

Cost per Child Analysis Guide 2019: Deworm the World Initiative

I. Introduction & Results Summary

Deworm the World Initiative (DtWI) conducts annual cost per child analyses across the geographies where we work. The outputs of these analyses show the cost per child per round of treatment in various geographies. Some geographies conduct annual deworming, whereas other geographies conduct biannual deworming, based on STH prevalence and in accordance with WHO guidelines; in the latter case the cost per child represents the average cost of one round of treatment. Deworming rounds occur at different times across the various countries, which results in varying model timeframes as detailed below.

Table 1: 2019 Cost per Child Results

Geographies included in 2019 Analysis	# of treatment rounds in 2019	Dates of Deworming Rounds	Cost per child per treatment round results
Kenya	1	March, June-July, September 2019 ¹	\$0.44
Cross River, Nigeria	1	October 2019	\$0.57
Rivers, Nigeria	2	July & November 2019	\$0.46
Oyo, Nigeria	2 ²	July & November 2019	\$0.32
Ogun, Nigeria	2	July & November 2019	\$0.66
Nigeria (combined)	See states above	See states above	\$0.45
Bihar, India	2	February & August 2019	\$0.04
Madhya Pradesh, India	1	August 2019	\$0.04
Uttar Pradesh, India	2	February & August 2019	\$0.05
Chhattisgarh, India	2	February & August 2019	\$0.07
Rajasthan, India	1	August 2019	\$0.05
Telangana, India	2	February & August 2019	\$0.09
Tripura, India	2	February & August 2019	\$0.21
Jharkhand, India	2	February & August 2019	\$0.06
Karnataka, India	2	February & August 2019	\$0.06
Haryana, India	2	February & August 2019	\$0.04
Uttarakhand, India	2	February & August 2019	\$0.10

¹ In Kenya, the standard window for costs has been July to June for past CPC analyses. A third wave for deworming actually occurred in September of 2019 due to delays in drug procurement during the earlier waves. Since the treatment figures from wave 3 are included in the 2019 treatment numbers, we have included implementation costs through Sept. in Kenya. This does not include program management, salary, fringe, and staff benefit costs between July-September.

² The second deworming round in Oyo state was incomplete and delayed under March of 2020; as such, costs through March 2020 have been included in the CPC model for Oyo.

India (combined)	See states above	See states above	\$0.05
Khyber Pakhtunkhwa	1	October 2019	\$0.49
Islamabad Capital Territory	1	January & April 2019 ³	\$1.23
Pakistan (combined)	See states above	See states above	\$0.55

II. Methodology

The 2019 cost per child analyses disaggregate costs incurred by Evidence Action, implementing governments, and other external partner organizations. We do not include spending that would still be incurred in the absence of a deworming program, such as maintaining health departments and education systems, teachers' wages, or government staff wages. We have been working on gathering estimates of some of the implicit program costs in certain geographies where we have more of an in-depth understanding of government staff hours dedicated to deworming activities; however, we do not have estimates across all of our geographies. We are continuing to gain a better understanding of the magnitude of these costs; however, we currently do not include them in our costing analyses. We *do* include imputed costs necessary for program execution, such as the value of drugs donated for treatment through the WHO global donation program.

Costs included in the analysis can be disaggregated by seven general program areas: 1) policy and advocacy; 2) prevalence surveys; 3) drug procurement and management; 4) training and distribution; 5) public mobilization and community sensitization; 6) monitoring and evaluation; and 7) program management and planning. Prior to 2017, costs were further classified into subcategories, such as office expenses, ground transportation, etc., however, analyses conducted post-2017 do not contain this classification. We have tried to find efficiencies in the analysis process and reduce time spent compiling outputs of limited analytical value. After reviewing the additional benefit that these types of detailed outputs provided relative to the time spent on analysis, we have decided to forego the subcategorization of costs.

A. Program Area Descriptions

Policy and Advocacy: All costs incurred for policy-oriented conferences, meetings, and events are included. Where stipulated in government norms and guidelines, per diems and travel allowances to government staff for their involvement in governance structures for deworming programs are included.

Prevalence Surveys: Prevalence surveys are essential for informing treatment strategies and assessing the impact of deworming on the disease burden. Surveys are conducted prior to deworming in a given geography to scientifically measure worm prevalence and intensity, and then following multiple rounds of deworming, subsequent surveys are conducted to understand changes in worm prevalence and intensity. Survey frequency varies across programs. We amortize the estimated cost of prevalence surveys across the treatment rounds they inform. Additional detail on prevalence survey costs are included in Section E.

³ Deworming in ICT is classified and costed as a single round – activities in January and April were the first and second wave, respectively, of the same round.

Drug Procurement and Management: We include drug costs, regardless of whether the drugs are obtained through donation from pharmaceutical companies via the WHO or purchased by the government. Either way, drugs are considered an essential input to the implementation of the program. Depending on available documentation and processes to reuse leftover drugs, drug costs are calculated in different ways across geographies. If there is a set policy in place for the reuse of leftover drugs, drug costs are calculated using per-round treatment numbers and the unit cost of the drug. Where we don't have information on how unused drugs are handled, drug costs are calculated using data on the total numbers of drugs distributed to schools and the unit cost of the drug. Additional detail can be found in Section E.

Training and Distribution: Training on school-based deworming is conducted through a multi-tier cascade to equip government personnel from the national (or state/province) level down to the teachers in schools (and sometimes preschools, depending upon the program target population) administering treatment. All training costs are included, such as hiring teams of qualified trainers, development and printing of training material, messaging and coordinating trainers and trainees, renting training venues, and travel stipends or other costs incurred by teachers for participation in training. When training takes place in spaces that are government-owned and covered by regular governmental operational costs, we do not include those costs.

Public Mobilization and Community Sensitization: All costs incurred to raise awareness in communities, at schools, and among parents about deworming are included, such as the costs of designing and producing promotional material in local languages. These materials include TV advertisements, village announcers, community launch events, and locally-distributed posters and fliers.

Monitoring and Evaluation: We include all costs of data reporting, monitoring of deworming days and other program processes, and validating the program coverage and results. These include both government reporting and monitoring activities as well as independent monitoring that Evidence Action funds. This often includes printing of treatment forms, and monitoring forms where applicable, developing and using mobile apps where applicable, data entry and analysis, travel for monitoring activities, and outsourced or in-house data analysis.

Program Management and Planning: Costs incurred to design and plan programs, as well as Evidence Action staff time (both in-country and global), are included in our calculation because these costs are incurred in direct relation to program implementation. Evidence Action's personnel costs are accounted for under the Program Management even though they are applicable across program areas. This is due to the way these costs are captured by Evidence Action's accounting system. Organizational overhead costs are also included, as a percentage of Evidence Action incurred direct program costs, to cover functions like finance and human resources that contribute to Evidence Action's support of the program.

B. Global Cost Allocation

For the cost per child analysis, we developed a methodology to apportion Evidence Action's 'global' costs across each geography. These 'global' costs do not have a specified geography in our financial system because they span geographies through our overarching programmatic support and shared global staff time. Over time, we have improved our financial coding processes at the global level to better attribute certain staff costs across our program geographies. As a result, we've become more accurate in directly apportioning some of our global costs to specific geographies such that the remaining global cost pool

without a geography specification has decreased compared to prior years. These remaining global costs without a specified geography are still central to program’s strategy, technical guidance, and operations, and therefore are spread across geographies in our costing models. We use the proportion of spending within each geography out of total spending as a benchmark and as an initial starting point to conceptualize the level of effort given to each geography. As our level of effort is not directly reflected through the proportion of spending in each country, we then adjust based on our estimation of global personnel time devoted to each area.

Table 2 below details how global costs were distributed across geographies for the 2019 costing rounds. The timeframe of incorporated global costs in the analysis is November 2018-October 2019. Although each individual model has a different timeframe of costs incorporated due to the difference in timing of deworming rounds across geographies, we standardized the timeframe of global costs within each model for consistency.

Table 2. 2019 Global Cost Allocation

Geography	Percent Cost Allocation
Kenya	16%
Bihar, India	6%
Madhya Pradesh, India	4%
Uttar Pradesh, India	5%
Chhattisgarh, India	4%
Rajasthan, India	3%
Telangana, India	4%
Tripura, India	3%
Jharkhand, India	2%
Karnataka, India	2%
Uttarakhand, India	2%
Haryana, India	2%
Himachal Pradesh, India ⁴	1%
India National	18%
Nigeria National	5%
Cross River, Nigeria	2%
Rivers, Nigeria	4%
Oyo, Nigeria	3%
Ogun, Nigeria	3%
Pakistan ⁵	8%
LF- Kenya ⁶	4%
Total	100%

⁴ Evidence Action does not support deworming in Himachal Pradesh, though we dedicated time to support other activities such as prevalence surveying.

⁵ Even though we have costed out the Pakistan at the province-level, we chose to allocate our global costs to Pakistan as a combined geography rather than by sub-location because of the way our current global staff engage with the Pakistan program.

⁶ We did not conduct a cost analysis for the 2019 deworming rounds in this geography, although global cost allocations were still applied. If we end up conducting cost per child analyses for this geography moving forward, these costs would be incorporated.

C. National Costs

In India, the unit of implementation for deworming programs is at the state level due to the devolved nature of government systems in the country. Accordingly, we conduct our cost per child analyses at the state-level. We also present a weighted average cost per child across all states in India. In Nigeria, the unit of implementation is also at the state level. We have presented the cost per child both by state as well as a weighted cost per child that looks at all costs incurred to support state programs in Nigeria against the total number of treatments we supported. In Pakistan, Evidence Action has entered into an agreement with Interactive Research & Development (IRD) to provide technical assistance to the Government of Pakistan to implement school-based deworming across three provinces and two territories. In 2019, deworming rounds occurred in only 2 geographies (ICT and KP), which is what is represented in the 2019 costing models. We have also presented a combined weighted cost per child for Pakistan.

Cost exclusion: There are certain costs, detailed below, that are incurred at the national level in both India and Nigeria, meaning they are not directly attributable to any state geography within the countries. This is because Deworm the World Initiative provides support to the national government in both of these countries, which benefits the government's deworming program beyond the areas where Deworm the World Initiative provides state-specific technical support. For this reason, we decide to exclude some of these costs from our models. Costs are *not* excluded for national-level support in Pakistan as deworming occurs across three provinces and two territories to which Evidence Action provides technical support. The current decentralized deworming structure within Pakistan is aligned with fairly autonomous provincial government structures which has resulted in our technical support being centered at the provincial and territory level and less so on national government support during the early stages of scale-up.

The total amount *not* included in our India state-specific cost models for the 2018-2019 timeframe within our financials is around USD\$597,000. These excluded costs amount to 15% of the total India-related costs within our financial system over the model time period.

Similarly, the total amount *not* included in our Nigeria state-specific cost models for the 2018-2019 timeframe within our financials is around \$93,000. These excluded Nigeria national costs amount to 6% of the total Nigeria costs within our financial system.

The national-level costs that we *do* include in our models include costs such as maintaining a national office, all salaries for staff based in the national office related to supporting state programs, strategy and review meetings with the national government, internal management meetings, design of awareness materials for use by all states (posters, banners, radio ads), National Deworming Day launch event (India-specific), and finance and administrative support. To determine the proportion of national costs attributable to national government support versus state-level support, we assessed the proportion of time and effort spent on national advocacy issues in comparison to our time and effort spent on state-specific support.

Cost allocation: To apportion the remaining national-level costs attributed to states across state-specific models, we apply a similar methodology as our global cost allocation method. We use the percentage of in-state spending out of total spending as a benchmark and adjust based on time and effort spent across state programs. The percentage of costs allocated to broader governmental support for both India and

Nigeria are determined based upon conversations with in-country program team members and depend upon on the proportion of their time spent on activities that support broader government programming versus specific Evidence Action-supported programming. This would include certain aspects of policy work to improve guidelines at a national or global level, for example, or engagement at the national level focused on capacity building for activities such as data management or drug procurement processes that support states that are not receiving technical assistance.

Different allocation percentages were applied for the February 2019 and August 2019 rounds in India, since proportion of spending and level of effort change as programs expand and mature. For more details, see Table 3 below. Table 3 details how India National costs were distributed across states and overall government support. The cut-off date to define the end of the February round and the beginning of the August round in India within our financial data was April 30, 2019.

Table 4 details the Nigeria National cost allocations across states and overall government support.

In Pakistan, Evidence Action does not have a separate cost pool for national costs like we do for our India and Nigeria programs. All of Evidence Action’s costs attributable to Pakistan are considered ‘global’ costs. However, IRD, our in-country partner, has a national cost pool that we’ve allocated out to province-level costing models. For both Evidence Action’s global costs and IRD’s national costs, we used the same allocation methodology as used in our Year 1 (Aug. ’18 – Sept. ’19) budget for Pakistan. To do this, we calculated the percentage of costs that were allocated to each sublocation out of the total budgeted national and global costs. Table 5 details the Pakistan cost allocations across sublocation.

Table 3. India National Cost Allocation

Geography	Percent Cost Allocation Feb '19 Round	Percent Cost Allocation Aug '19 Round
Bihar	8%	12%
Madhya Pradesh	3%	6%
Uttar Pradesh	10%	11%
Chhattisgarh	12%	7%
Rajasthan	3%	6%
Telangana	10%	7%
Tripura	3%	5%
Jharkhand	5%	6%
Karnataka	6%	6%
Uttarakhand	4%	4%
Haryana	6%	4%
National India government support	30%	26%
Total	100%	100%

Table 4. Nigeria National Cost Allocation

Geography	Percent Cost Allocation
Cross River State	12%
Rivers State	26%

Oyo State	25%
Ogun State	22%
National Nigeria government support	15%
Total	100%

Table 5. Pakistan National Cost Allocation⁷

Geography	Percent Cost Allocation
KP	42%
Sindh*	23%
ICT	7%
Punjab*	22%
GB*	7%
Total	100%

*Indicates that we did not conduct a cost analysis for the 2019 deworming rounds in these geographies, although global cost allocations were still applied. These costs will be incorporated when we conduct cost per child analyses for these geographies moving forward.

D. Costing by Treatment Round

For those areas that conducted biannual deworming in 2019, we conducted a cost per child analysis by treatment round and present an average cost per child per treatment round. We present the cost per child by treatment round rather than the cost per child by year because it is not possible to track individual children throughout both rounds of treatment to know whether the same children are dewormed. In some cases, the geographies and target population where deworming was implemented changed from one round to the next.

E. Additional Model Assumptions Described

Number of Children Dewormed: The number of children dewormed in each model is consistent with government reported figures. These finalized figures are based on government reported data and structured protocols that each school, and higher levels in the administrative “reverse cascade”, are instructed to follow on Deworming Day and Mop-up Day (in areas where Mop-up Day is conducted). Table 6 below provides the treatment figures used in the 2019 CPC analysis, with respective geographies and treatment round.

Table 6. Number of Children Dewormed (2019)

Geography	Number of Children Dewormed
Bihar, India Feb	32,604,689
Bihar, India Aug	15,528,312

Madhya Pradesh, India	26,516,556
Uttar Pradesh, India Feb	16,549,065
Uttar Pradesh, India Aug	43,870,748

⁷ Evidence Action provides technical assistance to the Government of Pakistan in three provinces and two territories. In 2019, deworming rounds occurred in only 2 provinces (ICT and KP), which is what is represented in this costing model. The remaining provinces will be included in the 2020 cost per child analyses.

Chhattisgarh, India Feb ⁸	6,141,566
Chhattisgarh, India Aug	9,924,380
Rajasthan, India	22,522,606
Telangana, India Feb	9,568,761
Telangana, India Aug	3,745,098
Tripura, India Feb	1,144,329
Tripura, India Aug	1,127,325
Jharkhand, India Feb	12,587,490
Jharkhand, India Aug	13,084,409
Karnataka, India Feb	16,320,379
Karnataka, India Aug	15,804,524
Haryana, India Feb	7,973,453
Haryana, India Aug	8,775,992
Uttarakhand, India Feb	3,244,502

Uttarakhand, India Aug	3,057,676
Kenya	6,134,128
Cross River State, Nigeria	594,529
Rivers State, Nigeria July	1,090,046
Rivers State, Nigeria Nov.	398,857
Oyo State, Nigeria July	759,322
Oyo State, Nigeria Nov.	1,627,156
Ogun State, Nigeria July	433,596
Ogun State, Nigeria Nov.	547,304
Khyber Pakhtunkhwa, Pakistan	2,705,937
Islamabad Capital Territory, Pakistan	200,320

Drug Procurement, Distribution, and Consumption Data: Drug costs are included in our costing models as an important incremental cost to running the program even if they do not pose a direct cost to Evidence Action or the government. In many cases, deworming drugs are procured through the WHO global drug donation program and do not pose a direct cost to Evidence Action, government, or other partners; however, their imputed value (based on treatment numbers and unit drug costs) is included in the model as an important incremental cost to running the program. Unit costs of drugs vary by geography depending on shipping and tax rates. In some cases, we can obtain information on the unit costs of drugs from government officials handling the procurement process.

In the absence of this data, we use median prices from the International Medical Products Price Guide by Management Sciences for Health (MSH). Past models refer to the Drug Price Indicator Guide by the WHO, which is no longer accessible. Costs for Albendazole and Mebendazole have noticeably decreased – from \$0.04 each to \$0.02 and \$0.03, respectively. In geographies where there is a clear implemented policy on the reuse of leftover drugs, we calculate total drug costs using per-round treatment numbers multiplied by the unit drug cost. In areas where there is no clear policy or implementation of drug reuse, we use data on the numbers of drugs distributed to schools multiplied by the unit drug cost and assume that the value of unused drugs remains a cost to the program given there is no way to accurately capture how unused drugs are handled. Within our India state models, as a conservative approach, we have calculated drug costs using the number of drugs distributed to schools rather than the number of children treated. This assumes that the value of unused drugs remains a cost to the program, when in reality there are many cases where unused drugs are most likely repurposed. For analysis purposes, however, we have kept this assumption consistent throughout our India models.

Prevalence Survey Costs: Prevalence mapping is conducted through field surveys prior to scaling up deworming treatment in a particular area to inform the treatment strategy. The WHO recommends that after approximately 5 rounds of effective treatment, a follow-up survey should be conducted to measure the impact of deworming through changes in worm prevalence and intensity, and to reassess the

⁸ The treatment number in the February Chhattisgarh model is inclusive only of the districts where national deworming day happened, not NDD and Lymphatic Filariasis treatment. This

excludes 8 districts where NDD+ LF did occur. Costs for LF treatments, however, are still included as it was not possible to disaggregate expenditures. As such estimates for CPC in Chhattisgarh are conservative and a likely overestimate.

treatment strategy⁹. For the geographies where we work, we either use the costs of surveys that we conduct, or collect prevalence survey costs when available, and we project the costs of future surveys based on previously conducted work. We amortize these prevalence survey costs (both the baseline and follow up surveys) across the number of treatment rounds that they are expected to inform. There is some uncertainty around when prevalence surveys will be conducted in the future, which, in turn, determines how many rounds the prevalence surveys may inform. We have projected when we think prevalence surveys will occur in an attempt to accurately estimate the number of rounds over which to amortize these costs; however, there may be changes in methodology moving forward as more information becomes available¹⁰.

For the 2019 cost per child models, previous estimates for prevalence survey costs were updated with actuals of prevalence surveys conducted in 2019 (or late 2018). This has been reflected in the models for Telangana and Tripura¹¹, Madhya Pradesh, Chhattisgarh¹², as well as Bihar and Rajasthan¹³.

In the absence of real cost data, we have estimated the costs of prevalence surveys in Uttarakhand and Haryana based off previous work done in surrounding areas, considering the number of sites visited for prevalence sampling. The cost estimated for two prevalence surveys in each geography have been amortized across the expected number of treatment rounds informed by the two surveys.

Prior amortization of prevalence survey costs in Nigeria have also been adjusted with understanding that the next round of prevalence surveys will not occur until 2021 at the earliest. The number of treatment rounds informed by the prevalence surveys has been adjusted across the Nigeria models.

Government Costs: We collect and/or estimate government costs that are incurred for the implementation of deworming programs in the geographies where we work. There are some cases where there may be minimal costs incurred by national governments that we have not included in the model due to the difficulties of accessing the data. As previously mentioned, we do not include spending that would still be incurred in the absence of a deworming program, such as maintaining health departments and education systems, teachers' wages, or government staff wages.

Partner Costs: Partner costs included in the model reflect the cost structures for operating in these geographies. These costs most often include partner administrative costs, taxes, and fees. They are operational costs required for the effective implementation of the program and are therefore included within the respective costing models. Since the structure of these costs vary by context, we've detailed below the different costs incorporated by geography:

Pakistan

⁹In 2017, WHO updated their guidelines recommending prevalence surveys be conducted ever 3-4 years. As a result, programs are starting to shift strategies, if feasible, to collect prevalence data more often. As we continue to implement changes in our programs per WHO guidelines, assumptions around the number of treatment rounds that prevalence survey inform may change.

¹⁰ The number of treatment rounds for upcoming years are subject to higher levels of variability due to COVID-19 impacts which will cause corresponding changes to prevalence survey amortization strategy.

¹¹ Prevalence survey actuals in Telangana and Tripura are significantly higher than previous estimates due to a change in methodology from school-based to community-based surveying. This change in survey strategy came at the request of CIFF.

¹² Prevalence survey actuals for Chhattisgarh were split between the 2018 and 2019 analysis periods. The total amount has been compiled in the most recent model and the previous estimate has been replaced with actuals.

¹³ Bihar and Rajasthan are also unique in having initial prevalence survey costs from 2011. Despite uncertainty around results and impact on subsequent treatment rounds, we have included these costs as a conservative assumption.

1. **Tax:** Costs incurred in Pakistan are subject to the country's turnover tax at a rate of 1.25%. This tax rate has changed over time but applied to all costs incurred in Pakistan for the timeframe of costs for KP and ICT as listed below.
2. **Indirect Rate:** IRD's indirect rate is 22% and is related to central management and administrative functions essential to supporting effective implementation of the organization's programs. In the Pakistan costing model these costs are included within each cost category.

In Pakistan, per the terms of the agreement with IRD, Evidence Action provides technical assistance to IRD, as well as the funds for implementation of deworming (government costs) and administrative costs for IRD staff. IRD then sources third party vendors or firms for the payment of deworming costs (i.e. teacher per diem payments, printing, IM, etc.) Therefore, government costs and IRD costs are presented together in this model. However, moving forward (2020 cost per child analyses) and with the finalization and use of provincial domestic budgets for deworming, these costs will be presented separately.

India

1. **Fee:** As a registered for-profit entity, PKIPL must generate a profit. Evidence Action incurs a 5% fee on all PKIPL direct costs. Evidence Action regularly engages with tax experts to ensure cost practices comply with India's laws governing business operations in India.
2. **Goods and Services Tax:** Costs incurred in India are subject to the country's Goods and Services Tax (GST) at a rate of 18%. Evidence Action regularly engages with Indian legal and accounting experts to identify costs and mechanisms to reduce the program's overall tax liability on specific cost types where possible and allowed by the tax laws.

These costs are recorded as National costs in our accounting system and are apportioned to state-specific models following the cost allocation methodology described in section C above.

Overhead Costs: Evidence Action's "indirect" or "overhead" costs are related to central management and administrative functions and are essential to supporting the effective implementation of all of the organizations' programs. The indirect costs and the rate are reviewed and analyzed regularly and is calculated by determining the percentage of the support costs relative to the direct program costs. The 2018/2019 indirect rate applied is 18% of all direct program costs, including on funds advanced to partners for implementation of deworming.

Exchange Rates: The exchange rates included in each model are the average exchange rates reported for the time period over which costs are included in that model.

Timeframe of Costs: The timeframe of costs included in each model vary by geography since deworming rounds do not occur at the same time. Table 7 below is a general description of the timeframe of costs included in each model; although, for newer geographies where this is the first costing analysis conducted, start-up costs are included prior to the timeframes listed. These timeframes only reflect the in-country costs and partner costs incurred, not Evidence Action's previously described global cost timeframe, which is standardized across models for consistency (detailed more in Section B).

Table 7. Timeframe of costs included

Geography	Timeframe of costs included
Kenya	July 2018-September 2019 ¹⁴
Bihar, India	Feb Round: November 2018-April 2019 Aug Round: May 2019-October 2019
Madhya Pradesh, India	November 2018-October 2019
Uttar Pradesh, India	Feb Round: November 2018-April 2019 Aug Round: May 2019-October 2019
Chhattisgarh, India	Feb Round: November 2018-April 2019 Aug Round: May 2019-October 2019
Rajasthan, India	November 2018-October 2019
Telangana, India	Feb Round: November 2018-April 2019 Aug Round: May 2019-October 2019
Tripura, India	Feb Round: November 2018-April 2019 Aug Round: May 2019-October 2019
Karnataka, India	Feb Round: November 2018-April 2019 Aug Round: May 2019-October 2019
Jharkhand, India	Feb Round: November 2018-April 2019 Aug Round: May 2019-October 2019
Haryana, India	Feb Round: November 2018-April 2019 Aug Round: May 2019-October 2019
Uttarakhand, India	Feb Round: November 2018-April 2019 Aug Round: May 2019-October 2019
Cross River, Nigeria	January 2019-January 2020
Rivers, Nigeria	Jul Round: January 2019-October 2019 Nov Round: November 2019-January 2020
Oyo, Nigeria	Jul Round: January 2019-October 2019 Nov Round: November 2019-March 2020 ¹⁵
Ogun, Nigeria	Jul Round: November 2018-Aug 2019 Nov Round: September 2019-January 2020
Khyber Pakhtunkhwa, Pakistan	September 2018-December 2019
Islamabad Capital Territory, Pakistan	August 2018-July 2019
Global Costs	November 2018-October 2019

¹⁴ In Kenya, the standard window for costs has been July to June for past CPC analyses. A third wave for deworming actually occurred in September of 2019 due to delays in drug procurement during the earlier waves. Since the treatment figures from wave 3 are included in the 2019 treatment numbers, we have included implementation costs through Sept. in Kenya. This does not include program management, salary, fringe, and staff benefit costs between July-September.

¹⁵ The second deworming round in Oyo state was incomplete and delayed under March of 2020; as such, costs through March 2020 have been included in the CPC model for Oyo.