

Q&A

Webinar Costing Child Wasting Treatment: The Use of Cost Data for Decision Making in Child Wasting Treatment

June 16, 2022

Question 1: Is the consistent use of the definitions across cost analyses for the outputs/outcomes, e.g., child treated vrs child recovered. My experience has been these terms are often not clearly defined and sometimes used interchangeably which is problematic.

Answer 1: I agree and this was a theme that emerged in the Save/AAH study that Bernie mentioned too. This is a part of the minimum standards that should be set for costing of child wasting.

And another benefit of aggressive transparency, showing the full underlying spreadsheets and not only the final number.

Question 2: Caitlin, wondering how your per child cost and cost range for SAM treatment compares to other child health programmes? Thanks

Answer 2: My sense is that cost per child treated for SAM is about in the middle of the range of other child health programmes. We have some immunization programs which cost less per child (in the \$30 to \$50 range), we have some more comprehensive programs that cost more in the range of \$200 per child. But in general, we don't use cost-efficiency (i.e. cost per child alone) to make comparisons across health intervention areas, because the effects on child health and survival will be so different.

Question 3: Does IRC have a database of estimated cost/ child treated or recovered by country? If yes, is this publicly available?

Answer 3: We do have an internal database, and we are working on writing up a paper covering that data set which I just showed, so all of the data but also the comparative analysis would be publicly available when that goes out. We would also hope to publish the full underlying cost model for each program, as part of this push for transparency. In the meantime, we have a public report we released some years ago which goes through this comparative analysis for a smaller number of programs: <https://www.rescue.org/report/cost-efficiency-malnutrition-treatment>

Question 4: It would be interesting to see the list of budget line items that were used to look at cost in the IRC study--will this be available? We conducted a comprehensive costing in Mozambique for IMAM and we tried to include: commodities, supplies, anthropometric equipment, in and outpatient supplies, human resources costs, also we averaged treatment length based on national treatment protocols. Did

you take into consideration-staffing (human resources), anthropometric equipment? other supplies? Also how did you approach average treatment length or you just used real data (assuming it was very detailed compared to regular monitoring)

Answer 4a: Yes, I completely agree! We are moving towards putting the full cost model out for all programs which we publish about, to allow for that transparency about what exactly we mean by "costs." In general, the IRC methods include all of the items you mention, with the exception of RUTF which is most-often donated. However, we are exploring if we can add that back into these analyses, using data on average RUTF usage and cost, for the number of children treated. We did not impose any assumption about average treatment length, we used the actual monitoring data on number of children who completed their treatment within the program window.

Answer 4b: I also agree. Transparency in what costs categories are (not) included is critical in being able to interpret cost results. I hope that we, as a community of practice, can move towards annexing the list of cost categories included as a standard practice in reporting

Question 5: Thanks, these are all cost-efficiency analysis yes? Do you have any cost-effectiveness analysis in terms of deaths averted or other health outcomes?

Answer 5: All of the data which I showed are cost-efficiency analyses. Using tools like LiST or others you can estimate the lives/DALYs saved from a given program in a given country, but in general we at IRC don't directly observe mortality changes in impact evaluations because (1) we generally do non-inferiority trials comparing a new protocol to an existing protocol not a "pure control" group, and (2) you need massive sample sizes to detect mortality impacts. However, other panelists are much more expert than me on cost-effectiveness analyses of CMAM programs and could say more if you have particular questions.

Question 6: Please share information about the working group

Answer 6: Thanks for your interest. We will share more information about the working group, future webinars, and other resources we are working on at the end of today's webinar.

Question 7: For the Indonesia study, is the report available in the public domain? We have just concluded a systematic review on this topic and we do not seem to have had come across this particular report.

Answer 7: The report has not been published yet. It's still in the process of finalizing. But we do have plan to publish it in the near future

Question 8: @Lani- do you have an indication of when the full report might be available?

Answer 8: My estimate is that it might be published within the next few months, hopefully sooner

Question 9: Q1: to calculate the cost-effectiveness, what methods has been used, is it decision tree or Markov? and what variables are required to generate the model?

Answer 9: live answered

Question 10: Q2: For BHA funding UN org for nutrition programming, what kinds of data/assessment BHA is interested to see from country offices to see how funds are utilized to reduce the burden of wasting? and is there a cost-effectiveness threshold for cost per child?

Answer 10: live answered

Question 11: How is costing efficient and effective where programmes are often disrupted due to security or supply chain breakdown?

Answer 11: live answered

Question 12: @Lani, on comparing the two models of care- were you comparing cost per children treated or cost per child recovered or other outcome measure?

Answer 12: As a first step, we compared cost per child treated only and no outcome measures since the main purpose was to support the scale up of IMAM with information on the total financial envelope required for the scale up. Future work could include cost per child recovered.

Question 13: Q3: When calculating the cost of implementation, is there a designed tool that can make the CE exercise easier?

Answer 13: live answered

Question 14: CHAI is doing work on cost per child recovered would be good to get in touch with them I know they are doing it in Mozambique and some other east African countries

Answer 14: Thank you for the information

Question 15: Thanks to the panel for the really useful discussion. From when the different speakers were speaking, I thought that the cost question is a compounded one as there are so many different things to consider, e.g., where to treat (model of care: outpatient/ community/ inpatient etc), how to treat (the interventions themselves) as well as the differences that might exist depending on the age group of children. I just wondered how programmes can bring all this information together for informed decisions?

Answer 15: Indeed, it is a complex and compounded issue and program decisions require consideration of many facets. One hope is that with more replicable, transparent, detailed and robust cost analyses we will be better able to understand how such programmatic decisions (like the ones you mention) and the context (including epidemiology) influence cost. This can then be reflected back to inform decisions based on cost and results.

Question 16: Do we always include 100% of health worker cost (salary) or we adjust it to the time committed to the specific activity (wasting treatment for instance if it takes one day per week)

Answer 16: That is a decision to be made by the costing analyst and it depends on the objectives of the costing analysis. I can provide more details if of interest

Question 17: Will the link to the recording be sent to all that have registered for this event?

Answer 17: Yes, it will. Recording will be sent to all and available on GNC Technical Alliance and CMAM costing sub group websites