are often overlooked, so that their value is visible in evidence and decision-making.

Applicability: Who, why, when and how to use these guidelines

These guidelines are intended for CLOs and other stakeholders seeking to understand, plan or support community-led HIV responses. However, many of the methods are likely to be relevant to CLRs beyond HIV. They can be used to design or expand interventions, assess and mobilize fair pay, prepare funding proposals, evaluate programme efficiency, or support advocacy and strategic planning.

They are particularly suited for users with some quantitative skills and a good understanding of programmes, but they do not require prior experience in costing and budgeting. They offer the foundational concepts of health economics and adaptable tools for costing and budgeting. While no advanced technical background is required, users should be comfortable with basic Excel functions such as entering data into spreadsheets, using drop-down menus and navigating between tabs. The tools are designed to be user-friendly, but familiarity with Excel will help ensure accurate and efficient use. Users who are unfamiliar with Excel may benefit from introductory training or support from a partner organization.

Overview of the guidelines

Users may enter the guidelines at the point most relevant to their needs—whether conducting retrospective costing or prospective budgeting. The document is organized into four parts:

Part 1: Foundations

Core concepts in CLRs and health economics are introduced. It defines CLRs, distinguishes them from community-based responses, and outlines key principles for costing and budgeting. Users learn how to define the purpose and scope of their exercise, including cost types, time horizons and outputs. It also presents the continuous learning cycle and explains how costing and budgeting fit within it.

Part 2: Planning

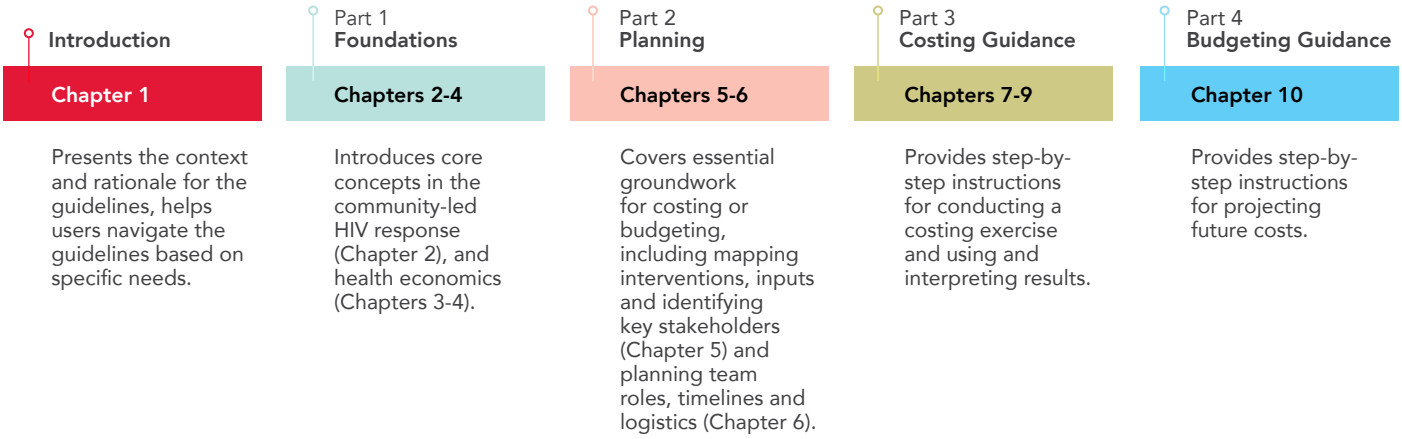
Part 2 guides users through the preparatory steps for a costing or budgeting exercise. This includes mapping interventions, identifying stakeholders and data sources, assembling a multidisciplinary team, and developing a workplan. Ethical considerations and stakeholder engagement are emphasized to ensure transparency and accountability. Tools are provided to support process mapping, stakeholder analysis and sampling strategies.

Part 3: Costing guidance

Here detailed instructions for collecting, analysing and interpreting cost data are provided. It introduces a combined top-down and bottom-up approach, supported by Excel-based tools. Users learn how to value financial and economic costs, allocate shared resources and calculate unit costs. Practical tips and case examples help users navigate common challenges, such as valuing volunteer time or allocating central costs.

Part 4: Budgeting guidance

This part focuses on projecting future resource needs. It explains how to use costing results or model assumptions to develop budgets for operational planning, grant proposals and strategic planning. An Excel budgeting workbook is provided to support these exercises. The section also discusses how budgeting can support funding gap analyses, sustainability planning and advocacy.



Key features of the guidelines

- Designed for quantitative analysts with limited prior experience in costing and budgeting who possess basic Excel skills (e.g. data entry, drop-down menus, navigating tabs).
- Emphasizes social value, equity and responsiveness to community needs.
- Applicable across diverse settings and adaptable to different implementation models.
- Promotes costing and budgeting as part of a continuous learning cycle.
- Supports both financial and economic costing and budgeting, including valuation of in-kind contributions.
- Includes Excel-based tools for data collection, analysis and budgeting.

Conclusion

By equipping CLOs and their partners with practical tools to estimate and advocate for the full value of their work, these guidelines can help contribute to a more equitable and effective HIV response. They provide a first step towards ensuring that community-led efforts are recognized and valued, creating the foundation for them to be more effectively resourced, sustained and scaled. The tools and methods provided are designed to be practical, adaptable and supportive of stronger planning, advocacy and sustainability.

Acronyms

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral treatment
CLM	community-led monitoring
CLO	community-led organization
CLR	community-led response
CPI	consumer price index
HIV	human immunodeficiency virus
HQ	headquarters
LCU	local currency unit
M&E	monitoring and evaluation
MOU	memorandum of understanding
NSP	national strategic plan
PrEP	pre-exposure prophylaxis
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

Chapter 1
Introduction to the guidelines

Chapter 1 introduces the CLR and describes the rationale, aim and purpose, scope, intended audience and structure of the guidelines.

By the end of the chapter, you should:
1. Understand why costing and budgeting CLRs is important and what gaps these guidelines aim to address.
2. Be familiar with the structure of the guidelines.
3. Follow how to navigate the guidelines based on your costing and budgeting needs.

1.1. Background

Community responses have been, and continue to be, a pillar of global and national HIV responses. CLRs are central to ending HIV as a public health threat by 2023, i.e. they add value by incorporating the needs and experiences of communities into intervention design and delivery while also improving the reach, uptake and quality of services (1). CLRs are integral mechanisms to achieving universal health coverage by facilitating community participation in primary health care (2). Furthermore, evidence shows that CLRs also generate broader societal benefits, including increased community trust in health systems, improved social cohesion within communities, decreased HIV-related stigma, and reduced interpersonal violence (3).

Within this landscape exists a diverse array of interventions, stakeholders, delivery models and levels of community engagement. Among these diverse efforts, both civil society-led, community-based and community-led approaches have proven vital to expanding access, tailoring services to context, and ensuring more inclusive and effective responses. Community-led organization (CLOs), a subset of civil society organizations, are differentiated by leadership, ownership and accountability by the communities themselves, specifically communities of people living with HIV, in all their diversity, key populations and other affected communities such as adolescent girls and young women. Key populations include gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs and people in prison.

In recognition of the importance of expanding the role of communities, the 2016 Political Declaration on HIV and AIDS called for greater involvement of key populations and people living with HIV and investment in CLRs and set a target for expanding community-led service delivery to cover at least 30 per cent of all service delivery by 2030. The 2021 Political Declaration on HIV and AIDS (4) further established specific targets for CLOs, groups and networks to deliver:

Estimating the costs of CLRs is important for informed planning and budgeting, strategic decision-making, effective advocacy, resource mobilization and sustainable implementation.

- 30% of HIV testing and treatment services,
- 80% of HIV prevention services targeting high-risk populations, and
- 60% of programs addressing societal barriers.

At the same time, the support that CLRs receive is often fragmented, short-term and insufficient. The costs do not always reflect the full value of resource needs and contributions of CLOs. In the face of evolving funding landscapes and increased political recognition of the importance of CLRs, it is essential that CLOs are equipped with the resources and tools to estimate and assess costs to support and sustain the work that they do.

1.2. Rationale for the guidelines

Estimating the costs of CLRs is important for informed planning and budgeting, strategic decision-making, effective advocacy, resource mobilization and sustainable implementation.

Standardized guidelines and tools exist for costing and budgeting HIV interventions or community-based public health interventions (**Appendix 1**) but none provide specific guidance on measuring and valuing the costs of CLRs. For example, existing guidelines do not differentiate between community-based responses, which refer to where an intervention is based and who an intervention serves, and CLRs, which are interventions implemented by and for communities themselves (Chapter 2) (5,6).

CLRs have distinct economic implications that are not addressed by existing guidelines. CLRs typically deliver a broad and complex set of interventions to address health, social and economic needs rather than a single-service delivery intervention. Guidelines rarely account for this complexity. CLRs also involve higher levels of engagement from CLOs, with increased time and resource contributions. Guidelines do not adequately address the valuation of these kinds of contributions—such as volunteer time or donated space—that are often essential and important for intervention delivery. Accounting for these unique features and their implications for costs requires specific guidance to facilitate complete estimations and projections.

Furthermore, while the benefits of community-led responses within and beyond HIV are well-established (3,7) less evidence is available on their costs. Literature reviews informing these guidelines found that existing empirical evidence often pertains to community-based interventions.

Overall, community responses, both community-based responses and CLRs, are essential to achieving an effective and equitable HIV response. However, the relative lack of cost data and tailored guidance for CLRs presents a critical gap. These guidelines aim to address that gap by offering practical approaches to estimating and budgeting for the full value of community-led efforts.

1.3. What are the guidelines?

1.3.1. Aim, purpose and scope of the guidelines

The aim of these guidelines is to improve the completeness and consistency of cost estimation of CLRs to enhance usability for decision-making and support for sustainable financing. The purpose of the guidelines is to provide standardized guidance and tools on costing and budgeting of CLRs.

These guidelines can be used to produce cost estimates for different purposes (**Chapter 3 and Chapter 9**), including to:

- Understand the full value of all resources used within an intervention to advocate for fair pay for volunteers, negotiate grants and inform social contracting negotiations.
- Project costs and inform budgets for strategic and operational planning, budget impact analysis, funding gap analysis, forecast models and investment cases (e.g. how much would be required from the Global Fund to develop a new CLR programme?).
- Support routine monitoring of costs (i.e. how are costs changing over time, are an increasing level of resources being spent on HIV test kits and could kits be purchased at a lower price?).
- Support decision-making and prioritization based on value for money (e.g. could the same level of resources be spent in a different way to achieve greater impact?).

Ideally, a budget should reflect actual resource needs, highlighting the importance of using observed costing to inform budgeting as part of a continuous learning cycle (**Chapter 3**). While cost estimates provide evidence of past costs to support future budgets, budgets guide future implementation, and subsequent costing helps again refine future planning and projections. This iterative approach is particularly relevant for adaptive planning and improving programme sustainability over time.

The scope of the guideline is limited to CLRs. However, these guidelines have broader applicability to other community responses, including community-based interventions, and can be applied across the HIV response at global, national and subnational levels.

1.3.2. Development of the guidelines

These guidelines were developed through a process of literature reviews, expert consultations and piloting. Literature reviews involved appraising costing and budgeting guidelines in public health and peer-reviewed articles in HIV to identify best practices and gaps. Expert consultation involved convening a technical advisory group of experts, including representatives of CLOs, to advise on the development of guidelines. In addition, researchers and implementers based in community-led organizations piloted the guidelines and tools in Sierra Leone, Togo, Zimbabwe and the Philippines. Based on feedback and lessons learned during these pilot exercises, the guidelines and tools were revised and refined to improve usability and relevance across diverse settings.

Throughout the guidelines, practical features are included to support users at every step. "Practical tips," "Case example" and "Exercise" boxes offer real-world advice, insights and lessons from implementation experience.

1.4. Who should use the guidelines?

The intended users of these guidelines include programme managers and implementers—including from CLOs—along with policy-makers, donors, advocates and researchers who produce and use cost data to support planning, budgeting, implementation and resource mobilization for community-led HIV responses. The guidelines assume no or limited prior knowledge of costing and budgeting and introduce foundational principles, concepts and methods with step-by-step guidance.

1.5. How should the guidelines be used?

1.5.1. Structure of the guidelines

These guidelines are organized into four parts.

Part 1. Foundations outlines core concepts in CLRs (**Chapter 2**), as well as principles and methods in health economics (**Chapter 3** and **Chapter 4**). Importantly, it helps users determine where to begin based on their context and needs.

Part 2. Planning provides guidance on preparing for a costing or budgeting exercise, including team setup, stakeholder engagement and logistical planning (**Chapter 6)**. It also explains how to map interventions, identify cost inputs and contributors, and determine appropriate data sources (**Chapter 5**).

Part 3. Costing guidance walks users through the steps of conducting a costing exercise, from data collection to analysis and interpretation or results.

Part 4. Budgeting guidance focuses on budgeting, including how to project future costs and use them for planning and advocacy.

Throughout the guidelines, practical features are included to support users at every step. "Practical tips," "Case example" and "Exercise" boxes offer real-world advice, insights and lessons from implementation experience. All organizations referenced in these examples provided their consent for inclusion. All figures and tables—with the exception of **Figure 2.5**—were created by the authors and are based on their own work.

The **Appendix** contains accompanying tools for data collection and analysis.

How the guidelines are applied by users will depend on their needs, see also **Figure 3.2**.

Box 1.1. Quick start: How to use these guidelines

New to costing or budgeting? Start with **Part 1** to understand the key economic concepts, why they matter, and how to plan your approach to costing and budgeting.

Already delivering services and want to understand your actual costs? Go to **Chapter 5** and **Chapter 6** to begin planning for the costing and **Chapter 7** and **Chapter 8** to follow guidance on costing.

Have not started implementation but need to project future budgets? Go to **Chapter 5** and **Chapter 6** to begin planning for the budgeting, then go to **Chapter 10** for guidance on budgeting.

Looking to use your costing results for advocacy, strategic planning or budgeting? See **Chapter 9** for guidance on interpreting and applying your results for decision-making and resource mobilization.

Need tools and templates for data collection and analysis? Find downloadable resources in the Appendix to support each step of the costing and budgeting process.

PART 1

Foundations

This section provides the foundations needed to understand and begin costing and budgeting community-led HIV responses. It explains the value of costing and budgeting, both separately and in combination, and introduces their roles as part of a continuous learning cycle. It also explains key components of CLRs and concepts in costing and budgeting, and outlines the main methods used to measure and value resources. The aim is to support users in navigating key decisions before moving to Part 2, which outlines critical planning steps before beginning the exercise.

Chapter(s) included:

Chapter 2
Understanding community-led HIV responses

Chapter 2 presents the scope of community-led HIV responses, presents core response areas and discusses the potential implications for costing and budgeting.

By the end of the chapter, you should:
1. Understand the differences between community-led and community-based interventions.
2. Anticipate the potential implications for costing and budgeting of your intervention.

For a more detailed discussion of HIV community-led responses, see UNAIDS Guidance: Partnering for sustainable, community-led responses to HIV (8).

2.1. Overview of the community-led HIV response

Community-led HIV responses are actions and strategies that seek to improve health and human rights, that are specifically informed and implemented by and for communities themselves and the groups, organizations and networks that represent them. CLRs are determined by and respond to the needs and aspirations of their constituents (5). Core areas of the CLR include: advocacy and campaigning and holding decision-makers to account; monitoring of polices, practices and service delivery; participatory research; education and information sharing; service delivery; capacity-building; and the funding of CLOs, groups and networks (**Figure 2.4**). CLRs can take place at global, regional, national, subnational and local levels and can be implemented virtually or in person (5).

CLOs, groups and networks, whether formally or informally organized, are entities for which most governance, leadership, staff, spokespeople, membership and volunteers reflect and represent the experiences, perspectives and voices of their constituencies—and which have transparent mechanisms of accountability to their constituencies (5). A single CLO may deliver multiple interventions across diverse areas and geographic scopes.

2.1.1. Community-led and community-based HIV responses

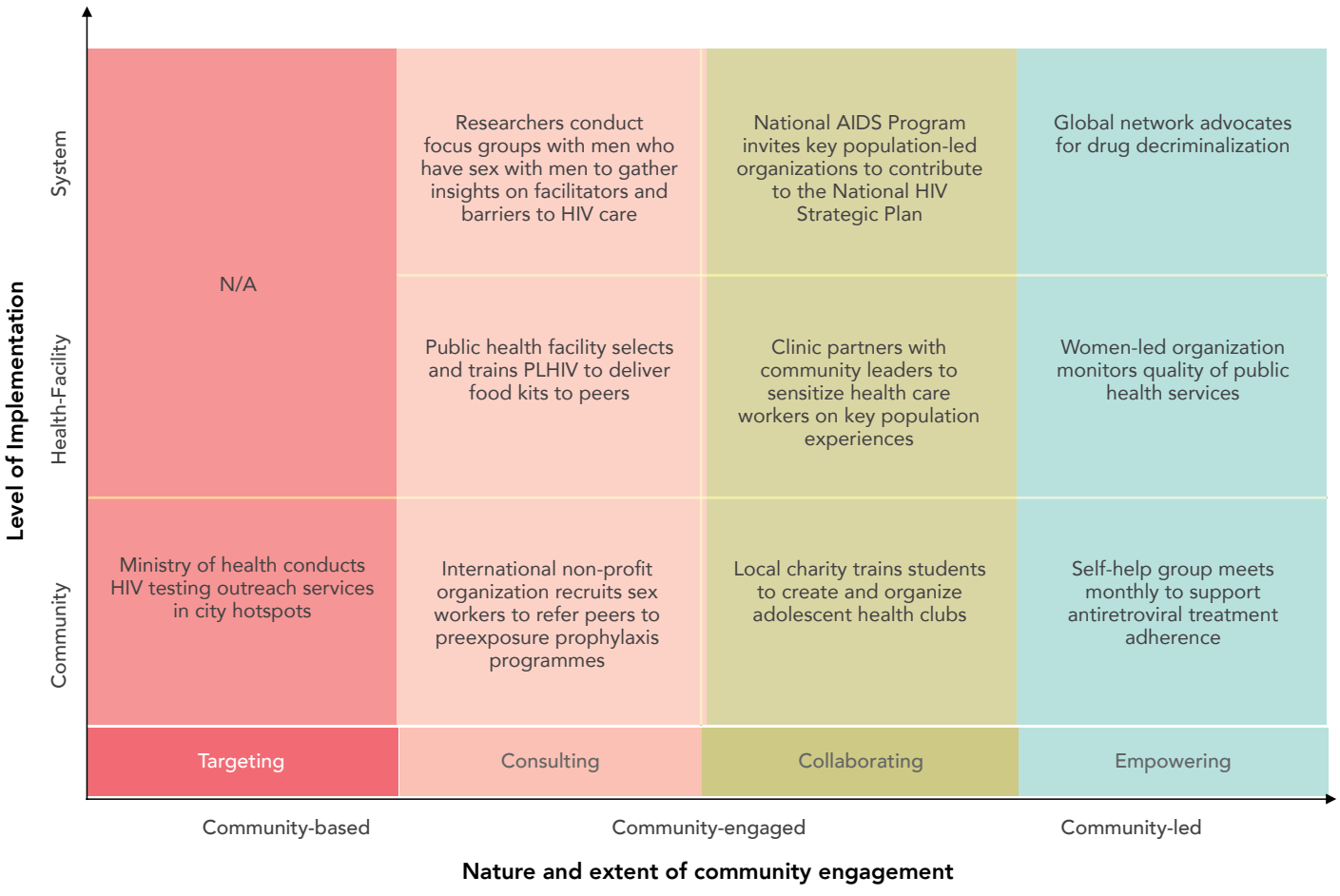
"Community" refers to a group of people with shared spatial or social characteristics or collective interests (9). In the HIV sector, "community" is used both to refer to interventions implemented outside of standard health facilities, as well as to interventions that involve people living with HIV and people affected by HIV, including women, adolescents and young people, and key populations. The term "community-based" is used to refer to both where an intervention is based and who an intervention serves. The term "community-led" describes who leads an intervention. Notably, not all responses that take place in communities are community-led (5).

Terms such as community-based, community-led and community-engaged are often used interchangeably to describe HIV responses. However, these terms refer to different dimensions of community action, whether physical (where interventions occur) or social (who leads and drives the intervention). To help illustrate the diversity of community responses and highlight the differences across these dimensions, **Figure 2.1.** presents a framework that maps community HIV interventions according to two axes (10). The horizontal axis describes the nature and extent of community participation; that is, whether decisions are made only by external organizations (targeting), mostly by external organizations (consulting), jointly by community and external organizations (collaborating), or mostly by community organizations (empowering) (11). The vertical axis describes the level of implementation; that is, whether interventions are implemented at the systems, service or community level.

The nature and extent of community participation in an intervention is represented by the horizontal axis. The level of implementation of an intervention is represented by the vertical axis.

Interventions can be categorized as community-based, community-led or both. For example, self-help groups for antiretroviral treatment (ART) adherence among people living with HIV is both community-led, since the intervention is being overseen by self-help groups, and community-based, since the intervention is being provided outside standard health facilities and services to a key population.

Figure 2.1. Framework for classifying community interventions



2.1.1.1. Is the organization community-led?

CLOs are characterized by three key elements: Organization, representation and accountability. UNAIDS proposes three criteria to identity a CLO (12):

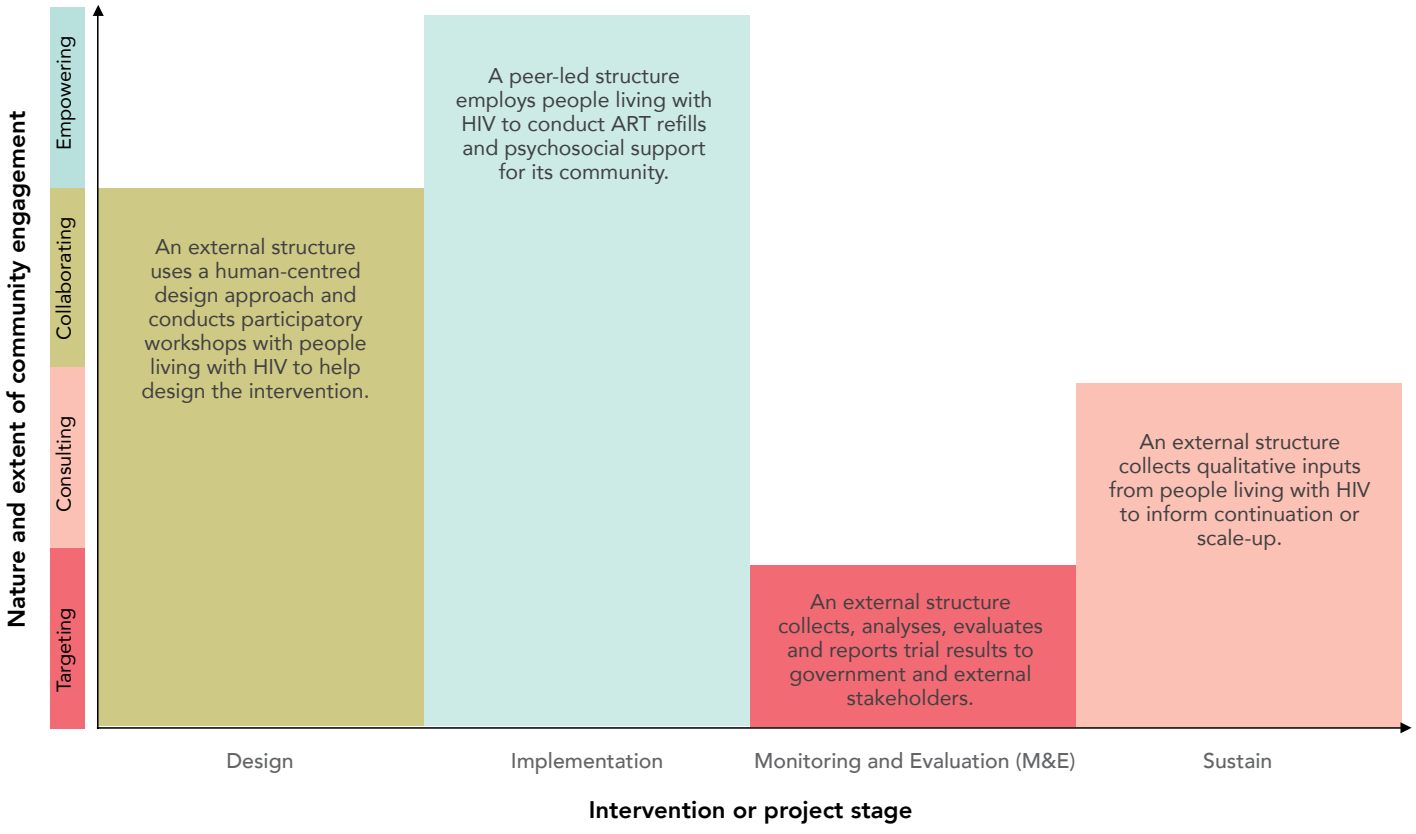
1. The group is either a formal or an informal organization.
2. At least 50% of the governance, leadership, staff and volunteers are drawn from the constituents that the organization serves.
3. Accountability mechanisms are in place for constituents to review the organization's work.

However, it is important to recognize that the role of a CLO may shift along a continuum over time depending on factors such as funding, staffing, governance or operating environment (**Figure 2.2**). Understanding the role is helpful for understanding the implications for costing and budgeting.

2.1.1.2. Are the interventions community-led?

Another way to consider community leadership is by evaluating the role of CLOs across different intervention stages, as shown in **Figure 2.2** (10). This figure illustrates the practical application of a framework to qualify community engagement across an intervention or project's lifecycle, including design (shaping the intervention's objectives and approach), implementation (carrying out the planned interventions), monitoring and evaluation (tracking progress, quality and

Figure 2.2. Framework for qualifying community engagement across an intervention's lifecycle



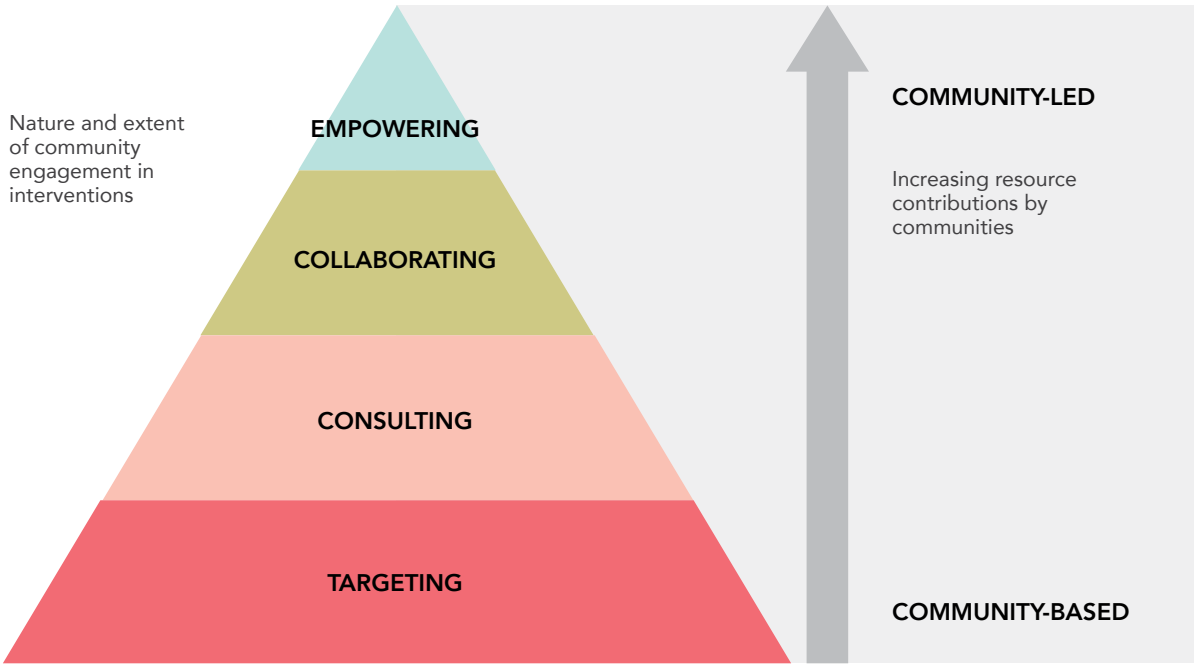
results), and sustainability (ensuring the intervention is maintained, adapted and owned by the community).**Figure 2.2** highlights an intervention delivering ART refills and adherence support to people living with HIV.

The bars in **Figure 2.2** visually indicate the level of community engagement in each programme phase, with higher bars representing greater participation. A simple colour scheme helps convey the level of engagement at a glance. If leadership by a CLO is only present during implementation—while design, monitoring and evaluation, and financing are externally led—the intervention may not be considered fully community-led. Again, the intent of this framework is to encourage CLOs to critically examine their role in interventions across the lifecycle and not just at a single point in time.

2.1.2. Costs of community-led and community-based HIV responses

Community-led interventions have unique implications for costing and budgeting. For example, as communities have more control over decision-making, they may potentially contribute more donated time and resources and incur additional costs that are often hidden and difficult to quantify and value, such as volunteer-led outreach activities, use of personal phones or transport, or unpaid time spent in planning meetings. On the other hand, greater control over expenditures may potentially also empower them to pay fair wages to those implementing activities. In some cases, however, if fully empowered and resourced, communities may prioritize sustainability and reduce reliance on unpaid contributions. It means more care is needed to assess full value of resources, beyond simple expenditure accounts.

Figure 2.3. Economic implications of community-led responses



Resource use is, therefore, undervalued when only financial transactions are accounted for rather than the actual value of resources used to deliver interventions, including donated time and resources. **Table 2.1** illustrates how the types of provider costs can differ based on the nature and extent of community participation.

2.2. Core areas of the community-led HIV response and factors influencing their costs

There are seven core areas of the community-led HIV response (**Figure 2.4**) (5). Other approaches to defining the CLR areas are presented in **Box 2.1.** In reality, the responses and activities that CLO lead are evolving and fluid. The next part of this section focuses on each of the seven areas in detail, including their unique cost implications. Users may choose to skip to the topics most relevant to them.

Table 2.1. Costs implications of community engagement

Nature and extent of community participation	Example of service delivery interventions	Provider	Implications for provider costs
Targeting	Home delivery of HIV care for people living with HIV by an international non-profit organization	International non-profit organization	Inputs include full cost of headquarters operations including staff, building, treatment-related equipment and supplies, supply chain management and transportation of staff to client homes.
Consulting	Dispensing of preexposure prophylaxis to people engaged in sex work at pharmacies informed by consultations people engaged in sex work	Pharmacies	Inputs include building space and related costs, salaries for pharmacy staff, consultant fees for research and development, and costs of preexposure prophylaxis and other consumables. If preexposure prophylaxis provided by the ministry of health, then this needs valuation in economic costs.
Collaborating	Co-creation and delivery of adolescent health clubs by schools	School & adolescent volunteers	Inputs paid by the school may include classroom space and related costs, time for teachers, and stationery. Volunteer contributions may include time and resources donated to curriculum development and running health clubs.
Empowering	Self-help and adherence support groups for people living with HIV	Self-help groups	Being fully empowered may mean the CLO mobilized funding to provide fair-pay to the self-help group coordinator. If group ART collection is included, reimbursement of transport costs for ART collection may or may not be found in accounts. Often, a substantial share of resources—including volunteer time for providing counselling and coordinating the group—may be contributed in-kind.

Figure 2.4. Core areas of the community-led HIV response

Box 2.1. Classification of community-led responses

There are different classifications available of CLRs. The core areas presented in this chapter are based on a UNAIDS framework, which groups a broad range of community-led interventions into seven key domains (**Figure 2.4**). Other stakeholders have proposed alternative frameworks, highlighting the range of approaches in conceptualizing CLRs:

- **The World Bank (2011)** categorizes community interventions into service delivery and enabling environments for advocacy, dialogue and stigma reduction (13).
- **The Global Fund (2014)** outlines community roles within its Community Systems Strengthening Framework, emphasizing community engagement, service delivery and enabling environments while exploring the integration and complementarity between community and formal health systems (14).
- **Greer et al. (2017)** propose three broad functions of civil society in health: Policy, service and governance (15).
- **Frontline AIDS (2019)** presents a community health framework that spans advocacy, accountability, service delivery and capacity-building within the context of primary health care and universal health coverage (16).

While this guideline adopts the most recent UNAIDS framing, these will continue to evolve over time. The list presented here is intended to help structure the discussion, but not to prescribe a fixed typology of what communities should or should not do.

2.2.1. Advocacy

Community-led advocacy aims to influence systems and institutions to improve access to HIV prevention and care and create more enabling environments, including by promoting protective laws and policies and challenging stigma and discrimination (13,17). These efforts are integral to enhancing the health and well-being of communities.

Examples of community-led advocacy efforts include (13):

- Advocacy and campaigning for HIV-related issues (e.g. improving availability, quality, accessibility, acceptability and affordability of HIV services and strengthening alliances).
- Advocacy and campaigning on broader health issues (e.g. advocating for improved access to sexual and reproductive health services).
- Advocacy and campaigning on human rights issues (e.g. challenging restrictive laws and policies that impact key populations).
- Advocacy for resources (e.g. mobilizing funding for HIV interventions).

Box 2.2. Factors influencing costs of advocacy

Factors that could impact the costs of advocacy include:

- **Advocacy design** incorporates responses that may require extensive planning and vary in form. Activities may involve media campaigns to raise awareness or pressure for change, coalition-building with other organizations to amplify influence, or direct engagement with policy-makers. Costs can include meetings, trainings and workshops held in-person or virtually. Advocacy often involves implementing activities and monitoring outcomes in cycles that continue until objectives are achieved.
- **Advocacy levels** reflect initiatives that target systems and institutions at global, regional, national and subnational levels. The level of advocacy will influence costs. For example, multicountry advocacy to improve government funding for HIV treatment will require multiple levels of coordination that can introduce additional layers of management costs.
- **Compensation and participation support** allows CLOs to allocate resources to ensure inclusive participation in advocacy events. These can include transport stipends, food and in some cases direct compensation for time, especially when engaging community members who would otherwise be unable to participate. Government staff may also require compensation to attend conferences or meetings, especially if conducted outside of the capital.
- **Frequency**, timing and the scale of activities can fluctuate depending on political windows and emerging needs. Unlike service delivery, advocacy is often event- or issue-driven. Advocacy opportunities may also arise unexpectedly through personal or professional relationships, where informal engagement can lead to rapid resolution of issues.
- **Enabling environments** allow CLOs to receive external funding and operate openly, allowing for more structured and sustained advocacy campaigns. In restrictive or underfunded contexts, advocacy may be informal, reactive and require community members to contribute time and resources for mobilization in-kind.

2.2.2. Community monitoring and community-led monitoring

While communities do many types of monitoring, including securing health system accountability and participating in monitoring policies and implementation of laws, we focus here on the most prominent form, community-led monitoring (CLM). CLM is an accountability approach used to evaluate HIV responses at various levels, led and implemented by communities living with and affected by HIV (18). CLM involves CLOs systematically and routinely collecting and analysing data on HIV service delivery and the broader social and policy environment. These data are then used to inform feedback loops with programme managers and decision-makers.

CLM involves assessing what works well, what does not work well, and what needs to be improved, and provides suggestions for targeted action to improve outcomes. It is one of many community monitoring approaches that exist, including initiatives like community-based monitoring (19), clinic-community collaboration (20), social audits (21), community scorecards (22), or citizen report cards (23).

Different stakeholders articulate various stages for CLM, but broadly considered, six stages are common to the CLM process. These include:

1. **Start-up:** Communities assess needs, clarify what they want to monitor and determine how CLM will be conducted. This stage can include learning about the determinants of diseases, existing standards of care and relevant legal or policy frameworks.

2. **Collect information:** Communities collect and document evidence through qualitative and/or quantitative data collection, drawing on sources such as health care providers, clients, community members and policy briefs.

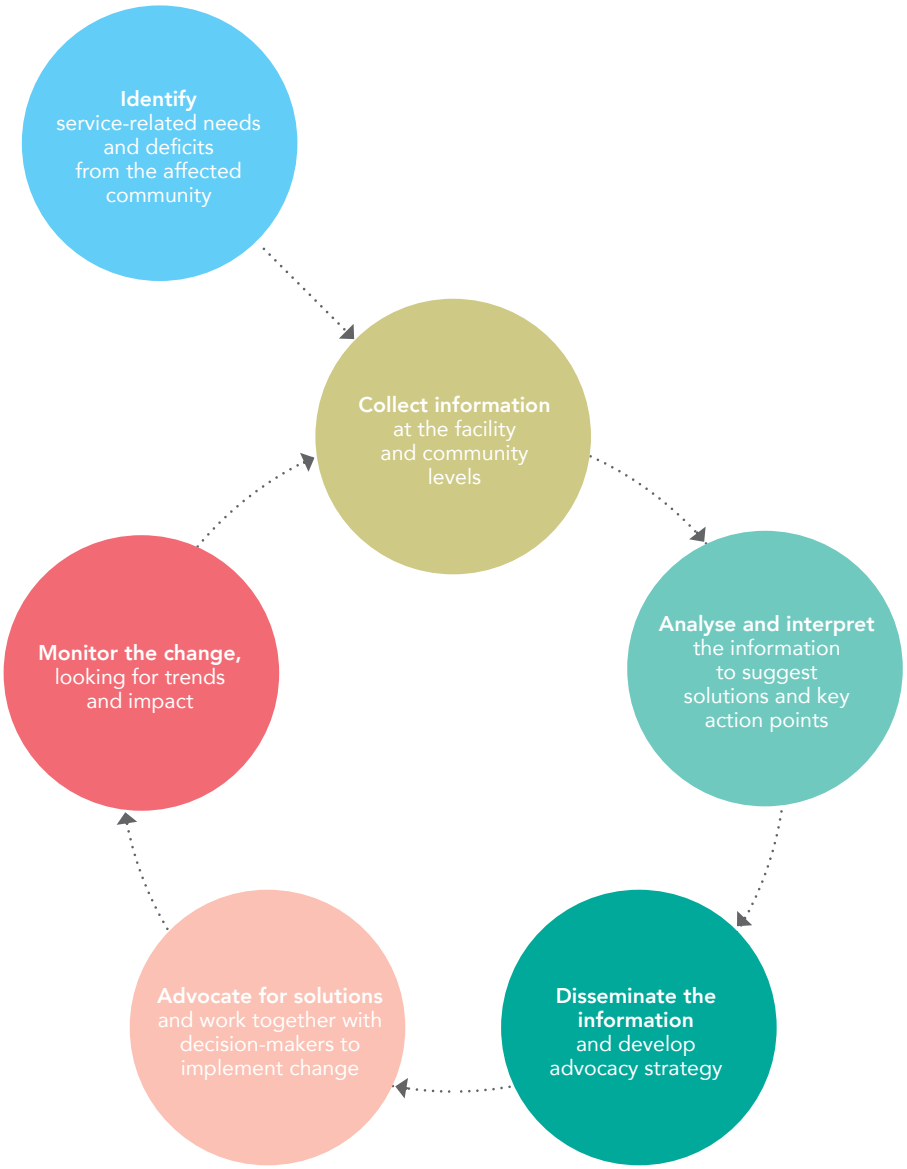
3. **Analyse and interpret:** Data are analysed and synthesized to identify problems, gaps and areas for improvement, with community monitors often working alongside coordinators, supervisors or data analysts. This process involves identifying patterns in service delivery and quality, comparing findings to established standards of care or community expectations, and developing initial suggestions for solutions and action points.

4. **Disseminate findings and develop advocacy strategy:** Findings are shared and discussed with a wider set of stakeholders within the community to codevelop strategies and actions collaboratively.

5. **Advocate for solutions:** Communities engage with duty-bearers, such as health providers or policy-makers to communicate evidence, propose solutions and advocate for system-level improvements. These efforts can occur at multiple levels of the health system, from facility-level interactions to district and national-level engagement, each requiring different approaches and stakeholder relationships.

6. **Monitoring the change:** Communities track the implementation of agreed actions and commitments, assessing both immediate outcomes and long-term impacts on services, stigma, policy and other determinants.

Figure 2.5. Community-led monitoring cycle stages



Source: Establishing community-led monitoring of HIV services. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2021. Accessible at: https://www.unaids.org/sites/default/files/media_asset/establishing-community-led-monitoring-hiv-services_en.pdf

Core functions of CLM include:

- CLM of intervention coverage and quality, including availability, accessibility, acceptability and affordability of services.
- CLM of health technologies and supply chains, such as availability of HIV test kits, antiretrovirals and other essential supplies.
- Documentation of key population experiences, including incidents of stigma and discrimination and rights violations in health-care settings.
- Participation in monitoring mechanisms to track implementation of national or local commitments, including policy adherence and service delivery standards.
- Oversight and accountability of duty bearers, including service providers, health facility managers, regional authorities, policymakers and donors. In CLM, issues are addressed first at the facility level, with unresolved cases escalated. Closing the loop means ensuring data is acted upon and leads to measurable improvements in service.

Box 2.3. Factors influencing costs of community-led monitoring

CLM is not a one-size-fits-all model but a set of adaptive practices that vary across settings and goals. As such, costs will depend on many factors and across CLM stages:

- **During the start-up stage:**
  - **Preparatory activities:** Includes coalition-building, community sensitization, defining focus areas, setting up workplans and budgets, developing data systems, and training peer monitors. These are capital investments with multiyear benefits.
  - **Data systems capacity:** The strength of CLO data systems, along with the technical capacity of staff to use them, will determine the level of training and external support required for developing and maintaining data systems and reporting routine indicators.

- **During data collection:**
  - **Implementation modality:** Whether data collection is completed in-person, virtually or through a hybrid approach affects resource needs. In-person visits may incur transport costs and routine trainings, while virtual platforms require digital infrastructure.
  - **Data platforms:** Costs can vary based on whether systems are manual, electronic or use cloud-based software, influencing needs for hardware, internet and technical support.
  - **Compensation of monitors:** Time and resources contributed by community monitors may be compensated, partially compensated or fully provided in-kind, which will impact the approach used to value their donations.
  - **Central human resources:** Beyond community monitors, CLM requires data analysts, supervisors, coordinators and programme managers. Costs will depend on whether these roles are 100% dedicated or shared across other programmes.

- **During the development of an advocacy strategy:**
  - **Compensation of community participants:** Time and resources contributed by community leadership and members to review and interpret data, agree on priorities and decide on action points may be compensated, partially compensated or provided in-kind. These contributions can be considerable and should be valued appropriately.

- **During advocacy and monitoring:**
  - **Feedback meetings and level of stakeholder engagement:** Costs will vary depending on the level and format of engagement. Local meetings, such as monthly facility-level reviews, may involve modest expenses for venue hire, refreshments and transport; national or multistakeholder meetings can require travel, per diems and more extensive preparation.

Additional practical guidance on how to cost CLM—including specific considerations across stages, inputs and valuation of community contributions—is provided in **Appendix 16**.

Box 2.4. Adapting community-led monitoring in resource-constrained contexts

Given current funding constraints at the time these guidelines were developed, there is a growing need—and opportunity—to design cost-efficient and context-appropriate CLM approaches. Such strategies may include:

- **Leveraging virtual approaches:** Using phone-based interviews with clients or using existing data platforms like District Health Information Software 2 (DHIS2) to access relevant clinic-based data can help reduce costs of transport and personnel. However, it is important to consider whether all target populations and facilities have reliable access to such platforms or infrastructure.
- **Using strategically sampled approaches:** Focusing on priority hotspots or sentinel sites may reduce coverage but increase feasibility and quality.
- **Integration with broader health systems:** While these guidelines focus on HIV, the future of HIV responses is expected to be more integrated across health areas. This shift not only opens new potential funding channels but can also generate economies of scope, where shared infrastructure, personnel and data systems support multiple health areas, reducing marginal costs per intervention. Some models are already emerging, such as joint data collection platforms for tuberculosis and HIV, which illustrate the potential for integrated monitoring systems.

While exploring ways to make CLM more cost-efficient, it is essential to ensure that cost savings do not come at the expense of adequate implementation and support, capacity-building and sustainability.

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2.2.3. Research

Community-led research is grounded in the broader tradition of participatory research, which emphasizes the involvement of communities not just as study "subjects" but as co-creators of knowledge. It draws from frameworks such as participatory action research (24) or community-based participatory research (25), both of which aim to democratize the research process and ensure the results serve the interests of study participants.

In the HIV response, community-led research involves communities living with and affected by HIV taking action by: Driving research priorities and questions; defining methods; generating, validating and interpreting results; and recommending actions (17). This type of research plays a critical role in ensuring that programming and policy decisions are responsive to community needs and experiences while also considering the broader structural and social context.

Examples of community-led research include \(13):

- Research on values and preferences of specific communities on new treatment and prevention technologies (i.e. introduction of the dapivirine ring, injectable PrEP, etc.).
- Research to understand real-time shifts in dynamics of local epidemics (i.e. "know your epidemic, know your response").

- Research on structural drivers of epidemics nationally and among key and vulnerable populations (e.g. HIV stigma index study).
- Research to reach communities and inform relevant policies and programmes (e.g. engagement in HIV modelling exercises).

Additionally, communities plan critical roles on community advisory boards, making the voices from the constituents heard. The time CLOs donate to these external board can be substantial and need to be costed too.

Box 2.5. Factors influencing costs of research

Factors that could impact the costs of research include:

- **Research design:** Input from stakeholders, including government representatives, are important to ensure the design of policy-relevant research. Start-up costs associated with meetings and consultations will therefore contribute to research costs.
- **Ethical and administrative fees:** Research involves various levels of ethical and administrative approvals that require both formal and informal fees. These costs are often overlooked in budgeting. Reimbursement of research participants is also often suggested to compensate for their time, transportation and other participant-related expenses.
- **Data systems capacity:** Depending on their technical capacity, CLOs may require various levels of training and external support for generating, validating and interpreting data.
- **Data platforms:** Use of either manual or electronic systems can affect costs of personnel, equipment and supplies required for data collection and management. The amount of data collected can also impact personnel time.
- **Compensation:** Where CLOs act as co-researchers or implementers, costs should reflect the full value of their time and resources, whether paid or unpaid.
- **Dissemination and publication:** Costs for producing, translating and distributing reports, as well as publishing in academic journals (including open access fees) should be considered in research budgets.

2.2.4. Education and information sharing

Community-led education and information sharing involve targeting HIV-related knowledge, attitudes and norms among policy-makers, service providers, programme managers, community members and the general population. Education is important not only to build literacy about the disease itself (e.g. how HIV is transmitted, prevented and treated) and available services (e.g. the importance of counselling and testing, understanding viral load testing results and information on specific prevention products), but also to ensure people know their rights and entitlements (e.g. access to free treatment, no user fees for services). These efforts can support better health outcomes and address broader structural and social conditions, including stigma, discrimination and harmful gender norms (17).

Examples of community-led education and information sharing include (13):

- Provision of health-care information to community-members that is accessible and appropriate (e.g. non-judgmental, non-stigmatizing and evidence-based).
- Training and sensitization of policy-makers; health-care, social and legal providers; and programme managers.
- Initiatives aimed at shifting harmful societal attitudes and norms that fuel stigma, discrimination, exclusion and criminalization of key populations (e.g. stigma reduction campaigns, storytelling or media advocacy).

Box 2.6. Factors influencing costs of education and information sharing

Factors that could impact the costs of research include:

- **Mode of delivery:** A substantial amount of time and resources is often invested in the development or adaptation of materials for training and information, education and communication, which can vary from paper-based pamphlets to mass media platforms. Implementation costs will also differ based on the educational approach, including whether education is delivered in person or remotely.
- **Compensation of educators:** Education may be delivered by volunteers who are unpaid for their time. In addition to potential stipends or salaries, costs may include transport, equipment and supplies, some of which may be privately owned and donated by volunteers.
- **Scale and reach:** The scale of delivery will impact costs. For example, a social media campaign will likely incur lower unit costs per activity delivered than an in-person campaign event, since costs will be spread over a larger number of people.
- **Adaptation:** Costs may also vary depending on the need to translate materials or tailor content and delivery strategies for specific audiences.

2.2.5. Service delivery

Community-led service delivery is essential to improve the availability, accessibility, acceptability and affordability of HIV services. CLOs contribute by directly delivering clinical, social and legal services and generating demand for these services (17). Compared with formal health systems, they are often best positioned to reach underserved populations and to effectively adapt services to community needs and experiences. Among the three domains of the 30-80-60 Political Declaration targets (4,26), the first two, service delivery for testing and treatment and prevention, tend to be the most well-resourced, with clearer roles, outputs and targets for CLOs.

Examples of community-led service delivery:

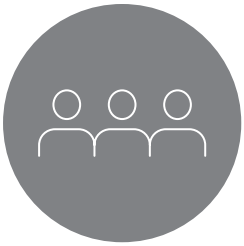
- Demand creation and maintenance for HIV prevention and care, with community-led outreach by trained peer educators, targeted promotion of new services in drop-in centres or community-based edutainment events, where educational content is woven into entertainment events, such as theatre.
- HIV prevention, such as distribution of clean syringes and condoms by peers across key hotspots for drug use and injection.
- HIV testing and linkage to care, including peer-assisted HIV self-test distribution with hotline support from a civil society organization.
- Initiating clients on HIV treatment and supporting retention in care through a differentiated service delivery model led by a CLO or through community-led self-help groups supporting adherence.
- Social and legal services, via peer para-legal or lawyer support or community-managed gender-based violence referral services.

Box 2.7. Factors influencing costs of service delivery

Factors that could impact the costs of community-led service delivery include:

- **Use of personnel, equipment and supplies:** Community-based services may rely on trained peer educators or lay volunteers rather than clinical staff, reducing some personnel costs but potentially increasing investments in training, supervision and quality assurance. For example, HIV self-testing kits can be distributed by peers with hotline support, while laboratory-based testing for chlamydia and gonorrhoea requires trained and salaried medical personnel and specialized equipment.
- **Demand creation and maintenance:** Community-led models often embed culturally tailored approaches to generate and sustain demand, such as edutainment events, peer referral networks or targeted mobilization at drop-in centres. These additional activities can raise costs but may increase uptake, retention and trust, improving cost-effectiveness over time.
- **Transportation:** Reaching people in their homes or community spaces can increase provider costs due to added travel time, transport and outreach logistics. However, this approach reduces costs for clients by eliminating travel expenses and lost time and may reach populations otherwise excluded from facility-based care.
- **Scale of service delivery:** The geographic and population scale of community-led services influences costs. Smaller, hyper-local programmes may have higher unit costs due to limited economies of scale, while national networks of CLOs may spread fixed costs across more sites but require additional coordination and overhead.
- **Scope of service delivery:** Community-led services may be stand-alone or integrated with other health and social services (e.g. referrals regarding sexual health and gender-based violence, and harm reduction counselling). Integrated delivery can spread shared costs (e.g. rent, utilities, administration) across multiple interventions, reducing average costs per service.
- **Context:** Social, legal and political environments can influence the scope and cost of community-led delivery. For example, restrictive laws may require discreet or mobile service models, increasing outreach costs. Strong community networks can make expenditures appear lower if there are high in-kind contributions of space, staff and volunteer time. Estimating the full value of these in-kind resources is critical to generate evidence to advocate for and mobilize funding for fair pay.
- **Population size and epidemiology:** Serving a smaller, hard-to-reach population may result in higher per-person costs because fixed costs are spread over fewer people and, additional effort is often required to locate and engage them.

Importantly, costing and budgeting of community-led service delivery must consider not just economic efficiency but also its social value, expanding equity, reach and responsiveness to meet community needs.



2.2.6. Capacity-building

Capacity-building plays a vital role in sustaining community leadership in the HIV response. Community leadership ensures that people living with and affected by HIV participate in setting agendas, defining strategies and informing policies and guidelines. To support this, interventions must continually build and reinforce the capacity of CLOs and broader communities to lead effectively (17). An important component in capacity building is adequate support supervision and quality assurance mechanisms for the CLR.

Capacity-strengthening may involve global community networks identifying the specific needs of CLOs and tailoring training and mentorship accordingly. For example, CLOs wanting to introduce CLM, integrate climate change or explore digital health may follow "training of trainers" models to ensure knowledge cascades downward. Other learning approaches could be explored, such as mentorship, job shadowing, job swaps, etc.

Examples of community-led capacity-building include:

- Trainings and mentorship for CLOs on thematic and technical areas (e.g. CLM, climate change).
- Leadership development interventions that build skills in governance, advocacy and strategic planning.
- Peer learning visits between CLOs to share performance results, challenges and strategies and foster mutual learning and adaptation.

Box 2.8. Factors influencing costs of capacity-building

Factors that could impact the costs of capacity-building include:

- **Mode of delivery:** Costs will vary depending on whether capacity-building activities, such as trainings, are conducted in person, virtually or through hybrid models. Additional costs may be required for development, adaptation and translation of material as well as follow-up technical assistance.
- **Geographic area:** Multiregional and multi-country trainings increase per diem, travel and translation needs, impacting training and coordination costs.
- **Ongoing training and time investment:** Capacity-building activities often require recurring engagement, with costs influenced by the number of participants, frequency of activities and whether capacity-building involves a single training or a series of sessions. This also includes paid and unpaid time for skill-building, constituency engagement and policy development.

2.2.7. Funding

Sustainable and equitable funding is foundational to the effectiveness and resilience of community-led HIV responses. CLOs must not only receive adequate, flexible and long-term funding, but they must also be positioned to access it and "make effective use of resources, sustain their work and be treated as partners within financial relationships" (13). This means influencing how funding priorities are set so that community-led interventions are included and budgeted in national plans—and having the capacity to secure, manage and distribute funds once awarded.

Examples of community-led funding efforts include:

- Positioning CLOs to access resources by participating in the design of sustainability roadmaps, national strategic plans, funding requests and social contracting mechanisms, ensuring that community priorities are costed and reflected in budgets.
- Mobilizing and diversifying funding by engaging with international donors, governments and private foundations to secure sustained support and reduce reliance on a single source.
- Managing and distributing funds to other CLOs, including sub-granting or network-based funding models and overseeing compliance, reporting and financial oversight.

Box 2.9. Factors influencing costs of funding-related efforts

Costs linked to funding efforts can arise in three common areas:

- **Participating in national or global-level meetings:** This may require travel and per diem costs. In some cases, senior staff require dedicated vehicles, which can be a sizeable cost for CLOs, particularly if the vehicle cannot be used for other implementation activities.
- **For grant acquisition and proposal development:** Applying for and managing grants requires technical and administrative capacity, including time, personnel and occasionally external consultants.
- **For grant management:** To receive and manage funds, CLOs often require strengthened administrative systems (e.g. financial reporting, audits, compliance) that, in turn, necessitate more technical administrative personnel and software like QuickBooks.

Across these areas, a major cost driver is the personnel time required of senior leadership and technical staff. Participating in decision-making spaces, raising funds and managing grants are core functions of the CLR that require sustained investment of skilled personnel.

Chapter 3
Defining the purpose and scope of a costing and budgeting exercise

Chapter 3 presents key economic principles and concepts that underpin all costing and budgeting exercises.

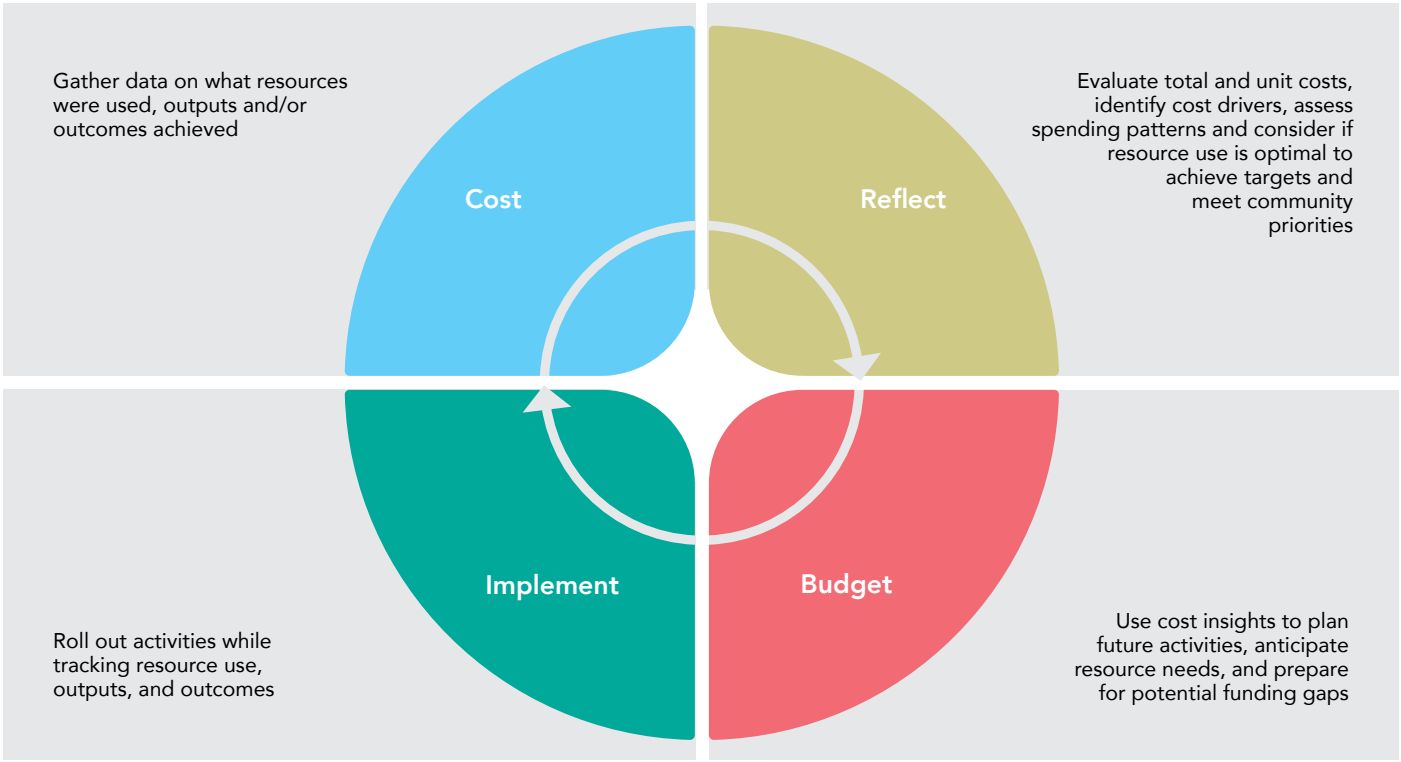
By the end of the chapter, you should understand:
1. The difference between costing (valuing resources used) and budgeting (projecting financial needs) and how one exercise can help inform another.
2. How purpose influences design of your costing or budgeting exercise.
3. How to define the scope of your exercise, including the perspective, time horizon, types of costs, inputs and outputs.

Supporting materials: **Appendix 2** (8).

3.1. When and why to cost or budget: A learning cycle approach

Costing and budgeting are not one-off technical tasks but tools within a broader learning cycle that can help CLOs plan, implement, evaluate and adapt their interventions. Whether preparing a proposal, adjusting a programme midway or assessing impact, understanding and applying cost information is key to better decision-making. **Figure 3.1** illustrates this learning cycle, which moves through phases of costing, reflection, budgeting, implementation and re-costing, allowing teams to better understand their resource needs, improve planning, track progress and make more informed decisions over time. Community members and other stakeholders should be engaged throughout the cycle to ensure relevance and accountability.

Figure 3.1. Costing and budgeting as part of a continuous learning cycle



To navigate this learning cycle, it is important to determine whether to begin with a costing or budgeting exercise. **Figure 3.2** provides a decision flow to guide that choice, which will be principally dictated by the implementation stage of the intervention and the type and quality of data available.

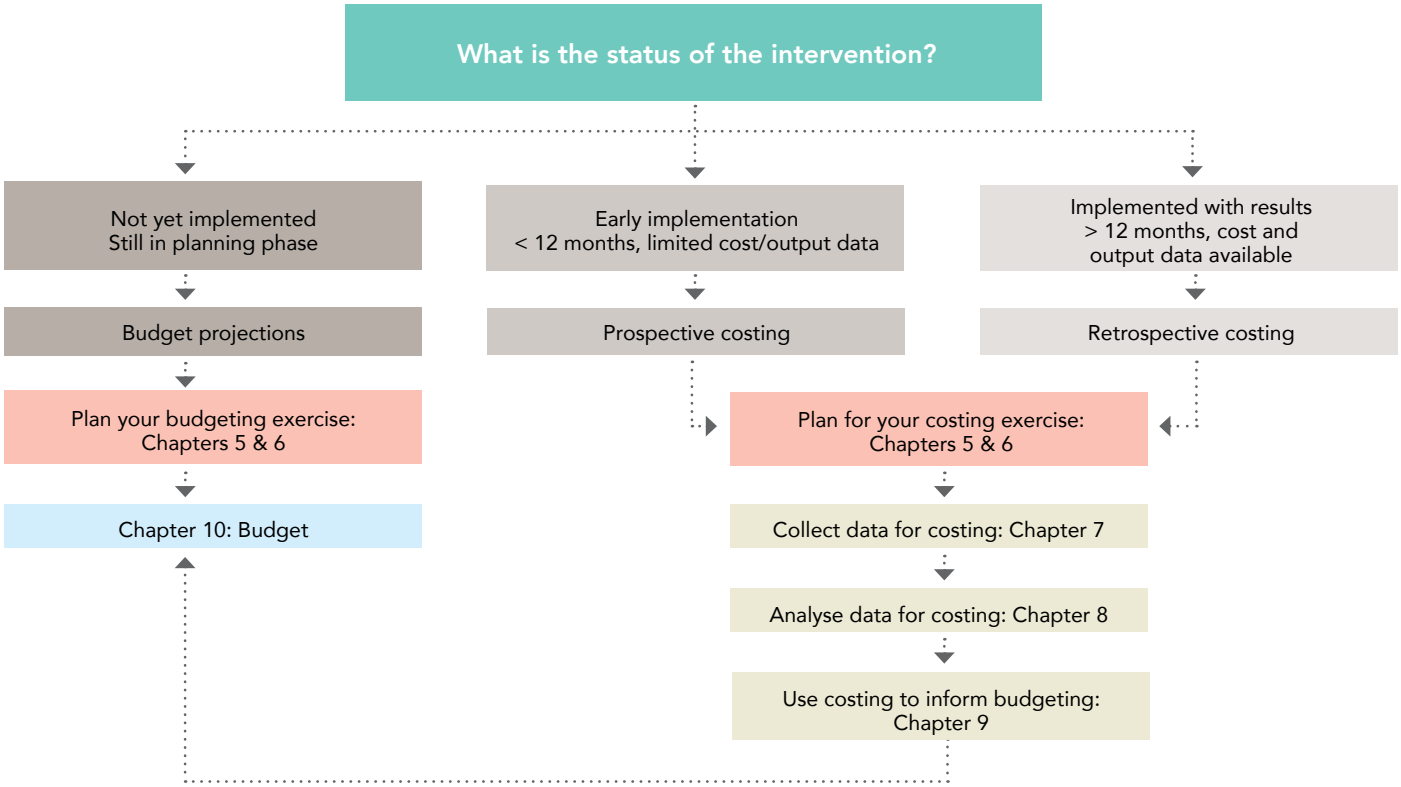
If the intervention is still in the planning phase, whether short-term planning, preparing a funding proposal or earmarking resources for national strategic plans, then budgeting is the appropriate starting point.

If the intervention is underway but fewer than 12 months of data are available, a prospective (real-time costing approach) can be used, tracking resources and outputs as implementation progresses.

If the intervention has been running for 12 months or more, either prospective or retrospective costing (i.e. looking back at resources used) may be appropriate. Prospective costing can be advantageous because it allows real-time tracking of resources, can capture details that may be missed in financial records, and supports ongoing monitoring and learning. Retrospective costing is often more practical when either time is limited, or the intervention has already concluded—provided that financial expenditures and outputs or outcomes have been routinely tracked.

Whether cost data are collected prospectively or retrospectively, the methods for estimating costs remain largely the same. In both cases, the resulting cost data can inform reflection, budgeting and improved implementation.

Figure 3.2. Where to start: Costing or budgeting?



3.2. Defining the purpose

After determining what needs to be done, whether to begin with a costing or budgeting exercise, the purpose of the exercise must be defined. A well-defined purpose keeps the work focused; it determines what data to collect, which costs to include or exclude and how findings will be used. Whether the aim is to estimate costs, assess efficiency, support funding proposals or inform strategic planning, the purpose will shape both the scope of the exercise (e.g. which interventions, time periods or types of costs are included) and the analysis.

Convening a core team including an advisory group with key stakeholders will be important during the initial stages (**Chapter 6.1**) and throughout. The team can help to identify what information the exercise aims to produce and how this information will be used to meet policy and programme needs. Relevant stakeholders may include CLOs, national HIV programmes and national AIDS councils.

Table 3.1 presents common purposes for costing or budgeting, along with the types of questions each seeks to answer. While some lean more toward costing (e.g. estimating unit costs), and others toward budgeting (e.g. projecting future needs), many require both. Identifying the purpose early ensures the exercise is relevant, targeted and useful. Key questions to guide this process include:

- What is the purpose of the exercise? Why is this information needed?
- Who is the audience? Who will use the information? How will the information be used?
- What information already exists and what new information is needed?

Table 3.1. Criteria for selecting the purpose

Purpose	Description	Examples of research questions
Monitoring	Monitor intervention costs and cost drivers	How much did police sensitization and training on sex work laws cost a CLO to implement, and what contributed to those costs?
Efficiency	Determine how to minimize costs or maximize outputs within a given intervention	How could a CLO reduce the costs or increase the number of persons tested in a HIV testing campaign for female prisoners?
Priority-setting	Support economic evaluation (like cost–benefit and cost-effectiveness analyses) to guide investments	Should a youth led CLO provide preexposure prophylaxis through their own adolescent-friendly clinics or referring adolescents to standard services, comparing costs per additional at-risk adolescent starting preexposure prophylaxis?
Informing pricing or funding	Estimate the price of interventions to help negotiate with payers, including donors (e.g. for grants) and governments (e.g. for social contracting)	What should the National AIDS Secretariat pay a CLO to deliver a prevention and testing package for sex workers in urban and rural settings under a social contracting mechanism?
Short-term planning and budgeting	Develop and rationalize short-term (annual) budgets for starting, continuing, expanding or replicating interventions (e.g. operational planning, grant proposals)	How much will it cost for a CLO to expand its gender-based violence response programme over the next year? What budget is needed to ensure fair pay for the volunteers?
Medium- to long-term planning and budgeting	Develop and rationalize medium- to long-term budgets for starting, continuing, expanding or replicating interventions	How much will it cost over the next five years for CLOs to implement a community scorecard to assess the quality of HIV care provided in public health facilities?
	Develop and rationalize budgets for strategic planning	How much will it cost to fund the community-led HIV package of care as part of the national health strategic plan?
	Identify funding gaps	Is there sufficient funding to sustain a national sex workers advocacy network led by CLOs?
	Estimate how different intervention options may affect budgets over time	Is integration of community-led HIV services with other sexual and reproductive health services affordable given the budget?
	Estimate the cost and potential return on investment of different interventions for use in investment planning	What is the "price tag" of investing in HIV testing and treatment when delivered through CLO-led outreach, drop-in centres, and peer-assisted self-testing? Will community-led support for treatment of HIV and hepatitis coinfection (e.g. peer navigation, adherence clubs) produce a return on investment by improving uptake and retention?

Note: Costing provides the foundation for many types of analyses, including economic evaluations, budget impact analyses and investment cases. These broader applications are shown in grey for context but fall outside the scope of this guideline and will not be covered in later chapters.

In community-led interventions, communities often act as both the provider and user of services.

3.3. Defining the scope

After defining the purpose of the costing or budgeting exercise, the next step involves defining the scope, that is, the boundaries of what will be included in and excluded from the analysis. Scope includes decisions about which costs, inputs and outputs to consider, over what period, and from whose perspective. These decisions will impact the methods used for measuring and valuing costs (**Chapter 4**). The scope should be identified based on the purpose. Feasibility should also be considered, as a narrow, well-defined scope will be more practical.

3.3.1. Perspective

The perspective is the point of view from which costs are estimated. Defining the perspective is important, as it determines whose costs are included and excluded in the exercise.

Costs can be estimated from the perspective of the:

- **Payer**, including donors and governments, to determine the costs of financing an intervention.
- **Provider**, including governments, CLOs and other non-governmental organizations, to determine the costs of providing an intervention, regardless of the amount paid by the payer.
- **User**, including community members, clients and beneficiaries, to determine the costs of receiving or accessing an intervention, including direct costs (e.g. out-of-pocket payments for transport) and indirect costs (e.g. income loss from time taken off work).
- **Society**, including the provider and user, to determine the costs of providing and receiving an intervention.

The perspective should be selected based on the purpose including the audience (see **Appendix 2** for detailed criteria and examples).

Single or multiple perspectives can be adopted. In community-led interventions, communities often act as both the provider and user of services. Furthermore, each perspective (provider, user or payer) may include multiple actors such as CLOs, their community members and partner organizations. To fully capture the costs of CLRs, it is useful to disaggregate costs by:

- Provider type (e.g. community-led, international partners, government): For example, a CLO may lead a mobile clinic while the government provides seconded health works and medical supplies.
- User (e.g. clients or community members): For example, clients may contribute their time or pay for transport to access services.
- Payer (e.g. donors, government): For example, a CLO may receive funding from multiple payers, including different donor entities and government sources.

This helps reveal which costs are borne by CLOs and which are absorbed by others. However, this level of analysis often requires detailed information across multiple actors and may be beyond the scope of what CLOs can reasonably do on their own. For most CLOs, a practical starting point is to focus on estimating their own service provision costs — the resources they directly use and contribute, whether paid or in-kind. Where possible, CLOs can also note major contributions from others (e.g.

government seconded staff, donor-provided commodities). More technical exercises that fully disaggregate across providers, users and payers can then build on this CLO-generated data.

In practice, these distinctions can be blurred. For example, self-help groups may simultaneously provide and receive services, making it difficult to separate provider and user perspectives. In some contexts, community organizations may also generate their own funding (e.g. through member fees, fundraising or charitable activities), further blurring the boundaries between funder and provider. Similarly, inputs from one actor (e.g. government) may be used by another (e.g. a CLO), and whether a cost is considered paid, unpaid or donated depends on the perspective taken.

Box 3.1. Exercise: Whose cost is it?

A youth-led CLO operates a mobile clinic. The government provides medical supplies and seconded health workers. Peer volunteers support outreach, and clients spend time travelling to the clinic.

For each input below, decide if this cost is relevant from each perspective:
- **Payer:** Financing the intervention.
- **Provider:** Delivering the intervention.
- **User:** Receiving or accessing the intervention.
- **Societal:** All resources used, regardless of who pays.

Use the answer key (at end of chapter) to check your understanding. Indicate:
- **Yes, paid:** Cost is directly funded by that perspective.
- **Donated:** Resource is deliberately given without payment (e.g. volunteer time).
- **Unpaid:** Resource is used but not paid for by that perspective (often supplied by and part of another organizations financial expenditures).
- **No:** Not relevant to that perspective.

	From whose perspective is this cost relevant?				
Input	Payer	Youth-led CLO	Government	User	Societal
Advocacy for resources by youth-led CLO					
Planning between youth-led CLO and government					
Rent and operation of mobile clinic by youth-led CLO					
Senior management time by youth-led CLO					
Government health-care provider time					
Peer volunteer time					
Client time					
Government medical supplies					

Box 3.2. Guiding questions to choose perspective

- Who will use the information: Funder, provider, user?
- What is the purpose of this exercise: To monitor spending, plan a financial budget or assess resource needs?
- Are there multiple perspectives or stakeholders whose costs should be included?
- For each perspective, should paid, unpaid or donated contributions be valued?
- Will disaggregating costs by provider or payer type help show who bears which costs?

3.3.2. Time horizon

The time horizon is the length of time that costs are being observed or projected. Several factors should be considered when selecting the time horizon.

First, the time horizon should be relevant to the purpose of the exercise (**Appendix 2**). For example, for planning and budgeting, the time horizon might be based on the disbursement and reporting cycles of funders. Second, the time horizon should account for seasonal variation in costs, using a time frame of at least one year—but otherwise, if justified. Third, the expected time horizon for items that have a lifetime greater than one year should be identified. For budgeting, it may be necessary to only identify the year when the item was purchased or will be purchased. However, for the purpose of costing, it will be necessary to assess how long each item is expected to last. For example, for the purpose of budgeting, it may be necessary to identify that a vehicle will be purchased in the first year of the project. However, for costing purposes, it will be necessary to estimate how long the vehicle will be usable by the project (e.g. the project expects the vehicle to be usable for an average of seven years).

Fourth, if applicable, costs should be disaggregated by relevant phases, such as start-up and implementation. For example, interventions often require initial capital investment, including training and sensitization, resulting in a greater proportion of early spending. Costs can also change as interventions mature, usually becoming more efficient over time. At the same time, interventions might also become less efficient as saturation is reached. For example, a community-led HIV testing campaign might require additional resources to reach more hesitant testers in later stages. Disaggregating costs by intervention phase could also be important. For example, in CLM, costs could be disaggregated into stages including start-up, implementation, community engagement, and advocacy and monitoring, which can help signal to payers and providers how much resourcing should be allocated to each phase when planning or scaling up.

Finally, the time horizon may be determined by feasibility considerations, including the time and resources available to conduct an observed costing.

Box 3.3. Questions to guide choice of a time horizon

- What decision is this exercise trying to inform?
- Does the time frame capture all major phases (e.g. start-up, routine implementation)?
- Are there seasonal variations that should be captured?
- How long is the lifespan of the capital items used in this intervention?
- What is a realistic time frame given the time and budget of this exercise?

3.3.3. Types of costs

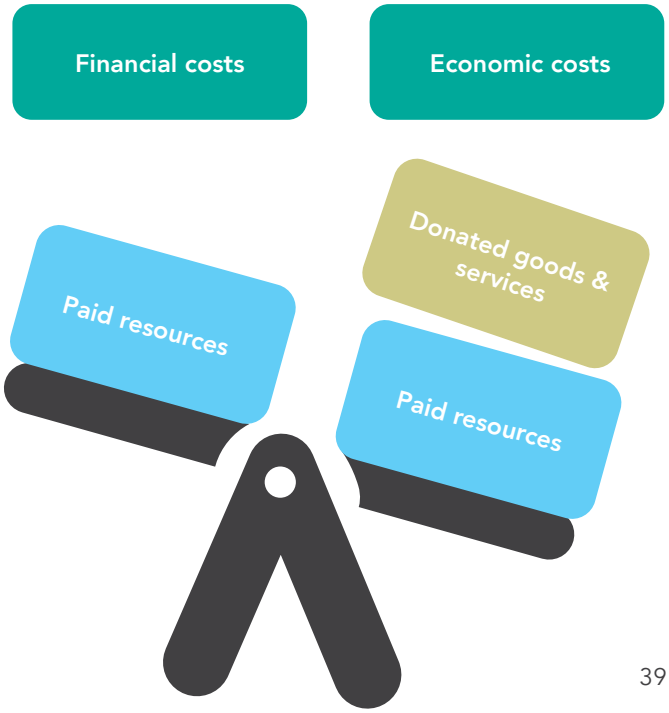
Distinct types of costs can be estimated for costing and budgeting: **Financial** versus **economic**; **full** versus **incremental**; **"best practice"** versus **"observed practice"**. The type of cost should be selected based on the purpose of the exercise and will affect the measurement and valuation methods selected. These distinctions are also important when interpreting or comparing cost estimates from other sources to avoid drawing inaccurate conclusions from mismatched methods.

3.3.3.1. Financial and economic costs

Financial costs are the costs that are paid for inputs, such as personnel time, equipment and supplies.

Economic costs are the value of all inputs used regardless of whether they are paid or unpaid and include donated goods and services. Economic costs are also referred to as opportunity costs, which reflect the value of inputs based on how they could be used alternatively. For example, volunteers are often not reimbursed for their time, but their time still has value; if they were not volunteering, they could be earning income elsewhere. This potential income is the opportunity cost of their time. As a result, economic costs often (not always) exceed financial costs, especially when interventions rely on unpaid labour, donated resources or subsidized inputs.

Figure 3.3. Financial vs. economic costs



Note: Economic costs include the value of both paid and donated resources. If economic and financial costs are equal, it means all resources used in the intervention are being paid for, i.e. no donated goods, unpaid time or subsidized inputs are involved.

Use of financial versus economic costs depends on the purpose of the exercise (**Appendix 2**), and their limitations should be considered. Financial costs reflect actual expenditures incurred, which is useful for budgeting and tracking spending. However, they exclude the value of unpaid or donated inputs, which can be substantial in community-led interventions. Meanwhile, economic costs capture the full value of resources but do not show actual cash outflows. Understanding when to use each type—and why—is essential to a costing or budgeting exercise.

Box 3.4. Exercise: Identifying and valuing financial and economic costs

You are costing a community-led drop-in centre that offers testing and treatment for sexually transmitted infections (STI), harm reduction counselling and peer outreach. Some inputs are paid directly by the CLO, but others are donated or subsidized by other stakeholders.

For each input below, decide:
- What is the financial cost of that item to the CLO?
- What is the economic cost of that item (i.e. full value of that resource)?
- How might you value the economic cost if it is not paid for?

For example, a community hall is provided free of charge by the local council for monthly support meetings:
- Financial cost: None. No payment made. The cost is borne by the local council.
- Economic cost: The market rental value of the hall for the proportion of time used. Identify the most reasonable local comparator (e.g. a similar venue in the same area), and multiply its rental rate by the hours used.

Compare your answers with the answer key at end of the chapter.

Type of input	Input	Financial cost	Economic cost
Donated time	Unpaid volunteers providing harm reduction counselling		
	Health-care providers paid by the government to deliver STI management in CLO drop-in centre		
Donated resources	Community hall provided by local council		
	Motorcycle owned by unpaid volunteers		
	CD4 testing device donated by manufacturer		
Subsidized time	Financial manager partially funded by a separate grant		
Subsidized resources	Antiretroviral therapy drugs subsidized by global funder		

Box 3.5. Guiding questions on capturing financial or economic costs

- Should the exercise reflect only actual cash needs and expenditures or the full value of resources required or used?
- Are donated goods, volunteer time, subsidized or other in-kind contributions substantial in intervention being costed or budgeted?
- Are those in-kind contributions sustainable, or will they require financial support in the future?
- Will valuing these in-kind contributions change the narrative, for example by demonstrating the scale of community contributions or by supporting requests for additional funding?

3.3.3.2. Full versus incremental costs

Full costs include the costs of all resources used to deliver an intervention, including both existing and new inputs. Incremental costs include only the additional resources required to add or expand an intervention to an existing programme. For example, consider a youth-led CLO introducing CLM to its existing services (**Figure 3.4**). Full costs include shared costs of building infrastructure, office equipment and management and administration, in addition to the specific costs of CLM. Incremental costs include only the added costs, such as community-monitors' time, stationery and transport costs to facilities.

Figure 3.4. Comparison of full versus incremental costs

The choice to use full or incremental costs depends on multiple factors. First, the purpose of the exercise should be considered. For example, a community-led drop-in centre for men who have sex with men expanding to offer HIV prevention services would likely choose to estimate incremental costs. Incremental costing is most appropriate when the new intervention is a small addition to an existing programme. If the new component vastly overlaps or reshapes the existing programmes, a full costing is appropriate. Otherwise, total resource needs will be underestimated. Second, feasibility is relevant, as measuring full costs is often more resource-intensive than estimating incremental costs. Lastly, the limitations of each approach should be considered. For example, incremental costs are often difficult to generalize to other settings without an understanding of existing resources available.

Box 3.6. Guiding questions to choose between full and incremental costs

- Is the intervention being delivered entirely from scratch or added to an existing programme?
- Is the purpose to estimate total resource needs (full costs) or only the additional resources required (incremental costs)?
- Does the new intervention used shared resources that will need to be costed (e.g. overhead costs, equipment, vehicles)?
- Will excluding shared resources risk underestimating total resource needs?
- Is there sufficient time and data to measure full costs?

3.3.3.3. Best practice versus observed practice costs

Normative best practice costs involve estimating costs based on established guidelines, protocols or procedures. For example, clinical guidelines often specify procedures that should be followed, with costs estimated based on how procedures should function. Observed practice costs involve estimating costs as implemented, which can deviate from best practices. For example, implementation of best practice guidelines may recommend regular distribution of condoms, lubricants, and clean syringes, which may not always be feasible due to national stockouts, or programme interruptions and reduced outreach frequencies. Defining use of best practice or observed practice costs is important, as each approach may give different results.

The decision to use normative best practice or observed practice costs depends on the purpose of the costing or budgeting exercise (**Appendix 2**). Feasibility should also be considered. For example, measuring normative best practice or observed practice costs for distribution of preexposure prophylaxis might depend on whether full clinical protocols are followed, including screening for sexually transmitted infections, laboratory tests, and extended counselling sessions, or whether these steps are abbreviated in practice due to resource constraints. In particular, it is unusual for a client to continue for a full year, therefor evidence on user behaviour, in this case average continuation, will be important in the estimation of cost per person year protected by PrEP. Further, each approach has limitations. A normative best practice approach does not consider constraints in the real world and may overestimate resource use. As a result, a budget may be overfunded, potentially shifting resources away from other interventions. Costing of observed practice interventions may also underestimate resource use. A budget based on a poor-quality intervention may result

in underfunding that perpetuates a similar level of poor quality. As an example, policies might recommend that community-led monitors allocate an extended amount of time to collect data from clients and health facilities (normative best practice). In reality, monitors may have time constraints and offer an insufficient amount of time for data collection (observed practice).

Box 3.7. Questions to ask when deciding whether to use real world or observed costs

- Is the aim to estimate costs based on guidelines or protocols or as implemented in real-world conditions?
- Will the results be used for planning or budgeting under optimal conditions or to reflect possible delivery constraints?
- Would costing under best practice risk over- or under-estimating resource needs?
- Would costing under observed practice risk over- or under-estimating future resource needs and perpetuate inefficiencies?

3.3.4. Future costs and/or savings

An intervention could result in future costs or savings. For example, early HIV diagnosis could reduce future costs associated with treating advanced HIV disease but also entail lifelong treatment costs. Similarly, investments in retention programmes may reduce the need for second-line ARTs. Measuring future costs and/or savings is useful for priority-setting exercises, including cost–benefit and cost-effectiveness analyses, that compare the net costs of alternative interventions. This is outside the scope of these guidelines.

3.3.5. Inputs

As part of the scope, it is important to specify which inputs used to deliver interventions will be included or excluded in cost estimation. This includes identifying the types and levels at which inputs are used.

3.3.5.1. Levels of inputs

Costs can be measured across three levels (**Figure 3.5**):

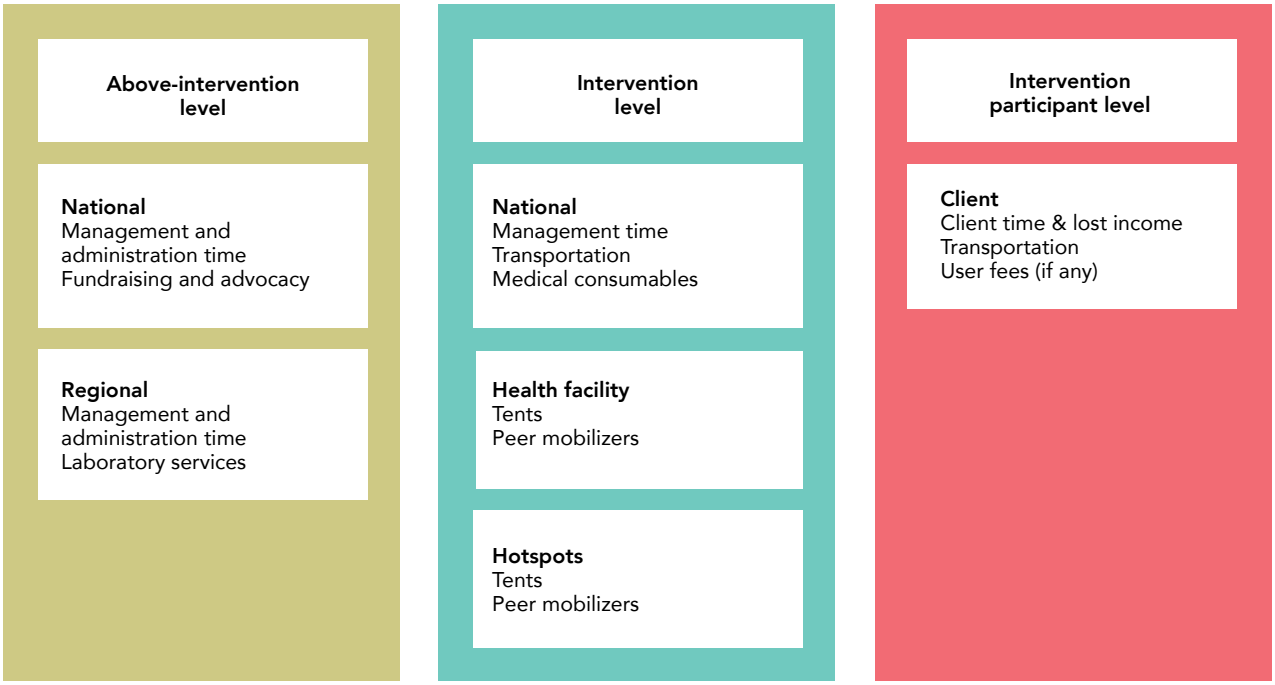
1. **Above intervention-level (or central costs):** Costs not directly tied to implementing an intervention but necessary for the organization to function, such as management and administration, information and record-keeping, procurement, and laboratory services. For some CLOs this may occur at national or regional headquarters; for others it may simply mean a small central office or shared administrative functions at the community level.

2. **Intervention level:** Costs directly associated with implementing the intervention, such as front-line staff, peer mobilizers, medical supplies and local transport. These costs are often incurred at facility or community sites.

3. **Participant level:** Costs incurred by intervention users or clients. While such costs may not be relevant for budgeting purposes, they are often useful to assess the financial barriers for clients who need to seek out services (e.g. clients who may not be able to leave work to seek services or who may not have funds to cover travel to a facility).

Figure 3.2 illustrates inputs used in an HIV testing campaign led by a national sex worker collective in conjunction with a government clinic. At each level, costs could be further segmented, for example, by site. Above-intervention costs include management and administration time, fundraising and national level advocacy, and laboratory services, which are incurred at national and regional levels. Intervention costs at national level include management time, transportation, and medical consumables, and may also include intervention specific advocacy. Costs of tents and peer mobilizer time are also incurred at the facility level as well as hotspots where campaigns are based. At the participant level, costs include intervention user time and transportation.

Figure 3.5. Comparison of costs at different levels: Above-intervention, intervention, and participant level



For example, in a community-led monitoring project:

- Above-intervention costs might include staff time for coordination, grant management, data system maintenance.
- Intervention-level costs might include training, peer monitors' time, mobile phone credit, transport for site visits, electronic tablets, and follow-up meetings with health facilities and district or national stakeholders to discuss results.
- Participant-level costs might include the time that health facility clients contribute to CLM interviews on their experience on the availability, accessibility, acceptability and quality of care.

The purpose and audience of the exercise will determine which levels are included. For instance, a CLO might receive external support for data system hosting or advocacy efforts, but if access to those expenditure data is limited, the scope may be restricted to the CLO's own intervention-level costs.

3.3.5.2. Types of inputs

Inputs that are to be included in the costing and budgeting exercise should be defined as part of the scope. There are two main categories of inputs or ingredients (**Table 3.2**):

1. **Capital costs** refer to inputs with a working life of more than one year. These include building space, vehicles and equipment. Start-up costs, including training, are also treated as capital costs, since their benefits can extend beyond a single year.

2. **Recurrent costs** refer to inputs with a working life of less than one year. Recurrent inputs include personnel time, supplies and consumables, and maintenance and operation for capital inputs (e.g. utilities, fuel).

Deciding which types of inputs to include or exclude will depend on the purpose and audience as well as relevance and feasibility. Consultations with the core team might reveal which inputs are more likely to be relevant to delivering interventions or are expected to have the greatest impact on costs. Feasibility should also be considered, including data availability as well as timeline and budget constraints. **In practice, it is recommended to focus on getting the largest cost components correct and to spend the most effort ensuring that these are accurately estimated.**

Table 3.2. Examples of inputs by cost category

Category	Description	Examples
Capital		
Training and other start-up activities	Training and other start-up	Venue hire, per diem and allowances for trainer and participants, stationery, food and refreshments
Building	Building space for activities and storage	Construction, renovation or rent
Vehicles	Transportation vehicles	Trucks, vans and cars, motorcycles, bicycles
Equipment	Medical and non-medical equipment	Medical and laboratory equipment, furniture, general equipment, information technology and office equipment
Recurrent		
Personnel	Time of permanent, fixed and temporary personnel and volunteers	Salaries, fringe benefits, per diem and allowances, fees. Replacement costs for unpaid personnel (in economic costings)
Supplies and consumables	Medical and non-medical supplies and consumables	Diagnostics, therapeutic, medical and laboratory supplies, general supplies, office supplies
Building operation and maintenance	Operation and maintenance of building space	Utilities (e.g. electricity, gas, water, waste management, security), internet charges, building repairs and maintenance
Transport, vehicle operation and maintenance	Operation and maintenance of vehicles	Transportation fare, fuel and oil, vehicle repairs and maintenance
Other recurrent	Other recurrent inputs	Telecommunications, printing and photocopying, postage and delivery, miscellaneous dues, fees, bank charges, food, and refreshments

Box 3.8. Exercise: Classifying cost inputs

For each input below, first decide whether it is a capital or recurrent cost and then determine which cost category it might fall under. See the end of the chapter for the answer key.

Classifying cost inputs

Item	Cost input	Category
Transport reimbursement to visit health facility site		
June 2025 staff salary		
Bank charge		
Rental fee for venue to conduct training of PrEP champions		
Food and refreshments for sensitization of religious leaders		
Office rent		
Fuel for office generator		
Per diem & transport for field staff supervision		
Maintenance fee for motorcycle		
Purchase of tablets for CLM data collection		
Printing of community education flyers		
Renovation of drop-in centre		
Annual subscription to online data platform		
Cash prizes for winners of peer-led edutainment event		
Value of community-led monitor's unpaid time spent on data collection		

3.3.6. Outputs

Outputs of community-led interventions reflect immediate results (e.g. volunteers trained, condoms distributed, educational materials produced) or intermediate health outcomes (e.g. persons tested, persons treated, persons virally suppressed) that are generated from routine M&E data sources at the intervention level. Unit costs, or the average costs, are calculated by dividing the total cost by a quantity of outputs or outcomes. For example, a CLO runs a mobile HIV testing campaign for key populations. Over a year, the total cost of the campaign (including personnel, supplies and transport) was estimated at US$ 10 000. Five hundred people were tested over that same period, and 25 of them tested positive.

Cost per person tested = US$ 10 000 ÷ 500 persons tested = US$ 20

Cost per person tested positive = US$ 10 000 ÷ 25 persons tested positive = US$ 400

Box 3.9. Exercise: Interpreting unit costs

Question:
Completely hypothetical scenario: A CLO must choose between one intervention that costs US$ 5 per person tested and another that costs US$ 350 per person testing positive. Which should be chosen?

Answer:
This is a trick question. These unit costs use different denominators and measure different outcomes. Comparing them directly is like comparing apples to oranges. If the CLO's goal is to test as many people as possible, the relevant measure is cost per person tested. If the goal is to identify as many HIV-positive individuals as possible, the relevant measure is cost per person testing positive. Always compare "like for like" when interpreting unit costs; it may be necessary to convert one unit cost estimate to a different denominator before making direct comparison.

Examples of unit costs by core area of the CLR are presented in Table 3.3.

Table 3.3. Unit costs by core response areas of the community-led HIV response

	Core area of the CLRs	Example of interventions	Example of outputs	Example of unit costs
	Advocacy	Training of police officers on risks and needs of people who use drugs	Number of trainings Number of officers trained	Cost per police officer trained
	CLM	Monitoring delivery of preexposure prophylaxis in primary health centres	Number of health centres monitored	Cost per health centre monitored
	Research	Focus group discussions to inform design of treatment adherence clubs	Number of focus groups Number of participants	Cost per focus group discussion Cost per participant
	Education and information sharing	Radio series targeting HIV-related stigma	Number of listeners Catchment population	Cost per listener Cost per population
	Service delivery	Social care supporting women engaged in sex work	Number of clients counselled	Cost per client counselled
	Capacity-building	Participatory workshops to strengthen alliances among networks	Number of workshops Number of participants	Cost per workshop Cost per participant
	Funding	Meetings to develop and project cost of national HIV response	Number of meetings Number of participants Number of proposals submitted	Cost per meeting Cost per participant Cost per proposal

3.4. Applying Chapter 3 concepts in practice: Costing community-led monitoring in the Philippines

To bring together the concepts discussed in this chapter, the following example illustrates how each element can be considered in a real costing exercise. In the Philippines, a CLO is implementing a CLM initiative assessing client experiences, identifying instances of stigma and discrimination, and improving quality of care. The initiative uses both virtual and in-person approaches; virtual CLM involves virtual surveys accessed via QR codes displayed at health facilities, while in-person CLM involves trained enumerators collecting feedback at facilities. The CLO serves as the national coordinator, while five other CLOs are responsible for advocacy and deploying peer enumerators to collect data.

To inform planning and advocacy, a costing exercise is being conducted to estimate the provider-side economic costs of implementing CLM over a one-year period, covering all phases including start-up, implementation, community engagement and advocacy. Note that cross site comparisons should be done with caution as total and unit costs will vary across facilities, by, for example, the size of the facility, the client profiles, location, etc. The table below outlines key elements of the costing scope and rationale for their inclusion.

Table 3.4. Summary of costing purpose and scope for community-led monitoring in the Philippines

	Inclusion	Rationale
Purpose	Short-term planning and budgeting	To support future planning and resource allocation by estimating total annual and unit costs across CLM models.
Scope		
Perspective	Providers (five CLOs and Coordinating CLO)	To capture all resources used by CLOs to implement CLM.
Time horizon	One year	Covers all key phases of CLM: Start-up, implementation, community engagement and advocacy.
Types of costs		
Financial and economic	Financial and economic	To reflect the full value of resources used, including contributions by CLOs themselves and their members. Financial costs also presented to capture expense flow.
Financial and economic	Financial and economic	To reflect the full value of resources used, including contributions by CLOs themselves and their members. Financial costs also presented to capture expense flow.
Best practice and observed practice	Observed practice	To reflect the costs of CLM in real-world settings, including constraints and adaptations.
Full and incremental	Full	To capture all provider costs as a baseline for planning and potential scale-up, including costs of the coordinating CLO'S central costs (overheads).
Future cost savings	Excluded	The exercise focuses on current implementation costs and outputs; estimating future savings is outside the scope of this exercise.
Levels and types of inputs		
Above intervention, intervention, participant level	Financial and economic	To reflect the full value of resources used, including contributions by CLOs themselves and their members. Financial costs also presented to capture expense flow.
Above-intervention and intervention levels	Captures central coordination (above-intervention) and local implementation activities by CLOs and peer enumerators (intervention level)	To reflect the full value of resources used, including contributions by CLOs themselves and their members. Financial costs also presented to capture expense flow.
Types of outputs		
Site, activity, participant	Number of facilities monitored, number of respondents	To calculate unit cost per facility monitored and per client respondent across different CLM Models.

Answer sheet to Box 3.1. Exercise: Whose cost is it?

	From whose perspective is this cost relevant?				
		Provider			
Input	Payer	Youth-led CLO	Government	User	Societal
Advocacy for resources by youth-led CLO	No	Yes	No	No	Yes
Planning between youth-led CLO and government	No	Yes	Yes	No	Yes
Rent and operation of mobile clinic by youth-led CLO	Yes	Yes	No	No	Yes
Senior management time by youth-led CLO	Yes	Yes	No	No	Yes
Government health-care provider time	No	Yes, as unpaid costs	Yes, as paid costs	No	Yes
Peer volunteer time	No	Yes, as donated costs	Yes	No	Yes
Client time	No	No	No	Yes	Yes
Government medical supplies	No	Yes, as unpaid costs	Yes, as paid costs	No	Yes

Where:

- Yes, paid: Cost is directly funded by that perspective.
- Donated: Resource is deliberately given without payment (e.g. volunteer time).
- Unpaid: Resource is used but not paid for by that perspective (often supplied by others).
- No: Not relevant to that perspective.

Answer sheet to Box 3.4. Exercise: Identifying and valuing financial and economic costs

Type of input	Input	Financial cost	Economic cost
Donated time	Unpaid volunteers providing harm reduction counselling	None	Value estimated based on income loss or local minimum wage rates or replacement values
	Health-care providers paid by the government to deliver STI management in CLO drop-in centre	None (from the perspective of the CLO, cost borne by the government)	Value estimated based on gross salary, including benefits
Donated resources	Community hall provided by local council	None (from the perspective of the CLO, cost borne by the local council)	Value estimated based on rent and the percentage of time used for the community meeting
	Motorcycle owned by unpaid volunteers	None	Value estimated based on resale price
	CD4 testing device donated by manufacturer	None (from the perspective of the CLO, cost borne by manufacturer)	Value estimated based on market price
Subsidized time	Financial manager partially funded by a separate grant	Partial price paid for salary	Value estimated based on gross salary, including benefits and the percentage of time actually worked on intervention
Subsidized resources	Antiretroviral therapy drugs subsidized by global funder	Partial price paid for drugs	Value estimated based on full cost of drugs, taxes, duties and shipping

Answer sheet to Box 3.8. Exercise: Classifying cost inputs

Item	Cost input	Category
Transport reimbursement to visit health facility site	Recurrent	Transport
June 2025 staff salary	Recurrent	Personnel
Bank charge	Recurrent	Other recurrent
Rental fee for venue to conduct training of PrEP champions	Recurrent	Training
Food and refreshments for sensitization of religious leaders	Recurrent	Other recurrent. Note here that stakeholder sensitization is not considered a training cost because the participants are not CLO personnel.
Office rent	Recurrent	Building space. Note this one is tricky: Rent should be recurrent, but building items are grouped together; in any analysis treat recurrent items, such as rent, differently.
Fuel for office generator	Recurrent	Building operation and maintenance
Per diem & transport for field staff supervision	Recurrent	Personnel & transport, vehicle maintenance. Note this one is also tricky as it contains two different cost categories in a single line item.
Maintenance fee for motorcycle	Recurrent	Transport and vehicle maintenance
Purchase of tablets for CLM data collection	Recurrent	Equipment
Printing of community education flyers	Recurrent	Supplies and commodities
Renovation of drop-in centre	Capital	Building space
Annual subscription to online data platform	Recurrent	Other recurrent
Cash prizes for winners of peer-led edutainment event	Recurrent	Other recurrent
Value of community-led monitor's unpaid time spent on data collection	Recurrent	Personnel

Chapter 4
Defining the methods for measuring and valuing resource use

Chapter 4 summarizes the principal methods used for measuring and valuing inputs in costing and budgeting and how to identify the data sources needed for the exercise.

By the end of the chapter, you should understand:

1. The main approaches for measuring and valuing inputs, including top-down, bottom-up, and this guideline's recommended approach—the combined method.
2. How to select data sources to identify, measure and value inputs, outputs and allocation factors.

Supporting materials: **Appendix 3**, Summary table of data sources by input type.

4.1. Methods for measuring and valuing resource use

Before beginning a costing or budgeting exercise, it is necessary to decide how to measure and value resources used to deliver interventions. This involves **identifying** what **inputs** (or resources) have been used or will be needed, **measuring** their **quantities**, and **assigning** a **value** or cost to each of them. There are two main methods to do this:

- Top-down (macro) costing: Start with total expenditures and break them down.
- Bottom-up (micro) costing: Start with individual inputs and add them up to get the total cost.

The choice depends on the purpose and scope (**Chapter 3**) and feasibility of the exercise. Each approach has strengths and weaknesses, which will be detailed below.

This guideline **recommends a combined approach to balance the trade-offs of each method (Table 4.1).** More details are provided in the sections below.

Table 4.1. Guideline recommendations for costing and budgeting methods

Aspect	Budgeting	Costing
Method	Bottom-up	Combined: Top-down to capture financial data, bottom-up to capture missing or non-financial items
Approach	Prospective, using past expenditures to help inform assumptions on future	Retrospective for past expenditures, prospective (or real time) to capture additional items and validate allocation factors

4.1.1. Top-down (macro) versus bottom-up (micro) costing

Top-down costing (also referred to as macro-costing) begins with total expenditures from financial records and allocates (or disaggregates) costs downward to sites or interventions to estimate costs per output. For example (**Figure 4.1**):

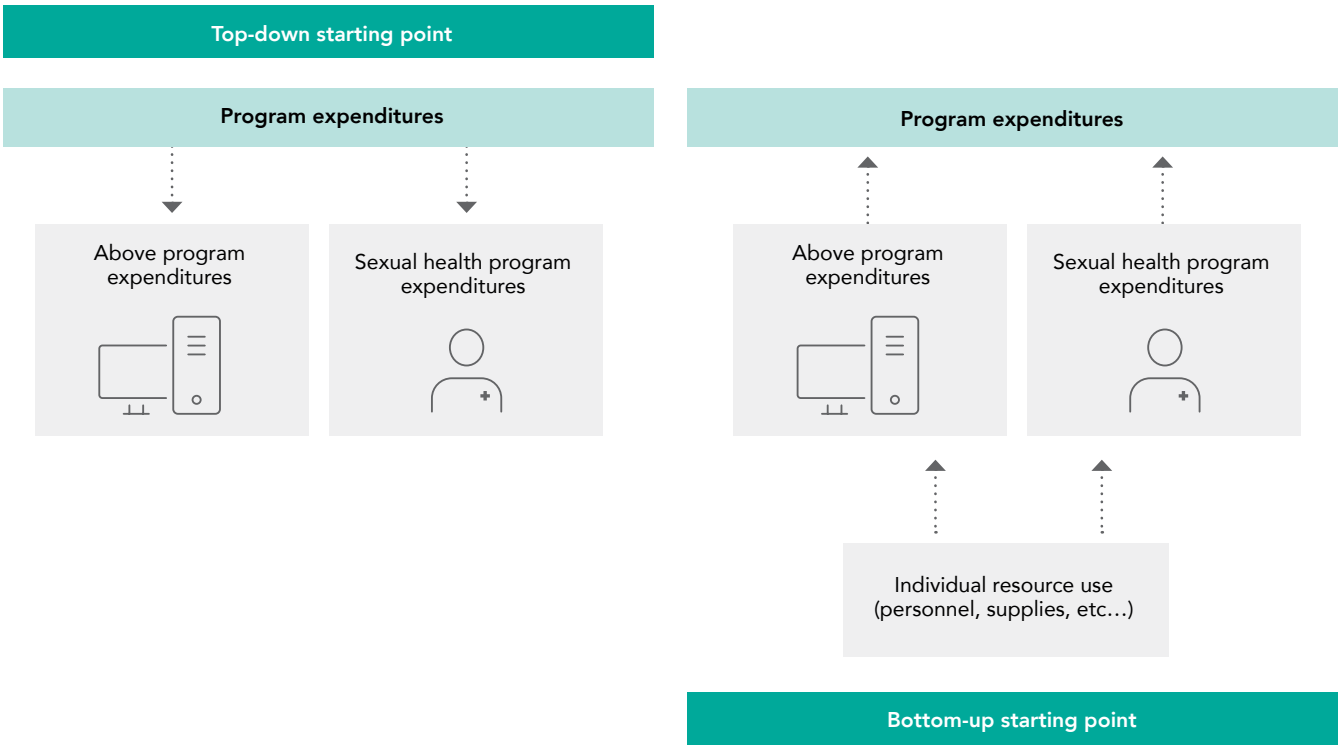
- The total annual salary for a peer paralegal working in a CLO is extracted from accounting records, for example, US$ 14 000 per year.
- Study time sheets show that the legal support requires 40% of a paralegal's time while advocacy activities claim the remaining 60%.
- This proportion is used to allocate a share of the paralegal's salary to legal aid, so 40% of US$ 14 000 = US$ 5 600.
- The total intervention cost—including the cost of the paralegal's time (US$ 5 600), building space, furniture and other input —amounts to US$ 12 000.
- This total is divided by the number of clients receiving, for paralegal support, for example, 600 people, resulting in a unit cost of US$ 20 per client assisted.

This approach works well when detailed financial records are available and when **shared costs**, such as central costs or overheads (**Chapter 3.2.5**), need to be allocated across multiple sites or interventions. The approach relies on reasonable and justifiable allocation factors—criteria that reflect how resources are actually used. In the example above, the distribution of the paralegal's time based on time sheets serves as the allocation factor.

Bottom-up costing, also referred to as **micro-costing**, starts by measuring individual inputs used to deliver interventions, which aggregates (adds them) upwards to obtain costs per output and total costs. For example:

- A paralegal is observed spending 90 minutes per client on legal aid services. At a wage of US$ 9.33 per hour this equates to US$ 14 per client.
- In addition to the paralegal's time, each client uses a consultation room and furniture (US$ 1), printing of legal rights materials (US$ 0.05), communication costs (US$ 0.25).
- The total estimated cost per client is US$ 15.30.
- Additional central costs (e.g. administrative support, utilities, overall coordination) are allocated at US$ 3 per client, bringing the adjusted cost per client to US$ 18.30.
- If the CLO serves 600 clients a year, then the total annual cost of legal aid services is 600 x US$ 18.3 = US$ 10 980.

Figure 4.1. Comparison of top-down versus bottom-up



For costing, the bottom-up approach relies on direct observations (such as time and motion studies) and interviews to identify all the resources used for service delivery. For budgeting a new intervention, the same approach depends on assumptions about which resources will be needed, in what quantities, how often, and at what costs.

Each approach has advantages and disadvantages (**Table 4.2**) and will not typically produce the exact same result, as shown in the examples above.

Table 4.2. Considerations for selecting top-down versus bottom-up costing

Method	Advantages	Disadvantages
Top-down costing (macro)	▪ Relies on existing data (e.g. financial records), making it less time- and resource-intensive to conduct. ▪ Captures full financial costs, including above intervention (central) costs.	▪ Dependent on availability and quality of financial data. ▪ Provides limited detail on the mix of inputs used to deliver outputs. ▪ Likely to exclude inputs not captured in financial records, including in-kind contributions. ▪ Records reflect the timing of purchase, not use. Items purchased before the study period (e.g. vehicles) may not appear in recent expenditure data.
Bottom-up costing (micro)	▪ Uses direct observation and interviews to measure resource use. ▪ Captures the actual mix of inputs used to achieve outputs. ▪ More complete inclusion of inputs not captured in financial records, including in-kind contributions. ▪ Highlights efficiency opportunities (e.g. reallocating staff time).	▪ More time- and resource-intensive to conduct. ▪ Potential for observation bias if staff modify behaviour while being observed. ▪ May miss above-intervention (central) costs unless explicitly measured. ▪ Requires careful design to avoid double-counting shared inputs.
Combined	▪ Combines strengths of top-down and bottom-up; top-down data capture financial costs, while bottom-up fills gaps, validates assumptions and captures in-kind contributions. ▪ Less costly than bottom-up alone but more detailed than top-down alone. ▪ Flexible across contexts and data availability.	▪ Risk of double-counting if the integration of the two approaches is not well-planned. ▪ Requires strong coordination to gather, reconcile and analyse data from multiple sources.

The purpose and scope of the exercise should guide the choice of approach. Top-down costing, with its full capture of accounting costs, may be better suited for estimating financial costs from the provider perspective and informing short-term budgeting. Bottom-up costing is useful for estimating economic costs, including in-kind contributions and other non-accounting costs. Each approach captures different dimensions of efficiency. For example, top-down costing reflects total personnel costs regardless of output achieved (e.g. a nurse's full-time salary), while bottom-up costing values only the portion of time spent on specific outputs (e.g. a nurse's time spent on consultations). This may overlook activities that support service delivery but are less visible, such as administration or record-keeping. These distinctions shape how resource needs are understood and used in planning.

In practice, a combined approach is recommended to balance these limitations. **This guideline endorses a mixed approach: Top-down to gather all relevant financial data and bottom-up to measure resource use and identify any items that may otherwise be missed, such as equipment purchased in previous years or in-kind contributions.**

In the context of CLOs, applying a mixed approach can be both practical and effective. CLOs often have fluctuating expenses as well as inconsistent financial records. At the same time, CLO staff frequently contribute unpaid or under-recognized inputs, such as volunteer time, donated space, or shared resources, which are best captured through bottom-up methods. Using both approaches together helps balance these realities: Top-down data anchors the exercise in available financial records, while bottom-up methods ensure that hidden contributions and resource use are not overlooked. This combined approach can provide a more realistic picture of the costs of CLRs.

4.1.2. Retrospective versus prospective

Costing and budgeting can draw on retrospective or prospective data or a mix of both. A **retrospective** approach involves looking backwards to measure the costs of resources that have already been used by extracting existing data or collecting recall data through interviews. A **prospective** approach involves tracking resource use in real time or looking ahead to estimate the costs of resources that have not yet been used. Each has strengths and limitations (**Table 4.3**).

Table 4.3. Considerations for selecting retrospective versus prospective

Method	Advantages	Disadvantages
Retrospective	▪ Extraction of existing data can be less time-intensive and expensive to implement	▪ Can be limited to data indicators that have been generated ▪ Potential for recall bias
Prospective	▪ Flexibility to determine what data are generated	▪ Can be more time-intensive and expensive to implement
Mixed	▪ Leverages existing data to reduce time and cost while using prospective collection to fill gaps, validate assumptions and capture inputs missed in records	▪ Greater risk of double counting if integration is not well-managed ▪ Potential mismatch if current observations do not reflect historical patterns of resource use

In practice, retrospective methods are often quicker and less costly, while prospective approaches offer greater flexibility but require more resources. **A mixed approach is recommended for community-led costing:** Historical financial records can provide a foundation, while prospective data collection helps validate assumptions and capture contributions often missing from records, such as volunteer time or donated goods.

4.1.3. Market pricing versus shadow pricing

How costs are valued will depend on whether the input has a **market price**. Market pricing refers to the price a person would pay to purchase or replace the item or service today. These prices may come from international or local markets, and they are typically available

When an input does not have a market price (like donated services), a shadow price is used.

for inputs that are either **tradeable** (like medical supplies and consumables, which can be bought across borders) and **non-tradeable** (like local staff salaries or building rent, which vary by country). Prices are also available for different years, with the base year (i.e. the specific year for which you are estimating costs, so all values are consistent and comparable) of the costing or budgeting exercise often most relevant. The value of donated and subsidized goods can be estimated using their replacement cost, for example the market price paid by the purchaser or using an average market price.

When an input does not have a market price (like donated services), a **shadow price** is used. Shadow pricing means estimating the input's opportunity cost, or its value in the next-best use (**Chapter 3.2.3.1**). For example, the value of a volunteer's time can be estimated by using the value of income earned elsewhere, i.e. the **opportunity cost**. Another way to estimate the value of a donated good or service is the **replacement cost**. If a lawyer donates time doing outreach with peer educators, it is the cost to replace the peer educator rather than the income lost to the lawyer. However, if the lawyer donates legal services, the replacement cost is indeed the value of income lost. The idea is to understand the full value of the donated resources, be it time or a tangible good, as it is used, not who provides them (see **Table 4.4** for a summary of different approaches to value volunteer time).

Table 4.4. Considerations for selecting data sources for valuing unpaid personnel inputs

Method	Advantages	Disadvantages
Minimum wage	▪ Standardized and publicly available	▪ May not reflect occupational skills required
Skills equivalent wage (replacement cost)	▪ Reflects professional experience, educational background and occupational skills ▪ Based on average rate	▪ May still overlook community expertise and risk exposure
Opportunity cost of labour forgone	▪ Reflects income (formal or informal) lost by volunteering	▪ Risks undervaluing women's and marginalized groups' time (reinforcing labour market inequities) ▪ Often self-reported and unverifiable

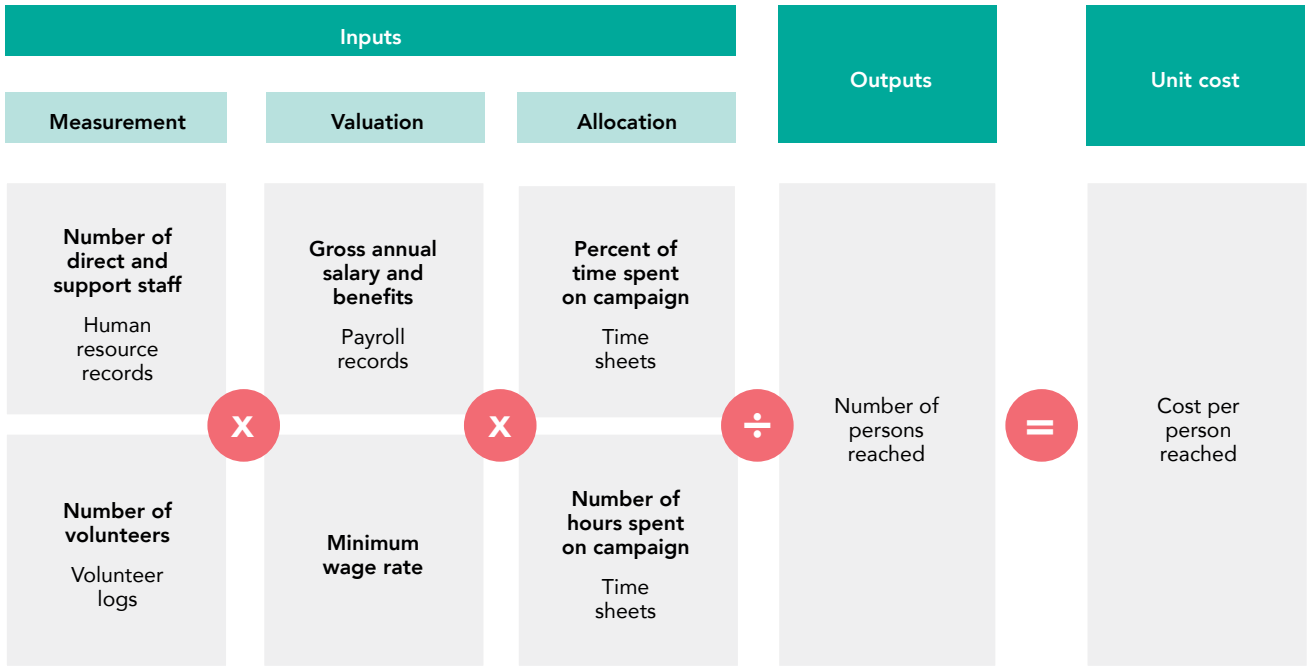
4.2. Data sources for measuring and valuing resource use

Data sources will need to be identified for inputs, outputs and allocation factors. Cost inputs are the resources used to deliver community-led interventions and activities (**Chapter 3.2.4)**, and are grouped into categories including capital, personnel and recurrent inputs. Capital inputs have a working life of more than one year, while recurrent inputs, including personnel, have a working life of a year or less. Inputs lead to measurable outputs at the activity or participant level (such as number of services delivered or people reached) (**Chapter 3.2.5**). Allocation factors are measures used to divide the cost of shared inputs across different interventions or sites based on how much of the input was used.

Figure 4.2 shows an example from an HIV prevention campaign using a combined top-down and bottom-up approach. It outlines the data sources needed to estimate unit costs:

- For staff, human resource records are used to count how many people worked on the campaign; payroll records give their gross annual salaries and benefits, and time sheets help estimate the percentage of time spent on the activity.
- For volunteers, volunteer logs provide the number of people involved; time sheets show hours worked, and the local minimum wage is used to assign a value to their time. It may be more appropriate to use replacement value for skilled labour, e.g. in the case of a volunteer accountant or lawyer.
- For outputs, such as number of persons reached by the campaign, registration logs are used.

Figure 4.2. Examples of resource measurement, valuation and allocation



To identify data sources, it is important to first define **the minimum data set** required to measure and value resource use. This means using the least time- and cost- intensive approach by prioritizing existing data that are already available. Once this is established, the team can weigh the trade-offs of collecting additional data, depending on the purpose, scope and methods chosen for the exercise (**Chapter 4.3**) as well as feasibility, as illustrated in **Figure 4.3**. For example, donated time and resources are often not captured in financial records. In such cases, time and motion studies, which involve directly observing time and resources used in activities, may need to be conducted to capture in-kind contributions.

Figure 4.3. Process of identifying data sources

In **Chapter 3**, the main input categories used in costing (capital and recurrent) are introduced. This section expands on those categories and describes common data sources for measuring, valuing and allocating each type of input and output. A summary table of this information is provided in **Appendix 3**.

4.2.1. Inputs

4.2.1.1. Capital

Building

- **Items under this category include:** Building space used for interventions (e.g. office, storage space); other building-related capital items such as equipment and repairs with benefits of more than one year. Interventions may also include donated spaces, such as public halls for outreach or private homes for office space. While it may seem contradictory, rented space is categorized as a capital cost but treated as recurrent in the analysis.
- **Sources to quantify space used include:** Physical measurement of rooms, building plans or mapping software.
- **Sources to estimate price or value include:** Expenditure reports; purchase orders; invoices; original sales records; insurance forms; tax forms; rental agreements; and real estate and construction quotes for the building or an equivalent space. Additional data collection may be required to value donated or borrowed spaces (**Box 4.1**).
- **Allocation factors for shared spaced, such as a consultation room delivering multiple services, can be based on several factors that include:** The proportion of time spent by providers across interventions in that space (time and motion studies); the proportion of floor space used (direct observations); or the proportion of intervention participants reached (activity registers).

Box 4.1. Practical tip: Donated government space

In some settings, CLOs may operate out of borrowed space. In such cases, the CLO does not directly pay for the office space, but it is still a resource that is being used and should be included when estimating the full provider cost.

You will need to request financial data from the relevant authority, not the CLO itself. If such data are not readily available, an alternative is to obtain an estimate of the equivalent rental cost from a local estate agent. This is a good example of an unpaid financial cost from the CLO's perspective, as discussed in **Chapter 3**. Even though no money is exchanged by the CLO, the opportunity cost of the resource still exists and should be accounted for in the economic cost estimate.

Vehicles

- **Items under this category include:** Vehicles used in interventions and other vehicle-related capital items, such as equipment and repairs with benefits of more than one year. While it may seem contradictory, rented vehicles are categorized as a capital cost but treated as recurrent in the analysis.
- **Sources to quantify vehicle use include:** Item counts; inventory registers; and vehicle logs (including for donated or subsidized vehicles, such as private motorcycles used by peer volunteers for outreach). Vehicle specifications should also be described to aid valuation.
- **Sources to estimate price or value include:** Expenditure reports; purchase orders; invoices; original sales records; and quotes or sales prices from automotive manufacturers or dealers. The value of donated or subsidized vehicles should also be captured.
- **Allocation factors for shared vehicle use across sites and interventions can be based on:** The proportion of time spent travelling to separate locations (vehicle time logs); or the proportion of distance travelled (odometer readings or mapping software).

Equipment

- **Items under this category include:** Furniture; general equipment; information technology and office equipment; and the medical and laboratory equipment used in interventions. Other equipment-related costs, such as shipping, freight, taxes, duties and tariffs should also be included in the valuation.
- **Sources to quantify equipment use include:** Direct enumeration through observations and interviews or a review of inventory registers (especially important for donated or subsidized equipment). Product specifications and approximate lifespans should also be recorded where available.

- **Sources to estimate price or value include:** Expenditure reports; purchase orders; invoices; internal procurement lists; national health agency or donor price lists; manufacturer or retailer quotes or advertised prices; and original sales records. For medical and laboratory equipment, prices from manufacturers or retailers are often used.
- **Allocation factors for shared equipment costs can be based on:** The proportion of time the equipment is used for specific services (time and motion studies); or the proportion of intervention participants reached (activity registers).

Box 4.2. Practical tip: Asset registries

When conducting a full costing or budgeting exercise, it is important to account for equipment that may have been purchased or donated in previous years. If you only rely on last year's financial records, you risk missing key items that are still actively used but no longer appear in current budgets or expenditures.

To avoid this, CLOs should create or update an asset registry (also known as an equipment inventory). This is not only critical for this exercise but is also a valuable tool for the CLO itself. An updated asset registry helps to:

- Track all equipment used by the CLO.
- Monitor the condition or status of items.
- Forecast future replacement or maintenance needs.
- Flag missing or stolen items.
- Document what was purchased or donated, for how much, and by whom.
- Support planning for expansion by identifying what equipment can be reallocated or needs to be purchased.

Maintaining an up-to-date asset registry can help strengthen internal management, asset tracking and accountability. See **Appendix 9** for an example of an asset registry.

4.2.1.2. Recurrent

Personnel: Items under this category include salaries and benefits, including allowances, for direct staff, support staff and volunteers involved in interventions.

- **Paid personnel**
  - **Sources to quantify time and roles:** Direct observations; interviews; and human resources/finance records detailing roles, responsibilities, type and duration of contracts.
  - **Sources to estimate price or value:** Full employer costs (salaries, benefits, taxes, pension contributions, allowances and other employment-related costs) from human resources and finance records. Include allowances contributed by personnel themselves (e.g. self-funded accommodation for training).

  - **Notes on valuation:** Skills-equivalent wages can vary by organization—or within the same organization—depending on the funder. Wages are also often set based on professional experience, educational background and occupational skills. In the context of the CLR, factors such as community expertise and risk exposure are often not considered in wage setting.

- **Unpaid personnel**
  - **Sources to quantify time and roles:** Direct observations; interviews; study time sheets; volunteer logs.
  - **Notes on valuation:** Different approaches can be used to value personnel time, each with its own limitations (**Table 4.4**). One approach is to value time based on opportunity cost; that is the value of labour forgone. However, using estimates based on formal or informal income earned elsewhere can lead to undervaluation. For example, women's time is often undervalued due to gender inequality and higher participation in care work. Another approach is to use the minimum wage rate, including for volunteers. However, the minimum wage rate might not fully account for the occupational skills required. These guidelines recommend using an average of skills-equivalent wages; that is, an average rate based on the skills required for the role. For example, the rate estimated for peer volunteers should be the rate used for community health workers if the skills required are similar. If differences emerge, rates should be averaged by, for example, an organization or funder.
  - **Allocation factors for personnel working across multiple interventions:** These can be based on the proportion of time spent across interventions (using study time sheets, time and motion studies, or interviews) or the proportion of participants reached per intervention (activity registers).

Note on valuing unpaid personnel

The contributions of peer volunteers are often undervalued or omitted in costing and budgeting exercises. As a result, the value of community-led contributions to interventions is often under-estimated, leading to an incomplete picture of what is required to deliver services and sustain programmes effectively.

While applying a standard benchmark may seem useful, wage levels and opportunity costs vary widely from context to context, making a reference range or benchmark inappropriate to include here. **These guidelines recommend using a replacement cost using a skills-equivalent wage**, where possible, and working with local stakeholders to identify context-specific proxies. For example:

- If you are costing time contributed by a peer navigator conducting tests, ART distributions and adherence support, consider using the government pay scale for community health workers or lay counsellors with similar responsibilities.
- If you are valuing the work of a community-led monitor, you could use local salary or stipend rates for enumerators or data collectors hired for research studies.
- For an unpaid intern conducting administrative tasks, you might apply the minimum wage for clerical or entry-level admin workers, adjusted for part-time or task-based contributions.

- For adolescent peer educators, consider using a proportion (e.g. 50%–75%) of the wage paid to an adult peer educator, thus adjusting for age and expected level of responsibility (27).

Box 4.3. Exercise: Valuing in-kind time of community-led monitors

A CLM project engages 10 volunteer monitors. Each volunteer works an average of 24 hours per month (around three full days) for 10 months in the year and receives a small stipend intended only to cover transport costs to facilities. Their time, however, is assumed to be provided in-kind.

Below are three ways to value their time:

- Minimum wage in the country, approximately US$ 1.50 per hour.
- Government rate for data collectors in research studies, US$ 3.00 per hour.
- Lowest salary level for staff in a CLO, US$ 2.50 per hour.

Task:

- Calculate the total annual economic value of the community-led monitors' time under each method.
- Compare the results and calculate the range between the lowest and highest valuation.
- Consider how these differences may influence how you report the results to other stakeholders. Which of these valuation methods is the most reflective of the monitors' contributions? How might undervaluing or overvaluing their time affect funding decisions or sustainability planning?

The answer key is available at the end of this chapter.

Regardless of the method used, transparent documentation of the assumptions and rationale used is essential. This transparency helps you to update or adapt the values in future exercises and ensures other actors can properly interpret the results.

Supplies and consumables

- **Items under this category include:** Medical and laboratory supplies; non-medical supplies; and office supplies used in interventions. Other related recurrent items include shipping, freight, taxes, duties and tariffs applied on used supplies.
- **Sources to quantify supplies used include:** Direct observations and interviews or review of inventory registers (especially important for donated or subsidized supplies). Recorded quantities should account for wastage, including expired, damaged or unused items. Where available, product specifications should be described for valuation. Single use and multiuse items should be differentiated.

Regardless of the method used, transparent documentation of the assumptions and rationale used is essential.

- **Sources to estimate price or value include:** Expenditure reports; purchase orders; invoices; internal or external procurement lists (e.g. ministries of health); manufacturers or retailers (via quotes or advertised prices); and original sales records—if available. All associated costs—such as shipping, freight, taxes, duties and other applicable fees—should be included.
- **Allocation factors for shared supplies can be based on:** The proportion of clients served by each activity (from activity registers); laboratory testing registers (for laboratory supplies); or the proportion of time used for specific interventions (from either direct observations or time and motion studies).

Building operation and maintenance

- **Items under this category include:** Utilities (e.g. rent, electricity, gas, water, sewage and sanitation, biosafety disposal); annual repairs for building and equipment; property fees and insurance; and cleaning and security services.
- **Sources to quantify use include:** Expenditure reports; purchase orders or invoices for purchased items; and direct observations or interviews to measure donated or subsidized items (e.g. self-reported electricity credit contributed by staff).
- **Sources to estimate price or value include:** The same financial records noted above, as well as rental agreements, service contracts, utility bills or local market rates for equivalent services.
- **Allocation factors for shared costs can be based on:** The same methods used for building-related capital items, such as the proportion of time a space is used for specific interventions (time and motion studies); the proportion of floor space used (direct observations); or the proportion of participants reached (activity registers).

Transport and vehicle maintenance

- **Items under this category include:** Fuel and oil; annual vehicle repairs; vehicle fees and insurance; and public transportation fares.
- **Sources to quantify use include:** Expenditure reports; purchase orders or invoices for purchased items; and direct observations or interviews to capture donated or subsidized contributions (e.g. self-reported out-of-pocket costs for tire repairs or fuel provided by personnel).
- **Sources to estimate price or value include:** The same financial records noted above, as well as fuel price lists, service contracts, insurance policies or market quotes for equivalent services.
- **Allocation factors for shared costs can be based on:** The same methods used for vehicle-related capital items, such as the proportion of time a vehicle is used for specific interventions (vehicle time logs); or the proportion of distance travelled (odometer readings or mapping software).

Client reimbursements are sometimes an important expenditure for CLOs. These reimbursements help encourage participation and reduce financial barriers for clients.

Other recurrent

- **Items under this category include:** Administration (e.g. packaging and shipping); communications (e.g. mobile phone credit); food and refreshments; bank charges; and other miscellaneous items.
- **Sources to quantify use include:** Expenditure reports; purchase orders; invoices; and—where applicable—direct observations or interviews to capture donated or subsidized items (e.g. refreshments provided in-kind).
- **Sources to estimate price or value include:** The same financial records noted above.
- **Allocation factors for shared costs can be based on:** Proportion of resources used for specific interventions (direct observation or time and motion studies).

Client reimbursements

- **Items under this category include:** Costs paid by the CLO to reduce financial barriers for participants, such as transportation reimbursements or incentives for attendance.
- **Sources to quantify use include:** Expenditure reports, petty cash logs or activity budgets; if reimbursements are not itemized, finance or programme staff may provide disaggregated estimates.
- **Sources to estimate price or value include:** The same records as above, supplemented by market rates for transport or incentive items, if applicable.
- **Allocation factors for shared costs can be based on:** Activity registers and attendance sheets to identify which clients received reimbursements and for what purpose.

Box 4.4. Practical tip: Client reimbursements

Although often not included in costing and budgeting exercises from a provider perspective, client reimbursements are sometimes an important expenditure in CLOs. These reimbursements, such as covering transportation costs or providing stipends for attending events, help encourage participation and reduce financial barriers for clients. If provided at scale, it is best to categorize these separately from other recurrent costs. While they are paid by the CLO, they represent support to the client and are more appropriately classified as user costs. Distinguishing them can help clarify how much of the intervention cost goes toward service delivery versus supporting client access.

If this support is provided informally or in-kind by staff (using their own money or resources), it may be useful to maintain an inventory or simple log of these contributions to track what is being provided, for whom, and how often (**Appendix 9**). Doing so can help the CLO recognize hidden contributions and advocate for funding to address those gaps. Moreover, introducing or removing these reimbursements will likely impact service uptake. While total costs may be higher, unit costs may be lower because of efficiency gains.

4.2.1.3. Training

- **Items under this category include:** Periodic and needs-specific training activities that use resources such as building space; vehicles and transportation services; equipment; personnel; and supplies and consumables. Trainings with benefits of more than one year are considered capital inputs (e.g. design of information, education and communication materials with long-term use). Trainings with benefits of less than one year, or that must be routinely repeated due to frequent staff turnover, are considered recurrent inputs.
- **Sources to quantify use include:** Training logs, which can also be used to determine the proportion of participants trained per site; building plans or measurements; vehicle logs; inventory registers; and personnel time records.
- **Sources to estimate price or value include:** Expenditure reports; purchase orders; invoices; internal procurement lists; and quotes or sales prices for facilities, transport, equipment or supplies used during training.
- **Allocation factors for shared costs can be based on:** The proportion of participants trained per site (training logs and participant sign-in sheets); the number of hours or days focused on a specific subject or intervention; or other relevant outputs from the training (e.g. number of service quality indicators developed for a particular intervention).

4.2.1.4. Outputs

Outputs of community-led interventions can occur at the activity and participant levels (**Chapter 3.2.5**). Unit costs are then calculated based on outputs. Examples of outputs and unit costs from interventions are shown in **Table 3.3**. Data on outputs should be collected for all interventions and activities that are being costed and should correspond with the time horizon of the costing period. Data sources used for outputs include reports, databases and registers from programmes and interventions (**Table 4.5**.).

Table 4.5. Common data sources for outputs

Level of output	Example	Common data sources
Activity level	Number of workshops	Workshop attendance logs, programme reports
Participant level	Number of clients counselled	Client registers, monitoring and evaluation service database
Population level	Number of radio listeners or reach of social media	Broadcast logs, media reach estimates
Health service level	Clinics monitored for pre-exposure prophylaxis delivery	Monitor logs, programme reports

Box 4.5. Exercise: Mapping data sources for inputs and outputs

A community-led organization runs a six-month livelihoods training programme for young people living with HIV. The programme includes vocational skills training (e.g. sewing and small business planning), peer mentoring, psychosocial support sessions and follow-up to help trainees start income-generating activities.

Inputs include: Training halls; sewing machines and other vocational equipment; paid trainers; volunteer peer mentors; training materials (e.g. fabric, stationery); snacks and refreshments for trainees; electricity for the training venue; transport stipends for trainees.

Outputs include: Number of trainees enrolled; number of trainees completing training; and number of trainees starting income-generating activities withing six months of completion.

Task:

- List the possible data sources for measuring quantities of each input (e.g. registers, observations, invoices, interviews).
- Identify valuation sources for each input, including how you would value donated or borrowed items.
- Suggest allocation factors for any inputs that are shared with other programmes or interventions.
- Identify any gaps where additional data collection would be needed before costing could be completed.

Answer key to this exercise is available at the end of this chapter.

4.3. Applying Chapter 4 concepts in practice: Budgeting advocacy campaign in Sierra Leone

To bring together the concepts discussed in this chapter, the following example illustrates how each element can be considered in a real budgeting exercise. In Sierra Leone, a CLO has been leading an informal advocacy campaign focused on building trust and collaboration between law enforcement and people who use drugs. The campaign emerged in response to increasing police raids, arrests and harassment, which have driven affected communities further underground and undermined public health efforts. The CLO's approach involves taking police officers and justices to drug use hotspots to engage in dialogue with community members and observe the CLO's harm reduction activities firsthand. These community encounters have helped shift attitudes and fostered more collaborative local responses.

To support scale-up, the National AIDS Secretariat has asked the CLO to develop a budget based on their past experiences. The aim is to formalize and expand the campaign. The table below outlines the methods and data sources identified for budgeting this intervention.

Table 4.6. Summary of method and sources for advocacy campaign in Sierra Leone

	Inclusion	Rationale
1. Methods		
Approach	Bottom-up costing	Activity not previously funded or tracked. A detailed breakdown of resources is needed to inform budgeting.
Timing	Prospective data collection	The budget is for planning future interventions. Past experiences inform prices and assumptions, but quantities and frequencies must be projected.
Valuation	Market and shadow prices	Market prices for direct financial costs; shadow pricing for in-kind contributions, such as volunteer time and community-provided space.
2. Data sources		
Inputs: Capital	Vehicle to transport officers and justices to hotspots; no equipment	Although no new equipment purchases are planned, the value of vehicle use for one day is included to reflect this necessary input. It remains uncertain whether a vehicle will be charged to the project or provided in-kind in future geographic areas. Including it allows for budgeting flexibility and visibility of this cost, regardless of funding source.
Inputs: Personnel	Includes time for executive director, programme manager and peer navigators	Personnel time estimated from past campaigns and adjusted for planned frequency. Peer navigators valued using typical stipend rates under other grants, deemed sufficient.
Inputs: Recurrent	Includes fuel, per diems, refreshments, phone credit, printing materials, safe needle exchange packs and small cash support for hotspot managers	Costs based on financial records where available; otherwise estimated from past campaign experience and supplier quotes.
Outputs	Number of police and judicial officers sensitized; number of campaign events held	Output targets set in consultation with stakeholders to guide budgeting and monitor planned interventions.

4.4. Answer key for Chapter 4 exercises

Answer sheet to Box 4.3. Exercise: Valuing in-kind time of community-led monitors

Step 1: Calculate total hours contributed

- Hours per volunteer per year: 24 hours/month x 10 months = 240 hours
- Total hours for 10 volunteers: 240 hours x 10 volunteers = 2400 hours

Step 2: Apply each valuation method

- Minimum wage (US$ 1.50/hour) = 2400 hours x $1.50 = $3,600
- Government data collector rate ($3.00/hour) = 2400 hours x $3.00 = $7200
- Lowest CLO staff salary ($2.50/hour) = 2400 hours x $2.50 = $6000

Step 3: Compare the results

- Lowest estimate: $3600 (minimum wage)
- Highest estimate: $7200 (government data collector rate)
- Difference: $7200–$3600 or a 100% increase from the lowest to the highest

Step 4: Reflection

- The difference in valuation method considerably changes the estimated economic cost, which could influence how stakeholders perceive the scale of resources contributed by community-led monitors.
- The government data collector rate may be the most reflective of the skills and responsibilities of community-led monitors, especially if their tasks and skill levels are comparable to formal data collection roles.
- Undervaluing their time risks underestimating the full economic cost of delivering CLM, potentially leading to an unsustainable programme, especially if scaled-up.
- Overvaluing their time might inflate the cost of CLM beyond realistic funding envelopes, which might make the programme seem harder to sustain.
- Transparent documentation of the chosen method and rationale is essential so stakeholders understand the basis for the valuation.

Answer sheet to Box 4.5. Exercise: Mapping data sources for inputs and outputs

	Data sources for...		
Cost input	Quantity	Value	Allocation
Training hall	Physical measurement of hall space, building plans, rental agreements	Rental contract, market rental rates for similar space, real estate listings	% of total hall time used for this training vs. other activities (training schedule)
Sewing machines, vocational equipment	Inventory registers, direct observation	Purchase orders, retailer/ manufacturer quotes, original receipts	% of time equipment used for this training vs. other projects (training logs)
Paid trainers	Staff contracts, time sheets, direct observation	Payroll records, HR databases, employment contracts	% of time trainers spend on livelihoods training vs. other activities (interview)
Volunteer peer mentors	Volunteer rosters, direct observation, interviews	Skills-equivalent wage rates, local wage surveys, nongovernmental pay scales	% of volunteer time spent mentoring trainees vs. other programme activities (interview)
Training materials	Inventory registers, procurement records	Supplier invoices, purchase orders	N/A, 100% use for training
Snacks/refreshments	Attendance registers (number of trainees per session)	Supplier invoices, petty cash logs	N/A, 100% use for training
Electricity	Utility bills, meter readings	Utility company tariffs, receipts	Same as training hall
Transport stipends for trainees	Attendance registers, reimbursement logs	Petty cash logs, finance records	N/A, 100% use for training
Outputs			
# of trainees enrolled	Programme registration forms, training database	N/A	N/A
# completing training	Completion certificates	N/A	N/A
# starting income-generating activities within six months	Follow-up survey, mentoring records	N/A	N/A

PART 2

Planning

This section builds on the foundational concepts reviewed in **Chapters 2–4** and translates them into practice to efficiently plan and prepare a costing or budgeting exercise. The following chapters guide users to define the interventions to be costed or budgeted, map the data to be collected, and identify their sources. It also explains the practical steps, including assembling a team, engaging stakeholders, preparing a workplan and budget, and determining whether ethical review is required.

Chapter(s) included:

Chapter 5
Mapping interventions, stakeholders and data sources

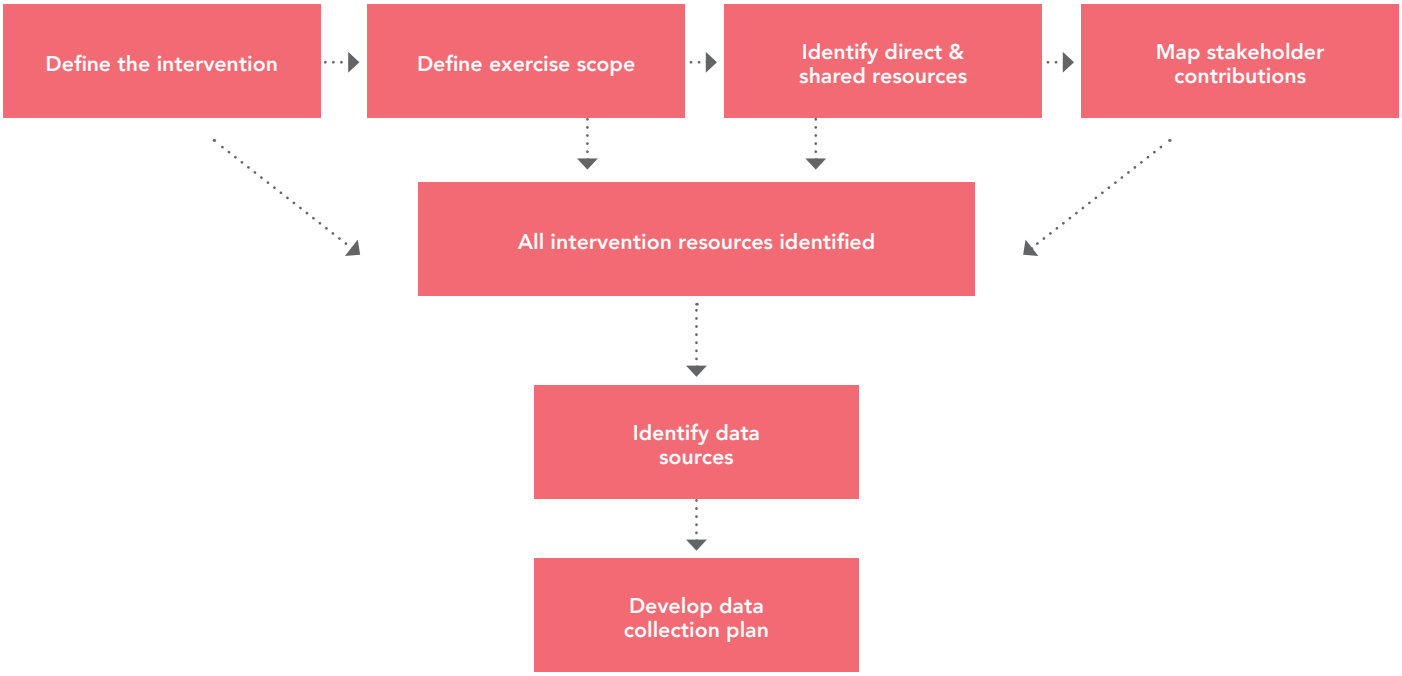
This chapter applies the concepts from **Chapter 2** (defining the community-led intervention), **Chapter 3** (defining purpose and scope) and **Chapter 4** (identifying inputs and data sources) to create a concrete data collection plan for your costing or budgeting exercise.

This chapter guides you to:
1. Define the intervention you are costing or budgeting.
2. Identify all direct and shared resources used.
3. Trace contributions from different stakeholders.
4. Determine what data are available and what must be collected.
5. Select an appropriate sample for costing.

Supporting materials: **Appendix 4** contains the Mapping interventions, resources and data Excel workbook.

The steps in this chapter build on one another to create a clear data collection plan. You will first define the intervention to be costed or budgeted. The workbook tools provided with these guidelines are designed to capture one intervention at a time, though the process can be repeated for multiple interventions. Next, you will identify the direct and shared resources used and then map the contributions of different stakeholders. These elements are then combined to determine what data are already available, what additional data need to be collected, and how to select an appropriate sample. **Figure 5.1** summarizes this sequence of steps as a roadmap for the chapter.

Figure 5.1. Steps for developing a data collection plan



5.1. Mapping interventions, resources and data sources

5.1.1. Defining the intervention: What intervention will be costed or budgeted?

The first step in costing or budgeting is to define the intervention. Identify which intervention(s) will be included in the exercise and use **Table 5.1** the Intervention Definition tool (**Appendix 4**) to describe their objectives and key characteristics.

Defining interventions can be complex, especially when activities overlap. For example, condom distribution may occur across multiple interventions, such as behaviour change communications or HIV testing campaigns. A single intervention might also be delivered in different settings, such as in a drop-in centre or in community hotspots. It is important to revisit and refine intervention definitions to ensure they are clearly distinguishable, each with a specific objective and measurable output or outcome.

Box 5.1. How to use the Intervention Definition tool

Objective:

- Identify and define the interventions to be costed or budgeted.

Method:

- **Who:** Costing or budgeting team, with input from staff who design or implement the intervention.
- **How:**
  - — Ask staff to present and describe the interventions they want to cost or budget.
  - — Record the key characteristics for each intervention using the template below.
  - — Note: If an intervention is delivered in multiple ways (e.g. at drop-in centre and in hotspots), record each delivery model separately and later link it to different resource use patterns during process mapping.

What to document:

	Description
Intervention	Short descriptive title
Objective(s)	What the intervention aims to achieve
Setting	Where is it delivered (e.g. drop-in centre, outreach, home delivery)
Context	Factors shaping delivery (e.g. rural/urban, legal environment)
Population groups	Primary groups reached by the intervention
Implementing CLO	Lead implementing CLO(s)
Partner(s)	Other actors directly involved in implementing the intervention
Core areas of the CLR	Refer to **Chapter 2.2**
Output or outcome indicators	Measurable results

Box 5.1. How to use the Intervention Definition tool, cont.

Here is a worked example:

A Kenyan CLO delivers legal rights and literacy workshops for sex workers, aiming to empower individuals and strengthen collective advocacy. The training is offered through workshops led by volunteer paralegals. The table below shows how their intervention could be defined.

	Description
Intervention	Legal literacy workshops for sex workers
Objective(s)	Inform sex workers of their rights and available legal recourse
Setting	Kenya, urban, peri-urban and subnational areas
Context	Generalized HIV epidemic, high HIV prevalence among sex workers; sex work legal but regulated; social/legal barriers to services
Population groups	Sex workers
Implementing CLO	[Name of Kenyan sex-worker CLO]
Partner(s)	National legal aid service, grassroots legal aid clinics, regional sex worker groups
Core areas of the CLR	Education and information sharing
Output or outcome indicators	Number of workshops held; number of participants reached (by gender, age, location); number of referrals to legal aid/paralegal services

Box 5.2. Practical tip: Defining interventions for the exercise

Based on past costing exercises, here are practical tips to help define clear interventions:

- **Start broad, then narrow down:** List all activities first. Next, group related activities into coherent interventions based on objectives, target population, delivery setting and common outputs or outcomes.
- **Define a measurable output or outcome:** For each intervention, determine such outputs as the number of people reached or tested, the number of new cases identified, or the number linked to treatment.
- **Differentiate overlapping activities:** If an activity occurs across multiple interventions (e.g. condom distribution), treat it as a cost component within each intervention, not as a stand-alone intervention.
- **Group by what is done and why, not by who funds it:** Costing should reflect intervention or service delivery, not donor structures. Funding sources for various cost inputs are still important and will be captured later, when mapping stakeholders and resource contributions. They should not drive how interventions are defined.
- **Be ready to iterate:** Intervention categories may need to be revisited and refined as you better understand implementation and available data. This is a normal and necessary part of the process.

5.1.2. Defining purpose and scope: Why is the exercise being conducted and what type and level of costs will it cover?

Next, it is important to be clear on why you are conducting a costing or budgeting exercise and what costs you will include. This may seem intuitive, but being explicit about purpose and scope ensures that decisions about which inputs, outputs and data sources to focus on are consistent throughout the exercise. It also helps all stakeholders understand what is and is not included in the final estimates, so results can be correctly interpreted. See **Chapter 3** for conceptual guidance; here, you will apply those concepts.

Box 5.3. How to use the Scope Framework tool

Objectives:

- Define the purpose and scope of the exercise, including the perspective, time horizon and types of costs and outputs to be included.
- Ensure all team members share a common understanding of whose costs and what costs will and will not be included in the exercise.

Box 5.3. How to use the *Scope* Framework tool, cont.

Method:

- **Who:** Costing or budgeting team, with input from staff and key stakeholders, including programme manager and other partner organizations.
- **How:**
  - — Discuss each element in the table below, referring to **Chapter 3** for definitions and considerations.
  - — Document the agreed purpose and scope before starting the process of mapping or data collection.
  - — Use this record to guide decisions throughout the exercise and to communicate parameters to all stakeholders.

What to document:

	Description
Purpose	Why is this exercise being done (e.g. monitor, assess efficiency, inform funding proposal, short-term budgeting, long-term planning)?
Scope	
Perspective	Whose costs and resources are included (e.g. a single provider/CLO, multiple CLOs, government contributions, other actors)?
Time horizon	What time period is covered?
Types of costs	
Financial and economic	Does this exercise only reflect financial costs (actual expenditures) or also economic costs (including value of in-kind or donated goods and services)?
Best practice and observed practice	Does this exercise reflect costs of interventions as they are delivered (observed practice) or as they would be delivered under optimal conditions (normative best practice)?
Full and incremental	Does this exercise cover the full cost of implementation or only incremental costs (additional resources required beyond what already exists)?
Levels and types of inputs	
Above intervention, intervention, participant	At what level will inputs be costed: Above-intervention (central administration), intervention (direct implementation), or participant (client level)?
Capital, recurrent	Will costs consider both capital (assets>1 year) and recurrent (consumed within the year) resources used for the intervention?
Types of outputs	
Site, activity, participant	At what level will outputs and outcomes be measured?

Refer to **Chapter 3.4** for a worked example of the completed table for costing of CLM in the Philippines.

5.1.3. Process mapping: How is the intervention delivered?

Once interventions are defined, the next step is to understand how they are delivered in practice. Process mapping documents where, who and what resources are involved in the direct implementation or delivery of services. This ensures that all relevant inputs (e.g. space, staff time, equipment, supplies) are identified, which is essential for accurate costing or budgeting.

For example, an ART refill may be provided by a nurse at a drop-in centre or by a peer worker delivering it to a client's home. Each scenario has different resource needs. Mapping the process step-by-step helps teams plan data collection, capture all relevant resources and understand variation across sites or delivery models.

If the intervention is centrally managed, such as financing or coordination, and does not involve fieldwork or direct service delivery, you can skip process mapping and proceed to identifying and mapping central-level resources.

Box 5.4. How to use the Process Mapping tool

Objectives:

- Identify and quantify all the resources used to deliver an intervention.
- Understand how interventions vary across sites or settings.
- Inform the design of data collection tools and cost tracking.

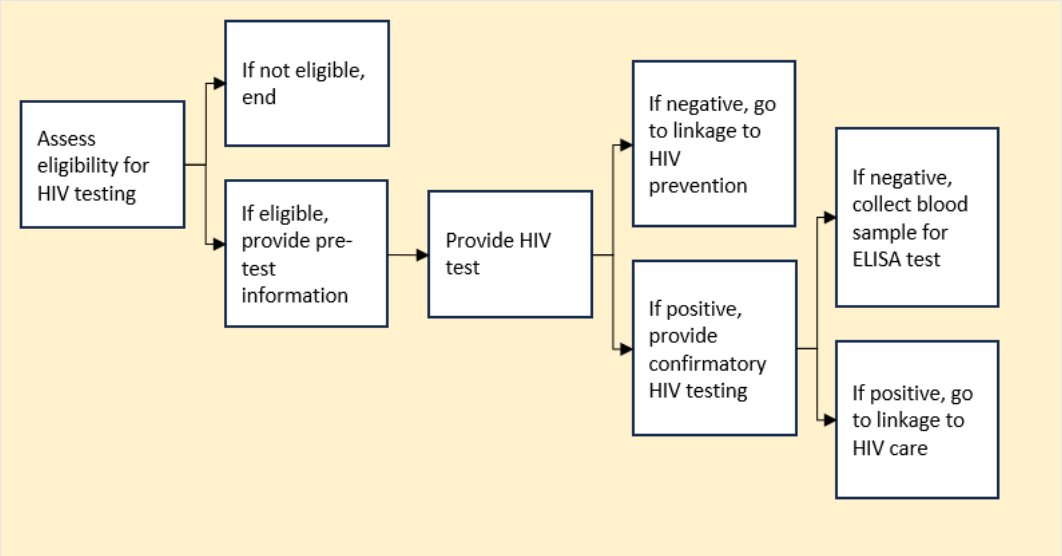
Method:

- **Who:** Costing or budgeting team, interviewing service providers or staff familiar with the intervention.
- **How:**
  - **Interviews:** Ask staff to walk through each step of the intervention, describing what happens, who is involved, where it happens and what is used.
  - **Observations:** Observe the intervention (if possible) or use role-play to simulate typical steps in service delivery.

What to document:

- **Step-by-step flow diagram:** Create to visually document all steps involved in interventions from start to finish. Prompt participants to identify alternative steps across different outcomes, if applicable.

Box 5.4. How to use the Process Mapping tool, cont.



— **For each step record:**

- Start and end times
- Location or space used
- Staff roles and time spent
- Supplies and equipment used

Tasks *List step-by-step tasks involved in completing the activity.*	**Time**			**Area or room** *What area or room is used to deliver the task?*	**Personnel** *What types of personnel are involved in delivering the task?*	**Supplies (Quantity)** *What supplies are used to deliver the task? What is the quantity of each item?*	**Equipment (Quantity)** *What equipment is used to deliver the task? What is the quantity of each item?*
	Start *What is the start time?*	**End** *What is the end time?*	**Total** *What is the time in minutes?*				
Assess eligibility for HIV testing	-	-	5	Tent	Peer counselor	Form (1)	Chair (2), desk (1), bin (1)
If eligible, provide pre-test information	-	-	5	-	-	-	-
Provide HIV test	-	-	15	-	-	HIV test (1), lancet (1), gloves (2), swab (1)	-
If negative, go to linkage to HIV prevention	-	-	-	-	-	-	-
If positive, provide confirmatory HIV testing	-	-	15	-	-	HIV test (1), lancet (1), swab (1)	-
If negative, collect blood sample for ELISA test	-	-	5	-	-	Vacutainer (1), swab (1), plastic bag (1), label (1)	-
If positive, go to linkage to HIV care	-	-	-	-	-	-	-

— Repeat the exercise for each intervention, activity or site.

5.1.4. Central resource mapping: What above-intervention level inputs support the intervention?

In addition to resources directly used in delivering an intervention, CLOs rely on cross-cutting inputs that operate above the intervention level. These include administrative staff, executive leadership, accounting systems, utilities, furniture and other equipment, rent for headquarters office, all of which are necessary to function as an organization but are not directly tied to a single intervention.

This step helps identify those shared or overhead resources that support delivery across multiple interventions, ensuring they can be appropriately allocated during costing or budgeting. Unlike process mapping, which focuses on direct implementation, this exercise focuses on central operations and their enabling functions.

Box 5.5. How to use the Central Resource Mapping tool

Objectives:

- Identify cross-cutting (above-intervention) inputs needed to operate the CLO.
- Document above-intervention level resources that will later need to be included in costing or budgeting.

Method:

- **Who:** Costing or budgeting team, in collaboration with executive, administrative and finance staff.
- **How:**
  - **Review organizational records:** Use budgets, expense reports, org charts and asset registries to identify other central inputs.
  - **Interviews:** Meet with central staff (e.g. executive director, finance manager) to identify routine organizational resources used across interventions. These interviews are critical to uncover resources that may not be captured in financial records or budgets, such as in-kind contributions, out-of-pocket costs paid by staff, or resources provided by external institutions.

What to document:

- For each major input category, list all types of resources used centrally or across interventions. No need to quantify or assign costs yet, the purpose of this step is to develop a complete list of relevant inputs. These may include:
- Be careful to capture easily overlooked central resources, such as:
  - Shared services like IT support, cleaning services or waste disposal.
  - Central resources donated or paid for by other institutions: Seconded-staff, rent-free office or warehouse space.
  - Taxes, registration fees or compliance costs for being a registered organization.
  - Organizational events (e.g. end-of-year staff gathering, annual planning retreats).
- Be thorough, but more importantly, focus your efforts on the big-ticket items that are likely to have the greatest impact on total costs.

Box 5.5. How to use the Central Resource Mapping tool, cont.

CENTRAL RESOURCE MAPPING		
Purpose: This sheet is used to identify cross-cutting, above-intervention resources that support the delivery of actvities and the functioning of the organization as a whole. It ensures that shared inputs are documented for costing or budgeting. **How to complete:** Work collaboratively with administrative, finance and executive staff. Use organizational records and interviews to identify central resources. Do not worry about quantifying or assigning costs/values at this time.		
Intervention being costed or budgeted:	Voluntary counselling and testing	
Input category	**Type of resource(s)** *What is the specific item?*	**Type of contribution** *What is the specific item?*
Building space	HQ office (rent)	Paid for by the government
Vehicles	1 motorcycle	Financial
Equipment	5 laptops , 1 printer, and office furniture	Electronics are financial, office furniture donated by partners
Personnel	Executive Director, Assistant and finance manager	Financial
Supplies and consumables	Office stationery	Financial
Building operation and maintenance	HQ utilities (water, electricity)	Paid out of pocket by executive director
Transport and vehicle maintenance	Maintenance and fuel of motorcycle	Financial
Other recurrent	Internet subscription	Financial

5.1.5. Stakeholder mapping: Who contributes resources?

Once the intervention, delivery process and central resources have been mapped, the next step is to identify who provides the resources needed at each stage. In CLRs, multiple actors often contribute to a single activity, whether through funding, staffing, supplying commodities or offering infrastructure. Stakeholder mapping helps trace the flow of these resources back to the institutions or actors responsible. This exercise is particularly important in CLRs, where the delivery of services often depends on a complex web of government partners, donors, technical agencies and communities themselves.

For example, a single intervention, such as differentiated ART delivery, may involve:

- A CLO coordinating and implementing the service.
- A ministry of health branch purchasing and supplying ARTs.
- A public health facility clinician prescribing medicines and providing clinical follow-up.
- A technical partner providing training to the CLO staff.
- Peer treatment champions volunteering time to provide psychosocial support.

Mapping these stakeholders allows the team to:

- Clarify all institutions or actors involved and their specific contributions (financial, in-kind).
- Decide which stakeholder contributions to include, depending on the purpose and scope of the exercise.
- Determine where and from whom to collect data.

Box 5.6. How to use the Stakeholder Mapping tool

Objectives:

- Identify all institutions or actors that contribute to each intervention and central-level resources.
- Clarify what each stakeholder provides (e.g. funding, commodities, infrastructure, time).
- Inform which costs to include in the exercise and guide data collection planning.

Method:

- **Who:** Costing or budgeting team, in collaboration with programme staff familiar with implementation.
- **How:**
  - — Start with the process map: For each activity step, list which resources are used.
  - — Include shared or central resources.
  - — Ask: Who provides or pays for this resource?
  - — Map contributions: Use a simple table to visualize relationships between stakeholders and resource flows.

What to document:

STAKEHOLDER MAPPING

Purpose: This tool helps document all institutions, organizations or actors that contribute to the delivery of interventions and shared organizational resources. It will clarify what each stakeholder provides and how (e.g. financial support, commodities, staff time, infrastructure) and help determine which contributions should be included in the costing or budgeting exercise.
How to complete: Refer to your completed process mapping and central resource mapping tools. For each task or input, ask: Who provides or pays for this resource? Include both intervention-specific and cross-cutting (central) resources. Note whether each contribution is paid (financial), in-kind or mixed.

Intervention being costed or budgeted:	Differentiated ART delivery			
Stakeholder/Actor *List all the stakeholders contributing resources to the intervention*	**Stakeholder role** *What role does this stakeholder play in the intervention.*	**Resources contributed** *What specific input does this stakeholder provide?*	**Type of contribution** *Paid, in-kind*	**Include in costing or budgeting?** *Justify*
CLO	Main implementer	Staff, transport, phone credit	Paid	Yes, costing covers full financial cost of providing service
Ministry of Health	Purchases and provides medical supplies	ARVs	Paid	Yes, costing covers full financial cost of providing service
Public health facillity (also under the ministry of health)	Pays clinician and laboratory tests needed for patient follow-up	Health facility space, clinician time, equipment, laboratory tests	Paid	Yes, costing covers full financial cost of providing service
Technical partner NGO	Helps build CLO capacity	Training to CLO staff	Paid	Yes, costing covers full financial cost of providing service
Peer treatment champions	Psychosocial support	Time	In-kind	No, not conducting an economic costing

Box 5.7. Aligning stakeholder cost contributions with purpose and scope

The table below builds on the differentiated ART delivery example, illustrating how the inclusion of specific stakeholder costs can vary depending on the purpose and perspective of the costing or budgeting exercise. It shows how several types of resource contributions may be included or excluded, depending on whether the focus is on incremental, full financial or full economic costs.

Stakeholder	Example resource	Include if…
CLO: Intervention-specific (direct) costs only	Nurse's time, transport, phone credit	you are estimating direct costs from the CLO's perspective.
CLO: Full organization (direct and central) costs for delivery	Central staff salaries, nurse's time, office rent, utilities, transport, phone credit	you are estimating the full financial cost of delivery from the CLO's perspective.
Community volunteers	Time spent supporting adherence	you are estimating the economic cost, including in-kind contributions.
Ministry of health	ARTs purchased and distributed centrally, clinician's time, equipment and laboratory tests conducted in public health facility	you are estimating the full provider cost of the intervention, including MOH contributions.
Technical partner	Training to the nurse	you are estimating the full provider cost of the intervention, including partner contributions.

5.1.6. Data mapping: What information is available and what needs to be collected?

This step brings together all the work you have done so far: Process mapping (for direct inputs), central resource mapping (for shared inputs), and stakeholder mapping (for contributors). The data mapping tool combines this information into a single view to guide your data collection plan.

Once cost inputs and stakeholders have been identified, the next step is to assess the availability and quality of data needed to cost each resource. This means mapping existing data sources, identifying gaps and deciding where additional data collection is required. To estimate costs, you need three main data elements for each input (introduced in **Box 4.5 Exercise** in **Chapter 4**):

- Quantity: How much of the input is/will be used?
- Price: What is the financial or economic value of the input?
- Allocation factor: What proportion of the input is/will be used for this specific intervention?

These data may come from a combination of existing records (e.g. invoices, payroll, registries) and field-based data collection (e.g. observations, interviews, time sheets). Some resources, especially in-kind or unpaid contributions, may not appear in financial records and will require primary data collection. More detail on data sources for measuring and valuing resource use is provided in **Chapter 4.2**.

Use the Data Mapping tool (**Appendix 4**) to list each cost input (using the results from the process mapping), identify who contributes to it (using results from the stakeholder mapping). Also determine whether it is financial or in-kind, and what data sources can best provide information on price, quantity and allocation. This tool helps develop a realistic data collection plan.

Box 5.8. How to use the Data Mapping tool

Objectives:

- Compile all cost inputs into a single view to guide data collection.
- Identify what data already exists and where they can be found.
- Flag gaps that require additional data collection.
- Plan how to collect cost data for each input: Quantity, price and allocation factor.
- Plan how to collect output or outcome data for the intervention.

Method:

- **Who:** Costing or budgeting team, with support from finance and programme staff.
- **How:**
  - — Collect the results from the process mapping, central resource mapping and stakeholder mapping and enter them under cost input. Add rows if necessary.
  - — For each cost input, identify the contributor and whether it is financial or in-kind.
  - — Using the three core data elements introduced in **Chapter 4**, identify the best data source for each element:
    - **Quantity:** Inventory logs, procurement reports, stock cards, staffing lists, volunteer registries.
    - **Price:** Expenditure reports, payroll, invoices, proxy market rates.
    - **Allocation factors:** Proportion of time, space or resource use (estimated via interviews, activity logs, building measurement, time and motion).
  - — Record the data source for outputs or outcomes (e.g. programme monitoring databases, registers, service records).
  - — Apply colour-coding in the tool as you go:
    - One colour for data sources already available and accessible via desk review.
    - Another colour for data points requiring new data collection.

Box 5.8. How to use the Data Mapping tool, cont.

What to document:

DATA MAPPING

Purpose: This tool helps identify what data already exists and where it can be found, flag any gaps that require additional data collection, and plan how to collect the necessary cost and output data for the costing or budgeting exercise. It builds on the information gathered through the process mapping, central resource mapping and stakeholder mapping exercises.
How to complete: Draw from earlier mapping tools to complete the sheet. For each input, indicate the best data source to estimate price, quanity, and allocation factor. Include both direct and central (shared) resources. Record data sources for outputs/outcomes.

Intervention being costed or budgeted:			Community-led monitoring						
	Cost Inputs	Cost Item	Indicate whether this resource is:			Stakeholder	What data source is best to obtain...		
			Financial		In-kind		Quantity	Price	Allocation factor
			Paid by CLO	Paid by other					
Direct	Building space	N/A	-	-	-	-	-	-	-
	Equipment	Tablets	Yes				Finance report	Finance report	N/A - 100% CLM
	Vehicles	N/A	-	-	-	-	-	-	-
	Personnel	Manager, monitors	Yes		Yes				N/A - 100% CLM
	Supplies	Stationery	No	Yes		UNAIDS	Stock card	UNAIDS invoice	N/A - 100% CLM
	Utilities, building m	N/A	-	-	-	-	-	-	-
	Transport, vehicle r	Transport	Yes				Petty cash log	Petty cash log	N/A - 100% CLM
	Trainings	Monitors, CLOs	Yes				Finance report	Finance report	N/A - 100% CLM
	Other recurring cos	Database	-	-	-	-	-	-	-
Central	Building space	HQ rent	Yes				Finance report	Finance report	% CLM office space
	Equipment	Furniture, IT	Yes	Yes	Yes	UNOPS, staff	Asset registry	Asset registry	% time on CLM
	Vehicles	N/A	-	-	-	-	-	-	-
	Personnel	Executive, Admin	Yes				Finance report	Finance report	% time on CLM
	Supplies	Stationery	Yes				Finance report	Finance report	% time on CLM
	Utilities, building m	Utilities	Yes				Finance report	Finance report	% CLM office space
	Transport, vehicle r	N/A	-	-	-	-	-	-	-
	Trainings	Finance training	No	Yes		Expertise Franc	Training Log	Fin. Report of EF	% time on CLM
	Other recurring cos	Registration fees	Yes				Finance report	Finance report	% time on CLM
	Outputs/Outcomes	# of facilities in CLM, # of respondents (by population type)					M&E database	N/A	N/A

5.2. Sampling for costing

When costing an intervention, it is important both to estimate the overall cost and understand how costs vary across different sites, populations or delivery models. These variations can help:

- Compare performance across locations or approaches.
- Identify opportunities to improve efficiency or reduce costs.
- Adjust future budgets or plans to reflect real-world differences.
- Understand what drives higher or lower costs (e.g. staffing, geography, delivery method).

To do this, the costing team selects a sample (i.e. a smaller group of sites, populations or interventions) that reflects the diversity of the programme. Sampling allows the team to capture meaningful variation without overburdening the exercise.

Sampling allows the team to capture meaningful variation without overburdening the exercise.

When selecting the sample, several considerations are important:

- What is feasible, given time, budget and access?
- What affects costs, like the type of staff used (e.g. peer educator vs. nurse), urban or rural setting, or scale of the intervention?
- What needs to be captured, such as variations between pilot and routine phases or across seasons?
- Which time periods should be observed (e.g. for a time and motion study, you may sample specific weeks that reflect typical operations, avoiding unusual period such as major events)?

Sampling also requires selecting a defined period. The goal is to ensure that the costing reflects typical operations, not an unusual or unrepresentative moment. Several factors should be considered including seasonal variation, (for example, fewer outreach events may be conducted during the rainy season), phases of implementation (costs may differ between pilot, scale-up and routine phases), and external disruptions (such as delayed funding, stock-outs or political events that impact operations).

Different sampling approaches are available, each with different strengths and limitations. **Table 5.1**. summarizes common sampling methods and provides practical examples to guide the selection of a suitable strategy.

Table 5.1. Strategies for sampling

Method	Description	Example
Random	Sites or participants are chosen at random to reduce bias.	A youth-led CLO wants to know how much it costs members to organize and participate in self-help groups. The costing team uses the organizational database to randomly select one-third of members to interview.
Stratified random	The sample is divided into meaningful subgroups, with random selection within each subgroup.	A CLO provides HIV testing to sex workers at venue- and street-based hotspots. The costing team randomly selects three sites from each type of hotspot.
Convenience	Sample is based on ease of access; fast and low-cost but may lack representativeness.	An international network for people who use drugs decides to limit the costing exercise to countries where government bodies will be able to fully support and finance the exercise, and CLOs are not put at risk.
Purposive	Sites or CLOs are deliberately selected based on key characteristics of interests.	The National AIDS Committee has initiated a costing of preexposure prophylaxis delivery. Several CLOs provide preexposure prophylaxis services. The costing team selects one CLO per key population served.
Sample size		
Comprehensive	All or most units are included to ensure full representation.	A CLO wishes to assess the cost of adding syphilis testing services to existing HIV testing services among transgender women. Since the pilot intervention operates in only two drop-in centres, the costing team decides to cost both sites.
Selective	A smaller sample is selected to reduce cost and complexity, though may risk bias.	The health department has commissioned a consultant to evaluate the cost of community-led HIV care services across the country. Since the budget is limited, the consultant uses a stratified random sampling approach to select health facilities that have high-, medium- and low-service coverage.

Chapter 6
Practical steps to prepare costing or budgeting

Chapter 6 builds on your data collection plan from **Chapter 5** and outlines key practical steps to prepare for implementing a costing or budgeting exercise.

This chapter guides you to:
1. Assemble a multidisciplinary team and clarify roles.
2. Engage stakeholders at key moments.
3. Prepare a budget to conduct the exercise.
4. Understand ethical considerations specific to costing.
5. Develop a complete workplan.

Supporting materials: **Appendix 5**, MOU between stakeholders; **Appendix 6**, Confidentiality Agreement; **Appendix 7**, Informed consent–CLO staff & service provider; **Appendix 8**, Training and workshop slide decks for key engagement meetings.

6.1. Building the team and engaging stakeholders

6.1.1. Assembling the team

A strong, inclusive team is essential for a successful costing or budgeting exercise. A participatory approach from the start will help facilitate data collection, strengthen data analysis and ensure results are useful, credible and easily interpreted by all relevant stakeholders. Building the team is the first opportunity to set the tone for collaboration, transparency and shared ownership of the process and results.

The exact composition of the team will vary depending on who is leading the exercise. In some cases, a single CLO may take the lead; in others, multiple CLOs may collaborate, or the exercise may be convened by a national programme or technical partner. The individual leading the process may be a cost analyst embedded within a CLO or a consultant hired by a stakeholder to work with CLOs. In all scenarios, the principle is to build a strong, inclusive team that ensures meaningful community representation and balances technical expertise and access to data.

Table 6.1. Members of the team

Role	Responsibilities
Core team members	
Lead	Oversees the process, including defining scope and methods, managing timelines, developing tools, coordinating data collection, guiding analysis and dissemination. May be based in a CLO or be an external cost analyst.
Co-lead community representatives	Ideally includes three key individuals from the CLO: (1) a senior leader, such as the executive director or programme director, who understands overall strategy and operations; (2) the most senior M&E staff member, who ensures data systems and outputs are well understood; and (3) the finance director, who supports access to financial data and interpretation or cost data. Together, they help ensure the exercise is well-integrated into organizational processes and that community perspectives are meaningfully represented throughout.
National HIV programme representative	Helps align the exercise with national planning and funding cycles. Can support access to relevant institutions, facilitate access to data (e.g. national stock purchase and distribution records) and promote uptake of results.
Data collectors	Conduct financial, programmatic or observational data collection. May include organizational staff or external enumerators.
Data clerk or manager (optional)	Supports entry, cleaning and validation of data. This role may be shared across the team or held by a dedicated person.
Advisory or oversight groups	
Technical advisory group	Provides input across the exercise, from planning to interpretation. Members usually have relevant technical or contextual knowledge and may include technical partners, donors, National AIDS Secretariat representatives or other ministry of health representatives, collaborating CLOs and representatives of key populations.
Steering committee	A higher-level group that ensures alignment with broader planning and policy processes. Useful for encouraging buy-in, sustainability and supporting dissemination.

While the roles in **Table 6.1** illustrate common functions, the way teams are formed will vary:

- **CLO-led exercise:** The lead may be a staff member already embedded within the CLO or a consultant contracted to work with the CLO. Community representation is anchored in that organization's leadership, M&E, and finance staff, with external stakeholders brought in as needed.
- **Multi-CLO collaboration:** A shared core team should be established with representation from each CLO. This helps ensure broader community ownership of the process and direction of the exercise. The decision on who leads the exercise and accesses CLO data—whether a representative from one of the CLOs or an external facilitator—should be made carefully, taking into account the local context and stakeholder dynamics (**Box 6.1**).
- **National programme-led exercise:** When governments or a technical partner convenes the process, strong community representation should be ensured by including representatives of each CLO in the core team. The lead may be a consultant or government analyst, but community leadership should remain central in planning, collection, analysis and interpretation of results.

Box 6.1. Practical tip: Composition of a costing team depends on context

In past exercises, both community-led and externally-led teams have been successful, depending on context.

For example, in a South African costing study, one region saw challenges after an umbrella CLO led the data collection, which caused partner organizations to hesitate sharing sensitive financial data. In another region, an external facilitator helped build trust and maintain neutrality. In still other countries, CLOs have collaborated seamlessly in costing exercises because of a lifetime of trust and familiarity.

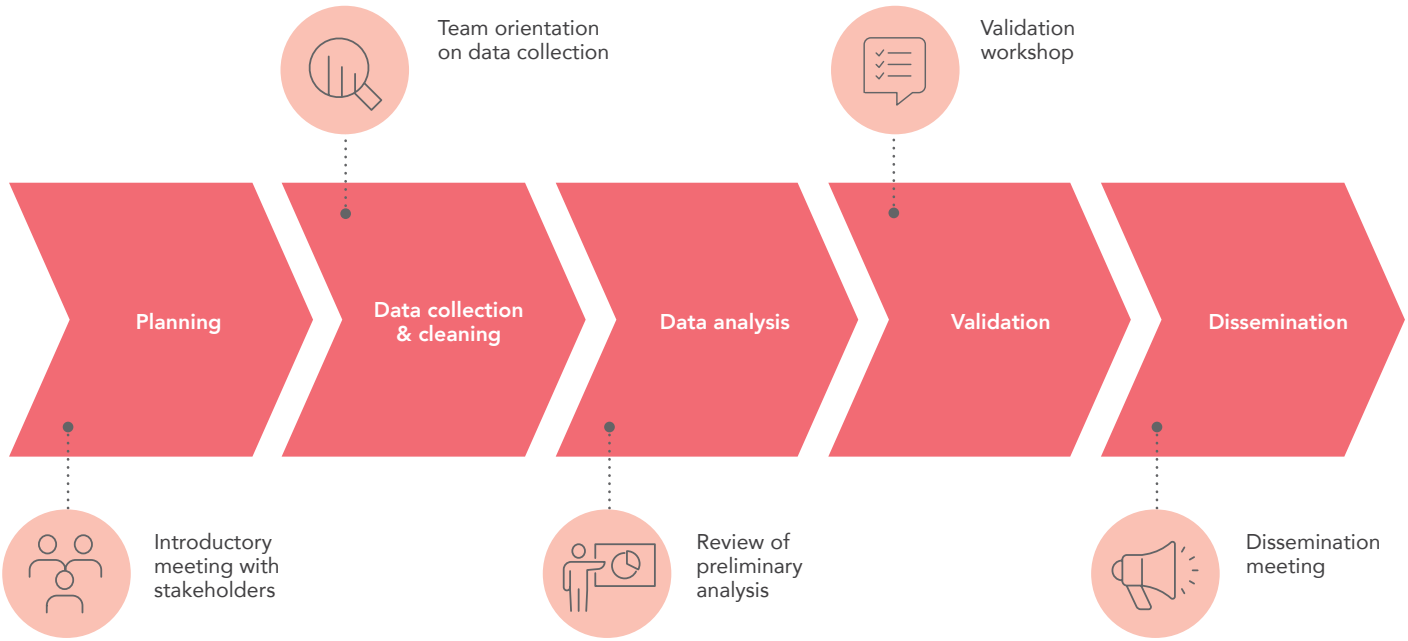
The key is to tailor the team's composition to the local context, preserving trust, cooperation and data integrity throughout the exercise.

6.1.2. Engaging and preparing stakeholders

Once the team is in place, it is important to engage key stakeholders to build shared understanding and buy-in. Ongoing engagement does not require constant meetings, but it should include well-timed workshops and check-ins aligned with the major phases of the study. These touchpoints promote accountability, support capacity-building and ensure the exercise stays on track.

Figure 6.1 presents the five main phases of a costing or budgeting exercise, along with corresponding stakeholder engagement and training workshops. Slide decks and facilitator notes to support each workshop are provided in **Appendix 8** and can be adapted to the local context.

Figure 6.1. Key moments for engagement across costing or budgeting timeline



Key moments for engagement and training include:

- **Introductory meeting with stakeholders:** Present the purpose, scope, methods, expected timeline and outputs; agree on roles and responsibilities; draft an MOU (**Appendix 5**) covering data ownership, sharing and protection and any compensations for participation; introduce the Confidentiality Agreement (**Appendix 6**) and ensure that all individuals with access to study data sign it before data collection begins.
  - — Milestones before this meeting: Draft scope and methods (**Chapter 5**); identify team composition (**Chapter 6.1.**); prepare initial MOU outline (**Appendix 5**).
- **Team orientation on data collection:** Provide a brief orientation on basic health economics concepts (**Chapters 3 and 4**) tailored to the study's aims; introduce data collection processes and tools (**Chapter 7**); and co-develop/revise tools with CLO members to ensure they are relevant and practical. Agree on the data collection timeline and workplan (**Chapter 6.3.2**).
  - — Milestone before this meeting: Draft tools prepared; allocation factor categories identified; logistics for data collection finalized.
- **Review of preliminary results and analysis:** Continue the introductory training by covering analysis concepts (**Chapter 8 or 10**); review early findings; validate and refine allocation factors; identify and address data gaps.
  - — Milestone before this meeting: Initial data entry and cleaning completed; preliminary allocation factors calculated; key financial/programmatic data collected and entered.

- **Validation of results:** Present final total and unit costs; discuss whether they are plausible; agree on any adjustments; decide how to present results (**Chapter 9**).
  - — Milestone before this meeting: Full analysis completed (total costs, costs per input, unit costs); draft results tables prepared.
- **Dissemination meeting:** Share final results; discuss implications for planning and advocacy; agree on next steps for applying findings.
  - — Milestone before this meeting: Results validated; dissemination materials prepared (summary briefs, presentations).

6.2. Ethics: When and how to seek approval

All exercises involving human participants or sensitive data must consider ethical implications. Formal ethical approval is generally not required for budgeting exercises but may be required for costing when client-level data are collected, participants (or human subjects) are directly involved, or results are intended for publication (**Table 6.2.**). Regardless of whether formal approval is sought, ethical considerations remain essential: Protecting participants, ensuring confidentiality and responsible data use, and maintaining trust with partners.

Ethical considerations come into play as costing exercises require handling sensitive data such as:

- Data on service delivery including detailed information on clients (names, addresses, phone numbers, health status).
- Data on staff salaries and payment structures.
- Observations of clients using or people delivering services.

The costing team will need to decide whether formal ethical approval is required based on the nature of the exercise and the extent of human participation and use of data. As a rule of thumb, exercises that involve client-level data or direct participation of human subjects, and especially those intended for publication, should seek formal ethical approval.

Table 6.2. Criteria for seeking ethical approval

Consider seeking ethical approval if the exercise:	Formal approval is generally not required if the exercise:
Includes activity data containing confidential information about intervention participants (e.g. name and HIV status)	Uses only public or aggregate data with no personal identifiers (e.g. published statistics, general aggregate data)
Uses survey data with responses provided by intervention participants (e.g. personal and health care expenses)	Uses only anonymous surveys with no personal or sensitive information
Contains the observations of intervention participants (e.g. health care consultations between providers and clients)	Uses only Internal data gathered by the CLO for the CLO using anonymized data sets
Incorporates external financial data (e.g. staff salary scales and volunteer stipends)	Has no plans to publish study results
Offers compensation to CLOs or participants for their participation (**Box 6.2**)	Offers no compensation or incentives to CLOs or clients for study participation

To seek ethical approval, the lead investigators must submit a study protocol to a research ethics committee, which could include a national board and/or an institutional board (e.g. academic). The protocol must include a full description of the costing exercise, including:

- **Background and rationale**
- **Aims and objectives**
- **Setting and population**
- **Methods:** Approaches for design; sampling and sample size; data collection; data management and analysis.
- **Ethical considerations and risk mitigation:** Procedures for informed consent; vulnerable populations; confidentiality. Measures for risk mitigation are detailed in **Table 6.3**.
- **Workplan and timeline**
- **Informed consent forms**
- **Data collection tools**

A template of an informed consent form for CLO staff and other service providers is available in **Appendix 7**. CLO representatives should inform and sensitize their staff about the study, including its objectives and overall methods, so they understand what will happen during data collection. At no point should clients be followed into private consultations with service providers; any observations or interviews should occur only between the team and the staff member.

To reduce potential risks to the very populations the exercise is aiming to support, several considerations are needed. The study protocol must address informed consent, working with vulnerable populations, confidentiality and data handling. **Table 6.3.** below provides a few tools that can support this effort.

Table 6.3. Strategies for risk mitigationm

Item	Description
Informed consent	
Participant information sheet	Prepare and include an information sheet that clearly outlines the purpose, procedures and any potential risks or benefits of the costing exercise. The information sheet ensures that participants are well-informed to consent.
Training on informed consent	Train data collectors on the importance of obtaining informed consent from participants, including the importance of using the information sheet to ensure voluntary and informed participation.
Vulnerable populations	
Alternative ethics board	If populations are criminalized, consider seeking ethical approval from an institutional ethics board, such as that of a university or international organization, rather than a national ethics board, especially if a partnership with such an institution exists.
Memorandum of understanding	If the costing exercise is led externally, draft an MOU with CLOs to ensure that specific measures and safeguards will be taken to protect community partners and participants. This should also include provisions for data ownership, with any CLO-specific data remaining owned, accessible and under the ongoing control of the CLO. The MOU should also set out details on any reimbursements and the mode of payment (**Appendix 5**).
Training on vulnerable populations	Ensure the whole study team receives training on vulnerable populations, covering the identification of vulnerable population categories, understanding the sociopolitical and economic factors driving vulnerability, and key considerations and ethical conduct when working with and for vulnerable populations.
Confidentiality	
Unique identification codes	Refrain from capturing names if personal data are also being collected and opt for the use of unique identification codes to maintain anonymity.
Anonymized data	Share exclusively anonymized data, ensuring that any personally identifiable information—such as names, phone numbers and addresses—is removed from data sets.
Minimize interaction with intervention participants	Minimize direct interaction with intervention participants or service clients and establish protocols that guarantee their privacy and safety during any observations of service delivery.
Data storage and management	Store all hard copies of informed consent forms with identifiable information in locked filing cabinets. Keep electronic copies of anonymized participant responses in a secure shared drive only accessible to the costing team.
Confidentiality agreements	These are needed for the data collection and research team, especially if these do not come from the communities themselves and need to emphasize the confidential nature of the data they are collecting as well as identities of any people they meet while doing site data collection exercises. See **Appendix 6** for an example.

Compensation is one area where ethical issues often arise. Compensation can recognize the time and effort participants or CLOs have contributed to the exercise, but it must be handled carefully to avoid unintended consequences (**Box 6.2**).

Box 6.2. Practical tip: Ethical considerations for compensation

- **For individuals (e.g. clients):** Use modest amounts that cover practical needs (e.g. transport reimbursement, refreshments) rather than large sums that could be seen as coercive or introduce bias.
- **For CLOs:** If the study is led externally, it may be appropriate to compensate the CLO and its personnel for time spent preparing, sharing or analysing data. It works best to provide compensation to the CLO as a whole rather than to individuals, as direct payments can lead to unintended conflict among staff or members.

Before offering compensation, consider if it is necessary and proportionate, clarify the purpose (time, effort, disruption) and decide on the mode (individual or organizational; monetary or other).

6.3. Planning logistics

6.3.1. Preparing a study budget

Budgeting exercises typically do not require a dedicated budget, but costing exercises often involve more intensive data collection and analysis and may require staff time, travel and external support. In these cases, preparing a detailed budget can help ensure the exercise is feasible and adequately resourced. Total costs will vary depending on the scope (**Chapter 3.3**), methods (**Chapter 4.1**), and sample size (**Chapter 5.2**). For example, a full economic costing using a bottom-up approach will cost more than a top-down incremental financial costing.

Common budget items may include:

- **Compensation** for the costing team, including members of CLOs. Not all contributors may require payment (e.g. technical advisors or national representatives).
  - **Dedicated staff time** to manage the costing. In past exercises, a dedicated person to coordinate the process has been essential for maintaining momentum. Without this, progress may stall as CLO staff often struggle to balance the costing exercise with routine responsibilities.
- **Stakeholder** meetings and coordination.
- **Ethics board submission fees**, if applicable.
- **Preparation activities** such as piloting tools.

- **Trainings** for data collection, data analysis and validation, interpretation, and dissemination.
- **Data collection**, including transport, accommodation, supplies, and staff time.
- **Dissemination**, including validation meetings or report production.

Dedicated staff time for someone leading a costing study is not always easy to gauge and is highly context specific. To support planning, **Table 6.4** provides an example baseline estimate of the number of days it might take for a lead cost analyst to cost an intervention for a single CLO. The table also suggests addtional days for engaging each additional intervention. These figures should be adapted to the local context, the scope of the exercise, and the methods chosen.

6.3.2. Developing a workplan

Table 6.4. Illustrative estimate of days required for costing a community-led intervention

Task	Baseline estimated days for 1 CLO and 1 intervention	For each additional intervention
Review CLR costing and budgeting guidelines and adapt tools and workbooks	7	
Stakeholder engagement	5	
Prepare and conduct trainings (three trainings, two days each) and stakeholder engagement meetings (**Chapter 6.1.2**)	15	
Conduct data mapping and develop data collection plan (**Chapter 5**)	5	
Collect data (**Chapter 7**)	5	2
Enter data and conduct preliminary review of results (**Chapter 8**)	10	4
Complete data analysis and validation (**Chapter 8**)	3	2
Prepare results for dissemination (**Chapter 9**)	5	2
Total	**55**	**10**

Box 6.3. Practical tip: Empowering communities to lead data collection

In a large Kenyan costing study (28)led by an academic team from University College London, the researchers confronted the challenge of limited resources and extensive study sites. Realizing the impracticality of conducting on-site observations and interviews at all network sites, they devised a different approach to optimize their budget while ensuring comprehensive data collection.

Instead of traditional fieldwork, the team prioritized sensitization and training sessions conducted at the outset of the study. These sessions aimed to inform and address concerns of CLOs, as well as train them on how to use and complete all the required data collection tools. Following a test pilot phase, CLOs were equipped with data collection tools and instructed to complete and submit them every week. At the end of the week, the research team reviewed the completed tools and promptly addressed any issues or provided clarifications as needed.

While budget constraints motivated this approach, empowering CLOs to lead data collection should be considered a best practice in any context. Community leadership helps ensure the right questions are asked, the right data are collected, and results are interpreted in ways that reflect community realities. This approach can also reduce costs without compromising data quality and supports a mutually beneficial study process. Key to success was strong community buy-in and rapid feedback from the central research team. At the same time, as highlighted in **Box 6.1**, community-led data collection may present challenges in some contexts, making it important to adapt team composition and roles to local realities.

By this stage, users should have a clear understanding of what data already exist and what data still need to be collected. The data mapping exercise (**Chapter 5**) will have clarified which data are available through desk review (e.g. financial records, existing reports), and which will require additional field-based data collection (e.g. interviews, site visits). Based on this, a detailed workplan should now be developed.

While preparation steps have been presented sequentially throughout this chapter, the actual process is often highly iterative. Data collection and analysis will happen in parallel, and early analysis often reveals gaps that require returning to earlier steps. This is normal, particularly in costing exercises.

Where CLOs are leading the exercise, it is important to assign a dedicated person to coordinate this work. Costing can be demanding and is often difficult to manage alongside day-to-day responsibilities. Timelines will vary depending on the purpose, scope and methods chosen. For example, a full economic costing across multiple CLOs and interventions will require far more time than a top-down costing of one or two interventions by a single CLO.

Finally, many of the tools and worksheets presented earlier, such as the stakeholder map, process map, and data mapping template, can now be used to structure and guide the workplan. These can help organize tasks, data sources, responsibilities and timelines into a single, coherent plan (**Box 6.4**).

Box 6.4. How to use the Scope Framework tool

Objective:

- To create a structured plan that outlines how and where all required data for the costing or budgeting exercise will be collected, analysed, validated and shared.

Method:

- **Who:** Costing or budgeting team.
- **How:** Return to your completed Data Mapping tool (Chapter 5) and add the following information for each data item:
  - — Who is responsible for collecting the data, and by when.
  - — Who is responsible for verifying the data, and by when.
  - — Add additional study steps (submission to ethics, stakeholder meeting, presentation of results) and set target dates.

PART 3

Costing guidance

This section provides step-by-step guidance for conducting an observed costing of community-led HIV responses. It focuses on the practical tasks needed to collect, analyse and interpret cost data, with instructions supported by Excel-based tools in the appendix. The emphasis is on actionable "how-to" guidance covering what to do, how to do it, and what to watch out for, enabling teams to apply costing methods in real-world settings and make full use of the results.

Chapter(s) included:

Chapter 7
Data collection for costing

Chapter 7 provides step-by-step guidance for collecting and organizing the data required to conduct an observed costing of community-led HIV responses using a combined top-down and bottom-up approach.

By the end of this chapter, you should be able to:
1. Identify and gather existing financial and output data through desk review of organizational records.
2. Collect missing data through fieldwork, observations and interviews.
3. Measure and apply allocation factors for shared and central resources.
4. Maintain data quality through routine review and validation.

Supporting materials: Appendix 9, CLR Costing_Data Collection workbook.

Chapter 5 outlined how to define what to cost by mapping interventions, identifying necessary resources for delivery and assessing the availability of existing data. **Chapter 6** then described how to prepare for data collection by assembling a team, engaging stakeholders, finalizing a budget and compiling a detailed workplan.

Building on that foundation, this chapter guides teams in collecting the data needed to measure, value and allocate inputs. It outlines a flexible, hybrid approach that applies top-down methods where detailed financial records exist, and bottom-up (micro-costing) methods where data are incomplete or unavailable. In practice, most costing exercises will combine both approaches.

Templates of the tools referenced in this chapter are provided in **Appendix 9**.

7.1. Extracting existing data

7.1.1. Financial records

A CLO's historic financial records are a critical starting point for costing. When sufficiently detailed, they allow for a top-down approach (**Chapter 4**), a method that uses total expenditure data to estimate the value of inputs. This approach is less resource-intensive than collecting data from scratch and is often preferable if existing financial data are detailed and reliable (**Box 7.1.**).

Costing should cover a period long enough (one year is best) to capture the full range of ongoing service delivery costs, not just start-up expenses. But at a minimum, the programme should be

operational for at least six months before initiating costing, with the selected period reflecting typical operations.

Begin by gathering expenditure records from this period, including central and site-level financial records, donor-specific reports and itemized bank or accounting system exports. These should capture all relevant inputs (e.g. salaries, operations, equipment, consumables and training), and link them, where possible, to specific sites or interventions.

Box 7.1. Practical tip: Is your financial data sufficient for top-down costing?

Before using a top-down approach, assess whether your expenditure records contain:

- Transaction dates.
- Clear item descriptions, including what was purchased, for what purpose, and where it was used.
- Amounts and currency.
- Supporting information like project codes or accounting categories.

Reliable sources include itemized bank statements or full export files from accounting software (e.g. QuickBooks). Importantly, summary-level reports will not be sufficient. If the data lack these elements, it may be necessary to strengthen financial tracking or use a bottom-up approach, collecting prices and quantities directly for each input.

In some cases, records will be split across donors, projects and sites, or between direct project costs and central-level or headquarters (HQ) costs. All relevant sources must be compiled to ensure a complete financial picture.

Here is a good example of financial records from a CLO's bank transaction export with detailed item descriptions, dates, amounts and project codes.

General Account : [Bank Code] - [CLO Name] Bank Account (SLL)

Account detail

DCC : 03 [CLO Name] Period From 01/01/2023 To 30/04/2023

Account Date	[Code]	[Account Code]	[Source Code]	Description	Credit	Cur.
09/01/2023	030006	22910	G3	Bank charges for January 2023	30,00	SLL
17/01/2023	030001	22110	G3	Transport refund for follow-up on cases of human right violations	300,00	SLL
20/01/2023	030001	22110	G3	Transport refunds for support group meetings	122.692,50	SLL
24/01/2023	030001	22110	G3	DSA to [Name] for monitoring in Port Loko	7.000,00	SLL
24/01/2023	030002	22110	G3	DSA to [Name] for monitoring in Bo	7.000,00	SLL
24/01/2023	030003	22110	G3	DSA to [Name for monitoring in Western Area	5.000,00	SLL
24/01/2023	030004	22110	G3	Fuel for monitoring H.Q	5.070,00	SLL
24/01/2023	030006	22910	G3	Bank charges for January 2023	100,00	SLL
11/04/2023	030001	23120	G3	Facilitation fee for training of trainers of religious leaders	1.500,00	SLL
11/04/2023	030004	22230	G3	Top up cards for coordination for training of trainers for religious leaders	1.500,00	SLL
11/04/2023	030006	28203 - GCT	G3	Stationery items for training of trainers of religious leaders	571,73	SLL
14/04/2023	030001	22110	G3	DSA,transport refunds,breakfast and lunch for training of trainers of religious leaders	97.979,75	SLL

Note how this financial record includes both central costs (bank charges or fuel for monitoring activities) and direct intervention costs (facilitation fees, top up cards and stationery items for the training of religious leaders). The transactions are sufficiently detailed to show what was spent (facilitation fee), why (training religious leaders), and where (in Freetown).

Begin analysis early to guide smarter data collection.

Important note: Start analysis as soon as you collect financial data. Do not wait until all data collection is complete before beginning analysis. As soon as financial records are obtained, review them in detail to identify gaps, inconsistencies or unclear allocations. This early analysis will highlight what additional data is needed (e.g. outputs, allocation factors, in-kind contributions) and whether data collection tools need to be adapted to capture it. Collection and analysis should be an iterative process, with findings from one informing the other in real time.

7.1.2. Output and outcome data

In addition to financial records, costing requires data on programme outputs and outcomes. These are used to divide total intervention costs to calculate unit costs (e.g. cost per person tested, per session delivered) and to allocate shared inputs across different interventions or activities.

Relevant output and outcome indicators, defined based on the interventions mapped in **Chapter 5**, should now be extracted from routine M&E systems, programme reports or partner reporting forms. Indicators may reflect immediate programmatic outputs (e.g. volunteers trained, condoms distributed, sessions held) or intermediate health outcomes (e.g. people tested, tested positive, treated or virally suppressed). Where M&E data are incomplete or inconsistent, additional efforts may be needed to fill gaps, such as reviewing registers, logs or internal databases.

When collecting output data, consider factors such as seasonality, which can significantly influence service volumes. For example, voluntary medical male circumcision numbers may peak during specific periods, affecting the representativeness of data if only part of the year is captured.

Important note: All output data must align with the same time period and geographic scope used for financial data.

Box 7.2. How to use the Output tool

Objective:

- To identify and quantify the results of each intervention.

Methods:

- **Who:** Costing team, in collaboration with M&E officers or programme managers.
- **How:**
  - Extract data from existing sources such as M&E databases, registers, activity reports or partner reporting forms.
  - Ensure all data are anonymized and lack all personal identifiers of clients.
  - Validate consistency across sites and time periods.

What to document:

- Define the output and outcome indicators for each intervention.
- Use the same reference period as the financial data (e.g. calendar year of 2024).
- For each indicator, disaggregate results by site and quarter.
- Enter available data into the tool.
- Repeat for all interventions included in the costing scope.

See example below of a CLO costing HIV testing that shows both the number of people tested (on left), and number of people who tested positive (on right) across three regions:

Intervention 1:	HIV Testing				
Output/Outcome 1:	Number of people tested				
Costing Period:	Q1	Q2	Q3	Q4	Total
Region 1	100	103	105	115	423
Region 2	20	13	23	14	70
Region 3	35	34	12	30	111
					0
					0
					0
					0
					0
					0
					0
Total (across sites)	155	150	140	159	604

Intervention 1:	HIV Testing				
Output/Outcome 2:	Number of people tested positive				
Costing Period:	Q1	Q2	Q3	Q4	Total
Region 1	3	2	3	5	13
Region 2	1	0	0	0	1
Region 3	1	1	0	2	4
					0
					0
					0
					0
					0
					0
					0
Total (across sites)	5	3	4	7	19

Box 7.3. Practical tip: Collating output and outcome data into a unified data set

Across many CLOs, M&E data may be stored separately across projects or donors, often in different formats, systems or reporting templates. While this meets short-term reporting requirements, it creates major challenges for CLOs in strategic monitoring, costing and planning.

For this exercise, data must be consolidated to reflect total outputs and outcomes across all funders and activities. This centralization is not only essential for accurate costing, but critical for the CLO's ability to monitor its performance, identify gaps and adapt.

Every CLO should be able to answer questions such as: How many people were reached last month? How many [insert relevant indicator] were conducted last quarter?

If the answers require navigating multiple systems and piecing together donor-specific reports, there is a problem.

Investing time in creating a single, unified output/outcome data set, whether through Excel or a shared database, can improve not only costing, but programme management, funding proposals, and impact storytelling. These data are the bread and butter of your work. Make sure it is in one place.

7.2. Filling gaps in cost data using bottom-up methods

Even when using a top-down approach, some inputs may be missing from existing financial records. These typically include previously purchased resources (e.g. buildings, vehicles, equipment), items paid for by other entities (e.g. medical supplies from government), and in-kind contributions (e.g. volunteer time, donated space). These inputs should have been identified in Chapter 5 through process mapping, central resource mapping, stakeholder mapping and data mapping.

This section presents practical guidance for measuring and valuing these inputs using a bottom-up approach. Each input type has a dedicated data collection tool. These tools can also be used for full bottom-up costing exercises when financial records are not available.

Table 7.1. What gaps typically require bottom-up data collection?

Type of input	Common examples	Explanation
Previously purchased capital items	Building owned by the CLO	These inputs may still be contributing to implementation but are not captured in recent financial records. Their value should still be included in a full costing.
	Equipment purchased years ago and still in use	
	Vehicles purchased in the past	
Resources paid for by other entities	Rent, staff or supplies covered directly by government or other stakeholder	These inputs may be used in the intervention but do not appear in the CLO's own expenditures. These need to be tracked and valued to reflect the full cost of the intervention.
	Training costs paid by partner organizations	
	Medical commodities from national supply chains	
In-kind contributions	Volunteer time (e.g. peer educators, champions, unpaid interns, board members)	These are unpaid or donated contributions that still consume resources and should be valued in economic costings.
	Use of community venues	

7.2.1. Capital inputs

Capital inputs include resources such as buildings, vehicles and equipment, including any input with a useful life of more than one year. When using a top-down approach, many of these inputs may be missing from current financial records because they were purchased in previous years, donated, or not directly expensed by the CLO. To fill these gaps, or when using a bottom-up approach, study teams should use the Capital tool described below to identify, quantify and value these resources.

Box 7.4. How to use the Capital tool

Objective:

- To identify and assign value to capital resources used for delivering interventions.

Methods:

- **Who:** Costing team, with support from site managers or administrative staff.
- **How:**
  - Review organizational documents such as procurement records, inventory logs or fixed asset registries to identify items that were purchased previously but still in use.
  - Conduct site visits and interviews with staff to conduct an inventory and confirm which items are currently operational and relevant to implementation.

What to document:

- **Buildings and land:** If the CLO owns land or building space, a practical approach is to estimate either the resale or rental value of the space today.
- **Equipment and vehicles:** For all items still in use, collect data through asset inventories, interviews and reviews of purchase records. Value using replacement cost for items of same condition. Vehicle relate quotes can be found online in many countries.
- **Document:**
  - **Item details:** Name and type of equipment, asset, vehicle or space.
  - **Condition:** Whether the item is in working order or not. Only include items that are still functional (have resale value) and contribute to the intervention.
  - Location/site
  - **Value:**
    - Use original cost if financial record is available.
    - Use current resale value or market replacement cost if original data are missing.
  - **Date:**
    - If using original purchase value, record original purchase year.
    - If estimating replacement or resale value, record current year.
  - **Quantity:** Number of units.
  - **Use and allocation:** Specify whether the item is used for a single intervention or is a shared resource across multiple interventions.

Box 7.5. Case example: Valuing donated building spaces in South Africa

In a South Africa costing study, the study team found that the municipal governments generously provided office spaces and community halls to CLOs for their operations. Determining the value of these donated spaces required a pragmatic approach.

Drawing on local expertise, the team leveraged staff knowledge of the local market to approximate the accurate value. First, they consulted staff of the CLOs themselves to gauge typical rental prices for similar spaces simply by asking, "How much would you typically have to pay to rent a space like this?" And, indeed, personnel members had a good sense of local average market rates and were able to offer a price range. The team then opted to use the lower end of the provided price range. This decision was informed by observing that the donated spaces were not too well-maintained compared to commercial rentals.

By relying on community insights and adjusting for the conditions of the spaces, the team was able to triangulate and arrive at a realistic valuation of the donated office spaces.

7.2.2. Personnel

Personnel are a key recurrent input and include both paid and unpaid staff who contribute to intervention delivery. This may include direct service providers (e.g. clinicians, peer educators); support personnel (e.g. finance, procurement, data officers); and volunteers. While payroll records may capture many salaried staff, some contributions—such as part-time workers, seconded staff and volunteers—may not appear in financial records. These gaps require additional data collection to identify, quantify and value personnel inputs.

Box 7.6. How to use the Personnel tool

Objective:
- To identify, quantify and value personnel inputs used across sites and interventions.

Methods:
- **Who:** Conducted by costing team, along with programme managers, finance officers, human resource staff or site-level personnel managing volunteer workforce.
- **How:**
  - — Review existing records such as payroll files, HR databases, staff time sheets, volunteer logs.
  - — Use the results of the process mapping exercise to identify any personnel whose contributions may not be documented.
  - — Conduct interviews with relevant staff to complete or verify missing data.

What to document:
- List all individuals contributing to the intervention, including those working full-time, part-time, casually or voluntarily.
- Indicate the location(s) where each person works and the specific interventions they support.
- Record whether each role is financial (paid) or provided in-kind (unpaid).
- Document the quantity of time worked and the corresponding unit of time (e.g. monthly salary, daily rate, hours per week).
- Identify salary and benefit information using HR or finance records. For unpaid roles, estimate the economic value using replacement or opportunity cost methods (see **Chapter 4.2.1.2** on valuing volunteer time).

Box 7.7. Case example: Quantifying and valuing peer educator time in Haiti

In a Haitian CLO, peer educators play a leading role in conducting HIV prevention activities among gay and other men who have sex with men. Although labelled "volunteers," they receive modest monthly stipends primarily meant to cover the cost of travelling to different sites. The CLO follows a structured approach to estimate the full economic value of their volunteers' time:

- **Quantifying peer educators:** The team refers to the CLO's volunteer registry and activity logs to identify how many peer educators were actively contributing over the 12-month costing period.

- **Measuring time worked:** To estimate hours worked, the team refers to the CLO's detailed volunteer log that records each volunteer's work, including the date and start and end times. From these data, an average number of hours worked per peer educator is calculated and applied across the group.

- **Valuing time contributed:** While stipend payments are already recorded in financial records, the team considers this amount insufficient to reflect the value of peer educators' contributions. For the economic costing, the team adds a separate line in the Personnel tool to value their time, using the national minimum wage rate in 2024 (see worked example in **Box 4.4**). This, they feel, better reflects the opportunity cost of their involvement.

This example illustrates how CLOs can go beyond financial records to more accurately reflect the value of community contributions, including roles that are partially but may not be fully compensated.

7.2.3. Recurrent Inputs

Recurrent inputs are those inputs that are consumed and replaced within one year and are required on an ongoing basis to deliver services. These include supplies and consumables (e.g. HIV test kits, gloves, stationery), building operations and repairs (e.g. electricity, water, cleaning services), transport and vehicle maintenance (e.g. fuel, public transport), other recurrent costs (e.g. communications, food).

Some of these inputs may be captured in existing financial records, while others, especially those paid for by other stakeholders or contributed in-kind, may require direct data collection. The Recurrent Inputs tool can be used to identify, measure and value these costs (**Box 7.8**).

Box 7.8. How to use the Recurrent Inputs tool

Objective:
- To identify, quantify and value recurrent inputs used across sites and interventions.

Methods:
- **Who:** Conducted by costing team, along with programme managers, finance officers, procurement staff or site-level personnel.
- **How:**
  - Review available documents such as expenditure reports, purchasing invoices, stock cards and inventory registries.
  - Use process mapping results (**Chapter 5**) to identify recurrent items that may not appear in financial records, including those contributed in-kind or by partners.
  - Where data are missing, conduct site visits or interviews with key staff to collect additional information.

What to document:
- **Details of the item:** Include specifications, brand/model, unit of measure (e.g. litres of fuel, number of pamphlets).
- Location (site).
- **Price/value:**
  - If purchased: Unit cost from invoices or partner-provided quotes.
  - If value unknown: Estimate value using market prices or procurement lists.
- **Date:**
  - If using original purchase value: Record original purchase year.
  - If estimating replacement or resale value: Record current year.
- **Quantity used:** Include all uses and wastage in the study period (e.g. expired or lost items).
- **Use and allocation:** Specify whether the item is used for a single intervention or is a shared resource across multiple interventions.

Box 7.9. Case example: Costing medical supplies in Togo

During a costing exercise in Togo, a CLO estimated the quantity and value of HIV test kits used in 2024.

- **Valuing the kits:** The CLO did not purchase the kits themselves; they were provided by the Togo Ministry of Health. To determine cost, the team consulted with government stakeholders who provided an estimated price of US$ 1.27 per test kit, inclusive of taxes, import fees and handling costs.
- **Quantifying the kits used:** The CLO reviewed its stock cards and distribution logs for the 2024 costing period. The total number of test kits used was calculated as:
  - Test kits used for client testing = 604
  - Test kits used in staff trainings = 10
  - Test kits lost to expiration/damage/loss = 36
  - Total to be costed = 650

Although 604 test kits were used for HIV testing, all 650 kits consumed in the year should be included in the costing exercise to reflect real use and costs.

7.2.4. Training

Training represents a distinct cost category because it is typically conducted periodically, either at project start-up or at regular intervals, and involves a combination of inputs such as personnel, supplies, equipment, venues and transportation.

Important note: This section refers specifically to training provided to staff or personnel, including community-based workers, peer educators and support staff—not training delivered to beneficiaries or community members.

Trainings may be delivered and paid for by other institutions (e.g. government, donors or implementing partners), in which case they may not appear in a CLO's own financial records. It is, therefore, important to conduct an inventory of all trainings received by staff during the costing period, regardless of who paid for them.

Trainings that yield benefits lasting more than one year (e.g. onboarding staff with durable skills) should be treated as capital inputs. Those that occur frequently or have short-term benefits should be considered recurrent, for example, in contexts with high staff turnover that require regular retraining.

The Training tool can be used to identify, measure and value these costs (**Box 7.10**).

Box 7.10. How to use the Training tool

Objective:
- To identify, quantify and value inputs used to conduct training activities.

Methods:
- **Who:** Conducted by costing team, along with programme managers or site-level personnel.
- **How:**
  - Extraction of existing data: Review expenditure reports, programmatic documents, training reports/logs and participant sign-up sheets.
  - Direct interviews: Interview key staff and managers to identify externally funded or undocumented training sessions.

What to document:
- **Training details:** Training title and purpose.
- **Date(s):** Of the training and duration.
- **Organization name:** The institution that conducted or paid for the training.
- **List:** all inputs used in the training including venue hire, transportation, equipment, per diems, facilitator's pay, supplies, meal and refreshments, etc.
- **Total:** The number of participants and the portion of CLO participants (**Box 7.15**).
- Indicate: Whether this is a recurrent training (happens annually) or capital training (occurs only once).
- **Valuation:**
  - Record whether this is a financial cost (paid) or an in-kind contribution (unpaid/donated).
  - When training is externally provided, record the estimated market cost if it had to be organized by the CLO itself.

Special notes:
- This tool is meant to capture training for staff/personnel only, not for beneficiaries or clients.
- Be sure to include in-kind contributions (e.g. free venue use, unpaid facilitator time) and trainings conducted or funded by external partners.

Allocation factor: A proportion used to distribute shared or central costs across multiple interventions, activities, programmes, or sites.

7.3. Collecting allocation factors for shared costs

Oftentimes, a single input, such as a vehicle, staff member or utilities, can be used across multiple interventions and sites. When this happens, the total cost of that input must be divided among its various uses. This process is known as allocation.

Allocation factors are measurable variables, ideally based on quantitative data, that help divide the cost of shared inputs in a way that is rational, consistent and transparent. They reflect how much of a resource is used for each specific intervention or site.

Common allocation factors include:

- **Time:** Such as number of hours a staff member spends per intervention.
- **Distance travelled:** Kilometres travelled per intervention.
- **Floor space:** Square meters dedicated to each intervention.
- **Volume of output:** Number of people reached per site.
- **Training:** Number of staff trained from each site.
- **Client mix:** Proportion of clients by service type (e.g. 20% STI patients, 40% patients on anti-retroviral treatment).

The goal is to approximate actual use as closely as possible. Teams should strive to apply consistent allocation rules across similar input types, using the most rational data available.

The following sections walk through each major input category (capital, personnel, recurrent and training) and present common allocation factors, along with examples of data sources and tools that can support the allocation process.

7.3.1. Allocating capital items

Common allocation factors for capital inputs include time, space, distance travelled, output produced or participants reached (**Table 7.1.**). The appropriate factor depends on the nature of the input and the availability of reliable data.

Table 7.2. Allocation of shared capital inputs

Inputs	Allocation factor	Data source	Examples
Buildings	% of time used by intervention	Process Mapping tool or Time Sheet tool	Cost of outreach site allocated based on the proportion of total time staff spent on each intervention at that site
	% of floor space	Building plans	Cost of drop-in centre allocated based on the proportion of total floor space used for each intervention (e.g. one room for ART, another for testing)
	% of intervention participants reached	Output tool	Annual office rent allocated to interventions based on the number of participants reached per intervention
	% of total direct costs per intervention	Cost summary sheets	Cost of headquarters office building allocated to interventions based on share of total direct costs
Vehicles	% of distance travelled	Vehicle logbooks Mapping software	Cost of a motorcycle allocated across different interventions based on the kilometres travelled for each
	% of time travelled	Time Sheet tool Vehicle logbooks	Cost of donated bicycle allocated based on time spent traveling for each intervention
Equipment	% of time used by providers	Process Mapping tool Time Sheet tool	Cost of tablet allocated based on community-led monitor's time spent using it for each service area
	% of output produced	Output tool	Cost of lab equipment allocated based on number of tests conducted per intervention
	% of intervention participants reached	Output tool	Cost of TV in waiting room of drop-in centre allocated based on number of participants reached per intervention
	% of total direct costs per intervention	Cost summary sheets	Cost of laptops, shared printers and furniture in the headquarters office allocated across interventions based on their share of total direct costs

Box 7.11. How to use the Vehicle Logbook Tool

Objective:

- To identify, quantify and value vehicle-related capital and recurrent inputs (e.g. value of vehicle, fuel, maintenance costs) across interventions and sites based on use and travel patterns.

Methods:

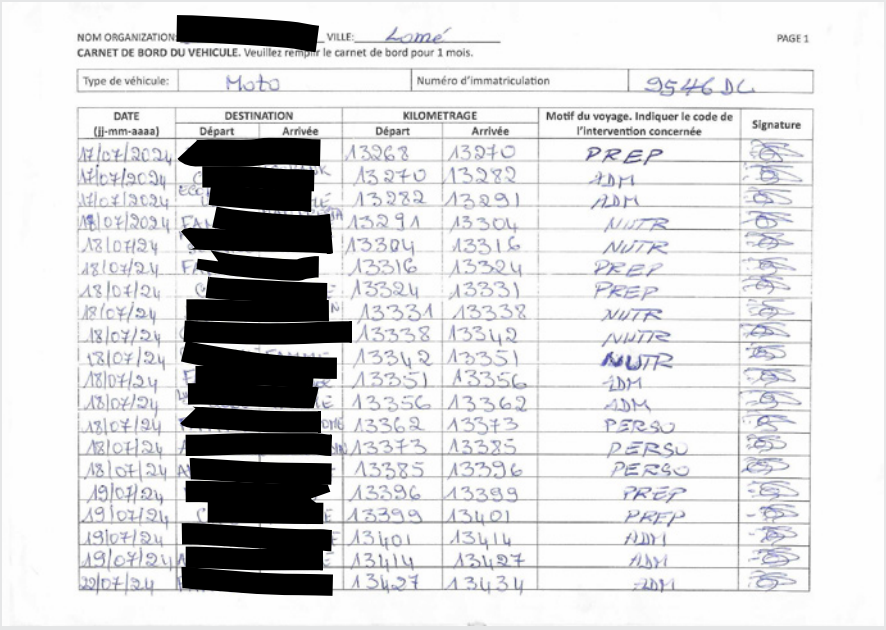
- Who: Staff using vehicles (e.g. driver and passenger(s).
- How:
  - Ask staff using organization-owned or personal vehicles for work to complete the logbook for every trip taken over a defined data collection period (e.g. one month).
  - To encourage compliance and quality, supervisors or the costing team can collect and review logbooks on a weekly basis.

What to document:

- Complete fields for vehicle type and licence plate at the top of the logbook.
- Date of travel.
- Starting location and destination.
- Starting and ending mileage. If the odometer does not function use starting and ending times instead.
- Purpose of travel (ideally select from a predetermined list of interventions including HIV testing, education, CLM).
- Signature for verification.

Box 7.12. Case example: Using vehicle logbooks for cost allocation

In Togo, a CLO used a vehicle logbook for their costing exercise, recording the date, destination, odometer reading and purpose of each trip for their motorcycle.



NOM ORGANIZATION [redacted] VILLE: Lomé PAGE 1

CARNET DE BORD DU VEHICULE. Veuillez remplir le carnet de bord pour 1 mois.

Type de véhicule:	Moto	Numéro d'immatriculation	9546 DL

DATE (jj-mm-aaaa)	DESTINATION Départ	DESTINATION Arrivée	KILOMETRAGE Départ	KILOMETRAGE Arrivée	Motif du voyage. Indiquer le code de l'intervention concernée	Signature
17/07/2024	[redacted]		13268	13270	PREP	
17/07/2024			13270	13282	ADM	
17/07/2024			13282	13291	ADM	
18/07/2024			13291	13304	NUTR	
18/07/24			13304	13316	NUTR	
18/07/24			13316	13324	PREP	
18/07/24			13324	13331	PREP	
18/07/24			13331	13338	NUTR	
18/07/24			13338	13342	NUTR	
18/07/24			13342	13351	NUTR	
18/07/24			13351	13356	ADM	
18/07/24			13356	13362	ADM	
18/07/24			13362	13373	PERSO	
18/07/24			13373	13385	PERSO	
18/07/24			13385	13396	PERSO	
19/07/24			13396	13399	PREP	
19/07/24			13399	13401	PREP	
19/07/24			13401	13414	ADM	
19/07/24			13414	13427	ADM	
22/07/24			13427	13434	ADM	

Over the period reviewed, the logbook showed: 22 km travelled for PrEP-related activities (e.g. procuring supplies, distributing PrEP); 58 km for administration at the central level (e.g. going to the bank, procuring office supplies); 45 km for nutrition-related activities; and 34 km for personal reasons (excluded from programme costing).

This totalled 159 km travelled, of which 125 km were for programme activities. Based on this, the CLO calculated the following allocation factors:

- PrEP: 22 km ÷ 125 km = 18%
- Administration (or central costs): 58 km ÷ 125 km = 46%
- Nutrition: 45 ÷ 125 km = 36%

If the total vehicle cost for the period (including the annualized value of the moto, maintenance and fuel) was US$ 1000, the costs allocated would be:

- PrEP: 0.176 × 1,000 = US$ 176
- Administration: 0.464 × 1,000 = $464
- Nutrition: 0.360 × 1,000 = $360

By recording trips in this way, the organization can allocate vehicle and vehicle maintenance costs to different interventions in a consistent and transparent manner.

7.3.2. Allocating personnel costs

Within a community-led organization, some personnel may divide their time across multiple interventions and sites. To allocate personnel costs accurately, it is important to understand how staff or volunteer time is distributed across interventions. This can be done by asking personnel to complete time sheets using the Time Sheets tool.

Alternatively, time can be estimated from activity records (**Table 7.2**). For example, if a peer educator's work is tracked by the number of outreach sessions conducted for different interventions, their time (and associated cost) could be allocated proportionally based on those records. This method works best when interventions take a similar amount of time per unit; if some interventions are more time-intensive than others, these differences should be reflected in the allocation.

Table 7.3. Allocation of shared personnel

Inputs	Allocation factor	Data source	Examples
Personnel	% of time spent on each intervention	Time Sheet tool	Stipend of peer educator counsellor allocated based on proportion of time spent on each intervention
	% of participants reached by each intervention	Output tool	Salary of drop-in centre manager allocated across the number of clients reached per intervention or service area, if each requires a similar amount of time per client
	% of commodities distributed for each intervention	Pharmacy logs, Recurrent tool, Output tool	Salary of pharmacist allocated across interventions based on proportion of drugs or commodities dispensed for each
	% of total direct costs for each intervention	Aggregate costing sheets	Salaries of executive director and central support staff allocated across interventions based on the share of total direct costs per intervention, with caution where high-cost commodities could distort allocations

Box 7.13. How to use the Time Sheets tool

Objective:
- To quantify time spent by paid and unpaid personnel across sites, interventions.

Methods:
- **Who:** Personnel or data collectors.
- **How:**
  - **Retrospective:** Involves asking personnel to retrospectively compete the tool based on organizational time sheets, personal calendars or recall. However, using recall is discouraged due to potential for bias.
  - **Prospective:** Involves asking personnel to prospectively complete the tool across a representative period as they conduct interventions and activities. This period should be feasible and reflect the typical work pattern of the personnel.
  - **Sampling:** In small CLOs, all staff may complete the tool. In larger CLOs, identify relevant staff categories and select a representative sample from each.
  - **Observation:** A data collector shadows the staff members and fills out the time sheet based on observed activities.
  - **Self-reporting:** Staff complete the tool themselves as they go about their workday.

What to document:
- **If data are collected prospectively, include:**
  - Dates and times.
  - Intervention and administrative activities (e.g. central management, management administration, HIV testing, lunch break).
  - Locations and sites.
- **If data are collected retrospectively, include:**
  - Dates of the reference period.
  - Intervention and administrative activities.
  - Estimated percentage of time spent across each intervention.

Box 7.14. Case example: Using time sheets for cost allocation in CLM, Philippines

In a costing study of CLM in the Philippines, the research team used a combination of retrospective and prospective methods to estimate personnel time across two CLM models: Face-to-face data collection and virtual data collection.

For the start-up phase, where central staff focused on designing systems, building tools and training community monitors, the team used a retrospective approach. Staff calendars and planning documents were reviewed, and personnel were asked to estimate how their time was divided across the different CLM models. This allowed the team to use their personal work calendars as memory aids to approximate time use during a period when real-time tracking had not yet begun.

For the implementation phase, where staff were actively supporting CLM data collection, validation and use, the team shifted to prospective methods. Central staff were asked to complete time sheets in real time, while community monitors working in the field were shadowed by data collectors, who observed their activities and filled out the forms based on direct observation.

This approach demonstrates that a flexible, mixed-method strategy can be essential for capturing time use accurately, especially in evolving programmes. By adapting to context and available resources, teams can improve both the completeness and validity of their personnel cost estimates.

7.3.3. Allocating recurrent costs

Recurrent inputs, such as supplies, building operations and transportation, are often shared across multiple interventions and sites. To ensure accurate costing, these shared recurrent costs should be allocated using measurable variables that reflect their actual use. Allocation factors may include the number of intervention participants, time spent by personnel, floor space used or distance travelled, depending on the input type (**Table 7.3.**). Often, the same allocation factor used for a capital input (e.g. a building or vehicle) can also be applied to its recurrent equivalent (e.g. rent, fuel or electricity).

Table 7.4. Allocation of shared recurrent inputs

Inputs	Allocation factor	Data source	Examples
Supplies	% of intervention participants reached	Time Sheets tool	Stipend of peer educator counsellor allocated based on proportion of time spent on each intervention.
Building operation and repairs	% of floor space	Capital tool	Cost of office repaint allocated to different interventions based on the proportion of floor space dedicated to each.
	% of time spent by providers	Process Mapping tool	Salary of pharmacist allocated across interventions based on proportion of drugs or commodities dispensed for each.
	% of intervention participants reached	Output tool	Cost of water supply allocated to different interventions based on the proportion of participants reached.
Vehicle operation, repairs and transportation	% of distance travelled	Vehicle Logbooks tool	Salary of pharmacist allocated across interventions based on proportion of drugs or commodities dispensed for each.
	% of time travelled	Time Sheets tool	Salary of pharmacist allocated across interventions based on proportion of drugs or commodities dispensed for each.
Other recurrent	% of intervention participants reached	Output tool	Cost of office drinking water allocated to different interventions based on the proportion of participants reached.
	% of total direct costs for each intervention	Aggregate costing sheets	Internet fees or cleaning supplies allocated in proportion to direct costs.

7.3.4. Allocating training costs

Training costs can be substantial, especially in community-led programmes where building staff capacity is essential. While trainings are often implemented centrally or by external partners, they may support multiple interventions or activities. As such, it is important to allocate these shared costs appropriately using measurable allocation factors.

Programmes should use existing training reports, agendas or attendance sheets to determine appropriate allocation factors. The Training tool is designed to guide teams in documenting this information.

Table 7.5. Allocation of shared training costs

Inputs	Allocation factor	Data source	Examples
Training	% of participants per training	Attendance log, Training tool	If a training includes three HIV testers and two ART adherence counsellors, costs may be allocated 60% to HIV testing and 40% to ART adherence.
	% of time or agenda content per intervention	Training agenda, programme reports, Training tool	If a five-day training dedicated two days to education and information and three days to advocacy efforts, costs may be allocated 40% to education 60% to advocacy.
	% of training outputs relevant to an intervention or service area	Training report	If a training produced 50 national HIV indicators for health care and 15 of those pertained to CLM, then 30% of the training costs may be allocated to CLM.

Box 7.15. Valuing shared external trainings

Sometimes, training is provided and paid for by an external institution, like UNAIDS, for multiple CLOs. In these cases, it is important not to assign the full cost of the training to a single CLO unless that organization was the sole beneficiary.

For example, UNAIDS conducted a training for a total cost of US$ 2500. The attendee log shows that 10 people participated, including two staff members from the CLO conducting the costing. In this scenario, the CLO should not include the full US$ 2500 in its costing. Instead, only the proportion attributable to the CLO's participation should be included. In this case, that is two out of 10 participants, or 20% of the total cost, which equals $500.

This quantitative approach ensures fair and accurate attribution of costs when resources are shared across organizations. Proportions can be based on:

- Number of participants
- Level of participation (e.g. if only partial days were attended)

CLOs are often required to maintain documentation for trainings, such as agendas, reports, or sign-in sheets as part of their reporting to donors or health ministries. These routine records can also be very useful to justify allocation factors in costing calculations. Where keeping participant names may pose confidentiality risks, organizations may retain anonymized or aggregated records.

7.4. Data management and quality assurance

Throughout the costing process, data will come from many different tools, stakeholders and sources. The best way to stay organized is to use the workplan as a live tracker, updating it as each tool is introduced, completed, reviewed and validated.

To ensure quality, it is good practice to walk through tools with CLO staff the first time, let them complete a few entries, and review the completed tools together to course correct if needed. During data collection, the lead researcher or data manager should regularly enter and review incoming data using the guidance in **Chapter 6**. This allows for continuous monitoring and quick resolution of issues.

Data quality issues are common in costing exercises, especially when information comes from multiple sources such as financial records, interviews and monitoring systems. Even when tools are well-designed and completed collaboratively, discrepancies can arise due to inconsistencies in reporting, irregular funding patterns or data entry errors. To help prevent these issues from affecting the final results, **Box 7.16** below highlights common culprits in data collection, along with practical tips for spotting and addressing them early.

Box 7.16. Practical tip: Common data quality issues and how to catch them

- **Buildings and rent payment:**
  - **Issue:** Rent is not always paid monthly and may not appear consistently in expenditure records.
  - **Tip:** Use rental agreements to determine total annual or monthly rent, especially when payment is irregular. Be careful not to double count: Choose either expenditure records or rental agreements, not both.

- **Personnel costs:**
  - **Issue:** Salary payments may be delayed, and expenditure records for one year may include payments owed from previous periods due to backlogs or disbursement delays. This can distort costs for the study period.
  - **Tip:** Prepare an inventory of all paid staff, including their roles, and their annual total salary and benefits. Compare this with salary expenditures reported in financial records. If there is a large discrepancy, further investigation is needed to determine whether costs have been misaligned across time periods.

- **Outputs data:**
  - **Issue:** Unusual spikes or inconsistencies in reported intervention outputs or outcomes.
  - **Tip:**
    - Check trends over time. If one month or quarter is much higher than others, investigate further.
    - Check internal consistency between related indicators—for example, positivity rates across quarters (number tested vs. number testing positive). Sudden jumps may indicate data entry or reporting errors.

- **Medical supplies:**
  - **Issue:** Misalignment between the intervention output and the number of supplies used.
  - **Tip:** Compare medical supply consumption (e.g. HIV test kits) with relevant reported outputs (e.g. people tested). A difference of less than 20% may be normal due to waste, but large gaps should be reviewed. Check whether the issue lies in supply records or M&E data and correct accordingly.

Chapter 8
Data analysis for costing

Chapter 8 provides step-by-step guidance for entering, cleaning and analysing data in the CLR Costing workbook to estimate total and unit costs for community-led HIV interventions. Building on the data collected in Chapter 7, this chapter walks users through how to use the workbook's templates, formulas and analysis features to generate transparent, consistent cost estimates.

By the end of this chapter, you should be able to:
1. Enter price and quantity data into the appropriate workbook tabs.
2. Validate entered data to ensure completeness and accuracy.
3. Input parameters to adjust for historical inflation, currency exchange rates and depreciation of capital and start-up costs.
4. Understand how these adjustments, such as annualization and inflation are calculated.
5. Allocate shared and central costs to the interventions being costed.
6. Generate and interpret cost summaries, including total and unit costs.

Supporting materials: **Appendix 10**, CLR Costing workbook (Excel); **Appendix 11**, CLR Costing workbook–Completed example with CLM (Excel); **Appendix 12**, CLR Costing workbook–Completed example with edutainment (Excel); **Appendix 16**, Guidance on costing CLM.

8.1. Overview of the CLR Costing excel workbook

To support the costing process, these guidelines are accompanied by an Excel-based CLR Costing workbook (**Appendix 10**), designed to automate calculations of total and unit costs. In addition, two completed examples are provided to illustrate how the workbook can be applied in practice—one for a CLM (**Appendix 11**) and one for community-led edutainment (Appendix 12). This chapter will guide users in navigating and using the workbook effectively.

8.1.1. Software requirements

Optimal use of the workbook requires a relatively recent version of Microsoft Excel:

- Recommended: Excel 2019 (vs.16.0) or later, including Microsoft 365 versions.
- Minimum required: Excel 2016 (v.16.0).
- Note: Earlier versions, and some free or web-based alternatives, will not support the functionalities embedded in the workbook. Using older or unsupported versions may result in calculation errors, broken links or missing features.

This workbook calculates unit and total costs for a single intervention. The workbook does the calculations—your focus is on accurate data entry and review.

Users do not need to create formulas or manipulate Excel beyond basic use. However, a basic understanding of how to navigate spreadsheets, enter data into cells, and read drop-down menus or filters is required. The workbook is designed to automatically calculate totals and unit costs once data is entered correctly.

8.1.2. What this costing workbook can (and cannot) do

This workbook is designed to help you estimate the total and unit costs of a single community-led HIV intervention. If you wish to cost more than one intervention, you will need to use separate workbooks. Similarly, if you want to cost the same intervention delivered through different models or approaches, each model should be entered in a separate workbook.

You can include the resources of up to three different stakeholders in your costing (for example, a CLO bearing most of the financial and economic implementation costs, a government agency supplying medical commodities and office space, and another partner delivering technical trainings). If your intervention involves only one stakeholder, simply complete one sheet. If more than three stakeholders are involved, you may copy and adapt the relevant sheets, but this will require advanced Excel skills to link the additional sheets to the results page.

This workbook allows you to calculate both financial costs (actual expenditures) and economic costs (including the value of donated or in-kind resources). If you are only estimating financial costs, you can ignore the sections dedicated to economic results.

Results are provided in both the local currency unit (LCU) and US dollars, making them easier to compare with other studies and international benchmarks. All costs are automatically adjusted for inflation, currency exchange rates and annualization of capital/start-up costs based on the parameters you enter.

The workbook does not include built-in scenario or sensitivity analysis (e.g. scaling results to other populations, modelling alternative delivery models or testing the impact of different assumptions). These can be done manually but require additional calculations outside the workbook and the scope of these guidelines.

The workbook also does not create graphs automatically for reporting results. However, the next chapter provides examples and general guidance on how to present results effectively.

8.1.3. Workbook structure

The workbook is organized into colour-coded tabs, located at the bottom. Each tab serves a specific purpose in the costing process. Below is an overview:

Table 8.1. Overview of the CLR Costing workbook

Colour	Title	Purpose
●	Instructions	Guidance on how to use the workbook
●	Parameters	Input parameter assumptions including currency, costing year, inflation, exchange rates and useful life years
●	Cost Data_1	Enter all costs relevant only to Stakeholder 1, identify cost type, and allocate to intervention
●	Cost Data_2	Enter all costs relevant only to Stakeholder 2, identify cost type, and allocate to intervention
●	Cost Data_3	Enter all costs relevant only to Stakeholder 3, identify cost type, and allocate to intervention
●	Results (LCU)	Enter relevant outputs or outcomes for the intervention being costed Remainder of the sheet automatically generates total and unit cost results in the LCU for the intervention
●	Results (US dollars)	This sheet automatically generates total and unit cost results in US dollars for the intervention[1]

Important navigation tips:

- Treat each blue cost data sheet as specific to one stakeholder or actor. If your intervention involves multiple stakeholders, enter each stakeholder's data in a separate sheet. For example, suppose you are costing an intervention where a CLO covers the main implementation costs (staff salaries, transport, community outreach), a government branch contributes specific inputs (e.g. medical supplies, office rent), and a technical partner provides training. In this case, you would use three separate blue cost data sheets (one for each actor).
- A single workbook is designed to cost one intervention only. If you are costing multiple interventions, create a separate workbook for each.

Box 8.1. Tips for using the workbook

- Complete all yellow cells; missing entries will lead to incomplete calculations.
- Use drop-down menus where available to reduce errors and ensure accurate calculations.
- Avoid altering grey formula cells to protect built-in calculations.
- Avoid adding/deleting/merging rows, columns and cells to protect the workbook structure.
- Save multiple backup copies throughout the process.

[1] Results in US dollars provide a common reference to compare and interpret costs across contexts and are widely used in donor and policy reporting. The workbook can, however, be set to any other currency by adjusting the conversion fields.

8.2. Completing Parameters (black tab)

The Parameters sheet sets the foundational assumptions and conversion values that the workbook uses in all subsequent calculations. This includes defining currencies, the costing year, inflation and exchange rates, discount rates and useful life years for capital and start-up inputs. Completing this sheet accurately is essential, as the information entered here drives all cost adjustments, conversions and annualization throughout the workbook. Incorrect or incomplete entries in the Parameters sheet will cause errors in later calculations and distort results.

Box 8.2. How to complete the Parameters sheet

Objective:

- The Parameters sheet defines the assumptions and conversion values used in your costing analysis. These parameters help ensure costs are comparable, inflation-adjusted and relevant for both local and international audiences.

Overall steps:

- Enter values in all yellow cells.
- Include a source for each value where applicable.
- Review prefilled entries (e.g. useful life) and adjust if locally relevant alternatives exist.

Parameters

This sheet contains the key parameters for your costing. Enter or review values in yellow cells to confirm they are relevant to your context. All subsequent calculations, including inflation adjustments, currency conversion, and annualization, depend on the values entered here.

Parameters	Description	Value	Source	Comments
Currency units				
Country	*Country name*	*Sierra Leone*	N/A	
Local currency unit (LCU)	*Local currency*	*SLE*	N/A	
International currency unit (USD)	*International currency used for specific purchases and converting results. Often US Dollars (USD).*	*USD*	N/A	
Costing Exercise				
Base year	*Reference year for cost analysis*	*2025*	N/A	
Inflation rates				
Inflation: Average Consumer Price (annual %)	*Average inflation rate of LCU using local consumer price index*	*16,67%*	World Bank CPI: https://data.worldbank.org/indicator/FP.CPI.TOTL.ZG	*Average inflation rate between 2022-2025*
Inflation: Average USD Consumer Price (annual %	*Average inflation rate of USD using United States Dollar consumer price index*	*3,41%*		
Exchange rates				
Exchange rate: USD per 1 LCU	*Amount of USD needed to exchange for 1 unit of LCU*	*0,04*	https://www.xe.com/currencytables/?from=SLE&date=2025-08-24#table-section	Date: Aug 24, 2025
Exchange rate: LCU per 1 USD	*Amount of LCU needed to exchange for 1 unit of USD*	*22,74*		
Discount rates				
Discount rate (%)	*Enter as percentage. Rate used to annualize capital costs in economic analysis. Input national rate for within-country assessments, or use 3% for international comparisons*	7%	Department of Science and Technology – Health Technology Assessment Unit. (2020). Philippine HTA Methods Guide (1st ed.). DOST. https://hta.dost.gov.ph/philippine-hta-methods-guide/	Local
Useful life, in years				
Land value	*Period of time over which assets are expected to provide an economic value. Use the recommended useful life years or change to reflect locally adapted life years.*	50	Interview with local accountant	*Changed to local useful live years*
Building value		50		
Vehicles		5		
Furniture		4		
Electronics		4		
Medical		2		
Start-up		2		

Box 8.2. How to complete the Parameters sheet, cont.

Step-by-step instructions:

- **Currency units:** To define which currencies are used in the costing analysis.
  - **Country:** Full name of the country where costing is conducted.
  - **LCU:** Local currency used for most purchases.
  - **International currency unit:** Currency for international comparisons—usually US dollars.

- **Costing year:** To set the reference year to which all costs will be adjusted.
  - **Base year:** The year to which you want all costs to be expressed (usually the year the costing is being conducted, i.e. your present year).

- **Inflation rates:** To adjust costs from previous years to the base year using inflation.
  - **Inflation: Average consumer price in local currency (annual %):** Enter the average inflation rate over the years covered by your costing, using your country's local Consumer Price Index CPI.[2] See instructions below.
  - **Inflation: Average consumer price in US dollars (annual %):** Enter the average inflation rate for the same period using CPI for the United States.[3]
  - **How to find these:**
    - Visit the World Bank's CPI data page
    - https://data.worldbank.org/indicator/FP.CPI.TOTL.ZG
    - On the right-hand side of the graph, go to Download and select Excel.
    - Open the downloaded Excel file and go to the first tab labelled "Data."
    - Search for your country.
    - Identify the years from which you are adjusting costs to the base year (e.g. 2021–2025).
    - Calculate the average annual CPI over this period and enter it as a decimal number into Cell C14.
    - Repeat steps but search for "United States" to obtain the US dollar inflation rate
    - Enter this rate as a decimal number in Cell C15.
  - To learn more about how inflation is calculated, see **Box 8.8**.

- **Exchange rates:** To convert between local and international currencies
  - **Exchange rate of US dollar per one LCU:** Enter how many US dollars are needed to purchase one unit of the LCU.[4]
  - **Exchange rate of LCU per one US dollar:** Enter how many LCUs are needed to purchase one US dollar.
  - **How to find these:**
    - Visit the XE currency table page: https://www.xe.com/currencytables/
    - Under currency, select your LCU
    - Under date, select today's date
    - Click View Table.
    - Look for the value listed in the "USD per unit" column- this is your US dollar per one LCU (enter this in cell C18)
    - Look for the value listed in the "Units per USD" column- this is your LCU per one US dollar (enter this in C19)

[2] CPI is a general and commonly used measure of inflation. In some cases, however, it may not reflect changes in specific cost categories. For example, government health sector salaries may have increased faster or slower than CPI. Where reliable sector-specific data are available (such as national wage index for health workers), consider using these figures instead.
[3] Or the average consumer price of the country used if another international currency unit is selected.
[4] Or if another international currency is used, enter the rate relative to that currency.

Box 8.2. How to complete the Parameters sheet, cont.

- **Discount rates:** To annualize capital costs by accounting for time preference and opportunity cost
  - — **Discount rate:** If the costing is intended for domestic decision-making, use the national discount rate.
  - — **How to find the national discount rate:**
    - Check if your country's ministry of health, Health Technology Assessment agency, or national health economics guidelines recommend a discount rate for economic evaluations. These may be published as part of a national Health Technology Assessment guidelines, costing manuals or evaluation protocols. Use this official rate if available.
    - If no recommendation exist, Visit BIS Central Bank List: https://www.bis.org/cbanks.htm by selecting your country's central bank and searching for the current policy rate and enter the chose rate in cell C22.
    - If the costing is to inform international donors, then use a 3% as a default, following customary practice in global health economic evaluations.

- **Useful life (in years):** To estimate the number of years capital items will retain economic value.
  - — The workbook includes default useful life values based on international guidance. However, you should review and adjust these values if more accurate or locally appropriate estimates are available.
  - — **How to validate or update these values:**
    - **Consult your or a partner organization's accounting or finance department. They may have:** An internal depreciation schedule, guidance used for audit reporting.
    - **Check with national or donor agencies:** They may have recommended standard asset lifespans.
    - **Consider local context:** Harsh operating conditions may reduce useful life (e.g. vehicles in rural or flood-prone areas). Well maintained equipment may last longer.
    - Update values in the sheet if local evidence supports a different lifespan
    - Include your source and rationale in the adjacent "Source" column.
  - — To learn more about how capital items are annualized using the discount rate and useful life years see **Box 8.9**.

8.3. Completing Cost Data (blue tabs)

This section will explain how to complete the Cost Data sheets so that the workbook can operate correctly and produce accurate total cost calculations. These instructions walk you through the required fields, the correct way to enter information, and common errors to avoid.

There is one Cost Data sheet per stakeholder. If the intervention involves several contributors—for example, a CLO bearing most of the financial and economic implementation costs, a government branch providing medical supplies, office space and another partner delivering technical trainings—you can track the financial and economic costs for each contributor separately by completing their respective sheet.

Once you have completed these steps, the workbook will automatically perform the necessary calculations to adjust, categorize and summarize your costs. The following section explains how and why certain calculations are made—not because you need to do them yourself, but so you understand the process and can interpret your results with confidence.

8.3.1. Entering Cost Data (columns A–M)

This section explains how to record the basic details for each cost input (item, price, quantity and date), using the data collected in **Chapter 7, section 1.1. and section 2**. Be sure to include both financial and in-kind costs, depending on whether you are conducting a financial or an economic costing. Accurate completion of these fields is critical, as they feed directly into all later calculations.

Box 8.3. How to complete columns A–M

Objective:

- Enter the collected cost data into the Cost Data sheet to record the quantity, price and other basic details for each input required to deliver the intervention.

Overall steps:

- Use up to three Cost Data sheets, one for each stakeholder/actor bearing costs for the intervention.
- If costing from a single stakeholder perspective, right-click and hide unused sheets to avoid confusion.
- Enter all data in yellow cells only; grey cells contain formulas.
- Complete every required field in columns A-N to ensure the data in the workbook calculates correctly.

Step-by-step instructions:

Column	Header	Description
A	Stakeholder	Name the stakeholder, actor, or organization (e.g. CLO, government agency, technical partner)
B	Data source–quantity	Indicate where the quantity information came from (e.g. financial reports, stock cards, asset inventory, volunteer logs)
C	Data source–cost	Indicate where the price information came from. This may be the same as the quantity source (e.g. financial reports) or different (e.g. procurement reports, resale value, minimum wage tables)
E	Cost Item description	List each cost item
F	Bank/charge/account codes (optional)	Use to track the financial code from the source document if available
G	Date of purchase/transaction	Enter the date associated with the cost

A	B	C	D	E	F	G
Sources				Expenditure inputs		
Stakeholder *Specify the stakeholder of*	Data Source: quantity *Specify the name of th*	Data Source: cost *Specify the name of*		Item *List all relevant cost items below*	Account code or other information	Date
CLO Name	Expenditure report	Expenditure report		Office Rental Regional North		Dec/22
CLO Name	Expenditure report	Expenditure report		Office Rental HQ		Dec/22
CLO Name	Expenditure report	Expenditure report		Field hire for edutainment in Capital		21/11/2022
CLO Name	Expenditure report	Expenditure report		Field hire for edutainment in Capital		21/11/2022
CLO Name	Expenditure report	Expenditure report		Field hire for edutainment in Capital		21/11/2022
CLO Name	Expenditure report	Expenditure report		Field hire for edutainment in Capital		21/11/2022
CLO Name	Expenditure report	Expenditure report		Field hire for edutainment in Capital		21/11/2022
CLO Name	Programme report	Equivalent found in exper		Field borrow for edutainment in East		07/07/2022
CLO Name	Programme report	Equivalent found in exper		Field borrow for edutainment in South		14/06/2022
CLO Name	Programme report	Equivalent found in exper		Field borrow for edutainment in North		10/03/2022
CLO Name	Assets Registry	Assets Registry		Bajaj Discovery M/C		16/08/2022
CLO Name	Expenditure report	Expenditure report		5% Social Security and Insurance for Staff 2022		15/12/2022
CLO Name	Personnel Inventory	Finance Dpt		Salary for M&E Officer 2022		15/12/2022
CLO Name	Personnel Inventory	Finance Dpt		Salary for Programme Manager 2022- Direct		15/12/2022
CLO Name	Personnel Inventory	Finance Dpt		Salary for Finance Officer 2022		15/12/2022
CLO Name	Personnel Inventory	Finance Dpt		Salary for Admin Officer 2022		15/12/2022
CLO Name	Personnel Inventory	Finance Dpt		Salary for Project Officer 2022		15/12/2022
CLO Name	Personnel Inventory	Finance Dpt		Salary for Executive Director		15/12/2022

Box 8.3. How to complete columns A–M, cont.

Column	Header	Description
I	Cost year	Specify the year the price relates to (e.g. purchase year, valuation year). For ease, you can enter the formula =YEAR (cell in column G) to extract the year from the date in column G. Check carefully for errors. If the year is incorrect or left blank, the workbook will not calculate correctly
J	Quantity	Usually "1" for items from financial reports; otherwise, specify the actual quantity (e.g. number of electronic tablets, number of HIV test kits, number of peer educators)
K	Unit	Specify the unit of measure (per person, per month, per item, per transaction)
L	Unit cost	Enter the cost per unit in the original purchase currency
M	Currency	Select the currency of the price entered in column M

I	J	K	L	M	N
			Costs		
Cost year *Specify year of purcha*	**Quantity** *Specify quantity*	**Unit** *Indicate if cos*	**Unit cost** *Specify the*	**Currency** *Select the*	**Total cost** **This field will**
2022	1	per year	28.000,00	SLE	28.000,00
2022	1	per year	1.200.000,00	SLE	1.200.000,00
2022	1	per event	1.400,00	SLE	1.400,00
2022	1	per event	1.400,00	SLE	1.400,00
2022	1	per event	1.400,00	SLE	1.400,00
2022	1	per event	1.400,00	SLE	1.400,00
2022	1	per event	1.400,00	SLE	1.400,00
2022	1	per event	1.400,00	SLE	1.400,00
2022	1	per event	1.400,00	SLE	1.400,00
2022	1	per event	1.400,00	SLE	1.400,00
2022	1	per purchase	20.000,00	SLE	20.000,00
2022	1	per year	9.870,00	SLE	9.870,00
2022	12	per month	2.050,00	SLE	24.600,00
2022	12	per month	2.350,00	SLE	28.200,00
2022	12	per month	3.500,00	SLE	42.000,00
2022	12	per month	2.500,00	SLE	30.000,00
2022	12	per month	2.050,00	SLE	24.600,00
2022	12	per month	4.000,00	SLE	48.000,00
2022	12	per month	1.580,00	SLE	18.960,00
2022	1	per transaction	1.500,00	SLE	1.500,00
2022	1	per transaction	250,00	SLE	250,00
2022	1	per transaction	250,00	SLE	250,00
2022	1	per transaction	9.072,00	SLE	9.072,00
2022	1	per transaction	8.470,98	SLE	8.470,98
2022	1	per transaction	1.400,00	SLE	1.400,00
2022	1	per transaction	9.450,00	SLE	9.450,00

Verifications:

- Columns J-M must be fully and correctly completed; missing or incorrect entries will cause errors in calculations later in the analysis.
- Check your entries by reviewing column N (grey). This column automatically multiplies the quantity by the unit cost. Scan down (or filter) the column to ensure there are no blanks, #REF!, #ERROR!, or #N/A messages

8.3.2. Identifying cost types (columns P–R)

Here you will classify each cost item by type and input category and specify useful life years for capital and start-up costs. The applied concepts here are explained in greater detail in **Chapter 4**.

Box 8.4. How to complete columns P–R

Objective:

- The cost type section (columns P–R) classifies each cost item as financial or in-kind, assigns it to a cost input category and specifies useful life years for capital and start-up items.
- The workbook then uses this information to categorize and calculate financial and economic costs, group costs by input type, and annualize capital and start-up items based on useful life years.

Overall steps:

- Use up to three Cost Data sheets, one for each stakeholder/actor bearing costs for the intervention.
- Complete this section after entering all cost data in columns A–M.
- For each row, select type of cost (financial or in-kind); cost input category (start-up, capital or recurrent); and useful life years (for all start-up and capital items).

Step-by-step instructions:

Column	Header	Description
P	Financial or in-kind	Select financial or in-kind from drop-down list If an item has both, split into two separate line items: One for the financial cost (e.g. stipend for transport), and one for the in-kind cost (e.g. volunteer time), valued using the methods practiced in **Exercise 4.3**.
Q	Cost input category	Use the drop-down list to select relevant cost input "ST" relates to "start-up" inputs, "C" to "capital" inputs, and "R" to "recurrent" inputs. Refer to **Chapter 4.2.1.** for definitions, examples and guidance on identifying cost input categories.
R	Useful life years	Required only for capital and start-up inputs. Select the appropriate category from the drop-down list The workbook will automatically calculate the appropriate method for annualizing capital and start-up items using the useful life years and discount rate from the Parameters sheet, and the cost type selected in column P.

Box 8.4. How to complete columns P–R, cont.

P	Q	R
	Cost type	
Financial or in-kind *Indicate if item is paid or*	**Cost input** *Select the type of cost input*	**Useful life years (only for capital and start-up inputs) Leave**
Financial	C1: Buildings/Land	Rent
In-Kind	C1: Buildings/Land	Building value
Financial	C1: Buildings/Land	Venue Hire
Financial	C1: Buildings/Land	Venue Hire
Financial	C1: Buildings/Land	Venue Hire
Financial	C1: Buildings/Land	Venue Hire
Financial	C1: Buildings/Land	Venue Hire
In-Kind	C1: Buildings/Land	Venue Hire
In-Kind	C1: Buildings/Land	Venue Hire
In-Kind	C1: Buildings/Land	Venue Hire
Financial	C3: Vehicles	Vehicles
Financial	R1: Personnel & Per diems	
Financial	R1: Personnel & Per diems	
Financial	R1: Personnel & Per diems	
Financial	R1: Personnel & Per diems	
Financial	R1: Personnel & Per diems	
Financial	R1: Personnel & Per diems	

Verifications:

- The cost type section (columns P–R) classifies each cost item as financial or in-kind, assigns it to a cost input category and specifies useful life years for capital and start-up items.
- Columns P–R must be fully and correctly completed; missing or incorrect entries will cause errors in calculations later in the analysis.
- Check your entries by reviewing columns AB–AC (grey). These columns automatically adjust costs for historical inflation and annualize capital and start-up costs using the information specified in the "Parameters" sheet. Scan down the columns to ensure there are no blanks, #REF!, #ERROR!, or #N/A messages.

Box 8.5. Practical tip: Verifying completeness of cost data

Before proceeding to the next step, take a few minutes to check that all relevant costs and resources have been capture in the Cost Data sheets. This helps identify any gaps early on, so you can return to your data sources and fill them before proceeding.

Step-by-step instructions:

- In the "Cost Data" sheet, go to the header of column Q "Cost input," and use the filter[5] to review cost items by input category. Items starting with C stand for capital inputs, while items starting with R stand for recurrent inputs.
- **For each category, review all items listed:**
  - C1: Buildings/Land: Is the full cost of office rent or building space capture for the intervention? Are all months of expenses included?
  - C2: Equipment: Are all pieces of equipment used in the intervention or by central administration listed, or only those appearing in financial records? As opposed to an incremental costing (**Chapter 3.3.3.2**), a full costing must also consider all shared central resources, which can be captured using an asset registry (**Chapter 8.2**).
  - Repeat this review for all other cost inputs. Focus on common "big-ticket" items such as personnel, medical supplies (if relevant) and transport costs.
- If doing an economic costing, check that all in-kind resources are included (e.g. volunteer time, donated goods, free use of building spaces).
- If anything is missing, return to the data sources and add the cost item along with price and quantity before proceeding.

Why this matters: This is the moment to check that all resources have been appropriately captured according to the purpose and scope of your costing exercise. Ensuring completeness now means the allocation and analysis steps will reflect the full set of resources you intended to measure.

8.3.3. Allocating costs to the intervention (columns AE–AG)

At this stage, you will indicate how each cost item is allocated to the intervention being costed, using the data collected in **Chapter 7.3**. This is particularly important for costs shared across multiple interventions. Correct allocation ensures that the workbook can apportion costs accurately and produce realistic unit cost estimates.

[5] Excel tutorial on using filter: https://www.youtube.com/watch?v=wMlTDXPEjag

Box 8.6. How to complete columns AE–AG

Objective:

- Columns AE–AG record the allocation of each cost item to the intervention being costed. This ensure shared costs are apportioned appropriately and direct costs are fully assigned.

Overall steps:

- Indicate whether the cost item is a direct intervention cost or shared central cost in column AE.
- Record the data source or justification for the allocation factor in column AF.
- Enter the allocation percentage for the intervention being costed in column AG. For direct intervention costs, enter 100%. For shared costs, apply the allocation factors identified in **Chapter 7.3**.

Step-by-step instructions:

- Identify if the cost is direct or shared in column AE
- Enter the allocation percentage in column AG.
  - — Direct costs: 100% to the intervention.
  - — Shared central costs: Percentage allocation.
- Document the source of the allocation factor in column AF.

AE	AF	AG
	Allocation to intervention	
Central/Direct *Indicate if cost is direct*	**Allocation factor** *Specify the source or*	**% Dedicated to intervention** *Enter the % of this input*
Shared central cost	% of Staff time in 2022 dedi	5%
Shared central cost	% of Staff time in 2022 dedi	6%
Direct intervention cost	100% Edutainment cost	100%
Direct intervention cost	100% Edutainment cost	100%
Direct intervention cost	100% Edutainment cost	100%
Direct intervention cost	100% Edutainment cost	100%
Direct intervention cost	100% Edutainment cost	100%
Direct intervention cost	100% Edutainment cost	100%
Direct intervention cost	100% Edutainment cost	100%
Direct intervention cost	100% Edutainment cost	100%
Shared central cost	% of kms travelled for edute	8%
Shared central cost	% of Staff time in 2022 dedi	6%
Shared central cost	% of Staff time in 2022 dedi	6%
Direct intervention cost	% of Staff time in 2022 dedi	10%
Shared central cost	% of Finance Officer's time	2%
Direct intervention cost	% of Staff time in 2022 dedi	6%
Direct intervention cost	100% Edutainment cost	100%
Shared central cost	% of Executive Director's tir	1%
Shared central cost	% of Staff time in 2022 dedi	6%
Direct intervention cost	100% Edutainment cost	100%
Direct intervention cost	100% Edutainment cost	100%

Verifications:

- Ensure a clear justification is provided in column AE for all entries, especially when allocation is less than 100%. This will allow you to easily filter and change allocation factors later, if necessary.
- As explained in **Chapter 7**, use quantifiable, measurable variables for allocation (e.g. floor space %, staff time %, number of sessions).
- During the validation workshop, present these allocation factors to CLO teams and staff for review, and adjust them if necessary.

8.4. Completing outputs in Results (orange tabs)

To enter data on outputs and outcomes, the analyst will need to refer to the data collected in the Output tool (**Chapter 7.1.2**) and summarize these data in the results sheet to estimate final unit costs.

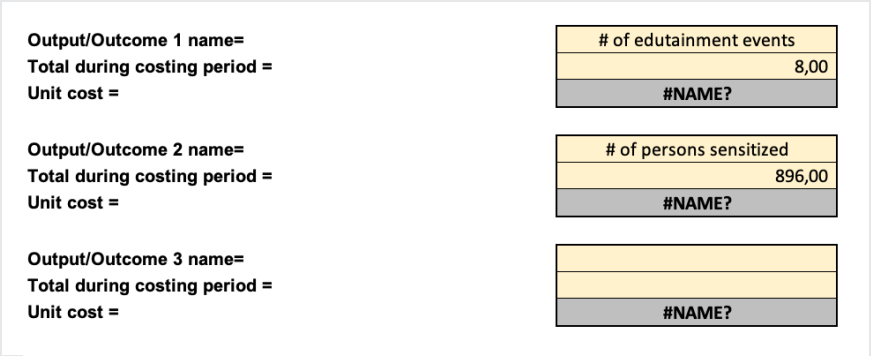
Box 8.7. How to complete the Results sheet

Objective:

- Summarize the output or outcome data collected for the intervention.

Overall steps:

- Enter data for outputs and outcomes in yellow cells
- Include up to three output or outcome indicators for the intervention being costed.



Step-by-step instructions:

- Name the output or outcome indicators in rows 85, 89 and 93. You can enter up to three indicators.
- Enter output or outcome totals in rows 86, 90 and 94.
- As explained in **Chapter 7.1.2**., the time period for total outputs and outcomes must match the period covered by the cost data.
- The unit costs will automatically be calculated in rows 87, 91 and 95.

8.5. Understanding cost adjustments

Once all the parameters, observed cost items and outputs have been entered across the relevant sheets, the workbook will automatically apply several adjustments to prepare costs for analysis.

These adjustments require no manual intervention; they are fully automated in the workbook once all required information is correctly entered. This section explains not only how the tool processes the data but also how these adjustments are carried out during the analysis stage of a costing.

8.5.1. Adjusting costs for historical inflation and currency exchange

Once items and their costs have been entered, the tool will automatically calculate costs in the LCUs. To ensure that all costs are expressed in the same year, items valued in years other than the specified costing year (base year) will be adjusted to account for inflation. Items purchased in different currencies are then converted to the local currency, though final results will be expressed in both local currency and in US dollars. For the calculation to compute successfully, it is important that information is entered on currency unit, costing year, inflation rates and exchange rates in the "Parameters" sheet. To learn more about how inflation is calculated see Box 8.8.

Box 8.8. Understanding and accounting for inflation

Inflation refers to the general increase in prices over time. As prices rise, the value of money decreases—meaning that the same amount of money buys fewer goods and services in the future.
For example, a vehicle purchased in 2000 would have cost much less than the same vehicle in 2024. Similarly, one US dollar in 2000 had more purchasing power than one US dollar today.

This means that costs from previous years cannot be directly compared with today's costs; they must first be adjusted to account for inflation, otherwise the results may underestimate the real value of goods and services.

If the cost data you enter was collected in a different year from the base year of the analysis, the tool will automatically adjust it using inflation rates.
The adjustment is made using a formula:

$$\text{Adjusted cost} = \text{Original cost} \times (1 + \text{average inflation rate})^{\text{number of years}}$$

For example, if a medication cost US$ 10 in 2018, and the average inflation rate is 5.4%, the cost in 2023 is:

$$10*1.054^5 = \$13.01$$

The tool uses two average inflation rates to adjust costs:

- Local CPI inflation rate: Used for local non-tradeable costs like personnel, buildings, utilities and other recurrent costs purchased locally. These items are affected by local economic conditions, so the local CPI is used to reflect how prices have changed within your country over time.
- US dollar CPI inflation rate: Used for international or tradeable goods like vehicles, equipment or supplies. These items are influenced more by global markets, so US inflation serves as a proxy to estimate how their prices have changed over time.

You are asked to enter both inflation rates in the **Parameters Sheet**. Once entered, the tool will apply them automatically to adjust each cost to the base year. In this workbook, inputs identified as buildings/space, personnel, building maintenance, transport, and other recurrent items are treated as non-tradeable, while equipment, vehicles, and supplies are treated as tradeable.

8.5.2. Annualizing start-up and capital cost items

As explained in **Chapter 3.3 and 5.2**, start-up and capital items such as trainings, buildings, equipment and vehicles are long-term investments that continue to provide value for several years. When analysing costs, it is important to treat start-up and capital inputs differently from recurrent inputs like salaries or supplies, which are consumed within a year. The process of spreading the value of a capital item across its expected useful life is called annualization. This ensures that the cost is fairly allocated across the years in which the item is used, instead of counting the full cost in a single year. There are different ways to annualize costs depending on whether the costing is financial or economic. See **Box 8.9.** for further explanation.

In the analysis tool, start-up and capital costs are annualized automatically. For the calculations to work correctly, users must enter the relevant data in the Parameters sheet: This includes the discount rate and useful life of each item, as well as cost item details (e.g. year, currency, unit cost) and type of cost (e.g. financial or in-kind, cost input category).

Box 8.9. How to annualize start-up and capital costs

Annualization is the process of distributing the cost of long-term start-up and capital items over multiple years. Certain start-up activities and capital items contribute value beyond a single year, so annualization ensures that this value is spread out fairly over the time they are used. The number of years a capital item is expected to last is known as its useful life. For example, a file cabinet may have a useful life of 10 years before it needs replacement. While standard assumptions are often used, such as 10 years for vehicles or 5 years for electronics, it is important to consider local conditions. In Sierra Leone, for instance, harsh road conditions mean vehicles are assumed to last only 5 years. These kinds of adjustments help ensure that the costing reflects real-world usage.

The analysis tool will automatically annualize capital cost items. In a financial costing, analysts apply straight-line depreciation, whereby the cost of the item is equally divided across the estimated years of useful life:

$$Financial\ cost\ of\ capital\ item = cost\ of\ item \div useful\ life$$

In an economic costing, straight-line depreciation is not appropriate because it fails to consider the potential value of alternative opportunities for the resources tied up in the capital good. Annualization is calculated by dividing the current value of an item by the annualization factor, which is determined by the discount rate and useful life of the item:

$$Economic\ cost\ of\ capital\ good = cost\ of\ good \div annualization\ factor$$

The annualization factor is calculated using this formula:

$$annualization\ factor = [1 - (1 + discount\ rate)^{-useful\ life}] \div discount\ rate$$

In short, financial costing spreads actual spending over time, while economic costing goes further by including the value of donated or shared items and adjusting for how people value money over time. The tool handles all these calculations for you automatically based on the data you enter.

Check before you interpret: Verify all data are complete and allocation factors applied correctly.

8.6. Reviewing Results (orange tabs)

Once cost data have been entered, adjusted, annualized and allocated to the intervention, you can proceed to the Results Sheets to review the total and unit costs generated by the workbook. There are two summary sheets: One in US dollars and one in LCU.

The summary analysis sheets present:

- Total cost of the intervention (B82 and I82)
- Total cost per stakeholder (rows 21, 42, and 62)
- Total cost and proportion by type of cost input (columns B,C and columns I,J)
- Unit costs of the intervention, financial and economic (rows 87, 91, and 95)

Each of these cost figures is available at three levels of analysis, with financial and economic results presented side by side. The next chapter discusses how to interpret, present and use these results in greater detail. Before doing so, there are a few verification steps needed to ensure the analysis has been completed correctly (Box 8.10).

Box 8.10. Practical tip: Verifying accuracy of cost analysis

Before moving on to interpreting results, confirm that your cost analysis is accurate and complete. This will help you identify any errors or missing data before sharing results.

- **Check totals against the Cost Data sheet:**
  - In the Results Sheet, note the total financial cost per stakeholder.
  - Go to the Cost Data sheet for that stakeholder and select all values in Column AG.
  - Compare the total sum (displayed in the bottom right corner of Excel) with the figure in the Results sheet.
  - If the totals do not match, some data may not have been captured. Re-check all data entry steps and correct any omissions.

- **If doing an economic costing:**
  - Repeat the steps above comparing the total economic cost per stakeholder with Column AH in the respective sheet.
  - The total economic cost should equal or be greater than the total financial cost.
  - If lower, recheck that all in-kind costs have been entered and correctly categorized.

- **Investigate error messages:**
  - #REF!- the cell is trying to reference a location that no longer exists. Check for deleted rows or columns.
  - #ERROR!- there is a problem with the formula or the data entered. Check for incorrect formats (e.g. text instead of numbers).
  - #N/A- the data the formula is trying to find is missing. Check for blank required cells or mismatched references.

- **Conduct an internal sense check:**
  - Are all relevant cost inputs captured?
  - Does the proportion of costs by input type make sense for this intervention?
  - How does the unit cost compare to the other unit costs published in the literature? Check it against the database from the systematic review of unit costs of community HIV interventions here (29).
  - If the figure is far outside the range of other published unit costs, check for errors either in the cost data or in the output/outcome data entered.

- **Validate with CLO team:**
  - Share the total and unit cost results with the CLO and relevant staff.
  - Use the validation workshop (**Chapter 6.1.2.**) to confirm that the figures reflect their understanding of the intervention and adjust if needed.

Chapter 9
Interpreting and using costing results

Chapter 9 provides step-by-step guidance for analysing and interpreting costing results from the CLR Costing workbook. Building on the cost data entered and analysed in Chapter 8, this chapter explains how to interpret total and unit costs, input-level breakdowns and comparisons between financial and economic costs. It also outlines how to identify key cost drivers and use results for the purpose of your exercise.

By the end of this chapter, you should be able to:
1. Analyse costing results, including total and unit costs by intervention, breakdowns by input, financial vs. economic costs.
2. Interpret these results to inform monitoring, planning, budgeting and advocacy, as discussed in **Chapter 3**.

So far, this part of the guidelines have focused on the technical foundations needed to carry out a costing exercise. Part 1 introduced the core health economics concepts, and **Chapters 7** and 8 walked through the technical steps and workbook functions needed to collect, organize and analyse cost data. Next comes the critical step of understanding what those results mean and how to use them.

Understanding how to interpret and use costing results is essential for turning numbers into action. Costing studies require considerable time and resources, but their true value lies in how the findings are applied. By analysing and interpreting results, CLOs can identify what drives costs, assess efficiency, advocate for appropriate funding, and mobilize the appropriate resources to sustain their efforts. Just as important, careful interpretation helps avoid misusing or oversimplifying the evidence. This chapter provides practical guidance to help ensure costing results are translated into insights that inform decisions, strengthen programmes, and demonstrate the full value of community-led HIV responses, while also highlighting how to interpret findings with care.

9.1. Reviewing total costs per intervention

The first step in interpreting costing results is to examine the total costs, which provides an overview of how much was spent overall for the intervention during the costing period. The CLR Costing workbook is designed to cost one intervention at a time. If you are costing multiple interventions, this can be done by using separate workbooks for each and then comparing the results, highlighting differences in resource allocation across interventions.

Box 9.1. How to read total costs in the CLR Costing workbook

Sheet: Results (US dollars) or Results (LCU) (orange tabs)

Where to look:
- Cell B82 shows the total financial expenditure for the intervention during the costing period.
- If costing multiple interventions, or multiple models of a single intervention, open each workbook separately and note the value in cell B82 for comparison.

How to present these results:
- To visualize these data, consider creating a stacked column chart[6] that displays the percentage share of each intervention's expenses relative to the total. This will provide a clear visual summary of how resources were distributed during the costing period, as well as relative and total costs per intervention (see worked example in **Box 9.2**).

Understanding total costs by intervention allows CLOs and partners to assess spending patterns across the range of interventions they deliver. It enables comparison between actual expenditures and planned budgets, helping to identify where spending diverged from expectations. Substantial over- or underspending should prompt reflection on the reasons why and where adjustments in operations or future budgeting may be needed.

For costing exercises that include multiple interventions, this analysis highlights which interventions are the most resource intensive. In cases where a single intervention is delivered through multiple models or approaches, the cost analysis reveals which model places greater demands on resources. These comparisons should, however, be interpreted alongside other considerations—cost alone does not determine which model is preferable, since the implications of higher or lower costs depend on the context (see discussion later in this chapter). Beyond comparing resource use, the analysis can also provide insight into a CLO's operating model: Some organizations choose to specialize in one area, while others spread their capacity across many areas to serve the diverse health, social and economic needs of their communities.

Total cost analysis thus helps organizations better understand how their portfolio is resourced and characterize the balance of their work. Externally, it offers a rough snapshot of CLO contributions to the national HIV response, showing which organizations are active in which areas. It can also support communication with partners by demonstrating how resources are allocated across interventions or activities, helping CLOs show use of existing funding, highlight under-resourced areas, and make the case for shifting or increasing support where priorities have changed.

[6] Stacked column chart tutorial on excel: https://www.youtube.com/watch?v=Y8DIiLNUKFU

Box 9.2. Case example: Comparing total costs across community CLOs in Sierra Leone

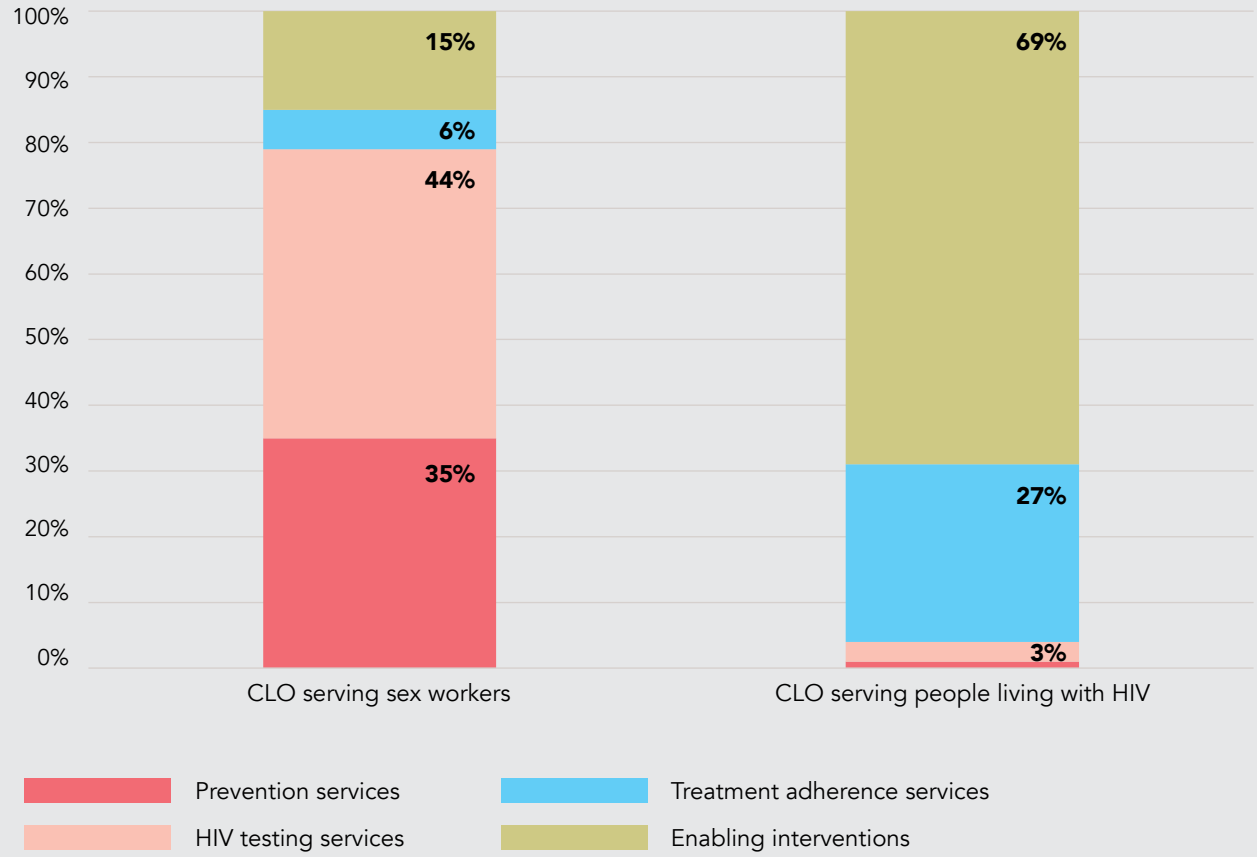
In Sierra Leone, a costing exercise was conducted across several CLOs working with different priority populations. By reviewing the total costs per intervention, clear differences emerged in the scope and focus of their interventions.

One CLO primarily served female sex workers. Their costing results showed that of total expenditures: 44% were dedicated to HIV testing; 35% to prevention, including behaviour change communication and distribution of pre-exposure prophylaxis; and the remainder to community support interventions, including stigma reduction, gender-based violence support and advocacy.

By contrast, another CLO serving people living with HIV, had a vastly different cost profile. About a quarter of total expenditure was spent on adherence support while the remainder went toward a range of other community support interventions, such as CLM, advocacy, stigma reduction and livelihood training.

These results illustrate how cost distribution can reflect each CLO's priorities. Analysing total costs by intervention helps clarify where each CLO's efforts are concentrated and how those efforts align with both their target populations and the intensity of resource use.

Distribution of total costs by response area



9.2. Analysing costs by input category

The next step is to examine the distribution of costs across input categories, such as personnel, supplies, equipment and transportation. This reveals what resources were used, how much, and whether the cost structure aligns with expectations or budget plans.

Box 9.3. How to read input cost distribution in the CLR Costing workbook

Sheet: Results (US dollars) or Results (LCU) (orange tabs)

Where to look:
- Go to column B to find the total spent per input category.
- Go to column C to find the percentage of each input category over total expenses.
- If costing multiple interventions, open each workbook separately and note the value in cell columns B and C for comparison across interventions.

How to present these results:
- Use a stacked column chart to show the distribution of cost inputs across the entire expenses (column C).

Analysing input cost breakdowns helps identify which types of inputs account for the largest share of total costs (also called cost drivers). For most organizations, programmes and interventions, personnel costs are typically the largest cost driver. However, this can vary substantially by context. But interventions that involve direct service delivery (e.g. HIV testing or pre-exposure prophylaxis) may have larger shares for medical supplies and transport, while in other cases, above-intervention (or central level) costs such as management and coordination can be the largest overall cost driver.

Second, comparing input distributions across interventions can highlight crucial differences, but these too are context specific. Some interventions may require more travel or supplies, while others depend more on staff time or training. Recognizing these differences is helpful for budgeting and planning similar interventions in the future but should always be interpreted in light of local conditions, delivery models, and target populations.

These figures can also be used to compare actual expenditures to budgeted amounts. Were sufficient funds allocated to high-cost inputs like transport, personnel or above-intervention (central level) resources? Are any inputs consistently underfunded? If considerable discrepancies are observed, organizations may need to revisit their budgeting assumptions in future planning. They may also consider whether increasing resources for areas such as training, transport for supervision, or quality assurance visits could help strengthen outputs, service quality, and community engagement.

Finally, consider the proportion of annualized capital costs, like buildings, equipment and vehicles, over total expenses. While they may seem small relative to recurrent costs, including them helps organizations plan for long-term asset maintenance and replacement, avoiding gaps or decapitalization over time.

Box 9.4. Case example: Comparing cost inputs for CLM approaches in Philippines

In the Philippines, a costing exercise was conducted for CLM, which was implemented using different approaches. Some approaches relied on in-person data collection at facilities, while others used virtual methods such as phone-based interviews.

The analysis focused on how cost inputs varied across these approaches:

- The in-person approach had higher personnel costs (e.g. stipends for enumerators) and substantial transport costs to reach health facilities.
- The virtual approach, by contrast, involved higher capital costs during the start-up phase (e.g. setting up digital infrastructure), but much lower recurrent costs during implementation.

This breakdown was useful to the CLO and its partners in understanding not only the total costs of each approach but also the cost structure—highlighting key resource needs and trade-offs that could inform decisions about future CLM scale-up and sustainability planning.

9.3. Reviewing central and direct intervention costs

The workbook allows users to compare total central costs and total direct intervention costs, helping organizations understand the balance between resources needed to keep the organization running and those required to directly deliver interventions.

Box 9.5. How to read central versus direct cost distribution in the CLR Costing workbook

Sheet: Results (US dollars) or Results (LCU) (orange tabs)

Where to look:
- Refer to columns E and F to find the total central and total direct costs.
- Refer to rows 22, 43, 63 and 83 to review the proportion of central versus direct costs.

How to present these results:
- Use a stacked column chart to show the distribution of inputs between central and direct costs.

Breaking down costs into central versus direct intervention categories can be especially useful for organizations to:

Identify the resources needed at central level to manage the CLO and oversee interventions.

Assess the share of central costs attributable to each intervention. When costing multiple interventions, this can highlight which ones place greater demands on central resources.

Compare central costs budgeted versus those actually used, to check whether central functions are adequately resourced.

Reveal whether central costs are under-funded, with gaps being covered by in-kind contributions from staff, management, or volunteers (e.g. interns).

Provide evidence on organizational sustainability: High central costs may reflect needed investments in quality assurance, monitoring, and support.

Strengthen advocacy: Showing that central costs are real and measurable part of delivering interventions, rather than an effusive overhead, can help CLOs negotiate appropriate funding.

Support planning: Understanding central versus direct cost patterns can inform decisions on whether central resources can absorb additional interventions, or whether expansion will require new investments at central level.

9.4. Interpreting unit costs

After reviewing total costs and input categories, the next step is to analyse unit costs (the cost per output or outcome delivered). Unit costs help assess the efficiency of an intervention by showing how much it costs to achieve specific results, such as reaching a person with services, testing someone for HIV or linking a client to care. This type of analysis is a powerful way to understand how resources are used and where efficiencies might be found.

This section outlines key principles for interpreting unit costs—including how to compare across delivery models, sites and populations—and how to identify drivers of variation. While the CLR costing workbook calculates total and unit costs for the intervention as a whole, more detailed analyses, such as comparing different delivery models or sites, will require either adapting the workbook or using multiple workbooks and combining results manually. The guidance here applies regardless of the tool used and can be adapted to other costing data sets.

Box 9.6. How to present unit cost results

Sheet: Results (US dollars) or Results (LCU) (orange tabs)

Where to look:
- Rows 87, 91, 95 display the unit costs of the intervention.
- These are calculated by dividing total intervention costs (from row 82) by the output or outcome results entered in rows 86,90, and 94.

How to present these results:
- If costing multiple interventions with different outputs or outcomes that are not directly comparable, use a simple bar chart[7] to visualize each unit cost separately. Place interventions on the horizontal axis and their corresponding unit costs on the vertical axis.
- If analysing unit costs for a single intervention (i.e. same output or outcome) across multiple sites or delivery approaches, use a box plot[8] to show the distribution, highlighting the median, minimum, maximum and any outliers. This can help identify patterns and variability.

As a first step, unit costs can help assess how efficiently resources were used to deliver results. They are especially useful when:

- Comparing the same intervention delivered in different ways (e.g. virtual vs. face-to-face CLM), or across different sites CLM in Region I vs. Region II.
- Assessing variability: Look at the range of unit costs across sites or delivery methods. Is the spread wide? If so, why?
  - Were costs higher in some locations (e.g. urban versus rural) or approaches (e.g. outreach versus drop-in centre)?
  - Were outcomes lower in others? Why might that be? Would additional resources or activities help improve outcomes?
  - Are there outliers that require closer investigation?

This analysis can help:

- Generate evidence to support resource mobilization efforts.
- Develop strategies to improve effectiveness in low-output areas.
- Identify potential efficiencies that could be replicated elsewhere.

[7] Bar chart tutorial on Excel: https://www.youtube.com/watch?v=fk-iFv5_Rdo
[8] Box plot tutorial on Excel: https://www.youtube.com/watch?v=39lsUsJsc2c

Efficiency alone doesn't tell the whole story. Higher costs may reflect the true price of reaching those most in need, sustaining quality, and empowering communities. For community-led responses, these are investments in quality, equity and lasting impact.

If multiple outcomes are used for a single intervention (e.g. cost per person tested vs. cost per person tested positive), they should be interpreted carefully. For example, a site may be expensive based on the cost per person tested, but inexpensive based on the cost per person tested positive. In this case, the focus should be on the objective (e.g. testing large numbers of people or identifying large numbers of infected individuals):

- Do costs appear high because fewer people reached the later stages of the cascade?
- Does a high cost for each person who tests positive reflect a low positivity rate or a strong outreach in a low-prevalence population?

Comparing unit costs across CLOs or against cost ranges from other studies can also help. To identify relevant comparators, you can check the CLR systematic review unit cost database (29) or conduct a simple online search using keywords such as "unit cost" and [name of intervention] can yield results from published literature. Before comparing unit costs with other sources, it is important to ensure comparability. Unit costs should reflect similar:

- Outputs or outcomes: Do not compare the cost per person tested with the cost per person tested positive.
- Costing approaches: Do not compare financial to economic costs, or full to incremental costs.
- Populations and delivery settings: Do not compare the cost of service to the general population to the cost of service to hard-to-reach populations, or an intervention for brothel-based female sex workers to one serving street-based sex-workers.
- Intervention costs: Do not compare intervention costs between different types of providers (e.g. comparing private sector with public sector interventions).
- Geographies and contexts: Do not compare the cost of a service delivered in Luxemburg with that in Eswatini, nor assume equivalence between services provided in rural and urban settings, as systemic contexts differ substantially.

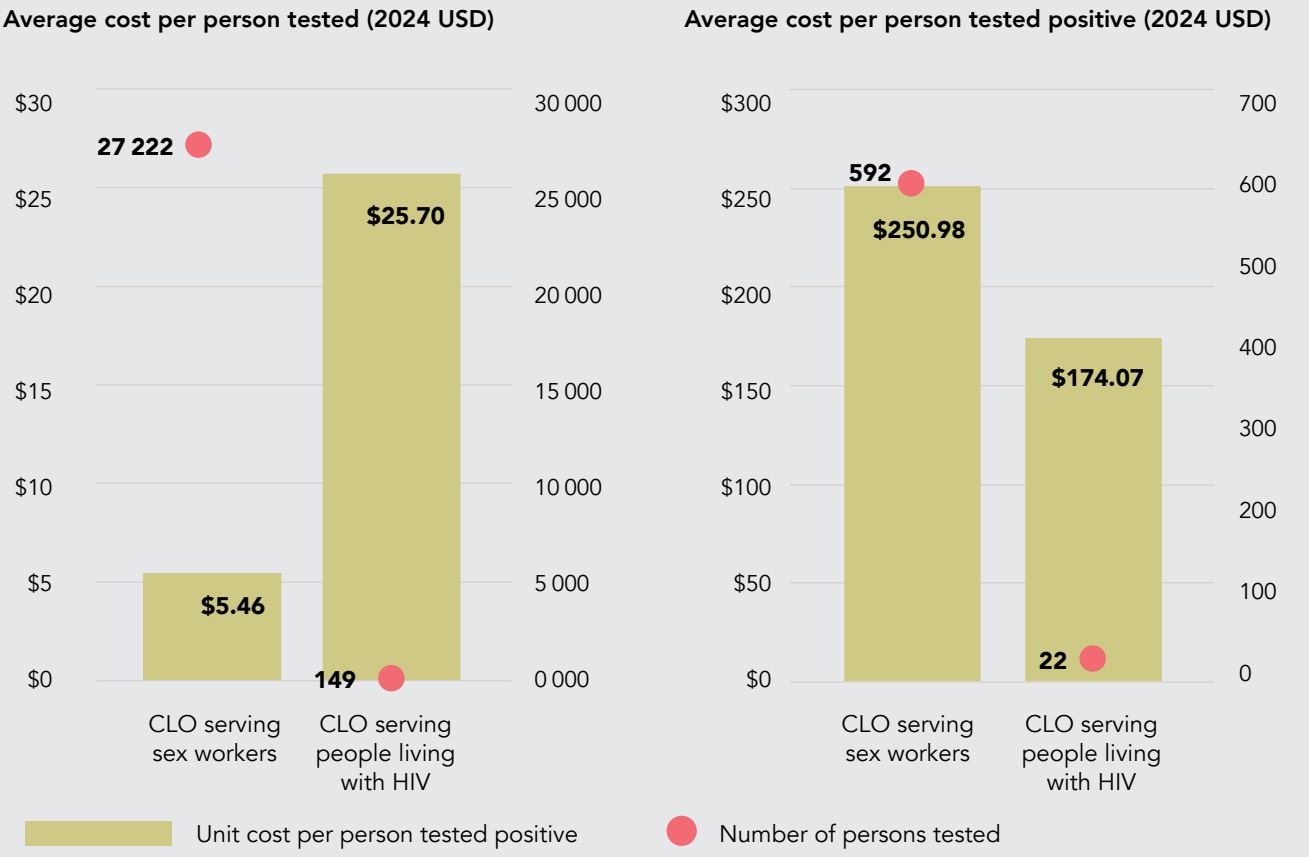
Once appropriately matched, comparing results can help to identify and explain context-specific cost variations. Importantly, costs should not be interpreted in isolation or assumed to mean that higher cost equals poorer performance—some populations are more expensive to reach, and certain delivery models may cost more precisely because they are higher quality or more effective. In other cases, higher costs may reflect deliberate investments in community engagement, empowerment, or accountability, generating social benefits that spill beyond measurable health outcomes, such as social cohesion, acceptability and increased trust in health services.

Understanding these differences can help make sense of higher or lower costs and strengthen interpretation. It can also support funding negotiations, justifying funding requests, and guiding adaptations when expanding interventions. Beyond the idea of simply doing more with less, unit cost analysis—can also indicate whether resources are sufficient—and provide insights on the activities for which resources need to be mobilized. It can value donated goods and services, moving towards fair pay for volunteer time. In some cases, increasing resources for demand generation, and supporting retention may raise total costs but improve outputs and efficiency, ultimately reducing unit costs.

Box 9.7. Case example: Comparing unit costs for HIV testing across two CLOs in Sierra Leone

In Sierra Leone, both a CLO serving sex workers and a CLO serving people living with HIV (Box 9.2) offered HIV testing services, but their approaches and target populations were markedly different. This was reflected clearly in their unit costs:

- The CLO working with sex workers, aimed to reach as many individuals as possible. In one year, they tested 27 222 people, resulting in a unit cost of US$ 5.46 per person tested. With a positivity rate of 2.2%, the unit cost per person testing positive was $250.98. Due to challenges in linkage to care, their unit cost per person linked to care was higher at $410.45, reflecting drop-offs between testing and treatment initiation.
- The other CLO, by contrast, worked with people living with HIV and implemented an index testing approach, offering tests to family members and sexual partners of new HIV-positive clients. Over the year, they conducted 149 HIV tests, but with a much higher positivity rate of 14.8%. Their unit cost per person tested was $25.70 (much higher than the other), but their unit cost per person testing positive was lower at $174.07, with 100% of positives linked to care.



This example highlights that higher unit costs are not necessarily a sign of "poor performance." Instead, costs must be interpreted in light of contextual factors, programme design, population characteristics and overall scale of impact. The CLO serving sex workers prioritized high-volume outreach in a high-risk population where repeated testing is common and necessary; this resulted in a large absolute number of people reached and linked to care. The other CLO serving people living with HIV used a highly targeted strategy to find new cases among close contacts, achieving high efficiency per positive case identified, but contributing fewer total cases to the national response. Both strategies are important within the national HIV response, but unit cost comparisons can also help identify areas for improvement, such as reducing dropouts between testing and care while balancing efficiency with overall contribution to public health impact.

9.5. Comparing financial vs. economic unit costs

The next step is to compare financial and economic unit costs. While financial costs reflect only actual expenditures, economic costs capture the full value of all resources used, including unpaid, donated or in-kind contributions while also accounting differently for capital costs (Box 8.10). Comparing the two provides a more complete picture of what it truly takes to deliver an intervention. This distinction is especially important in CLRs, where contributions from volunteers, donated facilities or other informal inputs may be substantial but go unbudgeted. Analysing both financial and economic unit costs side by side can help quantify these hidden contributions, make visible the extent to which programmes rely on unpaid work, and strengthen the case for sustainable financing.

Box 9.8. How to read financial vs. economic costs in the CLR Costing workbook

Sheet: Results (US dollars) or Results (LCU) (orange tabs)

Where to look:
- Rows 71-128 contain the same breakdowns shown earlier, but now based on economic costs (i.e. including non-financial and in-kind contributions).
- Rows 124-128 present the difference between economic and financial costs, which can help quantify the value of community and unpaid contributions.
- Economic unit costs are calculated using the same outputs as financial unit costs.

How to present these results:
- Use stacked column charts to compare financial and economic costs side-by-side, either by input category or intervention.
- If comparing unit costs, consider overlaying economic unit cost values on the same chart as financial unit costs to highlight any differences.

It is important to emphasize that unpaid or underpaid community contributions should not be seen as an appropriate way to reduce costs. Rather, they represent hidden subsidies from communities that risk undermining equity and sustainability. UNAIDS advocates that communities be fairly compensated for their time and expertise. Documenting unpaid contributions through economic costing is therefore the first step to measuring the full costs of community-led interventions, inform funders and policymakers, and support advocacy for fair and adequate remuneration.

Understanding the gap between financial and economic costs can be helpful to:

- **Quantify unpaid community contributions:** A substantial gap signals how much communities or CLOs are contributing without formal funding. This can include volunteer time, donated buildings or personally covered expenses.

Unpaid inputs aren't cost savings. They represent hidden subsidies from communities that can undermine equity and sustainability. Accounting for in-kind contributions is the first step to recognizing and valuing community efforts, and supporting advocacy for fair and sustainable funding.

- **Planning and advocacy:** Some in-kind resources, like an unfunded but essential position or rent paid informally by staff, may need to be budgeted for in the future. Demonstrating these gaps helps justify requests for additional funding.
- **Recognizing value in community-led efforts:** For governments or donors, the economic costs show the full resources required for programme delivery, especially in CLRs where unpaid inputs are common. This can inform policy and funding discussions, while also acknowledging communities as active contributors whose time and resources are integral to the response.
- **Comparing across interventions:** Some interventions rely heavily on volunteer time and other non-financial inputs, resulting in considerably higher economic costs compared to financial costs. Recognizing which interventions depend most on community or in-kind resources is important for assessing sustainability, identifying gaps for future financing, informing scale-up plans and evaluating efficiency.

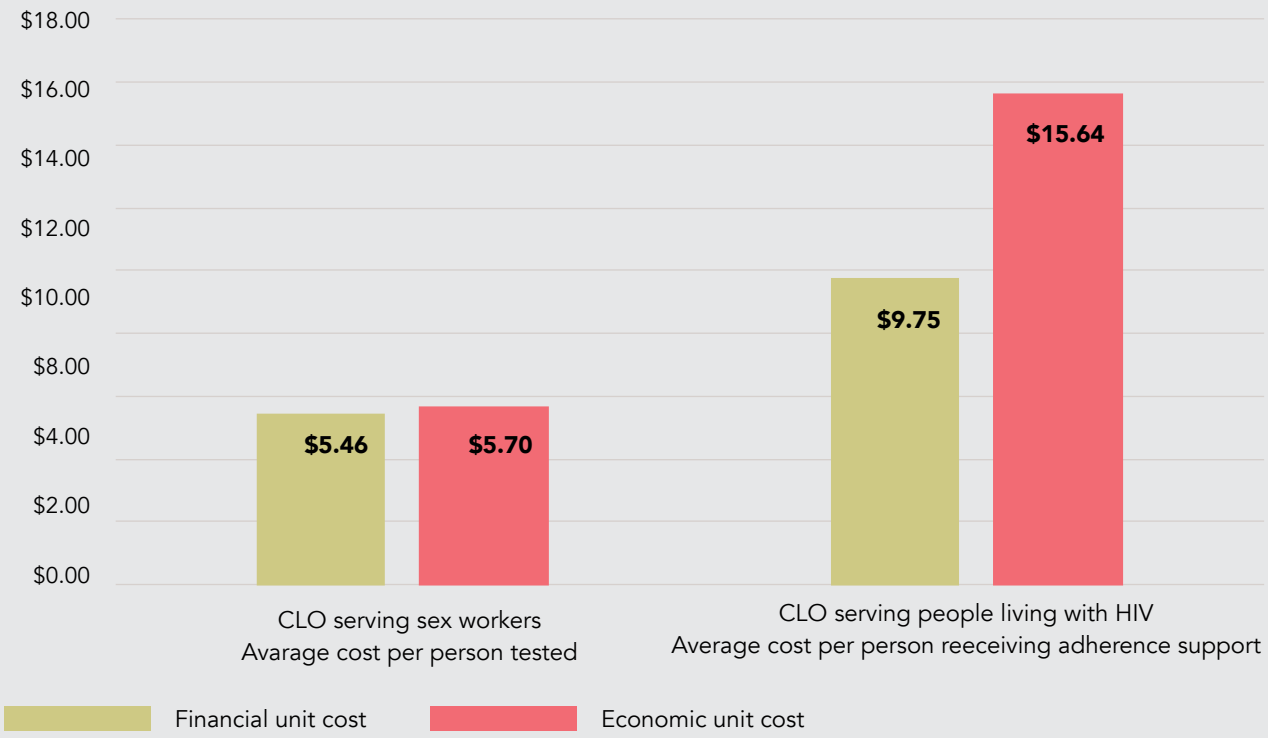
Box 9.9. Case example: Comparing financial and economic costs in Sierra Leone

In the Sierra Leone costing study, both a CLO serving sex workers and a CLO serving people living with HIV relied on peers to deliver services, but the role and intensity of community contributions varied by intervention.

At the CLO for sex workers, peer educators received stipends for their work conducting HIV testing and prevention outreach. These stipends were equivalent to the replacement market rate for similar work in Sierra Leone, meaning their time was already fully compensated in financial terms. As a result, the economic costs were only slightly higher than financial costs, indicating limited additional in-kind inputs.

In contrast, the other CLO supported people living with HIV through ongoing ART adherence interventions. These efforts involved treatment champions and self-help groups, whose contributions were substantial and sustained. The economic cost of ART adherence support was approximately 25% higher than the financial cost, reflecting substantial unpaid community inputs.

Comparison of financial and economic unit costs



This has important implications for scale-up and sustainability. In Sierra Leone, ART coverage among all people living with HIV was estimated at 83% as of 2023 (30). But for adolescents and young people aged 15–24 years, coverage was only 32% (31), with this group more likely to present with advanced HIV disease. Strengthening ART adherence, particularly for young people, is a national priority. However, doing so at scale will require mobilizing substantial community resources, and decision-makers must assess whether this is feasible without compromising quality of care or sustainability.cost comparisons can also help identify areas for improvement, such as reducing dropouts between testing and care while balancing efficiency with overall contribution to public health impact.

9.6. Additional analyses

Beyond descriptive cost analysis, there are several other analytical approaches that teams may consider if they have the appropriate data, skills and support:

- **Sensitivity analysis:** Helps assess how results would change under different assumptions. For example, what happens to unit costs if volunteer time is valued differently or if shared inputs are allocated using alternative methods? This can be done by testing one assumption at a time or by entering all best- and worst- case value at once to see the combined effect.
- **Scenario analysis:** Explores different "what-if" situations to support planning or budgeting. For instance, comparing costs under low-, medium- and high-scale implementation scenarios.
- **Cost-effectiveness analysis:** Assesses the value for money of an intervention by comparing costs with outcomes (e.g. cost per HIV infection averted, cost per life-year saved). This requires meaningful outcome or impact data and a comparator, as well as making certain that the analysis is utilizing economic costs.
- **Equity or distributional analysis:** Examines how costs or services are distributed across populations (e.g. by gender, age or geography), which can be useful for equity-focused planning.

These analyses can provide powerful insights, but they go beyond the core scope of this guideline and typically require additional methodological expertise and analytical tools. Where appropriate, CLOs may consider partnering with experienced researchers or analysts to pursue these extensions.

9.7. Applying cost data for planning, budgeting and advocacy

As introduced in Chapter 3, costing results can support monitoring, efficiency improvements, funding proposals, budgeting and long-term planning. This section outlines how to apply the results from the costing tool to each of these purposes, helping teams use costing not just as a technical exercise, but as a foundation for planning, negotiation and advocacy.

9.7.1. Monitoring

While total costs can show overall spending trends, they are sensitive to variations in funding availability or contextual and operational challenges (e.g. programme interruptions). Unit costs are far more informative for monitoring purposes, as they reflect how much is spent per person reached or per other outcome achieved. This allows programmes to track performance over time and across delivery strategies, helping to identify patterns, explain changes and support decision-making.

Programmes can use unit costs in routine monitoring:

- **Tracking unit costs over time.** Monitoring whether unit costs are rising or falling can provide insight into implementation dynamics. An increase may reflect rising input prices (e.g. fuel, staff time), difficulties reaching harder-to-reach groups, or even reduced quality due to limited resources (e.g. implementing in too short a time frame). A decrease may indicate more stable operations or increased reach. These patterns need to be interpreted with qualitative insights from staff and beneficiaries to fully understand the reasons behind changes and guide adaptations.

- **Monitoring how spending is distributed across inputs.** Reviewing how spending is distributed across inputs over time (e.g. personnel, transport, supplies) helps track what is driving cost changes. For instance, the team might consider whether using pooled procurement to negotiate better prices on major inputs could be more cost-effective than relying on smaller, repeated purchases.
- **Flag unusual trends for further exploration.** Sudden changes in unit costs or input distributions may point to data issues, implementation shifts or new contextual challenges. By monitoring these trends and identifying changes early, CLOs are better positioned to understand what is happening on the ground, respond proactively, adapt strategies, and champion and justify their needs to funders and technical partners.

9.7.2. Efficiency

Costings can be a powerful tool to identify opportunities to improve efficiency, defined here as maximizing outputs (e.g. the number of people reached) or minimizing costs for a certain intervention. Analysing unit costs, cost structures and trends can allow CLOs to reflect on how to deliver interventions more efficiently, without compromising quality or equity. The goal is not to cut costs haphazardly but to use evidence to make smart and strategic decisions about resource use. CLOs can use costing data to explore efficiency in several ways:

- **Identify outliers or high-cost sites/interventions.** If unit costs vary considerably across sites or delivery approaches for the same intervention, it may be worth investigating why. Are some sites using more resources than others for the same results? Are contextual differences driving cost variation? Understanding these differences can help identify good practices or areas for improvement.
- **Examine cost drivers.** Reviewing which cost inputs (e.g. personnel, transport, supplies) account for the highest proportion of total costs can guide further analysis of effectiveness. Personnel and medical supplies often represent major cost areas. These are not necessarily areas to reduce, but categories where efficiency gains may be possible. For instance, if a nurse is stationed in a drop-in centre with low client flow, their time might not be fully utilized. In such cases, teams can explore additional tasks that align with the nurse's role—such as follow-up calls, health education or outreach—to increase productivity and generate demand without compromising service quality. Similarly, if transport or supply costs are consistently high, joining with other CLOs to make bulk or pooled purchases may reduce unit prices and improve cost efficiency.
- **Link inputs to outputs.** CLOs can explore whether higher costs are associated with better outcomes, or if similar results could be achieved with fewer resources. For example, two sites may have similar unit costs, but one may be achieving better linkage to care or client satisfaction. This type of analysis can help distinguish between high-cost–high-impact strategies and high-cost–low-impact ones. Importantly, these comparisons should be interpreted considering access, quality and relevance to the population served. A strategy that appears less "efficient" on cost alone may still be the best approach if it reaches underserved populations, ensures high-quality care or meets specific community needs that others do not.
- **Explore scalability and resource needs.** Understanding which interventions or approaches are most efficient can inform scale-up plans. If one approach consistently achieves outcomes at a lower cost, it may be prioritized as funding becomes more limited or new grants are sought. When projecting costs for scale-up, consider economies of scale: As scale increases, fixed costs (e.g. management, equipment) are spread over more outputs, reducing unit costs.

Evidence is power. Transparent, well-documented costs help CLOs make the case for sustainable funding. Cost data are not just financial evidence — they are tools for equity and accountability.

9.7.3. Informing funding proposals

Costing data can strengthen funding proposals by grounding requests in real implementation experience. When CLOs present unit costs, input distributions and resource needs backed by costing data, they demonstrate transparency and credibility—qualities valued by funders. This can help justify requested amounts, explain variations in costs across interventions, and advocate for sufficient funding for interventions that may appear less "efficient" but are critical for community well-being. Costing results can help:

- **Estimate total resource needs.** CLOs can estimate how much funding is needed to reach a target number of people by multiplying a unit cost by the desired output. For example, if the unit cost of HIV testing is US$ 6.80 per person and a funder wants the CLO to test 1,000 people, the CLO can estimate an approximate total budget of $6,800 to meet that target.This serves to provide a useful starting point for discussion, allowing all stakeholders to assess feasibility and negotiate funding. Comparing the estimated resource needs with the actual budget can also reveal funding gaps, helping CLOs demonstrate where additional support is required to realistically achieve agreed targets. These unit costs include annualized capital costs, which is important to consider when budgeting over shorter periods or interpreting one-time investments spread across years. It is also worth noting that, as discussed above, there may be opportunities to reduce costs or improve outcomes over time, further refining future resource needs.
- **Estimate and justify cost inputs.** The costing exercise allows CLOs to estimate the costs of specific input categories and explain why certain interventions or delivery approaches may require more resources. This helps funders understand the drivers behind higher costs and supports more transparent, well-justified budgets.
- **Estimate and justify direct and central (above-intervention) costs**. If a full costing was conducted, the results can be used to estimate not only the direct costs of delivering specific interventions, but also the central or organizational costs required to support them (e.g. management, coordination, supervision). This helps clearly communicate what the CLO needs in terms of structure and capacity to deliver the interventions. Even if a funder has specific restrictions on what can be financed, presenting the full picture allows the CLO to track funding gaps and advocate for additional support or identify alternative funding sources.
- **Demonstrate gaps in financial support.** If economic costs reveal that a large share of resources come from unpaid contributions or in-kind inputs, CLOs can use this information in several ways. First, they can advocate for increased financial support from donors or governments to sustain efforts that are currently underfunded, such as stipends for peer educators, or to cover costs currently met through in-kind contributions, such as donated office spaces or personnel's out-of-pocket transport costs. These are essential to service delivery but often go unrecognized in financial budgets. Second, even if additional funding is not immediately available, documenting these contributions helps ensure they are acknowledged as legitimate and valuable inputs to the HIV response. This recognition can support future funding discussions, strengthen partnerships and help shift perceptions around the role and value of community-led work.

9.7.4. Short term budgeting

When preparing budgets for the coming year (whether to continue, expand or replicate interventions) costing data can serve as a practical reference point to improve the accuracy and realism of plans:

- **Use past prices to inform new budgets:** Costing results can help teams avoid guessing costs by using real, previously observed prices for goods, services and staff time. This is especially valuable for line items such as transport, supplies or personnel. Where needed, prices can be adjusted for inflation or changes in the market (**Chapter 10.2.2**).
- Estimate quantities and frequencies based on past implementation: **A common** budgeting challenge is overestimating how much can be achieved in one year. Costing data allows teams to review how many activities they conducted in the past and how often, providing a realistic baseline to inform new targets and resource quantities.
- **Use cost input proportions as a quality check:** The percentage breakdown of costs by input type (e.g. personnel, transport, supplies) from the costing can serve as a benchmark. For example, if 35% of total costs in the previous year were for personnel, teams can compare that to personnel costs in their new budget to ensure they are not under- or over-budgeting for major cost inputs. Large deviations should be reviewed and justified.
- **Check alignment between total cost, planned activities and unit costs:** Compare the projected total costs and projected outputs/outcomes in the new budget to the unit costs from past costing. If they do not align, this could signal unrealistic expectations, shifts in cost structure or changes in delivery approach. Teams can use this as a check to make sure their plans are grounded in experience.

Note that in costing exercises, capital costs are annualized or spread across the expected useful life of the item. However, attention must be paid in budgets to when money will be spent. If equipment or infrastructure needs to be purchased in the coming year, the full cost of that item must be included in that year's budget. On the other hand, if the item has already been purchased, it may not need to be budgeted again. Be sure to reconcile costing assumptions with real-world cash flow needs. To anticipate and plan for such costs, teams can refer to their asset registry (**Appendix 9**) to identify which items may need replacing in the coming years. This helps ensure that budgets are realistic and avoids surprises in cash flow requirements.

9.7.5. Medium/long-term planning and resource mobilization

Costing results can support national planning processes and efforts to mobilize and earmark resources for an equitable and effective HIV response. As countries develop national strategic plans (NSPs) or investment cases, it is essential to estimate what resources will be required. CLOs serve key and vulnerable populations must be adequately represented in these projections to ensure that national responses are inclusive, accessible and equitable.

- **Estimate future resource needs:** Average unit costs, especially if calculated across several CLOs, and the observed range between them can provide a foundation for estimating the cost of scaling up or sustaining CLRs. If costing data are available from multiple CLOs, this can help planners anticipate both typical costs and variation, which is especially important when considering service delivery in different geographies or for different populations. Estimating the resources required for CLOs to reach key and vulnerable populations helps ensure that national budgets and resource mobilization efforts reflect the full scope of the response, not just facility-based or government-led services.

- **Incorporate economic costs to value unpaid community contributions:** By comparing financial and economic costs, CLOs and national planners can estimate the value of unpaid contributions from volunteers, peer educators and community infrastructure. Including these in NSP estimates recognizes the role communities play in national HIV responses and can help inform long-term strategies to sustain these contributions over time.
- **Strengthen funding proposals and advocacy:** Demonstrating how much it would cost to reach specific populations or targets—and why—helps CLOs and their partners make more compelling and evidence-based cases for funding. Unit costs linked to clear outcomes allow for transparent, realistic budget discussions and can strengthen the credibility of funding requests in national and international forums.

For more guidance on how to estimate resource needs and apply unit costs in national HIV planning processes, see the **UNAIDS' National Strategic Plan for HIV Costing Guidelines** (32,33).

PART 4

Budgeting guidance

This section provides step-by-step guidance for developing budgets to support community-led HIV responses. While costing looks backwards to estimate resources used, budgeting looks forward to project the resources needed to implement planned interventions. Budgets can be developed using costing results by drawing on observed data to inform projections, or they can be created by modelling resource needs based on assumptions when cost data are not available. The approach emphasizes practical "how-to" steps and is supported by an Excel-based budgeting tool in the appendix.

Chapter(s) included:

Chapter 10
Budgeting future resource needs

Chapter 10 provides step-by-step guidance for projecting costs and developing budgets for community-led HIV responses. It highlights two main approaches: Using results from a costing exercise to inform projections and modelling resource needs based on assumptions when cost data are not available.

By the end of this chapter, you should be able to:
1. Align budgeting methods with your objectives.
2. Estimate projected costs using unit costs and activity plans, or by modelling assumptions.
3. Complete the Community-led HIV response budgeting tool.

Supporting materials: **Appendix 13**, CLR Budgeting workbook (Excel); **Appendix 14**, CLR Budgeting workbook–Completed example with CLM (Excel); **Appendix 15**, CLR Budgeting workbook–Completed example with community-led edutainment (Excel).

Budgeting refers to the process of projecting costs into the future to estimate spending for a defined period. Budgets are set using assumptions about the resources required to implement intervention and the expected prices and quantities of those resources. In **Chapters 7 and 8**, you were guided through the process of costing, where observed costs were estimated based on historical and actual use of resources. **Chapter 9** then explained how to interpret and apply these costing results, including how they can inform projections of future costs in the short and long term. Building on this foundation, budgeting may draw on results from costing or use other methods and data sources. This chapter aims to equip the budgeting team with the skills and knowledge to develop their own budgets, based on their purpose, scope, method and available data sources.

Before beginning the exercise, ensure you have completed the following steps:

- Defined the purpose and scope of your budgeting exercise (**Chapter 5**).
- Mapped out the interventions, direct and central resources, and stakeholders involved in the delivery of said interventions (**Chapter 5**).
- Identified the data sources to collect the input prices and quantities (**Chapter 5**).
- Reviewed historical costs—if available—using the costing tool (**Chapter 7 & 8**).
- Considered how results from costing can be applied to inform projections (**Chapter 9**).

10.1. Overview of the CLR Budgeting workbook

To support the budgeting process, these guidelines are accompanied by an Excel-based CLR Budgeting workbook (**Appendix 13**), a blank template designed to automate calculations of projected financial needs. The budgeting tool builds on the costing foundation, allowing you to either use observed costs or new projections to estimate future resource needs, while identifying when and how each cost will occur. In addition, two completed examples are provided to illustrate how the workbook can be applied in practice: One for a CLM (**Appendix 14**) and one for a community-led edutainment (**Appendix 15)**. Other budgeting tools that can be useful to the CLR are also available in **Appendix 1**. This chapter will guide users in navigating and applying the workbook effectively.

10.1.1. Software requirements

Optimal use of the workbook requires a relatively recent version of Microsoft Excel:

- **Recommended:** Excel 2019 (vs.16.0) or later, including Microsoft 365 versions.
- **Minimum required:** Excel 2016 (v.16.0).
- **Note:** Earlier versions, and some free or web-based alternatives, will not support the functionalities embedded in the workbook. Using older or unsupported versions may result in calculation errors, broken links or missing features.

Users do not need to create formulas or manipulate Excel beyond basic use. However, a basic understanding of how to navigate spreadsheets, enter data into cells and read drop-down menus or filters is required. The workbook is designed to automatically calculate totals and unit costs once data is entered correctly.

10.1.2. What this budgeting workbook can (and cannot) do

This workbook is designed to help you project the resources and costs of a single community-led HIV intervention. If you wish to cost more than one intervention, you will need to use separate workbooks. Similarly, if you want to cost the same intervention delivered through different models or approaches, each model should be entered in a separate workbook.

You can include the resources of up to three different stakeholders (for example: A CLO bearing most of the financial and economic implementation costs; a government agency supplying medical commodities and office space; and another partner delivering technical trainings).

This workbook allows you to project costs for up to four years.

You can classify resources as budgeted (financial) or non-budgeted (economic), ensuring that both paid and in-kind contributions are captured in your planning.

The workbook does not provide built-in functions for long-term financial planning beyond four years, nor for scenario or sensitivity analysis (for example, scaling results to other populations or testing the impact of different assumptions). These must be done manually and require additional skills outside the scope of this workbook.

The workbook also does not generate graphs or visuals for reporting budgets.

10.1.3. Workbook structure

The workbook is organized into colour-coded tabs, located at the bottom. Each tab serves a specific purpose in the budgeting process as outlined below:

Table 10.1. Overview of the CLR budgeting workbook

Colour	Title	Purpose
●	Instructions	Guidance on how to use the workbook
●	Parameters	Input parameter assumptions including currency, costing year, inflation, exchange rates and useful life years
●	Cost Data_1	Enter all costs relevant only to Stakeholder 1, identify cost type, and allocate to intervention
●	Cost Data_2	Enter all costs relevant only to Stakeholder 2, identify cost type, and allocate to intervention
●	Cost Data_3	Enter all costs relevant only to Stakeholder 3, identify cost type, and allocate to intervention
●	Results (LCU)	Enter relevant outputs or outcomes for the intervention being costed Remainder of the sheet automatically generates total and unit cost results in the LCU for the intervention
●	Results (US dollars)	This sheet automatically generates total and unit cost results in US dollars for the intervention[9]

Important navigation tips:

- Treat each blue cost data sheet as specific to one stakeholder or actor. If your intervention involves multiple stakeholders, enter each stakeholder's data in a separate sheet. For example, suppose you are costing an intervention where a CLO covers the main implementation costs (staff salaries, transport, community outreach), a government branch contributes specific inputs (medical supplies, office rent), and a technical partner provides training. In that case, you would use three separate blue cost data sheets (one for each actor).
- A single workbook is designed to project costs for one intervention only. If you are budgeting for multiple interventions, create a separate workbook for each.

[9] Results in US dollars provide a common reference to compare and interpret projected costs across contexts and are widely used in donor and policy reporting. The workbook can, however, be set to any other currency by adjusting the conversion fields.

Box 10.1. Tips for using the workbook

- Complete all yellow cells; missing entries will lead to incomplete calculations.
- Use drop-down menus where available to reduce errors and ensure accurate calculations.
- Avoid altering grey formula cells to protect built-in calculations.
- Avoid adding/deleting/merging rows, columns and cells to protect the workbook structure.
- Save multiple backup copies throughout the process.

10.2. Key considerations before using the budgeting tool

Before starting the budgeting exercise and using the tool, it is important to reflect on a few key elements that will affect how costs are projected and how the tool will be best used. This section highlights considerations such as: Defining the period; deciding whether to include economic costs; handling capital versus recurrent items; and applying allocation factors. These should be addressed before beginning the budgeting process.

10.2.1. Defining the time period

As explained in **Chapter 3**, the time horizon (the length of time over which costs will be projected) is a fundamental part of any budgeting exercise. It should align with the purpose of the exercise. For example, if the budget is intended for a funder, the time horizon should reflect that funder's grant cycle.

Within that time frame, special considerations should be given to seasonal variations and project phases. For example, outreach campaigns may be more intensive during dry seasons, while transport and community events may be limited during rainy periods. Costs are likely to differ between a pilot phase and routine implementation, with early periods requiring one-time start-up costs and later years benefiting from learned efficiencies.

Hard-to-predict external factors—such as late funding disbursements, political instability and national stock-outs—may impact when activities can realistically be implemented. Planning should be grounded in the realities of the operating environment to avoid overambitious timelines.

When completing the budgeting tool, make sure to:

- Define your budgeting period. This tool allows you to project up to four years.
- Identify when each input, identified in your process and central resource mapping, will be needed (e.g. one-time purchase versus recurring).
- If costing data are available, refer to them to review actual quantities of resources used and the frequence of activities. This can help determine what is realistically feasible to implement in each projected year.

When projecting costs across multiple years, it is important to account for inflation (the increase in prices over time).

10.2.2. Multiyear time horizon and inflation rates

When projecting costs across multiple years, it is important to account for inflation (the increase in prices over time). If inflation is ignored, budgets may underestimate the actual cost of delivering services in future years, particularly in contexts where prices change rapidly or unpredictably. CLOs may become underfunded if they base their projections on current prices but face higher costs when implementation begins.

Some donors provide inflation rates to use in budgeting. If no guidance is given, inflation can be estimated using:

- Local inflation rates for non-tradeable items, such as local salaries, office rent, utilities, local transport.
- International inflation rates for tradeable items, such as imported commodities (e.g. HIV test kits, lubricants, branded supplies), equipment and vehicles purchased internationally, any inputs priced in US dollars or other foreign currencies.

The budgeting tool allows users to enter inflation rates and apply them automatically across years. You will be asked to:

- Input the donor-provided inflation rate.
- If not available, input the average **local CPI**[10] (Consumer Price Index) and **US dollars CPI** (**Box 10.2** will take you through that step).

The spreadsheet then inflates current prices in future years using the CPI rate in US dollars for tradeable inputs and the local CPI rate for non-tradeable items. In this workbook, inputs identified as buildings/space, personnel, building maintenance, transport, and other recurrent items are treated as non-tradeable, while equipment, vehicles, and supplies are treated as tradeable. A worked example is included in **Box 10.2.** to demonstrate the formula used to apply inflation across years in the workbook.

[10] The CPI is a general and commonly used measure of inflation. In some cases, however, it may not reflect changes in specific cost categories. For example, government health sector salaries may have increased faster or slower than the CPI. Where reliable sector-specific data are available (such as a national wage index for health workers), consider using these figures instead.

Box 10.2. Example of adjustment for future inflation in budgeting

A CLO in Haiti is completing an internal budget, which requires projecting the future value of its personnel costs. The average local CPI[11] is used to estimate the future inflation rate for local non-tradeable items, such as local personnel costs and rent. In 2023, the annual personnel cost was 1.3 million Haitian gourdes (G) (about 10 000 US dollars). To take the specific example of projecting personnel costs for 2024 to 2026, the organization uses the average local inflation rate from 2018 to 2022, finds a rate of 21%, and applies the following formula:

$$\text{Future cost} = \text{Present cost} \times (1 + \text{Inflation rate})^{\text{Number of years}}$$

	2023	2024	2025	2026
Annual personnel cost	G 1 318 424	G 1 318 424 x (1+0.21) = G 1 595 293	G 1 318 424 x $(1+0.21)^2$ = G 1 930 305	G 1 318 424 x $(1+0.21)^3$ = G 2 335 669

In this same budget the CLO wants to include the costs of procuring branded condoms and lubricants. These are purchased internationally in US dollars and are, therefore, subject to a different inflation rate than items purchased with the gourde. To inflate the costs of internationally tradeable items such as condoms and lubricants, the organization looks up the CPI in US dollars[12] and calculates an average inflation rate of 2.46%. Using the same formula above:

	2023	2024	2025	2026
Annual cost of condoms and lubricants	US$ 10 000	$10 000 x (1+0.0246) = $10 246	$10 000 x $(1+0.0246)^2$ = $10 000	$10 000 x $(1+0.0246)^3$ = $10 756

[11] https://data.worldbank.org/indicator/FP.CPI.TOTL.ZG?locations=HT
[12] https://data.worldbank.org/indicator/NY.GDP.DEFL.KD.ZG?locations=US

10.2.3. Financial and economic costs

It is important to distinguish between financial costs and economic costs, as was done in the costing section of this guideline.

- Financial costs refer to expenditures that are paid by the provider(s). These are the items and services that are funded and appear in a grant or operational budget.
- Economic costs include both financial costs and unpaid or in-kind contributions, such as donated time, space or supplies. These reflect the full value of resources used to implement an intervention, regardless of whether they are paid.

Table 10.2. Summary of financial and economic costs

Methods	Description	Advantages	Disadvantages	Data sources
Financial costs	Cost of resources that are paid for	Provides insight into the direct funding needed to implement an intervention	Overlooks communities' in-kind contributions and assumes contributions will persist	Expenditure records, purchase orders, invoices, operational reports
Economic costs	Value of resources used, whether paid or unpaid	Considers both explicit financial expenditures and non-monetary contributions needed to implement an intervention	Complex and requires extensive analysis and consideration of the value of in-kind contributions	Market prices, interviews, minimum wage

While budgeting exercises typically focus on financial costs, it is important, especially in the context of CLRs, to also capture in-kind contributions. Many CLOs rely on volunteer labour, donated supplies or other informal support. These contributions are real and valuable, but they may not always be sustainable. Capturing them allows CLOs to:

- Understand the full resources required to implement an intervention.
- Identify where unpaid contributions are being used to fill funding gaps.
- Advocate for continued or increased support, whether financial or in-kind.
- Consider whether current community contributions can be maintained over time or whether additional financing will be needed.

The budgeting tool refers to these same concepts as:

- Budgeted costs: Resources that will be paid for (financed) and included in the budget.
- Non-budgeted costs: Resources that are expected to be provided in-kind or are not yet financed.

This distinction allows users to track both the financial resources of the intervention and any reliance on unpaid contributions, helping to assess the sustainability of implementation.

When completing the budgeting tool, make sure to:

- Review the list of key inputs identified through the process mapping, central resource mapping and stakeholder mapping (**Chapter 5**).
- Specify whether each input is:
  - — Budgeted (i.e. financed)
  - — Non-budgeted (in-kind or unfunded)
  - — Partially both (partially financed, partially in-kind)

If you choose to budget for financial costs only, you can disregard the columns labelled "unbudgeted" in the tool.

10.2.4. Capital vs. recurrent costs

- As described in **Chapter 3**, inputs used in implementing an intervention can be classified as either capital or recurrent costs:
- Capital costs are for items with a useful life of more than one year, such as vehicles, laptops or equipment. These may also include start-up costs for systems or materials that are not regularly replaced.
- Recurrent costs are for items with a useful life of less than one year, such as staff salaries, per diems, fuel, internet and office supplies.

In costing exercises, capital inputs are annualized (spread over their useful life) to reflect the use of the asset over time. But in budgeting (particularly when budgeting for financial costs) the focus is different: What matters is when the cost will be incurred and how much it will be.

In the budgeting tool, users are asked to list all capital resources required to implement the intervention. For each item, make sure to:

- Indicate whether the item is already owned or will be purchased during the budget period.
- Specify the year of purchase (if budgeted).
- Provide the useful life (in years).

The tool will then:

- Assign the full cost of any budgeted (new) capital item to the year of purchase.
- Track the remaining value of any non-budgeted (already owned) item across its useful life.
- Help users anticipate replacement needs for capital inputs that may expire during the intervention period.

For example, if a vehicle is budgeted for purchase in Year 1 at a cost of US$ 30 000, the full amount will appear in Year 1 of the budgeting tool. If the vehicle is already owned and has a useful life of 10 years, the tool will treat it as non-budgeted and automatically calculate an annual value of $3000 each year to reflect the ongoing use of an unfunded resource (see **Box 10.7** for an example).

10.2.5. Allocation factors

When budgeting across multiple interventions, delivery models or sites/stakeholders, some inputs may be shared between them. To accurately assign shared costs, the tool includes allocation columns in each input sheet. These allow you to indicate what proportion of each input is allocated to Intervention/Model/Site 1, 2 or 3. This ensures that shared resources are appropriately distributed and avoids double counting.

This step becomes especially important when:

- Inputs are used partially for the intervention you are budgeting.
- The same input supports multiple interventions or models.

For example:

- An executive director may only spend 30% of their time on the CLM intervention, so you would allocate 30% of their cost to that intervention.
- A tablet purchased specifically for CLM data collection would be allocated 100% to CLM.
- If you are budgeting for three different models of CLM implementation and a vehicle is used across all three, you might allocate the vehicle cost evenly (33%/33%/34%) or based on mileage logs or estimated usage.

If you have already completed a costing exercise, you will have used tools such as vehicle logbooks, time sheets, time and motion studies, or activity mapping to determine how shared inputs were used. These same allocation factors can be applied directly in the budgeting tool to inform how you distribute projected costs.

If you have not done a costing and are preparing a budget from scratch, you will need to make reasonable assumptions based on how you expect inputs to be used across your chosen interventions or models. See **Box 10.3** for an example.

Box 10.3. Example of using a top-down approach to account for above-service costs

A CLO aims to accurately allocate their overhead costs—such as administrative salaries, rent, utilities and general operational expenses—across their three interventions: 1) literacy classes; 2) after-school tutoring; and 3) vocational training.

Step 1. The organization starts by determining the overhead costs incurred by the CLO. They do this by reviewing financial records and budget reports to identify all the central costs associated with running the CLO. They input these individual costs in the workbook, totalling US$ 20 000.

Step 2. Once these overhead costs are determined, the organization allocates these costs to its interventions based on an allocation method. This method can be based on factors such as staff time dedicated to each intervention, the proportion of resources used by each intervention, or the relative proportion of direct costs.

The vocational trainings account for the largest share of direct costs compared to the other two interventions. Overall, 60% of programme expenses go directly to vocational training, 20% to literacy classes, and 20% to after-school tutoring.

Step 3. As a result, the CLO prepares a budget in which $ 12 000 of their above-service (or central) costs are borne by the vocational training, $ 4000 to their literacy classes, and $ 4000 to after-school tutoring. Funders are presented with a concise and transparent reasoning for each project's budget and estimated overhead costs.

- When entering allocation percentages in the tool, make sure to: Carefully consider any input that may be shared across more than one intervention or model. These will have been identified using the process and central mapping tools in **Chapter 5**.
- If costing data is available, use these to inform how much of each input is used for each component.
- If no data are available, make transparent, reasonable assumptions and document them separately.

10.3. Using the CLR Budgeting workbook

10.3.1. Completing Parameters (black tab)

The Parameters sheet sets the foundational assumptions and conversion values that the budgeting workbook uses in all calculations. This includes currencies, inflation and exchange rates and useful life years for capital items. Completing this sheet accurately is essential, as the information entered here drives all cost adjustments, conversions and annualization throughout the workbook. Incorrect or incomplete entries in the Parameters sheet will cause errors in later calculations and distort results.

Box 10.4. How to complete the Parameters sheet

Objective:

- The Parameters Sheet defines the assumptions and conversion values used in your cost projections.

Overall steps:

- Enter values in all yellow cells.
- Include a source for each value where applicable.
- Review prefilled entries (e.g. useful life) and adjust if more appropriate local values exist.

Parameters

This sheet contains the key parameters for your costing. Enter or review values in yellow cells to confirm they are relevant to your context. All subsequent calculations, including inflation adjustments, currency conversion, and annualization, depend on the values entered here.

Parameters	Description	Value	Source	Comments
Currency units				
Country	*Country name*	*Philippines*	N/A	
Local currency unit (LCU)	*Local currency*	*PHP*	N/A	
International currency unit (USD)	*International currency used for specific purchases and converting results. Often US Dollars (USD).*	*USD*	N/A	
Inflation rates				
Inflation: Average Consumer Price (annual %)	*Average inflation rate of LCU using local consumer price index*	*4,27%*	World Bank CPI: https://data.worldbank.org/indicator/FP.CPI.TOTL.ZG	*Average inflation rate between 2022-2025*
Inflation: Average USD Consumer Price (annual %	*Average inflation rate of USD using GDP deflator*	*4,20%*		
Exchange rates				
Exchange rate: USD per 1 LCU	*Amount of USD needed to exchange for 1 unit of LCU*	*0,017673048*	https://www.xe.com/currencytables/?from=PHP&date=2025-08-24#table-section	Date: Aug 24, 2025
Exchange rate: LCU per 1 USD	*Amount of LCU needed to exchange for 1 unit of USD*	*56,58333641*		
Useful life, in years				
Land value	*Period of time over which assets are expected to provide an economic value. Use the recommended useful life years or change to reflect locally adapted life years.*	10	Commission on Audit (2003). Table of Estimated Useful Life of Property, Plant and Equipment. https://blgf.gov.ph/wp-content/uploads/2021/05/Estimated-Useful-Life-of-PPE.pdf	*Changed to local useful live years*
Building value		30		
Vehicles		7		
Furniture		5		
Electronics		5		
Medical		10		
Start-up		2		

Step-by-step instructions:

- **Currency units:** Set working and reporting currencies.
  - **Country:** Full name of the country where budgeting is conducted.
  - **LCU:** Local currency in which most purchases will be made.
  - **International currency unit:** Currency for specific purchases, international comparisons or reporting; usually US dollars.

- **Projected inflation rates:** To apply inflation for forward projections.
  - **Inflation:** Average consumer price in local currency (annual %): Enter the average CPI[13] over the last five complete calendar years for your country.
  - **Inflation:** Average consumer price change in local currency (annual %): Enter the average US CPI over the last five complete calendar years.[14]
  - **How to find these:**
    - Visit the World Bank's CPI data page https://data.worldbank.org/indicator/FP.CPI.TOTL.ZG
    - On the right-hand side of the graph, go to "Download" and select "Excel."
    - Open the downloaded Excel file and go to the first tab labelled "Data."
    - Search for your country.

[13] CPI is a general and commonly used measure of inflation. However, in some cases, it may not reflect changes in specific cost categories. For example, government health sector salaries may have increased faster or slower than CPI. Where reliable sector-specific data is available (such as a national wage index for health workers) are available, consider using these figures instead.
[14] Or the average consumer price of the country used if another international currency unit is selected.

Box 10.4. How to complete the Parameters sheet, cont.

    - Calculate the average annual CPI over the five most recent complete years prior to your budget start year.
    - Enter decimal number into cell C11.
    - Repeat steps but search for "United States" to obtain the average inflation rate in US dollars.
    - Enter this rate as a decimal number in cell C12.
  - To learn more about how inflation is projected into the future, see **Box 10.2**.
  - **Note:** If a donor or government prescribes a planning inflation rate, follow that guidance and note the source.

- **Exchange rates:** To set conversion between LCU and US dollars.
  - **Exchange rate: US dollar per 1 LCU:** Enter how many US dollars are needed to purchase 1 unit of the LCU.
  - **Exchange rate: LCU per 1 US dollar:** Enter how many local currency units are needed to purchase 1 US dollar.[15]
  - **How to find these:**
    - Visit the XE currency table page: https://www.xe.com/currencytables/
    - Under currency, select your LCU
    - Under date, select today's date
    - Click "View Table"
    - Look for the value listed in the "USD per unit" column—this is your US dollar per 1 LCU (enter this in cell C15)
    - Look for the value listed in the "Units per USD" column—this is your LCU per 1 US dollar (enter this in cell C16)

- **Useful life (in years):** To estimate the number of expected life years of capital items.
  - The workbook includes default useful life values based on international guidance. However, you should review and adjust these values if more accurate or locally appropriate estimates are available.
  - **How to validate or update these values:**
    - Consult the accounting or finance department of your organization or a partner organization. They may have an internal depreciation schedule and guidance used for audit reporting.
    - Check with government ministries or donor agencies because they may have recommended standard asset lifespans.
    - Consider local context. Harsh operating conditions may reduce useful life (e.g. vehicles in rural or flood-prone areas). Well-maintained equipment may last longer.
    - Update values in the sheet if local evidence supports a different lifespan.
    - Include your source and rationale in the adjacent "Source" column.

[15] Or if another international currency is used, enter the rate relative to that currency.

If you are budgeting an intervention that you currently implement, anchor your assumptions in costing results or historical data wherever possible.

10.4. Completing Cost Data (blue tabs)

In this section, you will learn how to complete the Cost Data sheets so that the workbook can operate correctly and produce accurate total cost projections. These instructions walk you through the required fields, the correct way to enter information and common errors to avoid.

There is one Cost Data sheet per stakeholder. If the intervention involves several contributors—for example, a CLO bearing most of the financial and economic implementation costs, a government branch providing medical supplies and office space, or another partner delivering technical trainings—you can track the resources for each contributor separately by completing their respective sheet.

Once you have completed these steps, the workbook will automatically perform the necessary calculations to adjust, categorize and summarize your costs.

10.4.1. Entering Cost Data (columns A–K)

This section explains how to record the basic details for each resource line (item, price, quantity and year) using your planning data and assumptions. Be sure to include both budgeted (financial) and non-budgeted (in-kind costs), so the results reflect the full set of resources needed. Accurate completion of these fields is critical, as they feed directly into all later calculations.

If you are budgeting an intervention that you currently implement, anchor your assumptions in costing results or historical data wherever possible. Cross-check expected prices (recent invoices, salary scales, contract rates) and planned quantities (past service volumes, activity logs, staffing ratios). A common pitfall is being overly ambitious by setting quantities or targets that are unrealistically high, which can lead to over-budgeting and, later, under-absorption. If planning a scale-up, check targets against recent achievable performance and delivery capacity (staffing, procurement lead times, logistics) and briefly document the rationale and source for each key assumption.

Box 10.5. How to complete columns A–K

Objective:

- Enter the planned resource lines into the Cost Data sheet to record the quantity, price and other basic details for each input required to deliver the intervention.

Overall steps:

- Use up to three Cost Data sheets, one for each stakeholder/actor bearing costs or contributions for the intervention.
- If costing from a single stakeholder perspective, right-click and hide unused sheets to avoid confusion.
- Enter all data in yellow cells only; grey cells contain formulas.
- Complete every required field in columns A–K to ensure the workbook calculates correctly.

Step-by-step instructions:

Column	Header	Description
A	Stakeholder	Name the stakeholder, actor or organization (e.g. CLO, government agency, technical partner)
B	Data source–Quantity	Indicate where the projected quantity comes from (e.g. projected assumption, service targets or past volumes from financial reports, stock cards, asset inventory, volunteer logs)
C	Data source–Cost	Indicate where the projected price comes from (e.g. recent quotes, historical procurement reports, resale value, salary scales)
E	Cost item description	Description of the cost item/resource

A	B	C	D	E
Sources				**Expenditure inputs**
Stakeholder	**Data Source: quantity**	**Data Source: cost**		**Item**
Specify the stakeholder or	*Specify the name of the*	*Specify the name of*		*List all relevant cost items below*
Implementing CLO				Executive director
Implementing CLO				Executive director
Implementing CLO				Executive director
Implementing CLO				Executive director
Implementing CLO				Programme Officer
Implementing CLO				Programme Officer
Implementing CLO				Programme Officer
Implementing CLO				Programme Officer
Implementing CLO				Enumerators- Stipend
Implementing CLO				Enumerators- Stipend
Implementing CLO				Enumerators- Stipend
Implementing CLO				Enumerators- Stipend
Implementing CLO				Enumerators- Unpaid time
Implementing CLO				Enumerators- Unpaid time
Implementing CLO				Enumerators- Unpaid time

Box 10.5. How to complete columns A–K, cont.

Column	Header	Description
G	Year	Specify the year the cost will be incurred by selecting Year 1, Year 2, Year 3, Year 4 from the drop-down menu. For resources already in use and not newly budgeted (e.g., equipment), select 'Previously purchased.' For costs across multiple years, create a separate row for each year
H	Quantity	Enter the planned amount
I	Unit	Specify the unit of measure (per person, per month, per session)
J	Unit cost	Enter the projected cost per unit in the original purchase currency
K	Currency	Select the currency of the price entered in column J

G	H	I	J	K
			Costs	
Year *Specify the year the co*	**Quantity** *Specify quantity*	**Unit** *Indicate if cost*	**Unit cost** *Specify the*	**Currency** *Select the*
Year 1	1	per year	75.000,00	*PHP*
Year 2	1	per year	75.000,00	*PHP*
Year 3	1	per year	75.000,00	*PHP*
Year 4	1	per year	75.000,00	*PHP*
Year 1	1	per year	50.000,00	*PHP*
Year 2	1	per year	50.000,00	*PHP*
Year 3	1	per year	50.000,00	*PHP*
Year 4	1	per year	50.000,00	*PHP*
Year 1	72	per person month	570,00	*PHP*
Year 2	72	per person month	570,00	*PHP*
Year 3	72	per person month	570,00	*PHP*
Year 4	72	per person month	570,00	*PHP*
Year 1	72	per person month	610,00	*PHP*
Year 2	72	per person month	610,00	*PHP*

Verifications:

- Columns G–K must be fully and correctly completed; missing or incorrect entries will cause errors in calculations later in the analysis.
- Check your entries by reviewing column L (grey). This column automatically multiplies the quantity by the unit cost. Scan down (or filter) the column to ensure there are no blanks, #REF!, #ERROR!, or #N/A messages.
- If using duplicated rows for multiyear items, confirm that each year is represented once.

10.4.2. Identifying cost types (columns N-P)

Here you will classify each item by type (budgeted or non-budgewted), input category (capital or recurrent), and specify useful life years for capital items.

Box 10.6. How to complete columns N–P

Objective:
Classify each item to:

- Distinguish budgeted (financial) from non-budgeted (in-kind/donated) resources.
- Group items by cost input category.
- Set useful life years for capital items (for replacement planning and economic reporting).

Overall steps:

- Complete this section after entering all cost data in columns N-P.

Step-by-step instructions:

Column	Header	Description
N	Budgeted?	Choose budgeted or non-budgeted. If a single item has both paid and in-kind components, split into two rows (one budgeted, one non-budgeted) with appropriate sources. For example, you might put peer-educators' stipends in one row and the non-compensated hours on a separate line item.
O	Cost input category	Choose input category in capital or recurrent categories. Listed items beginning with C are capital items and beginning with R are recurrent items. Note: The Budgeting Tool does not include "start-up" as a separate category. Enter start-up purchases as one-off recurrent items in the relevant year, unless they are durable goods that meet your capital threshold.
p	Useful life years	Required only for capital items that are already owned and will be used during the budget period. The tool uses useful life to spread the non-budgeted (economic) value of these items across years. New capital purchases made within the budget period should be entered at full purchase cost in the year of purchase and are not annualized.

Box 10.6. How to complete columns N–P, cont.

N	O	P
	Cost type	
Budgeted? *Indicate if item is budgeted*	**Cost input** *Select the type of cost input*	**Useful life years (only for capital inputs) Leave blank if recurre**
Non-budgeted	R1: Personnel & Per diems	
Non-budgeted	R1: Personnel & Per diems	
Non-budgeted	R1: Personnel & Per diems	
Non-budgeted	R1: Personnel & Per diems	
Non-budgeted	R1: Personnel & Per diems	
Non-budgeted	R1: Personnel & Per diems	
Non-budgeted	R1: Personnel & Per diems	
Non-budgeted	R1: Personnel & Per diems	
Budgeted	R3: Transport/Vehicle operations & maintenance	
Budgeted	R3: Transport/Vehicle operations & maintenance	
Budgeted	R3: Transport/Vehicle operations & maintenance	
Budgeted	R3: Transport/Vehicle operations & maintenance	
Non-budgeted	R1: Personnel & Per diems	
Non-budgeted	R1: Personnel & Per diems	
Non-budgeted	R1: Personnel & Per diems	
Non-budgeted	R1: Personnel & Per diems	
Non-budgeted	R2: Supplies & Commodities	
Budgeted	R2: Supplies & Commodities	
Budgeted	R2: Supplies & Commodities	
Budgeted	R2: Supplies & Commodities	
Non-budgeted	R2: Supplies & Commodities	
Non-budgeted	R2: Supplies & Commodities	
Budgeted	R6: Other recurrent costs	

Verifications:

- Columns N–P must be fully and correctly completed; missing or incorrect entries will cause errors in calculations later in the analysis.
- Check your entries by reviewing columns Y–Z (grey). These columns automatically adjust costs for historical inflation and annualize capital costs using the information specified in the "Parameters" sheet. Scan down the columns to ensure there are no blanks, #REF!, #ERROR!, or #N/A messages.

Box 10.7. Capital items in the budgeting tool: New purchases versus already-owned assets

Example 1: Accounting for an already-owned vehicle
Suppose a vehicle was bought two years ago for US$ 30 000. This vehicle would be entered as:
- Column G: Previously purchased (in use)
- Column J: 30 000
- Column K: US$
- Column N: Non-budgeted
- Column O: C3: Vehicles, where C indicates a capital item
- Column P: Vehicles, with useful life set at 7 years as indicated in the Parameters sheet

The tool will treat the vehicle as an already-owned asset and spread its annual economic value across Years 1–4. In this case, the non-budgeted annual use value is US$ 4285.71 per year, recognized in Years 1, 2, 3 and 4.

Example 2: Planning to purchase a vehicle in Year 2
Suppose you plan to buy a vehicle in Year 2. This vehicle cost would be entered as:
- Column G: Year 2
- Column J: 30 000
- Column K: US$
- Column N: Budgeted
- Column O: C3: Vehicles, where C indicates a capital item

The workbook will show the financial cost of purchasing the vehicle in Year 2, in this case, US$ 30 000 recorded fully in Year 2.

Box 10.8. Practical tip: Verifying completeness of your budget

Before moving, take a few minutes to check that all relevant costs and resources have been captured. This step helps identify any gaps early so you can adjust assumptions or add lines before finalizing projections.

Step-by-step instructions:
- In the Cost Data Sheet, go to the header of column O (titled Cost input), and use the filter button to review cost items by input category.
- Scan for common "big-ticket" lines: Personnel, commodities/supplies, transport, rent/space, training.
- If presenting full resource needs, ensure non-budgeted contributions are included (e.g. donated space, volunteer time).
- Cross-check against prior costing results or historical expenditures to confirm all material items are captured and that prices/quantities are plausible.
- Check that multiyear or one-off items appear in the correct years.
- Where price or quantity is uncertain, note the assumption and source so it can be revisited during validation.

Why this matters: This is the moment to check that all resources have been appropriately captured according to the purpose and scope of your budgeting exercise. Ensuring completeness now means the allocation and analysis steps will reflect the full set of resources you intended to project.

10.4.3. Allocating costs to the intervention (columns R–T)

In this step, you will indicate how each cost item is allocated to the intervention. This is especially important for overhead or central resources shared across multiple interventions. Proper allocation ensures you project an appropriate share of central support, such as management, rent and utilities, needed to deliver the direct interventions. If you have previously completed a costing, use the allocation evidence you collected (e.g. data on staff time allocation, floor-space measures, utilization logs or direct-cost shares) to anchor your projections. Doing so provides a transparent, empirical basis for your assumptions and leads to more realistic budget estimates.

Box 10.9. How to complete columns R–T

Objective:

- Columns R–T record the allocation of each cost item to the intervention being costed. This ensures shared costs are apportioned appropriately and direct costs are fully assigned.

Overall steps:

- Indicate whether the cost item is a direct intervention cost or shared central cost in column R.
- Record the data source or justification for the allocation factor in column S.
- Enter the allocation percentage for the intervention being costed in column T. For direct intervention costs, enter 100%.

Step-by-step instructions:

- Note whether the cost is direct or shared, and enter the allocation percentage in column T.
  - — Direct costs: 100% to the intervention.
  - — Shared costs: Percentage allocation.
- Document the source or justification of the allocation factor in column S.

E	R	S	T
Expenditure inputs	**Allocation to intervention**		
Item	**Central/Direct**	**Allocation factor**	**% Dedicated to intervention**
List all relevant cost items below	*Indicate if cost is direct*	*Specify the source or*	*Enter the % of this input*
Internet bill office wifi Y1	Shared central cost	% of organizational budget a	30%
Internet bill office wifi Y2	Shared central cost	% of organizational budget a	30%
Internet bill office wifi Y3	Shared central cost	% of organizational budget a	30%
Internet bill office wifi Y4	Shared central cost	% of organizational budget a	30%

Verifications:

- As explained in **Chapter 7** and presented in the example in **Box 10.3**, use quantifiable and measurable variables for allocation (e.g. floor space %, staff time %, number of sessions, % of direct costs).
- During the validation workshop, present these allocation factors to CLO teams and staff for review, and adjust them if necessary.

10.5. Completing "Outputs"

In budgeting, the outputs section records your projected targets for the intervention over the budget period (Years 1–4). These projections are used to generate projected unit costs (e.g. budgeted cost per person reached) and to check whether resource plans are aligned with intended delivery. If you have previously implemented this intervention, check targets against historical performance or costing results to avoid being overly ambitious. You can plan to improve efficiency or scale volume, but targets should remain credible given staffing, procurement and delivery capacity.

Box 10.10. How to complete the Results sheet

Objective:

- Summarize the output or outcome data collected for the intervention.

Overall steps:

- Enter data for outputs and outcomes in yellow cells.
- Include up to three output or outcome indicators for the intervention being costed.
- Provide targets per budget year (Year 1–4), matching the budget time frame.

Output/Outcome 1 name=	# of health facilities in CLM				# of health facilities in CLM
Target during budgeting period =	11,00	30,00	50,00	60,00	60,00
Projected Unit cost =	**320.020,94**	**89.637,90**	**47.136,98**	**38.981,62**	**181.751,90**
Output/Outcome 2 name=	# of health facility clients reporting to CLM				of health facility clients reporting to CL
Target during budgeting period =	700,00	2.000,00	3.000,00	4.000,00	9.700,00
Projected Unit cost =	**5.028,90**	**1.344,57**	**785,62**	**584,72**	**1.124,24**
Output/Outcome 3 name=	# of severe CLM incidents* reported and followed-up				ere CLM incidents* reported and follo
Target during budgeting period =	20,00	70,00	100,00	148,00	338,00
Projected Unit cost =	**176.011,51**	**38.416,24**	**23.568,49**	**15.803,36**	**32.263,65**

*severe CLM incidents defined as cases of ARV stockout and reported incidents of violence, harassment, stigma, discrimination, and breaches of confidentiality

Step-by-step instructions:

- Name the output or outcome indicator in rows 85, 89 and 93. You can enter up to three indicators.
- Enter targets for each year of the budget in rows 86, 90 and 94.
- The total projected targets over the budget period will automatically be summed in G86, G90 and G4.
- The projected unit costs will automatically be calculated in rows 87, 91 and 95.

10.6. Reviewing Results (orange tabs)

Once cost data have been entered and classified, you can proceed to the Results Sheets to review the total and unit costs generated by the workbook. The workbook contains two results sheets, one in US dollars and the other in LCU, using the current exchange rate entered in "Parameters."

The summary analysis sheets present:

- Projected total cost of the intervention by year and overall: Row 82.
- Projected totals per stakeholder by year and overall: Rows 21, 42, 62.
- Projected totals and proportion by type of cost input: Columns G-H.
- Projected totals and proportion of central costs and direct intervention costs: Columns J–K.
- Projected budgeted totals and non-budgeted totals: Column G and column S.
- Projected unit costs by year, budgeted and non-budgeted, and across the overall budget period: Rows 87, 91 and 95.

Before sharing these cost projections with other stakeholders, there are a few verification steps needed to ensure the analysis has been completed correctly (**Box 10.11**).

Box 10.11. Practical tip: Verifying accuracy of cost analysis

- **Check totals against the Cost Data sheet:**
  - For each stakeholder and year, filter the Cost Data Sheet and confirm that the sum of row totals matches the corresponding results totals.
  - Spot-check a few items to ensure they appear in the intended year(s).
  - Verify the tradable/non-tradable flag drove the expected CPI path (CPI in US dollars for tradables; local CPI for non-tradables) and that currency conversions look plausible.

- **Budgeted vs non-budgeted balance:**
  - If you intend to show the full resource need, confirm that non-budgeted contributions are included (e.g. donated space, volunteer time).
  - Review the total cost of non-budgeted resources: Is it realistic and sustainable for the period? Flag heavy reliance on in-kind contributions and consider discussing with CLO team.

- **Check cost inputs:**
  - Compare the % of cost by input category (personnel, commodities, transport, rent, training, etc.) to prior costing results or historical expenditures. Large shifts should be explained (e.g. planned scale-up, wage changes, new delivery model).

- **Review the unit costs:**
  - If you previously costed this intervention, cross-check projected unit costs against observed unit costs.
  - If you have not costed this intervention, cross-check projected unit costs with others in published literature (**Chapter 9.4**).
  - If your projected unit cost is considerably lower than these benchmarks, consider:
    - Did you under-estimate the resources needed to implement the intervention?
    - Did you set unrealistic targets?
  - If your projected unit cost is considerably higher than these benchmarks, consider:
    - Did you over-estimate the resources needed to implement the intervention?
    - Did you set conservative targets?

- **Validate with the CLO TEAM:**
  - Share projected totals and unit costs with programme, finance and leadership. Use your validation session to confirm assumptions, allocation bases and targets; revise where needed.

In sum, budgeting results should be interpreted not in isolation but in relation to costing evidence, historical performance and broader sustainability considerations.

10.7. Interpreting and using budgeting results

Many of the principles for interpreting budgeting results are the same as those outlined for costing in **Chapter 9**. Readers are encouraged to review that chapter for detailed guidance on how to analyse total costs, unit costs and cost distributions. For budgeting, specifically, there are a few important considerations that merit attention.

A first step is often comparing budgeted resources with observed costs. As explained in **Chapter 9.5**, costing provides a record of how resources were actually used, while budgets project what will be needed in the future. By comparing the two, CLOs can assess whether budgets are realistic and aligned with implementation experience. Doing so can reveal systematic under- or over-estimation of both inputs and targets, and help explain discrepancies between plans and actual performance. Such comparisons can pinpoint which cost inputs may be under-resourced or over-valued, allowing CLOs to strategically reallocate or mobilize resources.

A second consideration is the sustainability of financial versus economic resources. As discussed in **Chapter 9.5**, costing results capture both paid (financial) and unpaid or in-kind (economic) contributions, whereas the budget tool allows CLOs to track budgeted and non-budgeted resources. Comparing the two allows CLOs to assess whether their resource base is sustainable over time and whether dependence on unpaid contributions is growing or declining. This analysis can guide advocacy with governments and donors to ensure that critical but undervalued inputs—such as peer educators' time, donated venues, or volunteer-led outreach—are adequately resourced in future budgets.

Finally, tracking changes over time is essential. Budgeting results, when compared year-on-year and against costing, can show whether implementation strategies are becoming more efficient, whether assumptions about inputs remain valid, and whether resource needs are shifting with programme scale-up or contextual changes. This kind of trend analysis links directly back to the monitoring and efficiency uses of costing data outlined in **Chapter 9.6.1, 9.6.2**, and provides a critical evidence base for adapting both programmes and funding strategies.

In sum, budgeting results should be interpreted not in isolation but in relation to costing evidence, historical performance and broader sustainability considerations. Used this way, they become part of a learning cycle for CLOs: Evidence from costing informs more realistic budgets; budgets guide implementation; and comparing projected with actual costs generates insights that feed back into future planning and advocacy. This iterative process allows CLOs to align plans with reality, identify and make the case for under-resourced inputs, and advocate for the long-term viability of CLRs.

Glossary

Activities

Tasks or actions undertaken as part of an intervention. Activities are the building blocks of an intervention and rely on quantifiable resources or cost inputs. They are usually measured through immediate outputs, such as the number of peer educators trained or community meetings held.

Advanced HIV disease

"WHO defines advanced HIV disease (AHD) as CD4 cell count <200cells/mm3 or WHO stage 3 or 4 in adults and adolescents. All children younger than five years of age are considered to have advanced HIV disease. This includes both individuals presenting to care who are antiretroviral therapy (ART) naive and those returning to care after interrupted treatment" (32, 33, 34, 35).

Allocation factor

A proportion used to distribute shared or central costs across multiple interventions, activities, programmes or sites. For example, staff time, vehicle use or office space may be attributed in part to each intervention or site.

Annualization

A method used in costing to spread the one-time cost of a capital input across its useful life. Instead of attributing the full cost in the year of purchase, annualization assigns a share of the cost to each year of use.

Bottom-up costing

An approach to costing that begins by measuring the quantity and price of individual inputs used to deliver an intervention. These inputs are then aggregated ("built up") to estimate the cost per output and the total cost of the intervention.

Budgeting

The process of translating planned activities and interventions into financial plans that project future expenses over a defined period. Unlike costing, budgeting allocates resources in advance, specifying when and by whom financial transactions are expected to occur.

Capital cost

One-time costs for items that have a useful life of more than one year, such as buildings, equipment or vehicles. Certain start-up activities, such as trainings, may also be treated as capital costs.

Central cost

Costs not directly attributable to a single intervention but essential for overall functioning (administration, information technology systems, building maintenance, procurement and record keeping).

Community-based

Interventions or services delivered in community settings or targeting specific community populations. Community-based activities focus on the setting or population reached, but leadership and decision-making may rest with external actors rather than the community itself.

Community-led

Interventions, services or responses that are initiated, designed, implemented and monitored by and for community members or constituencies. Leadership, decision-making power and accountability rest with community actors themselves.

	A community-led intervention may be delivered in community settings, but what defines it is community leadership.
Cost driver	An input or group of inputs that accounts for a large share of the overall cost of an intervention. Cost drivers highlight which resources most influence the cost structure. For example, personnel or transport may represent the largest proportion of costs in community-led HIV interventions.
Costing	The process of estimating the value of resources required to deliver an intervention. It involves three steps: Identifying inputs; measuring their quantity; and assigning a price. Unlike budgeting, which projects future expenditures, costing values the actual resources used.
Cost inputs	The resource types required to produce an intervention. Sometimes called cost categories or ingredients, inputs should not be confused with activities; for example, a meeting is an activity, while the staff time, supplies and space used for the meeting are the inputs.
Donated resources	Goods and services that are deliberately provided to support an intervention without payment. Examples include volunteer time, pro bono professional services, free use of space, or transport provided at no cost. In other guidelines donated goods would include those resource contributed by other organization and stakeholder beyond community contributions. However, it is important to differentiate these to highlight and value community contributions independently from otherwise financed contributions.
Economic cost	The full value of all resources used to deliver a service, including opportunity costs. Economic costs go beyond financial expenditures by valuing non-financial contributions such as volunteer time, donated goods or in-kind services.
Financial cost	The value of goods and services paid for the delivery of an intervention. Unlike expenditure data, financial costs spread the value of capital items (e.g. vehicles, equipment) over their useful life. They exclude non-financial contributions, which are captured in economic costs.
Full cost	The total cost of delivering a service, including all direct, indirect and shared resources. Full costs are often contrasted with incremental costs, which capture only the additional resources required for a new intervention.
Incremental cost	The additional cost of introducing a new service or activity on top of an existing programme. It accounts only for resources used beyond a defined baseline.
Inflation	The general increase in prices of goods and services over time, which reduces the purchasing power of money. In costing and budgeting, inflation is important to consider when comparing costs across years, since the same amount of money will buy fewer resources in the future.
In-kind contributions	A non-monetary resource provided to support an intervention. This includes both donated goods (e.g. free use of space, donated transport, pro bono professional support) and unpaid resources (e.g., volunteer time, community members' contributions). Although no money changes hands, these contributions are valued in economic costings.
Intervention	A set of actions or activities designed to achieve a specific objective within a response. Interventions are often measured through outputs and outcomes, such as persons reached or newly tested.

Key populations	UNAIDS defines key population groups to include: Gay men and other men who have sex with men; sex workers and their clients; transgender people; people who inject drugs; and prisoners and other incarcerated people. These populations often suffer from punitive laws or stigmatizing policies, and they are among the most likely to be exposed to HIV.
Opportunity cost	The value of the next-best alternative forgone when a resource is used for a particular purpose. This applies to both unpaid resources (e.g. volunteer time, donated goods) and paid resources where the market price does not reflect full value (e.g. subsidized drugs, foregone interest on funds).
Outcomes	The intermediary results of an intervention, typically at the individual or population level. Outcomes capture short- to medium-term changes in health or behaviour that arise from the delivery of services. Examples include the number of people tested, diagnosed or linked to care. Outcomes reflect the uptake or effects of what was delivered, rather than the delivery itself.
Outputs	The immediate results of an activity or intervention, often measured through routine monitoring data. Examples include the number of volunteers trained, condoms distributed or educational materials produced. Outputs reflect what was delivered.
Perspective	The point of view from which costs are measured in a costing study, indicating who incurs them. A **user** perspective captures the costs to clients for accessing or using a service or intervention. A **provider** perspective reflects the costs of producing services at the point of care by those defined as service provider(s). A **payer** perspective refers to the costs borne by the entity financing or reimbursing services, such as a government, health insurance scheme, or donor. A **societal** perspective is the broadest, including all costs incurred—regardless of who pays for them.
Recurrent cost	The cost of resources with a useful life of one year or less, such as salaries, per diems, supplies, utilities and routine maintenance.
Response	A coordinated set of interventions designed to address complex issues which may involve multiple approaches. In the context of CLRs, UNAIDS highlights seven key response areas: Leadership, advocacy, service delivery, education and information, participatory research, monitoring, capacity-building and funding.
Shared costs	Costs that benefit more than one service or intervention and must be allocated among them, such as administrative staff, shared vehicles or office space.
Societal enablers (also called critical enablers)	Interventions designed to address societal barriers that perpetuate stigma, discrimination, inequity or punitive laws. Societal enablers aim to create conditions that support service uptake, equitable coverage, rights-based delivery and quality care.
Start-up cost	One-time activities needed to launch an intervention, such as initial planning, training or mobilization. Start-up costs are treated as capital and annualized over their useful life.
Time and motion study	A method for measuring how staff time is allocated across different interventions. Data can be collected through direct observation by a researcher, self-reporting by staff using time sheets, or recall-based estimates elicited from providers. Time and motion studies are used to generate more accurate estimates of labour inputs for costing.
Top-down costing	An approach to costing that begins with total expenditures from financial or accounting records and then allocates (or disaggregates) those costs down to specific sites, interventions or outputs.

Unit cost

The average cost of producing one unit of service or output, calculated by dividing the total cost by the number of units delivered over a defined period.

Unpaid resources

Resources that are used in delivering or accessing an intervention but for which no payment is made by the perspective (the stakeholders whose costs are being estimated) under consideration. They differ from what we are defining as donated resources, which are deliberately provided without payment (such as volunteer time or pro bono services). Unpaid resources often arise when inputs are purchased or supplied by another stakeholder but are not reflected in the accounts of the payer, provider, or user being analysed. Examples include equipment or supplies procured by a partner organization, or personal items (such as phones or transport) used without reimbursement.

In other guidelines this would fall under donated goods, however, it is important to differentiate these to highlight and value community contributions independently from otherwise financed contributions.

Vulnerable populations

Defined by each country's unique social and epidemiological contexts, these populations may include: Adolescent girls and young women; adolescent boys and young men; pregnant and breastfeeding women; children or infants exposed to HIV; partners of people living with HIV; partners of women attending antenatal care; victims of sexual assault; people with disabilities; orphans and vulnerable children; uncircumcised men living in high-prevalence areas.

Sources

1. Costing-related definitions are adapted from the GHCC Reference Case for Global Health Costing (34), the PrEP Costing Guidelines (35), the Rapid Syphilis Test Toolkit Guidelines (36), and the Guidelines for Costing Social and Behavior Change Health Interventions (37).
2. Definitions related to community-led and community-based responses, as well as key and vulnerable populations, are adapted from UNAIDS terminology guidelines (5).
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Appendices

Appendices

Appendix 1. Existing tools and guidelines for HIV costing and budgeting

These are a selection of existing resources that may be useful when costing or budgeting HIV interventions. While not developed specifically for CLRs, they may offer helpful concepts, frameworks, methods or tools that can be adapted for use in this context.

Source	Description and use
Joint United Nations Programme on HIV/AIDS (UNAIDS) *Costing Guidelines for HIV Prevention Strategies* (1)	Outlines costing methods for HIV prevention interventions. Useful for national planners, analysts and implementers of prevention programs.
Population Council *Guidelines for Costing of Social and Behavior Change Health Interventions* (2)	Explains core costing principles and applies them to social and behaviour change interventions. Useful for research teams costing social and behaviour change programmes.
Global Health Cost Consortium (GHCC) *Reference Case for Estimating the Costs of Global Health Services and Interventions* (3)	Outlines key principles and standards for generating and reporting cost estimates in global health. While not specific to HIV or CLRs, it provides a foundational framework for methodological rigour and comparability across costing studies.
Community-led Accountability Working Group (CLAW) *How to Budget for Community-led Monitoring* (4)	Offers practical, tailored guidance for civil society organizations implementing CLM. It outlines the types of activities and resources to consider and offers key questions to guide planning and budgeting processes. Useful for both planners and implementers of CLM.
FHI 360 *Going Online: a budgeting and programming aid for virtual HIV interventions* (5)	Provides budgeting support for virtual HIV service delivery. Useful for implementers planning online or decentralized outreach programmes.
The Global Fund *Guidelines for Grant Budgeting* (6)	Provides standardized budgeting guidance for Global Fund grant proposals. Useful for organizations applying for or managing Global Fund grants.
International AIDS Society (IAS) *Community-led monitoring of programs and policies related to HIV, tuberculosis and malaria: a guide to support inclusion of CLM in funding requests to the Global Fund* (7)	Supports integration of CLM in funding requests to the Global Fund and related country and regional consultations, dialogues and strategy documents.
World Health Organization (WHO) Chapter 9 of the *Planning Guide for the Health Sector Response to HIV/AIDS* (8)	Provides high-level guidance on budgeting and estimating resource needs in HIV response planning. Useful for national health planners and policy-makers.

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Appendix 2. Reference tables for defining scope in costing and budgeting exercises

This appendix contains reference tables to support the selection of key decisions on scope when planning a costing or budgeting exercise. These parameters, including perspective, time horizon and cost type (financial or economic, normative best practice or observed practice), should be selected based on the primary purpose of the exercise and the intended use of results. They are intended as a practical reference, not prescriptive rules.

Table A2.1. Criteria for selecting the perspective

Purpose	Which perspective?	Why?
Monitoring	Payer, provider, user or society	Depends on what is being monitored: ▪ Payer: Cost of financing ▪ Provider: Cost of service delivery ▪ User: Equity and burden
Efficiency	Payer or provider	To understand how to maximize outputs within a given budget
Priority setting	Payer, provider, user or society	Depends on the decision-maker. However, adopting a societal perspective is often recommended to ensure that priority-setting accounts for the broader impact across society. In practice most cost-effectiveness analyses apply the provider perspective.
Informing pricing or funding	Payer or provider	Depends on who is setting or negotiating the price: ▪ Identify or mobilize budget to distribute fair pay to volunteers ▪ Payer for donor or government for social contracting ▪ Provider to ensure all costs are captured in grant or social contracting agreement
Short-term planning and budgeting	Payer or provider	Depends on the planner: ▪ Provider, if budgeting is for internal use. ▪ Payer, if budgeting is for financing or grants
Medium- to long-term planning and budgeting	Payer or provider	For strategic or national plans, usually a payer perspective is used to estimate required funding over time

Table A2.2. Criteria for selecting the time horizon

Purpose	Which time horizon?	Why?
Monitoring	One year (annually)	Annual costings allow CLOs to track changes, monitor cost trends and inform routine reporting and planning.
Efficiency	At least one year, ideally including start-up phase and at least six months of the implementation; multiyear if possible	A multiyear time frame helps assess how efficiency changes as implementation evolves.
Priority setting	Based on the relevant policy time frame; may include costs for a single year but should account for benefits over multiple years, as is common in cost-effectiveness analysis	Enables decision-makers to weigh long-term outcomes. For example, a one-year harm reduction intervention may produce health and social benefits long after the intervention ends, and these should be factored into the decision-making process.
Informing pricing or funding	Typically, one year or time frame relevant for full cost recovery	Funders and payers require average cost estimates over a defined period to inform pricing discussions or funding decisions. The period should reflect how long costs are expected to remain stable. For example, the price of a service like ART is often based on the average cost of providing one year of treatment, though it may also be disaggregated into initiation costs and ongoing annual costs.
Short-term planning and budgeting	One to three years	Aligns with most organizations and funders budgeting cycles.
Medium- to long-term planning and budgeting	Three to five years	Matches the time frame of strategic documents such as national HIV plans, investment cases or donor funding cycles.

Table A2.3. Criteria for selecting financial versus economic

Purpose	Which costs?	Why?
Monitoring	Financial and economic, based on perspective	Financial costs help track spending from a payer perspective. Economic costs capture full resource use for providers and users.
Efficiency	Financial and economic, based on perspective	Payers may focus on what was spent. Providers may estimate economic costs to evaluate efficiency of both paid and unpaid costs.
Priority setting	Economic	Enables decision-makers to make fair comparisons among alternatives, regardless of whether resources are paid or donated.
Informing pricing or funding	Financial and economic	Financial costs are often most relevant to set prices needed for cost recovery. Economic costs ensure fair compensation of donated time and resources and account for cases where these contributions may no longer be available.
Short-term planning and budgeting	Financial	In the short-term, planners may only be concerned with financial expenditures.
Medium- to long-term planning and budgeting	Financial and economic	Budgets often only consider financial costs. In the medium- to long-term, budget projections should account for observed economic costs to ensure compensation for all costs, including in-kind contributions by CLOs.

Table A2.4. Criteria for selecting best practice versus observed practice

Purpose	Which costs?	Why?
Monitoring	Observed practice	Most relevant for tracking actual costs and understanding real-world cost drivers.
Efficiency	Observed practice and best practice	Understanding the difference between service delivery protocols and observed practice can reveal inefficiencies in service delivery and the broader health system, helping to identify opportunities to decrease costs or increase outputs.
Priority setting	Best practice and observed practice	Allows comparison between ideal models and real-world delivery, especially for innovative or emerging interventions, to inform choices on where to allocate limited resources to maximize health gains.
Informing pricing or funding	Best practice and observed practice	Pricing decisions may be guided by ideal models or real-world delivery, depending on context.
Short-term planning and budgeting	Best practice and observed practice	Budget projections are usually guided by best practice, but price estimates can use either best practice or observed practice costs.
Medium- to long-term planning and budgeting	Best practice and observed practice	Budgets can be projected using cost estimates from either best practice or observed practice. However, economic costs of in-kind contributions are more likely to be captured in the real world.

Appendix 3. Summary table of data sources by input type

This table provides a quick reference to common data sources for each major input type in costing and budgeting exercises. Use it as a planning tool alongside the detailed descriptions in **Chapter 4**.

Table A3.1. Potential data sources by types of inputs

	Data sources		
Type of input	Quantity/Measurement	Valuation	Allocation
Capital			
Building space (e.g. office building, room, storage) and other building-related capital items	Physical measurement of rooms; building plans; mapping software	Expenditure reports, invoices, purchase orders, original sales records, insurance forms, tax forms, rental agreements, real estate or construction quotes, market value of similar buildings or spaces	Proportion of floor space used for intervention (observation); proportion of participants served per intervention (activity registers); proportion of time space used for each service (time and motion study)
Vehicles and other related capital items (e.g. equipment)	Item counts, inventory registers, vehicle logs	Expenditure reports, purchase orders, invoices, sales records, manufacturer/ dealer quotes, market value of similar vehicle specifications	Proportion of travel time used for each intervention (vehicle lot); proportion of distance travelled for each intervention (vehicle lot, odometer readings, mapping software)
Equipment (e.g. furniture, general, information technology and office, medical and laboratory) and other related capital items (e.g. shipping and freight, taxes, duties and tariffs)	Direct enumeration, inventory registers	Expenditure reports, purchase order, invoices, procurement lists, original or current sales prices, quotes	Proportion of time used for each intervention (time and motion); proportion of participants served (activity register, laboratory log)

	Data sources		
Type of input	Quantity/Measurement	Valuation	Allocation
Recurrent			
Paid personnel (e.g. direct staff, support staff)	Human resources or finance records (roles, contracts), direct observation, interviews	Paid wage: Expenditure reports, human resources or finance records, self-reported value. Include salary, benefits, taxes, pension and allowances	Proportion of time across interventions (study time sheets, time and motion, interviews); proportion of participants served (activity registers)
Unpaid or partially compensated personnel (e.g. volunteers, interns, peer educators, peer navigators, champions)	Volunteer logs, time sheets, direct observation, interviews	Skills-equivalent wage: References for national or regional wages Minimum wage: References for national or regional wages Opportunity cost of labour forgone: Self-reported value	Same as paid personnel.
Supplies and consumables (e.g. medical and laboratory, non-medical, office) and other related recurrent items (e.g. shipping and freight; taxes, duties and tariffs)	Direct observation, interviews, inventory registers, stock cards. Include wastage (expired or damaged)	Expenditure reports, purchase order, invoices, procurement lists, original or current sales prices, quotes	Proportion of clients served (activity registers), lab testing registers (for lab supplies), proportion of time used (observation, time & motion)
Building operation and maintenance (e.g. utilities, repairs, property fees and insurance, cleaning and security)	Expenditure reports, invoices, purchase orders, direct observation or interviews for in-kind items	Same as above, rental agreements, utility bills, local market rates	Same as building capital items.
Transport and vehicle maintenance (e.g. fuel and oil, repairs, vehicle fees and insurance, public transportation)	Expenditure reports, invoices, purchase orders, direct observation or interviews for in-kind items	Same as above, fuel price lists, service contracts, insurance policies, local market rates for common transport	Same as vehicle capital items
Other recurrent	Expenditure reports, invoices, purchase orders, direct observation or interviews for in-kind items	Same as above	Proportion used for each intervention (observation, time and motion)
Recurring trainings	Training attendance logs, training schedules and agendas, records of training frequency	Expenditure reports, invoices, purchase orders or local market rates for venue, trainer fees, materials, catering, travel	Proportion of time allocated to interventions (training schedule); proportion of participants (attendance logs)
Client reimbursements	Expenditure reports, petty cash logs, staff estimates if not itemized	Same as above, and market rates for transport	Attendance sheets, activity registers

Appendix 4. Mapping interventions, resources and data Excel workbook

Click the following link to download the Excel file CLR_Chapter5_Mapping Tools: [https://hivfinancial.unaids.org/A4_Mapping_interventions.xlsx]. The workbook includes a separate tab for each tool referenced in **Chapter 5** including:

Tab 1: Intervention definition

Tab 2: Purpose & scope

Tab 3: Process Mapping

Tab 4: Central Resource Mapping

Tab 5: Stakeholder Mapping

Tab 6: Data Mapping

Appendix 5. Memorandum of understanding between stakeholders

This MOU sets out an agreement between **[Name of Partner 1]** and **[Name of Partner 2]** for collaboration in the **[Name of Study/Exercise]**. It defines roles, expectations and safeguards for the collection, sharing and use of data during and after the exercise.

1. Parties to the agreement

- **Partner 1:** Insert name of organization, name of individual representative, contact information, and role in study/exercise.
- **Partner 2:** Insert name of organization, name of individual representative, contact information, and role in study/exercise.

2. Study scope

The purpose of this study is to **[cost / budget]** the **[insert name of intervention(s)]** delivered by **[insert name of provider(s)/organization(s)]** in [insert location(s)].

The objectives of the study are to:

- **[Insert main objective #1]**
- **[Insert main objective #2]**

The study will include the following activities: **[data collection, data verification, analysis, validation of results, dissemination of findings—edit as applicable]**.

The study is expected to run from **[insert start date]** to **[insert end date]**, with key milestones including: **[insert milestones aligned with the workplan]**.

3. Roles and responsibilities

Team members are expected to:

- Attend scheduled trainings and workshops, including **[insert planned sessions: e.g. data collection orientation, preliminary results review, validation, dissemination]**.
- Participate actively in data collection, verification and analysis as assigned.
- Review and provide timely feedback on preliminary and final results.
- Support dissemination of results as agreed.

Activity	Partner 1 role	Partner 2 role
Data collection	*Describe responsibilities*	*Describe responsibilities*
Data verification	*Describe responsibilities*	*Describe responsibilities*
Data analysis	*Describe responsibilities*	*Describe responsibilities*
Trainings/workshops	*Describe responsibilities*	*Describe responsibilities*
Validation of results	*Describe responsibilities*	*Describe responsibilities*
Dissemination of results	*Describe responsibilities*	*Describe responsibilities*
Publication (if applicable)	*Describe responsibilities*	*Describe responsibilities*

4. Data sharing and ownership

Partners agree to share relevant data solely for the purposes of this study. Each partner retains full ownership and ongoing rights to any data they contribute. The **[insert Data Owner name, role]** will hold the primary copy of the data set, with access provided to other partners as agreed.

Types of data to be shared include (add or remove as needed):

- Financial data: **[budgets, expenditures, salaries/stipends, procurement records]**
- Programmatic data: **[service delivery statistics, M&E reports, output indicators]**
- Operational data: **[staff time allocation, inventories, vehicle logbooks]**
- Qualitative data: **[interview notes, meeting minutes, contextual reports]**

Data Access and Storage:

- Data will be stored on **[insert platform name: e.g., SharePoint, Dropbox, institutional secure server].**
- Access will be restricted to: **[insert names and roles—e.g., executive director name, other organizational points of contact, lead researcher name, other research team members].**
- All individuals with access must sign a confidentiality agreement.
- Weekly backups will be made to **[insert backup method—e.g., encrypted external hard drive]** and handed over to **[insert organization name]** at the end of the study.

5. Confidentiality

- No personally identifiable information will be collected unless explicitly agreed and approved. This includes: Names, addresses, telephone numbers, email addresses, national ID numbers and health identifiers of clients, members, staff and volunteers.
- All data will be collected and reported at the aggregate level only.
- Salary and stipend data will be encrypted, stored securely and never shared in raw form.

If a breach or suspected breach occurs:

- Notify **[insert data owner's name]** and all partners within 24 hours.
- Take immediate steps to contain the breach (e.g. revoke access, secure files).
- Conduct a joint review to determine the cause and corrective actions.
- Agree on whether affected individuals or organizations need to be notified.

6. Risks and benefits

Potential benefits of the study/exercise:

- Strengthened organizational capacity in costing/budgeting methods, including skills development for participating staff.
- This study will generate detailed estimates of **[current/future]** costs of **[intervention delivered by provider] to help inform [programme planning / advocacy / resource mobilization]**.
- Opportunities to participate in and co-lead training workshops, data analysis and validation exercises.
- Improved visibility of the organization's contributions through inclusion in study outputs, subject to mutual agreement.

Potential Risks:

- Possible discomfort in sharing sensitive financial, operational or programmatic data.
- Minimal risk of confidentiality breaches, mitigated through the safeguards outlined in this MOU (e.g. secure storage, controlled access, encryption).
- Potential additional workload for organizational staff, which should be planned for in advance.
- **[Optional—insert context-specific risks here, such as risks linked to political or legal sensitivities in the operating environment].**

7. Decision-making and dispute resolution

Decisions will be made jointly and documented. In the event of disagreement:

- Partners will attempt to resolve the issue through direct discussion.
- If unresolved, a neutral third party will mediate:
  Designated neutral third party: [Insert name, organization and contact details]

8. Duration of agreement and post-study responsibilities

This MOU will remain in effect from **[insert start date]** to **[insert end date]** or until all deliverables have been shared.

After the study concludes:

- The **[insert data owner's name]** retains custody of the data set.
- All partners remain bound by the confidentiality provisions of this MOU.
- Any future use of the data, including publications, requires written agreement from all partners.

Name:	_____	**Name:**	_____
Role:	_____	**Role:**	_____
Organization:	_____	**Organization:**	_____
Signature:	_____	**Signature:**	_____
Date:	_____	**Date:**	_____

Appendix 6. Confidentiality agreement

This agreement confirms my commitment to protect the confidentiality of all data, documents and information accessed during the [insert name of study/exercise].

1. Parties to the agreement

Name of individual/role in the study

Lead organization or data owner:

2. Confidential information

For the purposes of this agreement, "confidential information" includes but is not limited to:

- Any personally identifiable information (names, addresses, telephone numbers, email addresses, national IDs, health identifiers) about clients, members, staff, volunteers or other individuals.
- The physical address of the CLO, and the locations of hotspots, outreach sites or any areas where services are provided to key population members or clients.
- Any information that could directly or indirectly identify key population members, clients or other vulnerable groups served by the CLO.
- Salary, stipend or other compensation information for staff, contractors or volunteers.
- Any unpublished study data, whether financial, programmatic, operational or qualitative.
- Information identified as confidential and shared verbally during meetings, workshops or training sessions.

3. My commitments

I agree to:

- Access and use confidential information only for the purposes of the study.
- Withhold confidential information with anyone who is not authorized under the study's MOU.
- Ensure all documents, files and data are stored securely (password-protected, encrypted or in locked storage).
- Transmit data only through the approved secure platform **[insert name, e.g., SharePoint, Dropbox]**.
- Report any suspected or actual breach of confidentiality to **[insert data owner's name/contact]** within 24 hours.
- Return or permanently delete all confidential information in my possession at the end of my involvement in the study.

4. Breach of agreement

I understand that failure to comply with this agreement may result in:

- Immediate removal from the study team.
- Notification of my employer or organization.
- Potential legal or disciplinary action as permitted by law.

5. Duration of agreement

This agreement is binding from the date signed and remains in effect **indefinitely** for all information classified as confidential, including sensitive data such as hotspot locations, CLO addresses and any information that could identify key population members or clients. For other study-related data, obligations remain in effect until all data are securely returned or deleted and all dissemination activities are complete.

Name: _____

Role: _____

Organization: _____

Signature: _____

Date: _____

Appendix 7. Informed consent—CLO staff and service provider

Date: [Insert date]

Introduction

Hello, my name is **[name]**, and I am working with **[institution name]** to conduct a costing study in on the costs of the **[health area]** community response.

Information sheet

CLOs are important because they help people in the community **[insert benefit/health outcome]** and play a key role in the country's response to **[health area]**. This study will estimate the resources needed to deliver services in **[service area]** by **[community organization(s)]**, allowing a better understand the contributions of these organizations and their costs.

If you agree to participate, we may:

- Measure the building space you work in, identify the equipment and supplies you use.
- Interview you about the services you provide, the resources used and the cost of your services, including your salary or earnings.
- Observe the time it takes to provide **[service(s)]** during a normal workday
- Ask you to complete a time sheet over a period of **[enter days]** to record how you distribute your time across **[enter interventions]**

This study is NOT evaluating or controlling the quality of care you provide. It focuses only on the time and resources used to deliver services.

Confidentiality and data management

- No information will be collected that could identify your clients, key population members or hotspots where services are provided.
- We will not be present during your private consultations with clients, and we do not need to record or register any information about your clients.
- Information about your salary or earnings will be kept strictly confidential and will be stored in encrypted files, accessible only to the study team.
- All study data will be stored securely on **[SharePoint / Dropbox / Other—specify]**, accessible only to **[Executive Director name]**, **[other organizational contacts]**, **[lead researcher name]**, and designated study team members.
- Weekly backups will be made to an encrypted hard drive and returned to [organization name] at the end of the study.
- Any information you provide will be reported in aggregate form so that individuals cannot be identified.

Compensation

Participation in this study is voluntary and **[unpaid/ accompanied by compensation/ supported by a token of appreciation].**

[Select option that applies:]

No compensation will be provided to you or your organization.

You will receive [specify amount or type of compensation, e.g. reimbursement for transport, currency amount, food and beverages].

Your organization will receive [specify amount] as compensation for the time contributed to this study

Approvals and contacts

The study has been reviewed and approved by the ethics committee **[enter committee name]**.

If you have any questions about the study, you can contact:

Lead researcher: **[name, phone, email]**

Ethics and Scientific Review Committee: **[name, phone, email]**

Voluntary participation

Your participation is completely voluntary. You may:

Refuse to answer any question.

Stop the interview or observation at any time.

Withdraw from the study without penalty or loss of benefits.

Consent statement

Please tick to confirm you understand:

- ☐ I have read (or had read to me) the information above.
- ☐ I understand what the study involves and why it is being done.
- ☐ I understand that my participation is voluntary, and I can withdraw at any time without penalty.
- ☐ I understand how my data will be kept confidential.
- ☐ I agree to participate in this study.

Participant name:		**Researcher name:**	
Signature:		**Signature:**	
Date:		**Date:**	

Appendix 8. Training and workshop slide decks for key engagement meetings

This appendix provides adaptable PowerPoint slide decks to guide the five core engagement and training workshops recommended in **Chapter 6**. Each deck is structured to help the lead facilitator prepare and deliver sessions that build capacity, strengthen stakeholder participation and achieve the milestones required for each stage of the costing or budgeting exercise.

Within this slide deck you will find five sections:

- **Introductory meeting with stakeholders:** Review purpose, scope, methods, expected outputs and MOU discussion.
- **Team orientation on data collection:** Health Economics 101 (introductory), data collection processes, tools and workplan development.
- **Review of preliminary results and analysis:** Health Economics 101 (analysis), preliminary findings, allocation factor validation, data gap review.
- **Validation of results:** Presentation and discussion of final results, interpretation and agreed changes.
- **Dissemination meeting:** Presentation of final results, discussion of implications and next steps.

Click here to download the training and workshop PowerPoint slides: [https://hivfinancial.unaids.org/A8_Training_workshops_slides.pptx].

Appendix 9. Data collection workbook for CLR costing

Click the following link to download the Excel workbook: CLR Costing_Data Collection: [https://hivfinancial.unaids.org/A9_Data_collection_workbook_costing.xlsx]

The workbook includes a separate tab for each tool referenced in **Chapter 7**, including:

Blue tab	Outputs
Green tab	Capital inputs (Buildings & Land, Equipment & Vehicles)
Yellow tab	Recurrent inputs (Personnel, Recurrent Inputs, Trainings)
Orange tab	Allocation factor tools (Vehicle Logbook, Timesheets)

Appendix 10. CLR costing workbook

Click the following link to download the Excel workbook template: CLR Costing Workbook: [https://hivfinancial.unaids.org/A10_Data_analysis_workbook_costing.xlsx]

This workbook is a blank template designed for you to fill in with your own data. It contains a series of tabs, each aligned with the costing steps described in **Chapter 8**:

Tab 1: Instructions

Tab 2: Parameters

Tab 3: Cost Data_1

Tab 4: Cost Data_2

Tab 5: Cost Data_3

Tab 6: Outputs

Tab 7: Results (LCU)

Tab 8: Results (US dollars)

Appendix 11. CLR costing workbook—Completed example with CLM

Click the following link to download the Excel workbook: CLR Costing Workbook_CLM Example: [https://hivfinancial.unaids.org/A11_Costing_worked_example_CLM.xlsx]

This appendix provides a completed version of the CLR Costing Workbook, filled with illustrative data from a CLM intervention. It is intended to show users how the blank template (**Appendix 9**) can be populated step by step.

Appendix 12. CLR costing workbook—Completed example with edutainment

Click the following link to download the Excel workbook: CLR Costing Workbook_edutainment Example: [https://hivfinancial.unaids.org/A11_Costing_worked_example_edutainment.xlsx]

This appendix provides a completed version of the CLR Costing Workbook, filled with illustrative data from a community-led edutainment. It demonstrates how the blank template (**Appendix 9**) can be applied to a different type of intervention.

Appendix 13. CLR budgeting workbook

Click the following link to download the Excel workbook template: CLR Budgeting Workbook: [https://hivfinancial.unaids.org/A13_Budgeting_workbook.xlsx]

This workbook is a blank template designed for you to fill in with your own data. It contains a series of tabs, each aligned with the budgeting steps described in **Chapter 10**:

Tab 1: Instructions

Tab 2: Parameters

Tab 3: Cost Data_1

Tab 4: Cost Data_2

Tab 5: Cost Data_3

Tab 6: Outputs

Tab 7: Results (LCU)

Tab 8: Results (US dollars)

Appendix 14. CLR budgeting workbook—Completed example with CLM

Click the following link to download the Excel workbook: CLR Budgeting Workbook_CLM Example: [https://hivfinancial.unaids.org/A14_Budgeting_worked_example_CLM.xlsx]

This appendix provides a completed version of the CLR Budgeting Workbook, filled with illustrative data from a CLM intervention. It is intended to show users how the blank template (**Appendix 12**) can be populated step by step.

Appendix 15. CLR budgeting workbook—Completed example with edutainment

Click the following link to download the Excel workbook: CLR Budgeting Workbook_edutainment Example: [https://hivfinancial.unaids.org/A15_Budgeting_worked_example_edutainment.xlsx]

This appendix provides a completed version of the CLR Budgeting Workbook, filled with illustrative data from a community-led edutainment. It demonstrates how the blank template (**Appendix 12**) can be applied to a different type of intervention.

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