

Table 1. Key differences between the robust and basic costing tools.

	Robust	Basic
Description	Users choose from the DMPA-SC strategy most appropriate for their setting, and the tool automatically populates activities for that strategy. Inputting basic cost information is required, but the process is more automated, with drop-down menu options. Enables scenario planning.	Users input basic costing information for each activity, and category costs are automatically generated. More manual entry for the user, but fewer inputs are required.
User design	Some technical assistance may be required if user is at a beginner level with Microsoft Excel.	Limited or no technical assistance is required.
Time horizon	Up to 5 years.	1 year only.
Outputs	Tabular and visual charts are available.	Tabular outputs only.
Not included/out of scope	These tools do not support a full health system (all health areas) cost or comprehensive family planning program costing. <i>Nor</i> are they intended to be used for microcosting purposes. Ideally, the tools will capture incremental costs associated with DMPA-SC specifically. The tools do not account for full health system costs such as health care provider time (i.e., salaries), costs to the client/individual (e.g., lost wages or travel costs), salaries of ministry of health personnel supporting the family planning program, or general supply chain program costs.	

Some of the data requirements for development and maintenance of the costing are price per dose of the product and any shipping costs to the country; a DMPA-SC supply plan; DMPA-SC and self-injection strategies and/or operational/implementation plans, including detailed health worker training plans; types and scope of demand generation or monitoring and evaluation activities; and policy/advocacy goals. For training in particular, which is a significant cost driver, detailed assumptions are required, such as number of providers to be trained (by cadre, year, and sector), training approach (e.g., in-person or virtual, on-the-job or centralized), and number of training days. Many unit costs (e.g., renting a vehicle or a hotel conference package in a major city) are available from costing exercises from other health areas.

Guiding principles and recommendations

Principle 1. Accuracy of costing inputs influences the utility of associated outputs

Identify additional implementation details that have not been included in the country's scale-up plan. Developing an operational or implementation plan by building on the country introduction and scale-up plan with detailed activities, timelines, quantities, and frequencies is a necessary step for costing. By gathering these inputs, costing highlights information gaps and encourages discussions around programmatic activities and status. Discussions with key ministry of health (MOH) staff can help determine how, when, where, and by whom activities in the plan will be implemented.

Indicate which costs are specific to DMPA-SC, rather than reflective of broader family planning or health systems costs, to avoid inflating the true costs associated with DMPA-SC. Although the AC primarily focused on costing DMPA-SC, it was not always feasible to omit other costs, since DMPA-SC activities were often integrated with broader family planning endeavors. For instance, the MOH in one AC country set a ten-day master training program that included other family planning methods in addition to DMPA-SC. This activity was included in the DMPA-SC introduction and scale-up costed plan; thus, the training session costs appeared high in comparison to other countries' master DMPA-SC trainings, which were also much shorter in duration. Similarly, demand generation in nearly all AC countries promoted the full contraceptive method mix, which aligns with the AC's goals of increasing options and access, but the demand generation costs were not DMPA-SC specific. Where possible, the proportion of the total cost of these broader activities that are specific to DMPA-SC should be estimated and broken out.

Anticipate extensive MOH and implementing partner coordination, due to the fact that donors provide substantial funding support for the MOH's introduction and scale-up of a new product in many countries. The AC costed the MOH's DMPA-SC introduction and scale-up plan. Meanwhile, across all seven AC countries (and in many other low- and middle-income countries), implementing partners (i.e., international or local non-government organizations, social marketing organizations, local community based organizations, etc.) used donor funds or other resources to implement activities to support the national strategy. However, partners' costs likely deviate from the MOH's costed plan because partner budgets often include components such as overhead expenses or personnel salaries, which are not part of the MOH's plan or costing. As such, the Access Collaborative did not account for partner costs like overhead or staff time since those expenses are not directly related to the MOH's introduction and scale-up plan.

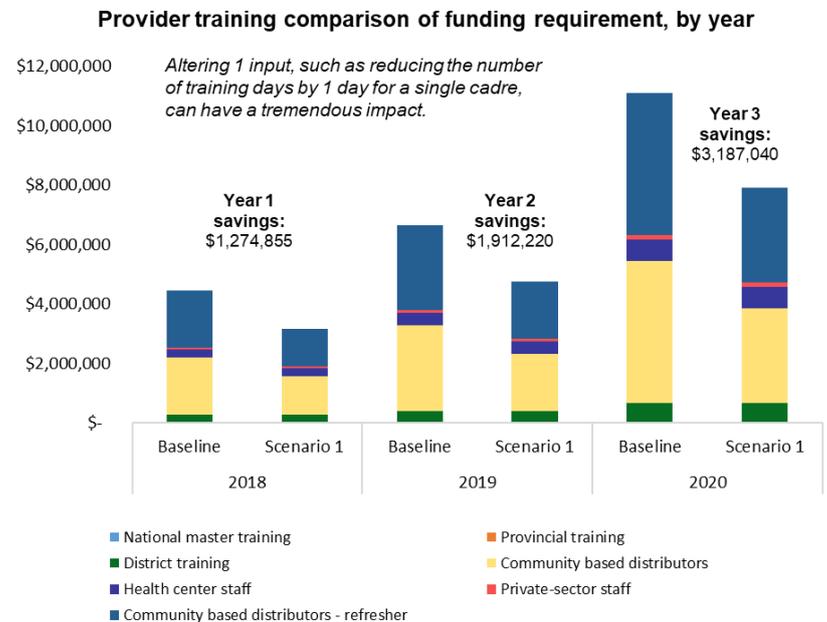
When lacking clear financial commitment data from partners or donors, consider using alternative methods to translate their support into dollar values. When the AC designed the costing tool, it assumed that it would collect financial commitment information from partners and map those against activities to understand the funding gap for the overall plan. However, partners and donors may not be willing or able to share financial information related to implementing some activities. As noted above, partner budgets account for other costs such as overhead, which would not be relevant. The AC quickly developed a creative solution to calculate partner commitments by estimating the *percentage* of the activity that was funded or committed by a certain partner. The team then applied that percentage against the total cost of that activity to come up with a dollar figure of what portion of that activity was “covered.” For example, a given country includes advocacy activities in its introduction plan. After costing the plan, it is estimated that these advocacy activities will cost roughly US\$20,000 in a year (e.g., four events at US\$5,000 each).

Afterward, the AC solicits feedback to determine if any partners will be supporting activities. In this hypothetical example, the AC learns of two partners that are planning to support one event each. Based on this information, the AC would estimate that this activity is 50% funded (US\$10,000) with a 50% funding gap remaining (US\$10,000).

Cost multiple scenarios of the introduction and scale-up plan when possible. If that is not possible, cost multiple scenarios of some sections of the plan. When the AC costed country introduction and scale-up plans in the first year of the project, inputs and assumptions provided by the MOH were used to establish a baseline. This often resulted in a very high plan cost. In subsequent years, the team worked with the MOH to vary some inputs and assumptions and compared these results with the “baseline.” For instance, as shown in Figure 2, the AC presented an alternate scenario of reducing the number of training days by one day for a single cadre, which could result in significant cost savings. Although scenario-based costing is more time-consuming, highlighting the trade-offs early in the introduction process can spark rich discussion that leads to more strategic and higher value-for-money options.

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Figure 2. Scenario-based costing for training.



Principle 2. Costing and funding gap analyses are a mechanism to inform programmatic decisions

Consider costing and corresponding partner commitment information as “living” inputs to be regularly monitored and revisited to track progress over time. To inform resource mobilization discussions or support advocacy opportunities, the AC updated components of the costing or partner commitments on a quarterly basis or in advance of a major stakeholder meeting. For instance, when a country had an updated DMPA-SC quantification, revised its training plan with a more streamlined approach, or eliminated an activity that was no longer needed, the AC refreshed the costing to reflect the change and ensure decisions were made with the most recent data. For example, in one AC country, the introduction plan and costing assumed that self-injection and provider-administered training were happening simultaneously. However, over time, the team realized that these trainings were not happening jointly and updated the costing and implementation plan to reflect this shift.

Assign priorities to the activities in the introduction and scale-up plan. The AC incorporated high, medium, or low priority scores halfway through the project—this was a lesson learned that could have further benefited the project had this approach been used from the beginning. This prioritized costing approach can be used to mobilize resources for high-priority activities first to avoid a large gap in funding for the full plan. This also helps the country, partners, and donors to concentrate on high-impact activities. For instance, most countries considered national- and regional-level training of trainers activities to be a high priority compared to training community-based providers. Conducting training of trainers activities was often a precursor to step-down or cascade training and thus a critical input to expanding overall training. Prioritizing activities helped decision-makers focus limited financial resources on the highest-impact activities.

With adequate feedback from partners and donors, use financial gap analyses to help mobilize resources for a particular country or activities. Over time, the AC integrated the costing output and corresponding gap analysis into the quarterly review meetings held in-country and attended by both MOH staff and partners. When this output was emphasized for partners, some countries focused financial resources on certain activities (e.g., prioritized master and provincial trainings before community-based distributor trainings) or streamlined their approaches (e.g., reduced the number of training days for providers that were already trained to administer intramuscular injectables).

In planning for introduction and scale-up of innovation, identify creative approaches to reduce training costs in particular—or be prepared for rollout to move slowly. In most cases, training was the major cost driver and accounted for more than 50% of the total cost of the plan. Countries took varying approaches to training, and there were often opportunities to reduce costs without sacrificing quality. As noted above, prioritizing specific aspects of detailed training plans can help ensure ongoing progress while resources are mobilized.

Summary

For countries introducing and scaling up DMPA-SC, conducting a costing exercise can yield valuable insights and aid in programmatic decision-making at both the country and global level. As introduction evolves, costing should, ideally, adapt to reflect the realities in implementation. As outlined above, this process is complex and iterative and has the potential to elevate key issues and increase accountability.

Key resources

The robust and basic costing Microsoft Excel tools mentioned above are available upon request. To request a copy, please email FPOptions@path.org. Conditions for use apply.

Other related resources include:

- General family planning costing tool (costed implementation plan): www.familyplanning2020.org/cip
- Public health impact of adding DMPA-SC to the method mix: www.healthpolicyplus.com/dmpa-sc.cfm
- World Health Organization OneHealth tool: www.who.int/choice/onehealthtool/en/

About the DMPA-SC Access Collaborative

The PATH-JSI DMPA-SC Access Collaborative provides data-driven technical assistance, coordination, resources, and tools to ensure that women have increased access to DMPA-SC self-injection as part of an expanded range of contraceptive methods, delivered through informed choice programming.

About PATH

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