Costing HIV-AIDS in Cambodia
Improving Unit Cost Data

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I. Background

Cambodia has been in the forefront of the fight against HIV and AIDS having successfully reversed its generalized HIV epidemic. Estimates and Projections published by National Centre for HIV/AIDS Dermatology and STDs (NCHADS) a unit of the Cambodian Ministry of Health) in 2012 show a steady decrease in prevalence in the adult population (aged 15-49) from a high of almost 2% in the late 1990s to a projected 0.7% in 2012. Moreover, a stronger health system and improved service delivery and linkages have made it possible for approximately 80% of adults and children living with HIV and in need of antiretroviral therapy (ART) to access care and treatment at Continuum of Care (CoC) sites.

Despite these successes, pockets of high prevalence continue to exist, particularly in most at-risk populations (MARPs)—entertainment workers (EWs), men who have sex with men (MSM), transgender women (TG), and people who inject drugs (PWID). Furthermore, more attention is now being paid to overlapping risk. This is because vulnerability among MARPs is compounded by multiple and overlapping risk behaviors, such as PWID who buy and sell sex, and EWs, TG and MSM who use drugs.

To achieve that objective Cambodian Authorities, in concert with development partners, are implementing new strategies to further impact the HIV epidemic. In order to determine the feasibility of those strategies, it is necessary to determine whether the costs of implementing those strategies can be financed by funds that are likely to be available in the future.

A. Evolution of this project

The U.S. Centers for Disease Control (CDC), at the request of NCHADS, embarked on an effort to improve the costing for HIV-AIDS programs. The CDC decided to engage the services of U.S. Treasury Office Technical Assistance (OTA), as one of its advisors (co-author of this report) was already engaged in Cambodian work, including work with the Ministry of Health. Key steps then included:

1. May 2012

The US Treasury Advisor's first mission found that there were well established models for estimating HIV costs, but that the principal elements needing improvement were the inputs to the models. Generally, that meant getting more precise information on unit costs.

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(For the full report for that mission refer to: 
Costing HIV Strategies.pdf)

2. October 2012

As a follow-up to the May mission, the OTA consultant produced a scope of work for conducting field research to improve information on unit costs. During that period, consultations with UNAIDS revealed that they were planning on a similar effort. As result of further consultations between CDC and UNAIDS it was decided to embark on combined effort. The OTA consultant (Lawrence Seale) was retained for the additional work and UNAIDS retained Anastasiya Nitsoy, who had previous experience in Cambodia with the National AIDS Spending Assessment (NASA) and in conducting costing and cost-effectiveness studies.

(For the Full Scope of Work refer to: 
HIV Unit Costs Scope of Work (2012-12-12)

3. January-March 2013

Work on unit cost was initiated during this period with both consultants onsite during February. However, urgent priorities related to completion of NASA IV and the submission of the Global Fund for Aids Tuberculosis and Malaria (GFATM) phase II application took priority over the detailed focus on improving unit costs. Nevertheless, fresh data from providers obtained in the NASA process and in budget workgroup sessions to prepare the GF application have provided additional data for the estimation of unit costs.

4. April 2013

The more detailed work was undertaken by both consultants resulting in the updated unit costs that are further explained in the body of this report. Although the revised unit costs require further consultations and approval of the stakeholders, at the current stage they are considered the best available data related on the HIV-related unit costs.

B. <u>Conceptual Basis of this project</u>

1. Unit Costs are useful in client driven programs

In the private sector, unit costs mean the total costs (fixed and variable) that are needed to produce a product for sale. In government programs the concept is similar, except that unit costs represent the total costs to provide a specified service (or package of services) to a particular client. This could be calculated "*per service*" provided, but for the sake of developing future budget projections and various cost-related analysis it is more useful to develop unit costs covering the *"total annual costs"* of serving the client. Thus, if an outreach worker should contact an entertainment worker every week, the unit costs would reflect the costs of 52 such contacts during the year.

Unit costs developed in this way are useful when programs are focused on serving identified clients. When the unit costs are multiplied times the number of clients to be reached, the total annual budget requirement for the service can be determined. That means good estimates of the number of clients is also needed, but that issue is not addressed in this report.

2. Not all HIV program costs can be determined through unit costs

While much of the HIV/AIDS program has the characteristic of being client-driven, parts of it are not susceptible to this approach. Activities necessary to create an enabling environment or policy development programs may not be very sensitive to the size of the client population and the budget for those needs to be developed in a different fashion.

3. Unit costs of outputs, not outcomes

This report addresses the unit costs of delivering defined service packages to clients. In public sector budgeting, these measurable service delivery packages are referred to as outputs. These outputs are intended to produce outcomes. In the case of the HIV programs the outcomes expected include, for prevention programs, avoiding HIV infection (averting the new cases of HIV) and for care and treatment programs, extending the life and independence of HIV infected persons.

While as a general rule, lowering unit costs would be desirable as it would allow the available funds to reach more clients, improved outcomes might require targeting more difficult clients or using more expensive service delivery models. This report does not address the outcome aspects of these service delivery packages, only the cost of the inputs needed to provide the services.

4. Updated Unit Costs are actual costs, not necessarily ideal costs

This project endeavored to find the actual costs of delivery the various service packages. It is possible that a different service delivery mode or techniques could result in less expensive unit costs without affective the effectiveness of the program. This report makes no judgment about whether the unit costs indicated are the best that can be obtained.

II. Updated Unit Costs Estimates

Unit costs have been used for previous projections of HIV program costs, so in that respect this project does not really break new ground. Instead, the results reported here are intended to make improvements in the validity of the unit costs that are used. Further improvements are possible and may be pursued in the future. This report indicates where there is relatively little uncertainty in the appropriate unit costs, or conversely where there is uncertainty in the costs estimate and improvements are possible.

The unit costs shown here are the costs that are actually operative in Cambodia. This report makes no judgment about whether these costs are optimal in the country context but takes into consideration the recommendations of the AIDS

Commission in Asia regarding which components should be included in the service package to ensure it is effective in achieving program outcomes. It is possible that there are service delivery approaches that could reduce these costs in the future.

The last published estimate of HIV/AIDS program costs were contained in the document "The Long Run Costs and Financing of HIV/AIDS in Cambodia (AIDS2031)," which was published in 2012, but based on cost data and the Resource Needs Model from 2009. For comparison purposes, we are showing the unit costs that were used in that projection along with the updated unit costs which are appropriate for use now. There is lack of information about the calculation strategy and sources of data for the AIDS2031 unit costs. However, the calculation files and the description of the estimation approach for most of the updated unit costs shown in this report are presented and described in the publication of "Costs and cost-effectiveness of HIV prevention and impact mitigation interventions in Cambodia (CEA)."

[NOTE: The unit costs presented in the following section are expressed in U.S. Dollars. The revised "current" unit costs reflect 2011 or 2012 prices, depending on the exact unit cost.]

A. Prevention

1. Client: Entertainment Workers (EW)

Service package:	AIDS 2031	Current
Cost per sex worker reached (direct)	22.40	133.00
Cost per sex worker reached (indirect)	22.40	133.00
Cost per male condom distributed	.11	.08

a) Service Package Content

These are services to entertainment workers (sex workers) to increase their use of safe practices. It was estimated that the cost of reaching one EW per year with the package of prevention interventions costs $ 145. The unit costs of $133 per EW per year presented above does not include condoms, which are costed and calculated separately as per the Resource Needs Model design.

The full EW prevention package included a number of contacts by outreach workers or/and peer educators (staff salaries or incentives), education in safe practices, provision of condoms (these are costed separately in the Resource Needs Model), conduct of rapid tests (once per year for all EWs), referral to voluntary counseling and testing (VCT) sites if needed, and referral for sexually transmitted disease tests and treatment. In addition to those direct costs, the cost of equipment and management overhead is also included in the service package.

b) Source/methodology for updated Costs

These costs were derived from a detailed review of the actual costs in 2011 of a major NGO provider of USAID's "Smart Girl" program. The total annual cost of that provider's program at selected sites was divided by the number of entertainment workers reached with the service. The summary of the components of this unit cost is presented in the Section IV of this report, "Technical Annex." The detailed description of the costing of this service package is also presented in the CEA publication mentioned earlier.

Prices of different components of the unit costs were obtained from the organizations that do the procurements of the various commodities (e.g. cost of condoms came from Population Service International (PSI), cost of HIV tests was provided by NCHADS based on the GFATM grant prices).

c) Reliability of this Unit Cost

This unit cost is reliably calculated based on the actual costs determined from a review of the provider's data. It is assumed that the sites surveyed are typical and therefore approximate the national average for this service. It is also assumed that the "Smart Girl" program is relevant for the whole country.

Not all entertainment workers have the same risk. Some are more active than others. If services to this group were differentiated depending on the degree of risk, it might be possible to derive different unit costs for the different categories and therefore obtain a more precise estimate of the overall costs. As the scope of the services may be redefined in future (referring to the new Boosted Continuum of Prevention to Care and Treatment (CoPCT) Standard Operating Procedure (SOP), of the Cambodia 3.0 strategy and the current work on the SmartGirl+ concept development), the unit cost for this population is likely to be changed in the coming years. The changes will occur in the Voluntary Confidential Counseling and Testing (VCCT) component (as 95% of all reached MARPs are to be tested with an HIV rapid test twice a year) and Sexually Transmitted Infection (STI) component (as the new strategy assumes that 90% of all MARPs will require STI screening and treatment). These strategic changes are also reflected in the renewal request to the Global Fund (Phase II workplan and budget).

Additionally the NASA IV (National AIDS Spending Assessment for the years 201 and 2012) analysis of the program cost of the nation-wide (from all financing sources) coverage of EWs in 2011 suggests that it was relatively higher ($177 per 1 EW reached per year across all programs) than the estimated effective package shown here ($145 per 1 EW reached per year). The NASA estimate of the unit cost of reaching one EW within USAID-funded SmartGirl program in 2012 (assuming that 18,000 EWs were reached) is $165 per EW per year which is lower than the national average.

2. *Client: Males having Sex with Males (MSM)*

Service package:	AIDS 2031	Current
Cost per MSM reached (visible)	22.40	51.00
Cost per MSM reached (hidden)	22.40	141.00

a) Service Package Content

The cost of HIV prevention among MSM (the RNM differentiates between visible and hidden MSM) was estimated using the similar approach as in prevention among EWs, and included a number of contacts by outreach workers or/and peer educators (staff salaries or incentives), education in safe practices, provision of condoms (these are costed separately in the Resource Needs Model), conduct of rapid tests (once per year for all EWs), referral to voluntary counseling and testing (VCT) sites, referral for sexually transmitted disease tests and treatment, the cost of equipment and management overhead associated with the service implementation.

The revised unit cost of $51 per visible MSM per year contains all the components above excluding condoms, while in the $141 per hidden MSM per year the cost requirements for condoms are included.

b) Source/methodology for updated Costs

Similarly to the EW prevention unit costs, the cost of reaching MSM with HIV prevention is based on a review of the actual costs in 2011 of a major NGO provider of USAID's "MStyle" program. The total annual cost of that provider's program at selected sites was divided by the number of MSM reached with the service. The summary of the components of this unit cost is presented in the Section IV of this report, "Technical Annex." The detailed description of the costing of this service package ($142 per MSM reached per year) is also presented in the CEA publication.

c) Reliability of this Unit Cost

If the Resource Needs Model will be used for the future projections, more work should be done to identify the best service delivery package for the transgender population (long-hair MSM), because of the higher risk of HIV transmission. The projections can be made using the Hidden MSM data package, but the unit cost may be higher than currently anticipated for the visible MSM.

As explained in the EW section above, the package and the intensity of some of its components (VCCT and STI) are likely to be changed in future, resulting in the changes of the unit cost per client per year.

In NASA IV the unit cost of reaching one MSM in 2011 was estimated by dividing the total MSM-targeting prevention expenditure by the number of MSM reached in 2011. It appears to

be significantly higher ($474 per one MSM reached in 2011) than the estimates done in late 2011 for the CEA ($142 per one MSM reached per year).

3. *Client: Injecting Drug Users (IDU)*

Service package:	AIDS 2031	Current
Cost of drug substitution per IDU	185.00	398.00

a) Service Package Content

The "current" costing was produced in late 2011 and represents existing service delivery mode based on the MMT clinic in the Khmer Soviet Friendship hospital. The unit cost includes: staff of the clinic, methadone, VCCT, STI, NSP, referrals (transportation cost), TA, training and management. The unit cost presented in the table above and used in the revised RNM for the Phase II grant renewal request assumes that the clinic operates on its full capacity (250 patients). However, at the time of the unit cost assessment, the clinic had only 105 patients which increased the unit cost per patient per year to $798. This means that the MMT unit cost may vary significantly in the next years depending on the number of patients receiving the service. Additionally, if the country decides to introduce another MMT site, it will significantly change the unit cost per patient per year, due to a substantial investment required to start a new site.

b) Source/methodology for updated Costs

Data on the MMT clinic service delivery was obtained from FHI and WHO which are providing technical assistance and guidance to the MMT service delivery. Additional source of the MMT unit cost can be found in the study on the costing of the MMT Programme which was conducted by HLSP for HAARP (AusAid) in August 2011. This study provides a range of unit cost values depending on whether international TA or/and capital investment is included or excluded. The detailed reference to both costing strategies can be found in the CEA publication.

c) Reliability of this Unit Cost

As stated above, the fluctuations in the unit cost may happen in the future it is highly dependent on: (a) number of people receiving service, and (b) number of sites providing the service. Further discussion is required on the issue of the technical assistance to the Methadone Maintenance Treatment (MMT) programme. Considering that it is constantly provided to the MMT service, the decision can be made to make it part of the unit cost for this intervention for the future resource needs projections.

4. *Client: Injecting Drug Users (IDU)*

Service package:	AIDS 2031	Current

Cost of NSP per IDU	22.30	205.00

a) Service Package Content

The "current" unit cost of the Needle and Syringe Exchange programme (NSP) ($205 per client per year) is based on the combination of Drop-in center (DiC), mobile DiCs and outreach service delivery. It includes the following components: outreach staff and peer educators (incentives), needles and syringes (including waste management cost), hygiene kits, condoms, referrals (transportation cost), VCCT, STI, management.

b) Source/methodology for updated Costs

The "current" unit cost was estimated in late 2011 and represents an average between two biggest service providers of the NSP service—Mithsamlanh and Korsang – based on the analysis of their monthly and annual expenditure reports. For the purpose of the use of the unit cost in the future and whenever the existing services did not include sufficient number of services (e.g. very limited VCCT rate among IDUs), the frequency of the service provision was increased to follow the recommendations of the AIDS Commission in Asia on the effective prevention package.

More details on the unit cost estimation are contained in the CEA publication.

c) Reliability of this Unit Cost

According to NASA III and NASA IV findings Cambodia is spending much more on the NSP programme than needed. One of the possible explanations is the existing overlap in programming for non-injecting drug users (DUs) and injecting drug users (IDUs). Although in NASA IV the DU-related spending was attempted to be estimated separately, the cost of the harm reduction interventions was much higher than the costing of the package suggests.

5. *Clients: Users of Voluntary Counseling and Testing Centers (VCT)*

Service package:	**AIDS 2031**	**Current**
Cost per VCT at new site	29.77	20.51
Cost per VCT at existing site	11.25	20.51

a) Service Package Content

Generally the services at a VCT center included taking a blood sample that can be tested for the presence of HIV, providing counseling to clients on risk factors, and if the test is positing about the next steps.

b) Source/methodology for updated Costs

There is not enough information on how these costs were estimated. In the updated version the average between two AIDS

2031 unit costs was used, which reflects the existing VCCT service delivery model (mix between new sites and old sites).

The most recent data on the prices of the cost of the rapid tests, HIV tests and reagents and confirmation tests can be obtained in the budget of the Phase II of the GF HIV grant, although the budget and workplan have not been approved yet.

c) Reliability of this Unit Cost

A separate study may be required to update the estimates of the VCCT considering that large amount of VCCT will be done using rapid tests (for most-at-risk populations) and introduction of the Point of Care testing.

6. Clients: Those being treated for Sexually Transmitted Diseases

Service package:	AIDS 2031	Current
Cost of STI treatment	7.14	20.73
Cost of STI treatment in clinics	20.73	20.73

a) Service Package Content

These are the costs of testing for the presence of sexually transmitted infections and providing appropriate treatment, usually anti-biotics.

b) Source/methodology for updated Costs

Similarly to VCCT there is not enough information on how the original AIDS 2031 cost was estimated.

However, the reason of using the higher clinic-based unit costs in the first line (updated current unit costs) is that there is no STI treatment provided on the outreach basis in Cambodia.

The most recent data on the prices of the STI screening and treatment can be obtained in the budget of the Phase II of the GF HIV grant, although the budget and workplan have not been approved yet.

c) Reliability of this Unit Cost

A separate study may be required to estimate clinic-based STI treatment cost.

B. <u>Care and Treatment</u>

1. Clients: HIV infected individuals

Service package:	AIDS 2031	Current
Cost per person receiving home-based care	46.32	105.00

a) Service Package Content

The updated Home-based care package includes self-help groups, home visits to sick patients, food support for some People Living

with HIVM (PLHIV) and Orphans and Vulnerable Children (OVC) households, transportation cost to the health care facilities, limited income generation activities.

b) Source/methodology for updated Costs

The original unit cost was updated based on the budget proposal of one of the NGOs (RHAC) as a part of the Phase II HIV grant renewal application. The total requested budget for 2014 was divided by the number of PLHIV to be reached with the package of the home-based care services. The cost and the service package is also similar to what was actually implemented by RHAC in 2011 and 2012.

c) Reliability of this Unit Cost

It is important to mention that the Resource Needs Model projects the need of the Home-based Care only for the PLHIV who are not currently on antiretroviral (ARV) treatments. At the same time, the national application of this intervention is that the service is provided for both non-ARV and ARV patients as an outpatient medical and social supervision. It is widely used to prevent patients receiving ARV from dropping out of that treatment. According to the GFATM grant targets, over 17,000 PLHIV are planned to reach with Home Based Care (HBC) in 2014.

2. *Clients: ART patients*

Service package:	AIDS 2031	Current
Cost of first line therapy	376.00	192.00
Cost of second line therapy	1,199.00	496.00

a) Service Package Content

The unit cost presented above in the "Current" column combines a weighted average cost of the first line ($100 per patient per year) and second line ($404 per patient per year) regimens and a cost of the annual HIV laboratory monitoring for the patients starting ART or already on ART ($92 per patient per year). The cost of the ARV therapy already includes tenofovir-based regimens (for around 40% of the patients), which is more expensive than the current stavudine-based regimens (using stavudine in a large number of ART patients makes a weighted average cost of the first-line ART at the level of $86 per patient per year in 2012).

Drug-related unit costs are also adjusted to a 5% wastage rate.

The cost of the laboratory monitoring is based on the procurement prices of NCHADS, but includes a much broader number of tests (as suggested in the national treatment guidelines) than is being provided at the moment. If the treatment guideline is correctly followed in terms of the intensity of required CD4 and Viral loads

per patient per year, the cost of the HIV laboratory monitoring package may exceed the cost of the 1st line ART.

b) Source/methodology for updated Costs

Prices of drugs and commodities were obtained from the GF PR NCHADS who manages all ARV-related procurement in the country, and CHAI which provides technical assistance to NCHADS in the related procurement and works on the future projections of the treatment needs.

c) Reliability of this Unit Cost

Cambodia has achieved a significant progress in reducing the cost of the drugs and commodities for treatment program. Current estimations are based on very accurate data on the number of patients and ARV regimens provided in the country, and the cost of drugs and tests.

Further work is required to estimate other related cost of ART service such as: (a) the cost of the facility-based inpatient or outpatient care, (b) laboratory cost other than cost of commodities (currently included in the unit cost but requires revision), (c) prophylaxis and treatment of the opportunistic infections (OI).

III. Recommended Future Steps

A. Further Improvement to Unit Costs

The updates to unit costs in this report do not cover the full spectrum of unit costs. While this report represents the principal deliverable from this project, supplemental work is expected to take place in June which may refine some of these costs or others not reported on so far. Anything beyond that is outside the present scope and will need to be addressed by a subsequent mission.

Some unit costs which are uncertain and deserve further research are the following:

1. Entertainment Workers-

Because this population is large and also varied in its risk profile, there may be the need to come up with different unit costs for different strategies for different categories of entertainment workers.

2. Drug Substitution for PWID

Because there are high fixed costs in this program (methadone clinic maintenance), the unit costs are very sensitive to the volume of injecting drug users reached.

3. Workplace Programs

The consultants were not able to get more detailed information on the cost composition of providing workplace services. As this component

contributes more than $5,000,000 to the annual costs in future years, it deserves further analysis.

4. VCT

These costs are potentially very significant in the long-term and can change dramatically whether testing is done by outreach workers with rapid tests versus performed in clinic settings. The service delivery model here appears to be evolving, meaning this cost element will deserve watching. VCCT for general population targets have to be clearly set.

5. STI

In the coming years RGC is planning to significantly increase the coverage of the most-at-risk populations with STI screening and treatment. This requires additional data collection and unit cost analysis to estimate the future resource requirements. The total cost is highly dependent on the service delivery mode (e.g. clinic-based vs outreach approach, or using mobile STI clinics).

6. Non-ART care

Cost components for this are not clear and deserve to be studied more. Specifically, additional attention is required for inpatient and outpatient care for PLHIV, laboratory cost, OI prophylaxis and treatment etc.

7. Home Based Care

Strategy of the service delivery and the cost components for this are not clear and deserve to be studied more.

B. <u>Clarifying client population estimates</u>

As mentioned earlier unit costs are only part of the equation in making a projection of overall HIV-AIDs program costs. The unit costs are for services provided to clients and basic projection formula is "unit cost per client X number of clients served = total costs."

In some cases where it is the policy to serve all potential clients, the number of clients drives the costs. For example, in the case of HIV Treatment it is the policy to provide treatment to all who need it. So it is a matter of a demographic/epidemiological project to estimate the number of clients that will need services.

In other cases the number to be reached can be constrained by the amount of funds available to reach the clients. Here an example may be programs for injecting drug users. As these may prefer to remain hidden (yet are at high risk for getting or spreading HIV infection), how many of the population can be reached may be a function of how much is spent on outreach.

These population estimates have not been studied during this mission and there is no particular reason to doubt the estimates that have been recently used. However, an accurate over-all HIV program cost projection will also

need to validate or update client projections (or adjust them to available funding, once that is more clear).

C. Updating HIV program cost projections

Ultimately the updated unit costs here will be used to provide updated cost projections using one of the existing HIV projection models. That effort will need to be done in consultation with NCHADS and other stakeholders in the HIV program area to gain agreement that the model properly reflects the current strategies. In all likelihood, more than one projection will be required. If an unconstrained projection results in cost projections exceeding available funding, Cambodian policy makers will need to consider adjustments to strategies to bring costs with available funding while trying to preserve as much effectiveness as possible.

D. Unit Cost Monitoring

A separate deliverable from this project will be recommendations on monitoring and updating unit costs in the future. Unit costs may evolve for different reasons, and future projections should make use of the most current data, so a regular process of reporting on outputs in connection with service delivery costs could facilitate the future updating of unit costs.

IV. Technical Annexes

The following material provides some further financial data and information about methodology relating the unit costs presented in Section II of the Report

A. Prevention

1. Client: Entertainment Workers (EW)

The information came from research for the document "Costs and cost-effectiveness of HIV prevention and impact mitigation interventions in Cambodia (CEA)." The research combined costs from several service centers managed by an NGO for the USAID "Smart Girl" Program. The cost components are as follows:

	Inputs	Annual Cost USD	% of Total
1	***Behavior change***		
2	Management and admin	37,953	14.6%
3	Coordinators and outreach	72,994	28.0%
4	EW activities	55,657	21.3%
5	DU activities	1,980	0.8%
6	Male Clients activities	19,371	7.4%
7			
8	***Commodities & services***		
9	Indirect cost	18,788	7.2%
10	Referral to VCCT	2,310	0.9%
11	Referral to STI	4,880	1.9%
12	Referral to RH	1,788	0.7%
13	Referral system and fees	7,419	2.8%
14	Rapid tests	1,440	0.6%
15	***Enabling environment***	7,003	2.7%
16	***Investments***	2,700	1.0%
17	***M&E***	4,851	1.9%
18	**TOTAL Annual Costs**	239,133	100.0%
19	*EWs reached*	1,800	
20	UNIT COST per EW (line 18/19)	**133**	
	(Excludes Condoms, shown separately below)		

	Condom Costs		
1	Condoms for Ews	17,280	
2	Condoms for clients	4,400	
3	Total Condom Costs	21,680	
4	EWS reached	1,800	
5	Condom Unit cost per EW (line 3/4)	**12.04**	

2. Client: Males having Sex with Males (MSM)

[This section and the rest of the Technical Appendix to be completed in a later draft]

	Cost component	Annual Cost USD	% of Total
1	***Behavior Change***		
2	Staff	36,483	13.9%
3	Training	9,462	3.6%
4	Running Cost	11,069	4.2%
5	DiC Cost	11,655	4.4%
6	Incentives	7,920	3.0%
7	Commodities & Services		0.0%
8	Consumables	24	0.0%
9	***Enabling Environment***	3,543	1.3%
10	***Investments***	1,260	0.5%
11	***MER***	12,539	4.8%
12	Total, without condoms	93,955	35.7%
13	Condoms	169,360	64.3%
14	Total, With condoms	263,315	100.0%
15	MSMs reached	1,856	
16	Unit Cost, without condoms	**51**	
17	Unit cost, with condoms	**142**	