

# **COSTING NATIONAL AIDS STRATEGIES: EXPLORING TWO DIFFERENT APPROACHES**

## **Some Lessons of Experience and Recommendations**

### **Preface**

This paper on lessons of costing a national AIDS strategy has been prepared as part of the AIDS Strategy and Action Plan (ASAP) service work program.

ASAP is a service of UNAIDS, hosted by the World Bank on behalf of UNAIDS, in association with its main partners within UNAIDS<sup>1</sup> as well as with other UN agencies and multilateral and bilateral providers of financial and technical support. ASAP was created in 2005 by the Global Task Team (GTT) on Improving AIDS Coordination Among Multilateral Institutions and International Donors and began its operations in 2006 with funding from UNAIDS and other partners. ASAP's roll-out in 2006 has been closely aligned with the work of the Global Steering Committee on Scaling Up Towards Universal Access. Information on ASAP's operations can be found on its website: [www.worldbank.org/asap](http://www.worldbank.org/asap). In general, ASAP's objective is to provide support to countries in: (i) enhancing AIDS strategies to make them more prioritized, evidence-based, costed and capable of being implanted; and (ii) preparing action plans to promote efficient, effective and inclusive implementation. As part of its knowledge sharing and capacity building program, ASAP has developed a strategy self-assessment instrument and guidelines, a road map for preparing strategies, and case studies/practice notes.

This study aims at sharing lessons on costing an HIV/AIDS strategy. It was prepared by Tim Lee (UNAIDS Technical Support Facility, Southern Africa), Dominic Haazen (World Bank), Jonathan C. Brown (World Bank) and Derek von Wissel (Director, Swaziland National Emergency Response Committee on HIV and AIDS - NERCHA) on the basis of reviewing the experience of costing HIV/AIDS. The study benefited from a visit of one or more of the authors to Swaziland and to Guyana, which provided valuable contextual information. However, while the study explores two approaches used in Swaziland, and the approach recently used in Guyana, the case study's overall lessons are drawn from world-wide experience. Based on this, recommendations are made for utilizing the best features of tools described to help improve the strategic planning process and improve the effectiveness of national systems to support overall HIV/AIDS response.

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<sup>1</sup> ILO, UNDP, UNESCO, UNICEF, WHO and the UNAIDS Secretariat.

## **INTRODUCTION**

National AIDS strategies should be prioritized and costed.

Priority-setting is important for two main reasons. First to guide implementation—it helps to ensure that the most important or urgently needed activities are funded first and given required emphasis. Second, aspirations often exceed the ability to pay or capacity to implement. Therefore, priority-setting assists countries to focus their plans and ensure they are achievable.

Costing is important to ensure that the selected interventions are realistic and affordable, and to provide vital information to those managing and monitoring the strategy's implementation. There are many approaches to costing. Some involve a very small team doing the work, whilst others rely on wide participation from stakeholders. In some cases costs are standardized so that budgets are generated by accountancy formulae; in others, the individualized demands and estimates of implementing partners are aggregated. The activity of costing can also come at many different points in the process of strategy development.

In theory, prioritization should precede costing of a national strategy. In reality, however, planning, prioritizing and costing are often interrelated and iterative processes. For example, the costing of even a prioritized set of interventions may indicate that the total amount needed is in excess of the amount available, so that further refinements to the priorities may be needed.

This paper illustrates two different approaches, both employed in Swaziland as part of the finalization of the *Second National Multisectoral HIV and AIDS Strategic Plan 2006 – 2008* and the development of the *National Action Plan 2006 – 2007*. The 'activity based costing approach'—was developed by staff of the World Bank. This was a swift accounting exercise completed by a small team. A similar approach was also undertaken in Guyana, although with slightly different parameters. The second approach, 'participatory planning', was developed by a team from the UNAIDS Southern Africa Technical Support Facility (TSF). This was a lengthy participatory planning and costing process with wide stakeholder involvement.

These approaches are described, their pros and cons identified, and then some general lessons about costing are presented.

## **THE ACTIVITY-BASED COSTING APPROACH**

### *Overview*

In **Swaziland**, this approach took two weeks, and involved a core team of three people (one from the World Bank and two local consultants). The team prioritized and the costed the activities identified for the first year of the implementation of the country's AIDS strategy. This list of activities had been identified by the team that developed the strategy itself, and also included a preliminary identification of priority activities that was considered by the costing team. The end result of the activity-based costing approach was a prioritized list of activities costed at Emalangeni 745 million over three years (roughly U.S. Dollars 95.8 million).

### *Priority-setting*

This was performed by the consultant team using three criteria, with different weights assigned to reflect relative importance:

- **Capacity** (given a weight of 3<sup>2</sup>)—the degree to which capacity was available to carry out the specific action effectively, including the capacity to conduct the necessary preparatory activities
- **Benefit** (given a weight of 2)—the degree to which the action would provide immediate benefit to those at risk, orphans and vulnerable children (OVC), others who are vulnerable because of the effects of HIV/AIDS or persons living with HIV/AIDS
- **Long-term** (given a weight of 1)—the degree to which the action had the potential for long-term improvements in quality of life for PLWHA or their families, or in the reduction of HIV/AIDS infection rates.

In addition, activities were scored on a scale set at 1 for low, 2 for medium, and 3 for high. Thus the maximum any activity could score was 18 (3X3 for capacity + 2X3 for benefit + 1X3 for long-term).

This approach relies heavily on the interlinked individual pages (or worksheets) of a spreadsheet document.

First, activities were listed in a worksheet. Then the team allocated weights and scores for each activity. From this, formulae were created to automatically calculate the priority rating of each activity (i.e. multiply the criteria weight by the score). This data was carried forward to a separate 'Priority Ranking' worksheet, which was sorted in descending order by weighted score. This list was then sub-divided into three categories—high priority, medium priority, and low priority. In the case of Swaziland, this sub-division was relatively easy because the team found natural breaks in the prioritized list, with approximately one third of activities in each group.

### *Data on scale and schedule*

Once a prioritized ranking of all activities had been achieved, the next step was to estimate the scale and scheduling of activities. This involved asking three main questions:

- How many people or organizations are to benefit (i.e. the target group)?
- What volume of service should each of the targets receive (i.e. how many units of inputs per target group member)?
- When should different amounts of the service be delivered (i.e. relevant when a program is being scaled-up or withdrawn over time)<sup>3</sup>?

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<sup>2</sup> The rationale for this was that **capacity** would largely drive the achievement of the last two variables, and the magnitude of the current problem would favor immediate benefits over longer-term ones.

<sup>3</sup> For more information, see **Annex 1: The Potential Target Group Approach (PTG)** in *Costs of Scaling HIV Program Activities to a National Level in Sub-Saharan Africa: Methods and Estimates*, World Bank, March 2001.

### *Attaching costs*

The activity-based costing approach relies on the accurate and methodical entry of data into a series of interlinked worksheets in a spreadsheet document. It is also essential to record detailed descriptions of all the activities and any assumptions that have influenced the identification of specific activities, expenditure items and costs.

Once the data is in place, costs can be generated relatively easily by creating formulae that multiply data from one worksheet with that from others. To prepare the relevant worksheets, the following data were entered:

- A list of all expenditure items
- The standard cost for each unit of each expenditure item
- Alternative costs to cover exceptional cases
- The numbers of units of each expenditure item required per target group member for each activity.

The list of expenditure items—often referred to as a ‘chart of accounts’—covered all the things on which money needed to be spent, as well as the standard units of measurement for each item (e.g. person months, square meters, etc.)<sup>4</sup>. Standard costs can be specified in either a local currency, or in a global currency such as U.S. dollars or Euros. Alternative standard costs are recorded to cover cases where something different to the standard is required, for example if a computer for a specific purpose requires a special type of monitor rather than the usual type.

After this data has been entered, the costing process was relatively straightforward. For **each expenditure item** for **each activity**, formulae multiplied the **number in the target group** by **number of units** by **unit cost** (standard or alternative).

The process in **Guyana** followed essentially the same, but with some methodological differences. First, a great deal of prioritization and refinement of activities had already been done for the Guyana strategy, so there were considerably fewer activities (192 versus 910 in Swaziland) in the initial list. However, some of the activities in Guyana were much broader in scope, so individual activities often involved many more expenditure items (an average of 1.8 discrete expenditure items per activity in Swaziland and 5.0 items per activity in Guyana).

Second, the basic chart of accounts in Guyana was initially taken to reflect the expenditure classifications used in the Government of Guyana budget. While this has obvious benefits in terms of the use of country systems, it was also clear that these classifications were too general to be useful in terms of identifying unit costs. To remedy this, a series of “Product Codes” were created within most expenditure categories. For example, “drugs and medical supplies” was broken down into “male condoms”, “female condoms”, nutritional supplements, and so on, and unit costs were assigned for each.

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<sup>4</sup> In the case of Swaziland, the final chart of accounts included 7 major and 45 minor account classifications, with the major groupings including staffing, supplies, operating costs, drugs, equipment and vehicles, buildings and grants/financing.

Finally, the team used in Guyana had much different composition. While the Swaziland team was comprised of financial managers and planners, the team in Guyana consisted primarily of program managers, who joined the meeting to discuss the activities related to their own program area. To ensure some measure of continuity, some managers stayed to “hand over” to the next group, resulting in some of them becoming quite familiar with the process. This helped to move along the costing process and allow a large number of activities to be costed within a relatively short period of time. Over the week that the costing took place, a total of 130 activities were costed (about two thirds of the total number of activities), representing a total cost of 18.95 billion Guyanese dollars (equivalent to \$94.8 million) over three years.

### ***Advantages and disadvantages***

The main *advantages* of this approach include:

- Costing can be done relatively quickly by a small team of people
- As long as costs are known, target groups and units specified, the process can effectively be carried out by external consultants and does not necessarily demand much time from national AIDS program staff
- By creating a ‘chart of accounts’, it is possible to analyze expenditure patterns in various ways (e.g. proportion spent on capital investment versus direct program delivery). This is useful in the process of finalizing plans and budgets, but also for reporting and communications more generally
- To lay the foundation for the accounting approach, considerable time must be invested to create a series of interrelated worksheets and formulae. However, once the system is designed, the process of costing can be achieved relatively swiftly and with a high degree of consistency since entries (and changes) made in one place can be carried through automatically to other parts of the system
- The spreadsheets created to carry out costing should be usable for many years, with minor alterations and additions as required.
- The information base created provides a tool that can also be used for monitoring implementation of the strategy and identifying the source of variances that may occur. For example, was the number of people in the target group correctly estimated? Or was the number of units per target group member higher or lower than expected? Finally, were the projected unit costs achieved during actual implementation? This information can then be used to both update the costing for subsequent years and improve the accuracy of future costing exercises. Of course doing analysis of this type would require ongoing monitoring of each of these elements as the strategy was carried forward, so systems would need to be set up to do this.

The main *disadvantages* of this approach include:

- If local costs are not documented, the process can not be undertaken by external consultants; national expertise is definitely required
- It may be difficult to find appropriate consultants - strong experience in designing or operating national AIDS strategies is required, to ensure that appropriate priorities are picked and relevant costs attributed to activities
- The lack of stakeholder involvement may reduce ownership in the process as a whole and create challenges for implementation, e.g. disagreement over priorities, budgets deemed inappropriate, etc.
- The complexity of the accounting approach means that implementing agencies may struggle to understand how their budgets have been constructed. Local level planning and budgeting tends to create figures and targets at divergence to those generated centrally, leading to confusion, disputes and failure to achieve stated targets
- Standardization of costs can oversimplify the costing process. For example, independent NGOs that raise their own funds can legitimately operate different volunteer allowances to those recommended by the national coordinating body.

Based on the experience to date, a number of these disadvantages can be mitigated by improvements in the process and systems used. For example, the increased involvement of local procurement and/or finance staff can help to ensure that the costs used are the most accurate available and reflect local (national or regional) conditions to the extent possible.

In the Guyana costing, the concept of “Product Codes” was added to allow the identification of costs at a lower level than the expenditure item, as described above. This allows a better definition of unit costs and more understandable and recognizable costing figures.

It is also important to note that these preliminary exercises were fairly short interventions, and a slightly longer-term, iterative process is likely needed to get the full value of the approach. With more refinement of the costing software (currently being pursued), it should be possible to utilize the approach at the local or sub-national level and build up the national costing from these different elements. This would also provide the opportunity to discuss, and hopefully resolve, differences regarding the number of people in target populations, units per person and other issues.

## ***THE PARTICIPATORY PLANNING APPROACH***

### *Overview*

This approach took three months, and involved a core team of four people (two international consultants and two local consultants) as well as significant time inputs from many hundreds of stakeholder representatives. Stakeholders were assisted to identify, plan and cost activities they would undertake to contribute to the achievement of the priority objectives that had been determined by the national body coordinating the HIV and AIDS response.

The end result was a prioritized list of activities costed at Emalangeni 270 million for the first year (U.S. Dollars 34.7 million).

### *Priority-setting*

This was conducted by the national body coordinating the HIV and AIDS response. Prioritization was achieved by analyzing the main ‘drivers’ of the epidemic (i.e. the main factors influencing the spread or curtailment of the epidemic), correlating the main strategic issues identified in the National Strategic Plan with these drivers, and then identifying a series of primary goals and objectives that address the key drivers. The result was a list of 24 priority objectives to be tackled via 35 priority strategies.

### *Participatory planning process*

The main implementing agencies in the response to HIV and AIDS were identified from the public sector (government departments), private sector (i.e. business response), civil society, and the traditional sector (comprised of traditional, cultural groups). These implementers were invited to partake in individual planning and costing workshops. A total of 14 workshops were held—lasting between 1 and 2 days each, depending on the capacity of each implementing partner and the scale of its operations—with participant numbers ranging from 5 to 30. The workshops were designed to fulfill many purposes, including information sharing and capacity development training, as well as planning and costing.

The workshops were used to generate three-year, implementer-specific action plans. Detailed plans and budgets were required for year one (2006-7); years two and three were expected to be less detailed and with ballpark figures attached if possible.

In the workshops, participating agencies first sorted the list of priority objectives to determine which they would address and which they would not. Then for each priority strategy that they had chosen, the participants sorted the list of priority strategies to determine which they would utilize and which they would not. Participants were then in a position to identify the activities they would implement under each priority strategy they had chosen for each priority objective they had chosen.

A simple matrix/log frame was used to structure the process and record results. This required information on the nature of the proposed activity itself, timeframe (3 years), indicators and verifiable evidence, targets, budget (3 years), and responsibilities for implementing the activity.

At the culmination of their workshop, in most cases implementing agencies had finished capturing and costing their plans. In a small number of cases, however, some required additional time or information or support from the facilitation team to complete their submissions.

### *Costing process*

Costs for activities were generated typically by means of the facilitators assisting participants to generate simple formulae, such as:

$$[\text{Number of participants and facilitators} \times \text{number of workshop days} \times \text{workshop venue costs}] + [\text{number of}$$

participants x average transport cost] + [number of facilitators X number of preparation and workshop days X facilitation fee] + [budget for stationery and materials]

Whilst some costs were standardized, as laid down by the national AIDS coordinating body, the majority of budgeting took the form of trend planning (i.e. based on knowledge of the costs of similar previous activities) and best guess.

These plans for individual implementing agencies were then collated into 4 sectoral action plans (i.e. Public, Private, Civil Society, Traditional), and these were reviewed by the national AIDS coordinating body. Follow up discussions were conducted where necessary to ensure accuracy and feasibility of plans and budgets, to address gaps and avoid overlaps and duplication.

At this stage, the different teams within the national AIDS coordinating body included their own plans and budgets and health components were added. The latter had been developed in a different process by the Ministry of Health.

Plans were then scrutinized in light of the country's financial position (i.e. available funding from government and the Global Fund), funding committed by development partners (i.e. international donors, UN, charitable sources, etc), and targets for fundraising.

Finally, plans and budgets were analyzed together in an iterative process to ensure that priority objectives were adequately addressed and fundraising targets were realistic.

### ***Advantages and disadvantages***

The main *advantages* of this approach include:

- Over time, the greater involvement of stakeholders and implementers should greatly increase the quality of a nation's plans
- Stakeholder involvement in planning and costing greatly increases their sense of ownership of national strategies and plans
- Participatory approaches help build the capacity of stakeholders and implementers in such critical areas as planning, prioritization, and budgeting
- In some cases, cost estimates for individual items and activities may be more accurate when recorded by the actual implementers of activities themselves
- Accessibility is enhanced by using relatively simple tools and methods.

The main *disadvantages* of this approach include:

- Participatory approaches take a lot of time and facilitation. They need to be well planned well in advance, and require considerable administrative and logistical support

- The process is jeopardized if capacity is weak among the stakeholders and implementers invited to contribute to planning
- Similar expenditure items are costed inconsistently by different stakeholders; if standardized costs are later used in estimating allocations, there can be problematic mismatches between budgets and disbursements
- It is difficult for many stakeholders to understand the 'Big Picture'; collectively, therefore, plans may reflect the diversity of individual stakeholder concerns rather than a coherent programme of activity to address the epidemic on a national scale
- Since costs are attributed to the individual activities of specific implementers, making alterations to budgets is an extremely laborious business.

### **OVERALL LESSONS LEARNT**

- If implementers are to be meaningfully involved in planning and costing activities, their capacity development needs should be adequately addressed. This is true at senior staff member level, but also on a much wider basis across the organizations. Over the long term, the greater involvement of a wider staff and group of stakeholders (such as service beneficiaries or volunteers) should improve the relevance and accuracy of planning and costing, and reduce what is often an excessive burden on senior implementing agency staff.
- Participatory approaches take longer but are better at capacity building of the wider stakeholder group. However, the activity-based costing approach has greater potential to pass on high level skills, say to the senior financial staff of national AIDS coordinating bodies.
- However costing is approached, sooner or later the process requires staff and consultants with strong capacity in IT skills, especially use of spreadsheets. It should be noted, however, that the development of more "user friendly" software is currently being considered, which should alleviate some, but likely not all, of this issue.
- The greater the degree of participation, the more time needs to be allowed for planning and costing. The process needs to be mapped out in considerable detail and this information disseminated well in advance, so that all relevant parties can schedule appropriate time to devote to the exercise. It is valuable to leave time in between key steps to allow consultation, reflection, and improvement.
- It is always important to describe in detail each activity in a plan, and how it is to be implemented. This documentation process allows costs to be checked and means that any assumptions can be revisited and changed later if necessary. Such documentation also serves as an 'institutional memory' in case of staff turnover. This documentation is also essential if the costing document is to be used in monitoring implementation progress.

- However budgeting is done, there is considerable danger in asking people to cost activities when they do not have the capacity or relevant experience to do so. This encourages expression of wildly exaggerated and/or grossly under-estimated costs...Review and revision by the senior, local, financial managers of the response unit (typically the Finance Director of the national AIDS coordinating body) takes further time and can be seen as disempowering, but it is essential in all cases. To address this issue, and based on the experience to date, there is a strong case to be made for including senior managers, program managers, as well as financial and procurement staff in the costing process. The senior managers can ensure that distortions in the scope of activities and/or priorities are kept to a minimum, while program managers can provide essential technical input, and finance and procurement staff can ensure that the unit costs and the overall approach are both fiscally sound.
- Standardization of costs greatly simplifies the budgeting process. It can also promote fairness. However, it is essential that unavoidable variations in costs are adequately covered to ensure equity of treatment is preserved across different implementation agencies.
- Effective prioritization and optimal planning occur in the presence of budget targets, even if these are rough estimates compiled by the national coordinating body. Costing in the absence of budget targets easily becomes an exercise in 'wish-listing', and is potentially very wasteful of time, as well as technical and human resources. When wish lists are eventually and predictably pruned (usually by the national coordinating body), this can be misinterpreted and prove damaging to relations with stakeholders.
- Resource tracking is an integral part of the planning, prioritization and costing process. Without knowing the contributions to be expected from government and development partners, it is impossible to know what is a realistic aggregated budget, and hence difficult to know how many actions can be prioritized and achieved within any given timeframe. Unfortunately, an effective system for resource tracking is missing in many countries at this time.

## **CONCLUSIONS AND SUGGESTED APPROACH**

It is clear that both of these approaches have much to offer in the prioritization and costing of national HIV/AIDS strategies. In fact, there is a strong case to be made for using important elements of each to maximize the effectiveness of the process and the value of the results.

Consultative processes such as the participatory approach are probably best used for priority-setting, but there may be some value in applying some explicit scoring system – such as the relatively simple one included in the priority-setting phase of the activity-based costing approach – as part of the consultation process. This may help to better focus the attention of these stakeholder meetings on the key issues and arrive at agreement on priorities more quickly.

Stakeholder involvement may also be very useful in the dimensioning process, especially in identifying the number of individuals in each target group and the number expected to be affected by a particular activity each year. As in many things, this may be an iterative process, since some specific targets may be set at the national level (e.g., number of individuals on ARV treatment), and these may need to be discussed with stakeholders, while the numbers for other target groups can simply be compiled from the estimates the various stakeholder groups/consultation meetings. It will be important to ensure that appropriate preparatory work is done prior to the consultation, so that the stakeholders can focus primarily on the dimensions themselves rather than the logistics of setting things up to capture this information.

The selection of expenditure items (chart of accounts) and unit costs are probably best left to the financial and procurement staff of the national HIV/AIDS response group, technical specialist agencies (e.g., MOH, UNAIDS, etc.) and external consultants, where available. As much as possible, country systems should be used as the basis for the chart of accounts, although it is acknowledged that most external aid organizations and development partners currently use their own financial systems that are not compatible with each other or with the government's system. Using government systems for this process may help foster harmonization. However, as the Guyana example illustrates, there will likely be need for a lower level of detail (e.g., "product codes") to allow meaningful unit costs to be assigned.

With these initial steps completed, the various pieces can be put together by a group of senior managers, program managers, as well as financial and procurement staff, under the guidance of an expert/facilitator, if available, who can help guide the group through the remainder of the process. The potential problems noted above with respect to inconsistencies that can arise in a "costing by consultation" suggest that this type of forum is not optimum for the detailed costing step of the process, although it may be useful for reviewing the results to ensure acceptance and buy-in.

In most countries – where resources available for HIV/AIDS programs are inevitably constrained, there will need to be a phase of matching the costed plan against the available funding. Modifications to the costed plan could include reducing the priority of some interventions (e.g., given the cost, it is less of a priority ...), reducing the coverage targets, changing the number of units per individual or other changes. Again this may be an area where there is substantial scope for using participatory approaches, although at some point the hard decisions will have to be made.

Once the plan is accepted and adopted, the difficult process of program implementation must begin – or in most cases, continue. If sufficient detail is included in the costed plan, this document can be used for monitoring and evaluation purposes. As noted above, explicitly stating the number of target group individuals, the units per individual and the unit cost allows all of these elements to be tracked over time, and allows variances to be explored and analyzed. Moreover, if the planning cycle is sufficiently aligned with the budget/MTEF cycle, the costed plan can provide a critical input to the annual planning and budgeting of HIV/AIDS interventions, and the information from the costing system can help in this process.

In this way, the planning/costing process can be an integral part of the cycle of activities essential for effective program management and implementation (see below).

