Estimating costs to scale-up a postpartum family planning intervention in Rwanda

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16 November 2018

Motivation for analysis

- Inform discussions on the scale-up of PPFP in Rwanda
- Understand the key cost drivers for scaling up an integrated PPFP training and mentorship intervention
  - Based on MCSP support to Government of Rwanda (GOR) to implement the PPFP training and mentorship model
- Estimate the costs for the GOR to sustainably maintain intervention coverage

Methodology

- Used **activity-based costing approach** that identified the core activities of the PPFP approach as implemented by MCSP

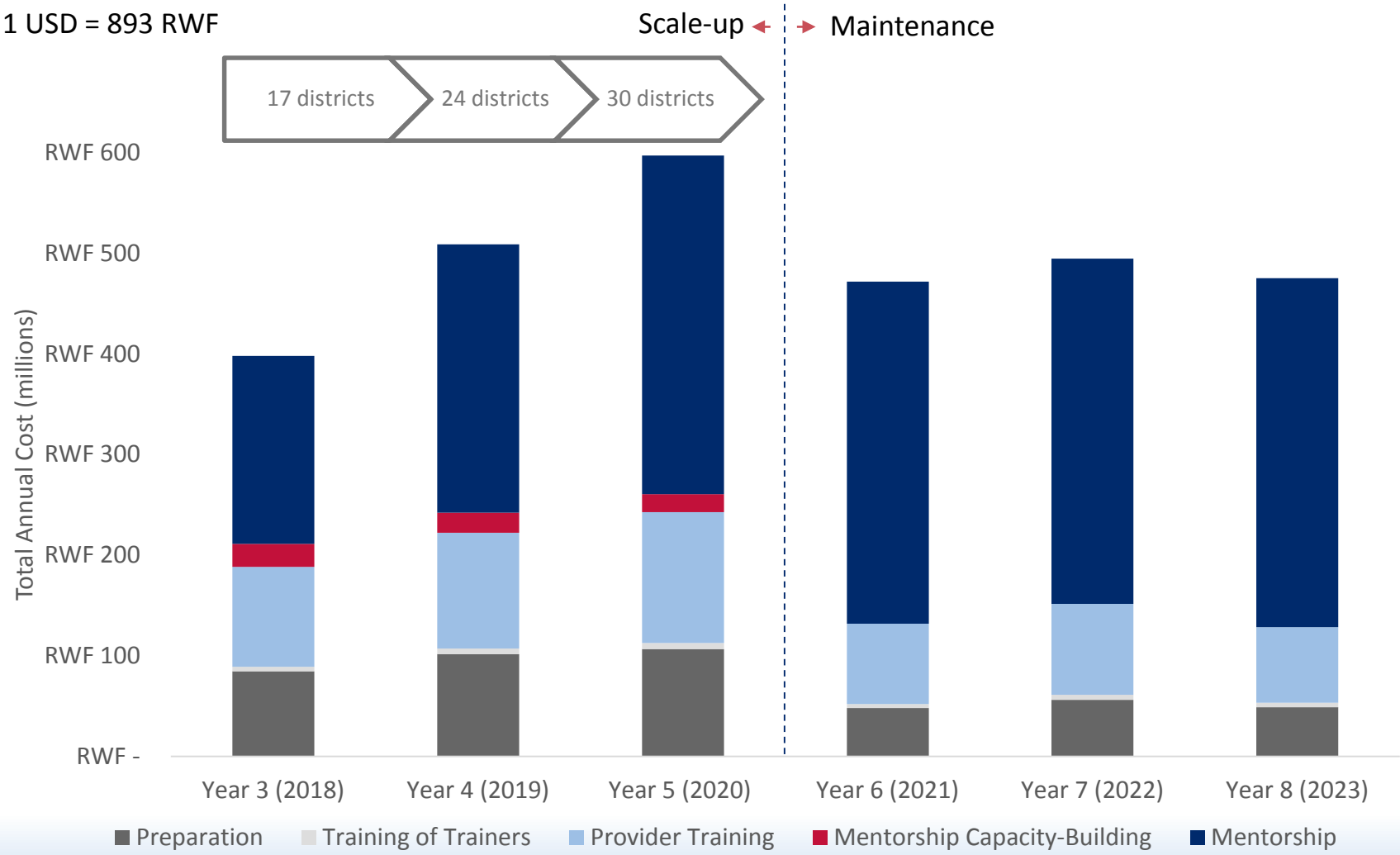
- **Retroactively collected data on costs and quantities of inputs** based on MCSP approach in four initial districts

- Using MCSP input quantities and standard GOR/MOH unit costs, ***modeled*** **financial costs for the GOR/MOH to scale-up approach in other districts while maintaining approach in original ten MCSP-supported districts**

Costed Activities from Intervention

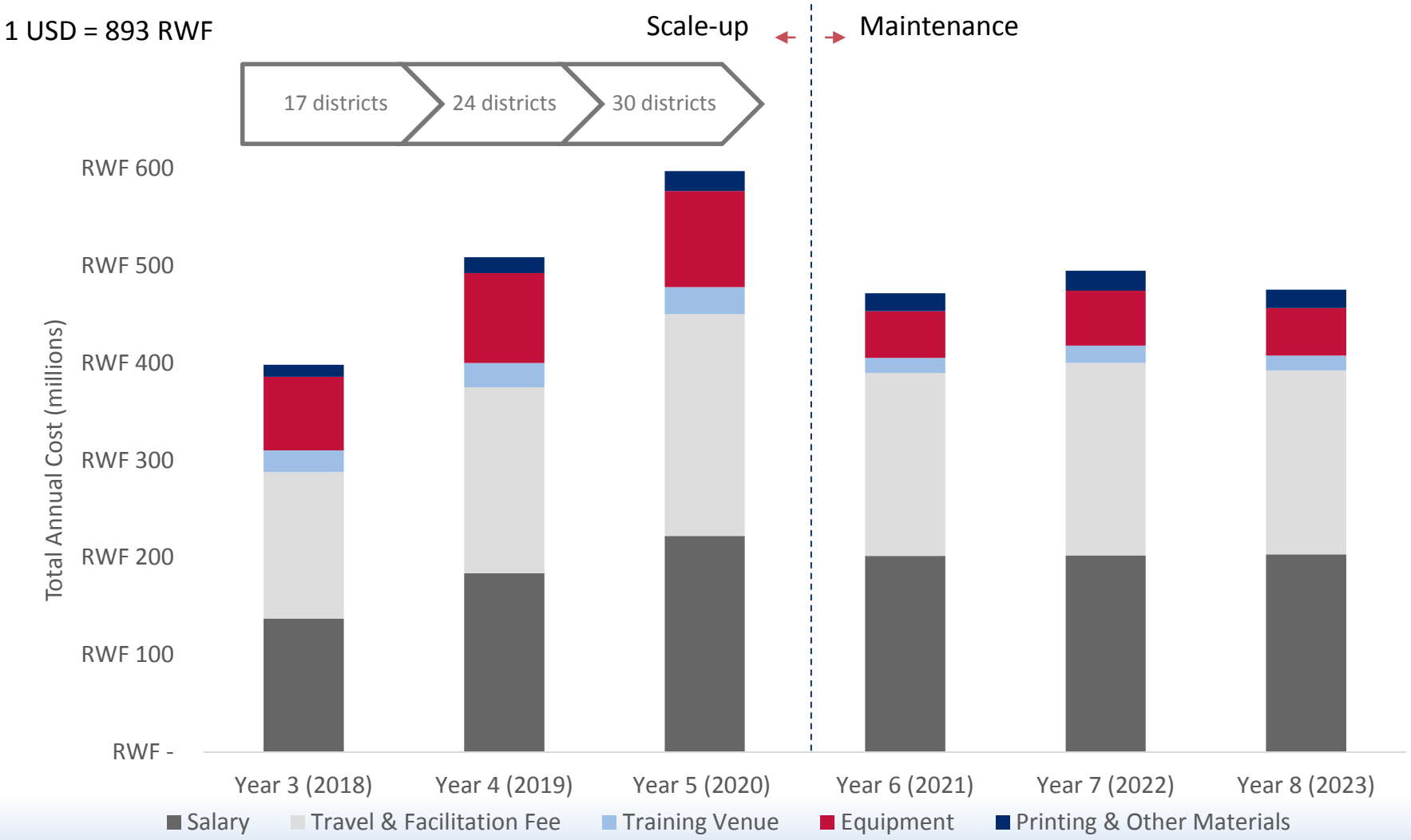
Preparatory	• Provider skill assessment and trainer identification • District orientations • Training model procurement
Training of Trainers	• National TOT (with follow-up) • Refresher TOT
Provider Training	• FP counseling skills (follow-up and refreshers every 2y) • PPFP clinical skills (follow-up and refreshers every 2y)
Mentor Capacity Building	• Capacity building of selected mentors to serve as district-based mentors
Mentorship	• Bi-monthly visits during first 1-2 quarters of implementation • Average 8 mentor visits per year after first year • Regular mentor oversight visits

Mentorship is the largest cost driver for implementation (excluding PPFP commodities)



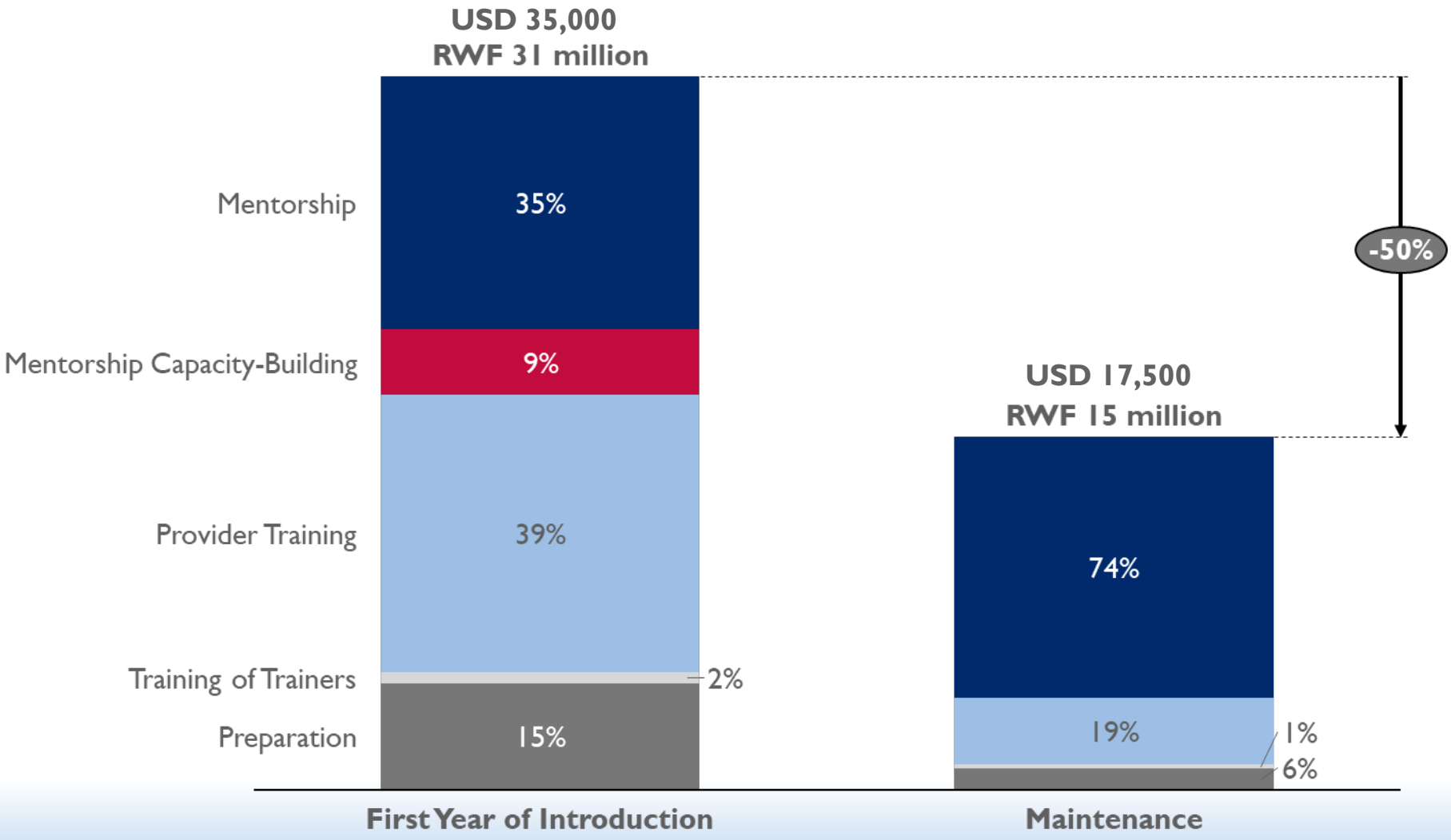
Note: "Start-up" refers to costs associated with district receiving implementation package for the first-time that year; "Maintenance" refers to districts that have received package in previous year(s).

Travel costs & facilitation fees comprise the majority of costs, underscoring the resources needed to conduct mentorship*



*Excludes PPFP commodities

Annual maintenance costs *per district* are approximately 50% less than costs during first-year of introduction



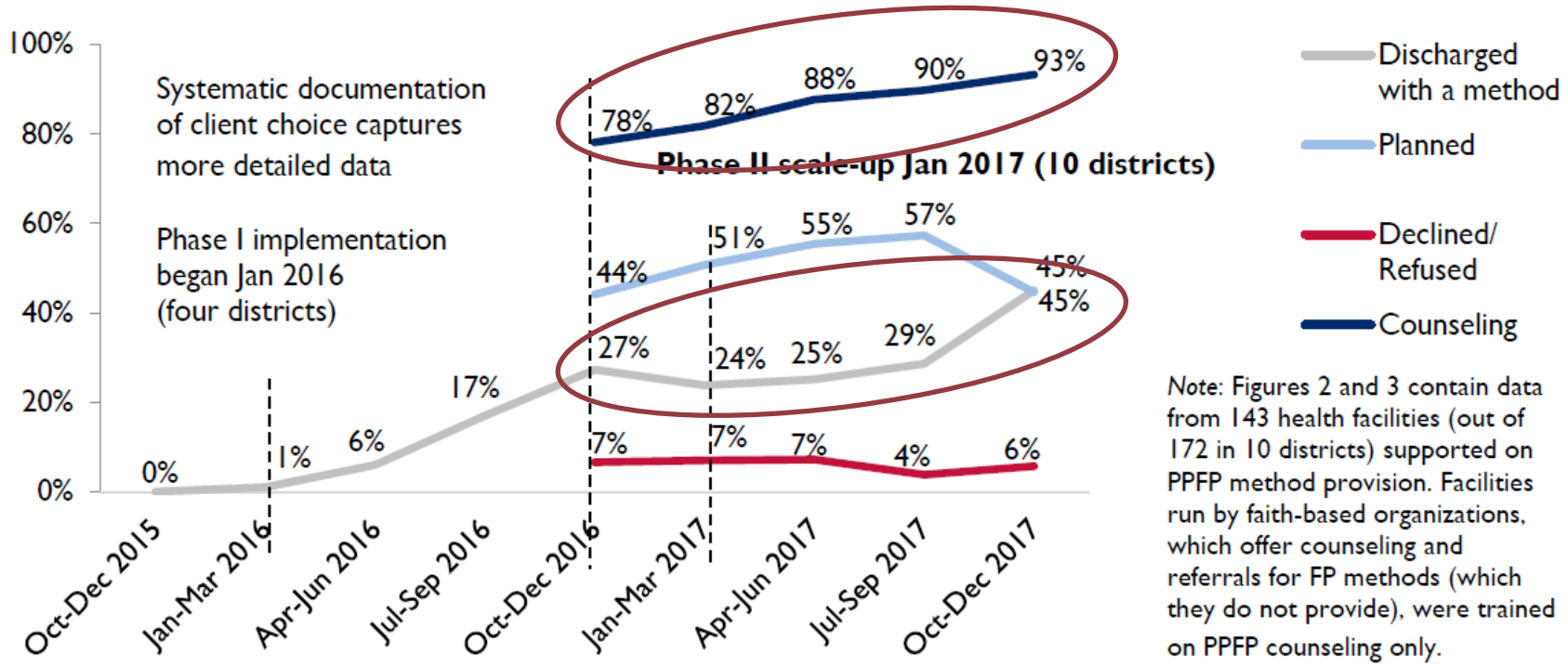
Note Preparation category includes training equipment replacement in maintenance years

Estimated costs of package suggest it is a relatively low-cost intervention

- **Average annual district cost:**
  - RWF 31 million / USD 35,000 in first year of introduction
  - RWF 15 million / USD 17,500 in subsequent years to maintain
- **Annual cost per capita**
  - First year of introduction: RWF 87 / USD 0.10
  - Annual per year maintenance: RWF 37 / USD 0.05
- **Annual cost per woman of reproductive age***
  - First year of introduction: RWF 326 / USD 0.40
  - Annual per year maintenance: RWF 140 / USD 0.20
- RWF 450-500 million / USD 500,000 total cost per year to maintain represents less than 0.5% of domestic government expenditures on health** (excluding PPFP commodities)

*Based on approx. 3 million women aged 15-49 (2017 UN Population Prospect); 11.92 million pop
**Global Health Expenditure Database

PPFP training and mentorship intervention demonstrated increases in counseling and PPFP method uptake



Note: Figures 2 and 3 contain data from 143 health facilities (out of 172 in 10 districts) supported on PPFP method provision. Facilities run by faith-based organizations, which offer counseling and referrals for FP methods (which they do not provide), were trained on PPFP counseling only.

The PPFP training and mentorship intervention is relatively *low-cost* and has shown to *increase counseling and uptake of PPFP methods*.

Source: MCSP 2018

Using costing data for advocacy

- Ensure *perspective* of costing speaks to what costs a *government* would need to assume to scale and maintain an intervention

- Communicate costs in *easily understood units* (e.g., per capita or per district/administrative unit)

- Relate costs to current *levels of domestic spending (*when available)

- Demonstrate relative *affordability against outputs/outcomes* of an intervention (when available)

Questions?

Thank you!

For more information, please visit

www.mcsprogram.org

This presentation was made possible by the generous support of the American people through the United States Agency for International Development (USAID), under the terms of the Cooperative Agreement AID-OAA-A-14-00028. The contents are the responsibility of the authors and do not necessarily reflect the views of USAID or the United States Government.

Additional slides

Costed Activity Detail

Strategy	Activity	Description
Preparation	Provider skill assessment	Situational analysis in 10 districts for 4 technical areas; assume 12.5% for PPFP
	District field visits for trainer identification	Field visits in PPFP sites to identify potential trainers
	District stakeholder orientation meetings	Orientation meeting for HF managers in each district; costs reported are for one district
	Health center orientation on new knowledge and skills	Visit health facilities to facilitate introductions of new activities on-site
	Training model procurement	Procurement of Mama-U postpartum uterus training models and PPIUD kits (2) per facility; replaced every two years
National ToT	National ToT on PPFP clinical skills	Train national trainers on PPFP clinical skills; 9 trainees Y1
	National ToT follow-up on PPFP clinical skills	MCSP staff member will follow-up with national trainers at their respective HF; completed follow-up of 9 trainees in 4 days
	Refresher TOT	Occurs every two-years assuming turnover and replacement of trainers
Provider Training	Counseling training	Counseling training of clinical staff from all health facilities; 2 people/HF (approx. 30 trainees)
	Counseling post-training follow-up	Post training follow-up of trainees using a checklist
	Clinical skills provider training	Training off-site at hospitals using anatomic models at the district level; approx. 18 people per district for four-days
	Clinical skills post-training follow-up	Post-training follow-up at health facility
	Refresher training - Counseling	Refresher training for counseling; only included in model
	Refresher training - Clinical skills	Refresher training for clinical skills; only included in model
Mentor Capacity Building	District trainer capacity building for mentorship	Capacity building of selected staff at health facility level to serve as district mentors
Mentorship	Clinical mentorship	Mentor visits to facility staff; select number of visits first year and then subsequent years; user selected
	Monitoring of PPFP mentorship	Central level staff monitor the implementation of mentorship at districts; user selected

Assumptions

- Activities remain consistent across scale-up and maintenance period
- Salary costs include:
  - Technical management roles
  - Coordinator roles
  - Trainers
  - Mentor oversight
- Other costs include: transport, facilitation fee, equipment, training costs, printing
- Used MOH salary rates and transport/per diem rates for projecting costs
- Mentoring visits covers more FP methods than just PPFP
- Annual cost increase of one percent*
- Costs ***not*** included:
  - Commodities other than training devices
  - Facility/infrastructure costs
  - Indirect costs other than management of technical activities

* Based on annual changes in Rwanda consumer price index (RNSI)

Modeling Assumptions

- Standard MOH salary bands and transport/per diem rates
  - Key findings exclude salary costs of mentors in relevant activities
- Annual cost inflation of 1%*
- Mentoring visits covers more FP methods than just PPFP
- Excludes indirect costs other than management/oversight of technical activities
- Excludes PPFP commodities

Activity assumptions in cost model scenario	
ToT trainees per year:	8
Training kits per facility:**	1
Counseling trainees per district:	30
Clinical skills trainees per district:	18
Trainee annual turnover:***	15%
Refresher TOT and training frequency (counseling and clinical skills):***	2 days every 2 years
Mentors per district:	1 mentor:3 facilities (4-8)
Avg. mentor visits per facility per year (first year; bimonthly 4 months):	8
Avg. mentor visits per facility per year (maintenance years):	8
Mentor oversight visits per district per year:	4

*Based on 2016 v 2017 CPI comparison from NISR

**Includes one training mannequin and two PPIUD kits; replacement every two years

***Based on Lopes, et al. (2016) on cross-country rates of health workforce attrition; 15% average for low-income countries. Assumes new trainees in each district every year; refresher training cohorts align with the new trainees per year and accounts for turnover

When including mentor salary costs, total annual costs increase by approximately 33%