Global Strategy and resource estimates for effective policy

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Health, Education, Equality, Protection
ADVANCE HUMANITY

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Outline

- Introduction
- Global Strategy – scaling-up of evidence-based nutrition interventions building on existing and more intergrated Health, WES and Social programming
- Approaches to estimating costs of reaching MDG1 ‘hunger and undernutrition target’
- Cost estimates
- Implications
- Conclusions

Introduction

- More than 815 million people are classified as hungry by FAO figures – 300 million are children
- Estimated by WFP to have increased by 100 million people due to food prices crisis
- Almost 150 million children underweight or 27% (UNICEF) ; MDG 1 target C is 16.5%
- Only ~8% of the 300 million children are victims of famine or emergency situations
- Every 3.6 seconds a person dies of undernutrition-related causes and most are children under 5 years

Introduction

- Different approaches
- Using total estimated costs or incremental
- Do not usually include necessary costs of health system strengthening or human resource capacity building
- Presentation does not address cost-effectiveness or cost-benefit (both of which are considered adequately justified from the literature - not to mention moral and equity issues)
- Costs of implementation of evidence-based interventions - different ‘packages of interventions’ costed
- Will demonstrate very wide ranges but not very different conclusions

Introduction

- Estimates of poverty recently increased to more than one quarter of the developing world's population
- 430 million more than previously thought
- Estimated to be 1.4 billion people globally living below $1.25/day
- Had previously much under-estimated the cost of living in the poorest nations
- And this does not take into account soaring prices of energy and food in past 2 years
- New WHO Report on Social Determinants of Health demonstrates the profound impact of inequities in living conditions on death and disability

Introduction

- Would the private sector start on an enterprise of this magnitude not having an estimate of the costs, and just start estimating them seriously more than half way through a 15- year proposed timeframe?

Approaches

- UNDP – estimation of total resources needed in a country to meet health-related MDGs (4,5,6&8)
- World Bank – different sections with emphasis on ‘poverty targets’
- Marginal Budgetting for Bottlenecks (UNICEF/WB)
- WHO (Child Health Cost Estimation Tool- MDG4)
- Millennium Development Project (Sachs et al.)
- Bellagio Study Group on Child Survival Study (MDG4)
- ECHUI (University of Washington/WFP/UNICEF)
- REACH: ending child hunger & undernutrition (BCG/WFP/UNICEF with FAO and WHO)

Approaches

- Others e.g.
  - Mason, Musgrove, Habicht 2003: more about cost-benefit
  - Copenhagen Consensus (Hoddindot & Behrman 2002): more about cost-effectiveness
  - CORE plus with MSH (USAID-funding)
  - PROFILES – useful tool that looks mainly at cost-effectiveness and cost-benefit advocacy
- Most estimates for Sub-Saharan Africa

U.N. and partners

- UNDP: Integrated Health Model ‘coherent scale-up of integrated health services’
- NORAD, UNFPA, UNICEF, UNAIDS, UNDP, WHO, WB, USAID (through the Health Systems 20/20 and BASICS Projects) and PMNCH conducting a review of 13 costing tools relevant to the Health MDGs
- MDG1 target C not obviously being addressed

World Bank

- In mainstreaming nutrition approach, for micro-nutrient programmes alone for Africa $235 million
- Other estimates even larger e.g. $750 million just for 2 doses vitamin A
- $1 billion for USI (global) including $800 million or more leveraged form private sector
- $3 billion for community nutrition programmes
- More rigorous estimates promised – preliminary meeting on concept paper next week

Study Group on Child Survival

Bryce et al. The lancet 2005

- US$5.1 billion in new resources needed annually to save 6 million child lives in 42 countries responsible for 90% of child deaths in 2000
- Represents $1.23 per head
- Average cost per child life saved of $887
- Range $3.1 million to $8 billion
- Concluded that addressing child survival is affordable for donors and developing countries
- Also noted cost estimates for single diseases have meant increased international support

Millennium Development Project

- Suggests increase substantially the funding through the International Development Association (the concessional lending arm of WB)
- Current flows in order of $8 million and need to be tripled to be consistent with the scale of need identified by Sachs et al. i.e. (presumably) $24billion/y
- Form should be in grants not loans
- In 2002, 27% of the net transfer of bilateral ODA to sub-Saharan Africa took the form of budget support
- Continuing to work on costing but not on single MDGs and rightly interpret interventions for MDG1 Target C very widely and with agricultural emphasis

Approach for developing the cost estimates

Define each intervention	Research typical costs	Analyze available cost data	Determine cost per child <5
Define the parameters of each intervention • E.g. technologies, delivery channels, approaches	**Review existing key reference analyses** • E.g. DCP2, Copenhagen Consensus, etc	**Determine whether source programs align to REACH interventions**	**Calculate cost / beneficiary** • E.g. often P&L mothers are the direct beneficiary
Identify whether some interventions typically will integrate into others • E.g. deworming into vitamin A or other mass campaigns	**Gather additional data on program delivery and material costs** • From literature • Via expert interviews	**Identify potential outliers** • E.g. where program costs were excessive due to economic conditions, or where source programs didn't match REACH interventions	**Translate cost / beneficiary into cost / <5 child** • To generate an overall package cost / <5 child

Reflects a top-down approach

REACH: ending child hunger & undernutrition – global goals

	Action area	Sentinel indicator	1990	2006	2011	2015
1	**Improve breastfeeding and complementary feeding**	% of <6 month olds that are exclusively breastfed	33	37	45	60
2	**Increase micronutrient intake**	% of 6 to 59 month olds fully covered with 2 doses of VAS in the last year	16	72	80	80
3	**Improve diarrhea and parasite control**	% of preschool children at risk treated with deworming tablets in the last year	TBD	21.3	50	75
4	**Increase treatment of severe acute malnutrition**	# of countries with severe wasting rates > 10%	TBD	25	18	12
5	**Improve household food security**	Proportion of population below minimum level of dietary energy consumption	20% (823M)	17% (820M)	15% (800M)	10% (582M)

Two lenses for allocating intervention costs to children <5

	1 Reflecting direct costs for children <5	2 Reflecting full program costs (i.e. "fully loaded" costs)
Definition	• Captures only the costs attributable to children <5 – Does not capture costs of serving other beneficiaries	• Attributes full program costs to children <5 – Allocates costs of serving all beneficiaries to the <5s
Rationale	• Reflects the actual costs attributable to serving children <5	• Reflects the full cost of implementing programs to serve <5s – The direct cost figures underestimate the true cost of implementing the intervention
When to use	• When calculating the allocated cost of serving an <5 child	• When calculating high-level program budget estimates for interventions that typically serve entire households or populations – Micronutrient fortification – Household water treatment – Local homestead food production – Conditional cash transfers

Estimated cost per child <5: REACH estimate

		Cost per beneficiary (USD)	Cost/child <5 (USD) Reflecting direct costs	Cost/child <5 (USD) Reflecting full program costs	Allocation basis
Improve BF and CF	**BF / CF**	$2.50 per P&L woman	1.25	1.25	• N/A
Increase micro-nutrient intake	**Micronutrient supp.**	$9.26 per child <5	9.26	9.26	• N/A
	Micronutrient fort.	$0.36 per capita	0.36	**3.55**	• Assumes 10% of population are children <5
Improve diarrhea and parasite control	**HH water treatment**	$4.00 per household	0.80	**2.00**	• Assumes households include 5 ppl, including two <5s
	Handwashing	$1 per woman	0.50	0.50	• N/A
	Malaria: bednets	$4.97 per child <5	4.97	4.97	• N/A
	Malaria: IPT	$1.36 per P&L woman	0.68	0.68	• N/A
	Deworming	$0.38 per child <5	0.38	0.38	• N/A
Increase treatment of SAM[1]	**Therapeutic feeding**	$283 per SAM child	9.91	9.91	• N/A[2]
Increase household food security	**Supp. feeding**	$50 per MAM[3] child	3.25	3.25	• N/A
	Homestead food prod.	$22 per household	4.40	**11.00**	• Assumes households include 5 ppl, including two <5s
	Cond. cash transfer (CCT)[5]	*$56-339 per household*	*11 - 68*	***28–170***	• Assumes households include 5 ppl, including two <5s
	Total cost w/o CCT		**$36**	**$47**	
	Total cost including CCT		$47 - 104	$75–217	

Previous ECHUI package estimate $79 per HH

- Based on 100 million households – so total estimation 79 billion
- Translates into $22 per <5 child c.f. $1.23 of Child Survival Study Group
- Subsequent calculation by BCG group had more recent figures and estimates and some slightly different assumptions.
- Laos and Mauritania pilots will use the cost model as part of the country action planning process

Implications

- Policies should be aligned with 2015 time horizon (PRSPs 3 years usually)
- Even if MDG1 Target 1.C reached still will only be half of those suffering hunger and undernutrition
- Absorptive capacity should be seen as targets of opportunity for public investment especially in human resources and managerial capacity
- Need to be guided by bottom-up rather than ‘ex ante budget constraints set by donor countries’- ie. undertake real needs assessment and then seek resources

Implications

- PRSPs and medium term expenditures are usually for three years and usually do not include nutrition interventions and are not aligned to MDGs
- PRSP targets tend to be ‘too optimistic and the cost of them tends to be underestimated’ (Christiansen, Scott, Waden; WB, 2002).
- Uncoordinated and supply-driven development assistance from the 23 bilateral donors (DAC) places unnecessary transaction cost burdens on recipient country Governments.

Implications

- Form should be in grants not loans and debt cancellation deepened
- In 2002, 27% of the net transfer of bilateral ODA to sub-Saharan Africa took the form of budget support.
- Especially for Health and Nutrition and Education, need new notions of sustainability; support will be needed at least for a decade or more
- Countries will require 20-30%GDP in annual development assistance
- ODA flows need to be more predictable (IMF 2004))
- More partnerships with INGOs and Civil Society

Conclusions

- Many models and approaches
- Most directed at Health MDGs which often does not include MDG1 target C
- Other single diseases have managed to do this – HIV/AIDS, TB, Malaria and powerful resource-raising tool
- Depends on what is being costed: packages of interventions, total costs, incremental costs, capacity etc.

Conclusions

- One estimate is a total financing gap for all MDGs $135 billion ($80-$124 per capita)
- For nutrition some convergence around $5-$10 per capita ($15 for ‘effective programmes’)
- SCN had estimated ‘direct cost of doing nothing about child hunger and undernutrition adds up to US$20 to $30 billion’
- Until WB figure comes out go with *REACH: ending child hunger & undernutrition* figure of an annual resource gap of $1323 to $1762 million for preventive actions and $173 to $338 million for curative (Sub-Saharan Africa)
- Round figure of US$4040 million per year