

October 31st, 2022

Submitted by: Dr. Dylan Walters

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Nutrition International

A letter to GiveWell in response to the Change Our Minds Contest

Introduction

Even as a relatively new philanthropic foundation, GiveWell's efforts to incorporate cost-effectiveness analysis into its grant-decision making is admirable and sets an example for other not-for-profits organizations (and even some governments, development institutions or agencies) aiming to make an impact in the health, nutrition and development sector. In addition, GiveWell's dedication to transparency - including publishing a list of "mistakes made"¹ - and continuous improvement is unmatched in the sector. This openness to learn and evolve will be key to GiveWell and their contributor's long-lasting impact and ability to do good in the world - a world that is in desperate need for this financial support.

GiveWell's influence has now grown to a point where this approach could benefit from some re-thinking. Small organizations do not have the human and financial resources to conduct rigorous economic evaluations for all investments, and simplified approaches are often necessary, or relying on reviews from literature of the best value for money in health and development. The GiveWell cost-effectiveness model was ground-breaking for a small philanthropic foundation. Now, with the potential to influence billions of dollars in investment in the next few years, GiveWell's model has become a victim of its own success, whereby its influence has outgrown its analytical capability.

In this letter to GiveWell, we wish to express our gratitude to GiveWell for being an exemplar of innovation in philanthropy, but we also offer encouragement to continue to disrupt the field by reinventing its model for investment decision-making with the goal of seeking value for money in investments and supporting sustainable development around the world.

Although we did not have time to conduct a comprehensive review, in this letter we offer a few general recommendations on the conceptual approach and logic of the GiveWell cost-effectiveness model and a few specific recommendations for the VAS intervention analysis.

CRITIQUES TO METHODOLOGY AND CONCEPTUAL APPROACH:

Problem #1: Using cost-effectiveness as primary metric for informing investments

The GiveWell cost-effectiveness model relies on a cost-effectiveness metric (cost per death averted) as primary metric for informing decision-making. While this is better than the absence of any economic evaluation to guide decision-making, this metric may not be adequate for decision-making and could result in a skewed view of the best investments for countries that may have a diverse set of short, medium, and long-term goals for the health and development of their population. We recognize that GiveWell has made attempts to include non-fatal health benefits of interventions, but the approach could be vastly improved.

Recommendation #1: Adopt a "Value for Money" approach

¹ <https://www.givewell.org/about/our-mistakes>



We recommend that GiveWell changes to Value for Money (VfM) approach to donor funding since GiveWell is now at a maturity and scale of donor funding that demands consideration of other complex factors.

There are different approaches and frameworks for assessing Value for Money such as the Global Fund example², however in general they each focus on the similar key elements: **Effectiveness, Efficiency, Economy, Equity and Sustainability.**

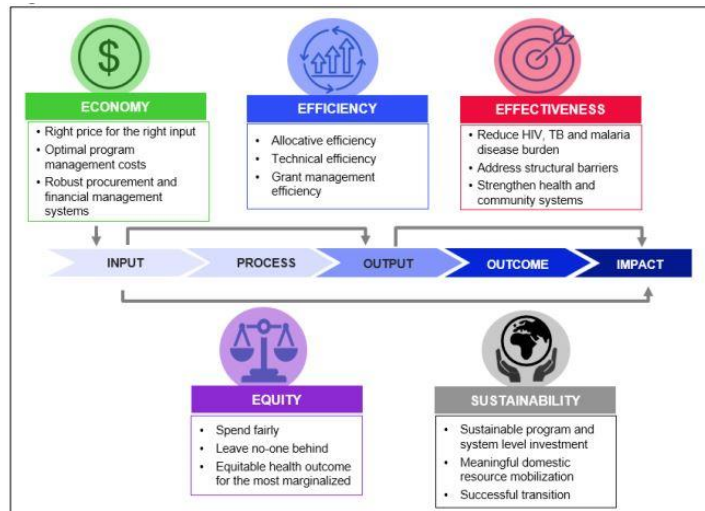


Figure 1. Value for Money Framework - Global Fund (2022)

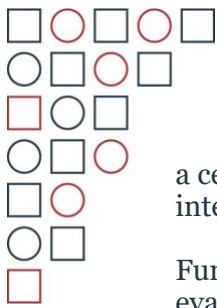
The GiveWell approach seems to favor investments that lend themselves well to effectiveness or technical efficiency in preventing mortality, which is important, but the long-run impact of these investments may be jeopardized if other aspects such as sustainability and domestic program and systems strengthening, domestic resource mobilization, allocative efficiency, and equity are not considered. It is difficult to estimate, but a value for money approach could in theory drastically change how GiveWell allocates funding over the long-term and bring its approach in line with modern approach to development aid effectiveness.

Problem #2: Mixing of economic evaluation of interventions and organizations

The current approach by GiveWell blends the economic evaluation of health, nutrition, and development interventions with the evaluation of organizations. It is unclear why this approach was taken, and likely jeopardizes GiveWell's ability to find the most cost-effective delivery mechanisms for three reasons: 1) The valuation of an intervention is dependent on the inputs/costs of the pre-selected organization, which almost certainly is not the most cost-efficient at delivering an intervention in all countries/geographies/contexts simultaneously, and 2) It creates undue risk on GiveWell by investing in only one organization per intervention globally, and 3) appears to be anti-competitive by selecting only one organization.

For example, it is highly unlikely that one organization can be most cost-effective at delivering an intervention in all districts of all priority developing countries, and thus achieving best value for money requires working in partnership with multiple organizations and agencies depending on their strengths and experiences. In many other industries – and even in the sectors that GiveWell works in – there can be a competitive grant or RFP process either at the global level or national level (by a domestic government) for the selection of an organization to deliver certain programs, and in particular interventions that require supplements or distribution of a product. The approach does not take into account the existing infrastructure available to certain NGOs that allow for cost reduction or self-subsidization of certain interventions. While this may in reality serve as a potential advantage for selection of

² Global Fund (2022) Technical Brief on Value for Money. Allocation period 2023-2025. https://www.theglobalfund.org/media/8596/core_valueformoney_technicalbrief_en.pdf



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a certain organization, it should not be part of the overall costing exercise for an intervention.

Furthermore, allowing international non-profits to be at the centre of the economic evaluation process does not support the development of country ownership, alignment, and harmonization goals of the Paris Declaration for Aid Effectiveness³ (2005) for developing countries, which are critical to the long-term sustainability of investments.

Recommendation #2: Change to a two-stage value for money process: Interventions first, implementers second.

We recommend that GiveWell change its economic evaluation process to prioritize the value for money of an intervention (and their delivery platform) first, while being agnostic to the charity, non-profit or system of implementation partners. This approach may allow GiveWell and donors to ensure that they are supporting the sustainable scaling of health, nutrition and development interventions before the selection of organizations, which currently feels more arbitrary than evidence-based.

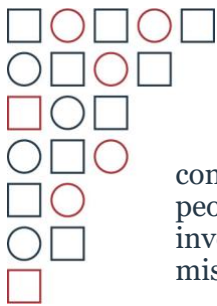
Once an intervention and delivery platform in a certain country or district has shown the potential to be good value for money by meeting the criteria for *Effectiveness, Efficiency, Economy, Equity and Sustainability*, then GiveWell can assess, in a second stage, what is the most cost-efficient delivery partner, whether it is a government agency or external non-profit based on their technical and programmatic efficiency. This second stage analysis also allows for direct comparison of organizations based on their experience, reputation, capacity, costs, and other factors in different contexts. In addition, given the scale of the public health and development problems affecting millions and billions of people that GiveWell is targeting, this also opens up GiveWell to the critical need for utilizing multiple organizations, partnerships, and alliances to address these societal challenges in a meaningful way.

Problem #3: Not using standard methods for economic evaluation

As mentioned, the current GiveWell Cost-Effectiveness model relies largely on the “cost-per life saved” metric for serving as the basis for informing investment decision-making. This metric alone would provide a distorted view for prioritization of investments in global health and nutrition favoring life-saving interventions over those that improve well-being, reduce diseases, or improve human capital, and, critically, interventions that do both save lives and improve lives. However, GiveWell has attempted to create its own solution in its model to incorporate other benefits with the use of “moral weights”, “development benefits” and “supplemental intervention-level adjustment factors.” These adjustments in the model were designed to make assessments between interventions comparable, however as GiveWell continues to invest in this model, the model is moving farther and farther away from being comparable to the generally accepted methodologies for economic evaluation in health and development.

GiveWell’s rationale for using “moral weights” demonstrates good intentions, and GiveWell has even invested in attempting to find weights from countries in Africa. Currently, the moral weights for the value of a non-fatal benefits are either based on staff input (10%), incorporating donor preferences (60%), and also a recent limited sample size surveys in two countries in Africa (30%). Unfortunately, this approach

³ The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action (2005) <https://effectivecooperation.org/system/files/2020-09/Paris%20Declaration%20on%20Aid%20Effectiveness%20.pdf>



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continues to fail to support what matters most – the desires of countries and their people that are the potential recipients of these health, nutrition and development investments. Weighing the donor and staff preferences too highly risks in being misaligned with domestic priorities and needs for sustainable development.

While the GiveWell cost-effectiveness model is innovative and transparent, the lack of use of generally accepted methods for economic evaluation may generate an unnecessary lack of clarity, consistency and comparability to the evaluations, studies, and tools that the rest of the sector utilize in their decision-making. For example, while GiveWell's divergent approach makes it impossible to compare to other systematic reviews on the value for money including the Disease Control Priorities 3⁴, Copenhagen Consensus⁵, the World Bank's Global Investment Framework for Nutrition⁶, Global Financing Facility for Maternal and Child Health (GFF) Country Investment Cases, and other single program-evaluations and studies.

Recommendation #3: Application of generally accepted methodologies for economic evaluation in health and development

In recent years, the development sector has developed new guidelines on the economic evaluation of health and development interventions and a plethora of new modelling tool in order to bring more consistency and quality to economic evaluation studies to informing planning, advocacy, and decision-making for investments in this area. The NICE International and BMGF Methods for Economic Evaluation Project (MEEP)⁷ and the Harvard SPH and BMGF Reference Case Guidelines for Benefit-Cost Analysis in Global Health and Development⁸ set out new guidelines and approaches for economic evaluations in global health and development.

Suggestion 3.A: Estimate Disability-Adjusted Life Years (DALYs) averted of interventions rather than only lives saved.

Firstly, we suggest that GiveWell re-examine the potential to capture both the mortality and morbidity averting benefits by quantifying the number of Disability-Adjusted Life Years (DALYs), which is a standard and commonly used methodology instead of the moral weights approach. This approach is widely used across the health and nutrition sector, allows for the non-fatal benefits of interventions such as disease prevention, cognitive development gains, and other wellbeing factors, and will improve over time as part of the global burden of disease initiative.

Furthermore, this would allow for a more widely used metric to estimate the cost-effectiveness such as the "Cost per DALY averted," which could be compared to estimates to the literature such as the recent Disease Control Priorities 3 (DCP3) book review of child and adult intervention (Figure 2)⁹. In addition, this figure could

⁴ Disease Control Priorities 3 - <https://dcp-3.org/chapter/1552/returns-investment-continuum-care-reproductive-maternal-newborn-and-child-health>

⁵ Copenhagen Consensus (2012)

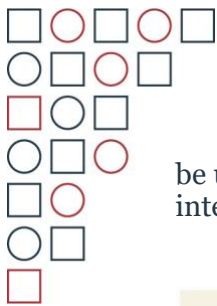
<https://www.copenhagenconsensus.com/sites/default/files/hungerandmalnutrition.pdf>

⁶ World Bank Group (2017) - <https://openknowledge.worldbank.org/handle/10986/26069>

⁷ NICE International and BMGF (2014) Methods for Economic Evaluation Project (MEEP) <https://www.idshealth.org/wp-content/uploads/2015/01/MEEP-report.pdf>

⁸ Harvard and BMGF (2019) Reference Case Guidelines for Benefit-Cost Analysis in Global Health <https://cdn1.sph.harvard.edu/wp-content/uploads/sites/2447/2019/05/BCA-Guidelines-May-2019.pdf>

⁹ Horton, Sue (2018). DCP3: Cost-Effectiveness Analysis in Disease Control Priorities: Chapter 9. <https://dcp-3.org/chapter/2561/cost-effectiveness-analysis>



be used for comparison with government thresholds for cost per DALY averted or international thresholds.

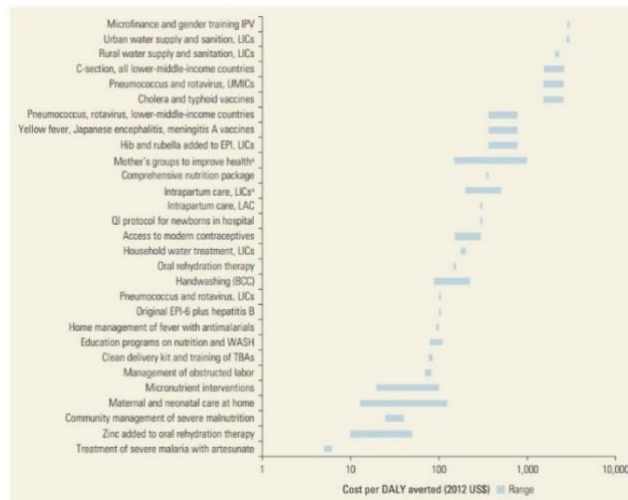


Figure 2. Cost per DALY of interventions for children from the DCP3.

We agree with GiveWell that saving and improving children’s lives in a cost-effective manner is critically important. To demonstrate the importance of properly weighing morbidity effects in investment decisions-making, we look to a recent analysis of the potential benefits of scaling large-scale food fortification in seventeen strategic countries. Fortification is often cited as a cost-effective intervention, but in a recent paper we estimated that nearly 40% of the preventable burden (5 million DALYs per year) were in the form of morbidity such as anemia and neural-tube defects (NTDs) averted in surviving children¹⁰ in addition to the mortality averting benefits from NTDs, which shows that some interventions have both significant roles to play in saving lives and improving lives.

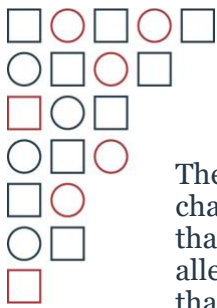
In addition, with recent advancements in new modelling tools for health and nutrition (Optima Nutrition, LiST, OMNI, MINIMOD, MAPS) etc, GiveWell could easily model the other types of health outcomes that their investment could achieve.

We hypothesize that this change alone could significantly change the order of GiveWell’s top programs for funding allocations. In the example above from food fortification, not accounting for the non-fatal health benefits could **change the potential value of an intervention by 40%**. This change makes the model comparable to others in the sector and more-easily “adoptable” by others and be more understandable to health policy makers.

Suggestion 3.B: Incorporate benefit-cost analysis into decision-making

We suggest that GiveWell consider incorporating benefit-cost analysis in addition to cost-effectiveness into its value for money framework and methodology. Another argument by GiveWell in using a “moral weighting” approach was that it could incorporate outcomes related to consumption and economy. This is already the purpose of benefit-cost analysis, which accounts for the non-health development benefits of investments that can be substantial and even as important in the long-run development of low- and middle-income countries where resources are scarce and poverty alleviation remains a top priority.

¹⁰ Kancherla et al. (2020) Reducing the Burden of Anemia and Neural Tube Defects in Low- and Middle-Income Countries. <https://www.mdpi.com/journal/nutrients>



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The recent efforts by the World Bank¹¹ and the African Development Bank to champion the human capital and stunting agenda highlight the need for investments that will pay-off in terms of increased education, cognition/intelligence, poverty alleviation and labour productivity in addition to reducing mortality. It is estimated that the cost of malnutrition could be as high as US\$3.5 trillion per year¹² and a recent study estimating that childhood stunting alone could cost *the private sector* at least US\$135.4 billion in sales annually¹³.

In addition, a benefit-cost analysis can incorporate fiscal savings such as reductions in health care expenditures due to reduced disease incidence as well as household savings. which are key short-term monetary benefits that influence ministries of finance in their decisions to find the highest return on investments (ROI) given limited domestic resources. For example, Nutrition International & Alive & Thrive Cost of Not Breastfeeding Tool¹⁴ crudely estimated that breastfeeding according to recommendation could lead to \$23B USD in health system savings each year by the prevention of infectious disease alone. Nutrition investments into interventions such as VAS, breastfeeding promotion, WIFAS, and USI have been associated with significant human capital and economic benefits as well. These economic gains, private sector sales increases, and health system savings potentially attributed to investments are substantial, and yet not accounted for anywhere in GiveWell's cost-effectiveness model. These types of economic and financial benefits speak to domestic policy makers and contribute to their sustainable development when financial resources are scarce.

The Harvard and BMGF Guideline for Benefit-Cost Analysis (2019) offers a reference guide for conducting benefit-cost analyses in this sector. The gold-standard methods for benefit-cost analyses can be completed, yet there it may be possible to also use a simplified methodology using a "monetized DALY approach using a statistical value of a life year" to estimate an economic value of an investment. This approach could be easily incorporated into GiveWell's model if maintaining a simple online and comparable model is critical. It is true that there are drawbacks to this methodology, but it would create a comparable approach to others in the sector. Even though few non-profits conduct benefit-cost analyses of their investments, adopting some form of the analyses would bring GiveWell's approach more closely aligned with the most influential institutions, think tanks and research network such as the World Bank Group, Global Financing Facility for Maternal Newborn and Child Health, World Health Organization, Copenhagen Consensus, and the Disease Control Priorities 3.

Suggestion 3.C: Invest in field-level cost data collection and costing analysis

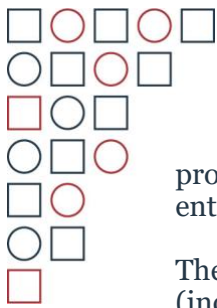
Perhaps the most overlooked aspect of all economic evaluations in the global health and development sector is the importance of quality of program cost data to inform investment decisions. It is true that it is difficult to collect good cost data in the field for interventions, but given that program cost variation between geographies, implementation organizations, seasons, and interventions can be one of the key drivers of uncertainty in any cost-effectiveness model – it is potential the most important change that GiveWell could make. GiveWell's approach that relies on non-

¹¹ WBG Human Capital Project (2022) <https://www.worldbank.org/en/publication/human-capital>

¹² Glopan (2022) <https://www.glopan.org/cost-of-malnutrition/>

¹³ Akseer et al. (2022) Economic costs of childhood stunting to the private sector in low- and middle-income countries [https://www.thelancet.com/pdfs/journals/eclinm/PIIS2589-5370\(22\)00050-5.pdf](https://www.thelancet.com/pdfs/journals/eclinm/PIIS2589-5370(22)00050-5.pdf)

¹⁴ Nutrition International and Alive & Thrive Cost of Not Breastfeeding Tool (2022)



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profit organizations to provide program cost data to them risks the credibility of the entire model.

The small cost of conducting a field-level costing analysis of an intervention (including all implementing partners) relative to the growing level of GiveWell investments will pay-off in terms of ascertaining the real-costs of an investment from multiple perspectives and discovering key reasons for variation in costs that could limit program cost-effectiveness if not addressed and ensuring that the lowest cost options or scenarios are pursued without sacrificing quality. This change in the conceptual approach could significantly change the value for money achieved by GiveWell.

CRITIQUES TO VAS COST-EFFECTIVENESS METHODOLOGY

Problem #4: The VAS effect size on mortality

The current effect size used by GiveWell for the reduction in all-cause mortality rates may overestimate the number of child deaths averted by Vitamin A Supplementation (VAS). Nutrition International has championed VAS programs for 25 years and provided over ten billion capsules since 1997 in 55 countries. A commonly cited effect size for VAS reduction on child-mortality of 24% all-cause mortality is used by GiveWell, however we believe this may generate overestimates for the impact of VAS on preventing child mortality.

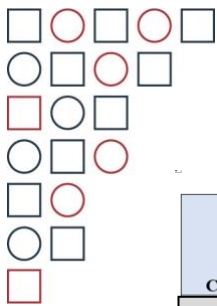
Recommendation #4: Use the more conservative mortality reduction effect size for VAS

A suggestion could be to use the 12% all-cause mortality reduction effect size among children 6-59 months of age (rather than 24%), which Nutrition International uses in our internal modelling to estimate the health impact of VAS programs¹⁵. In a recent analysis (publication forthcoming) on the modelled impact of COVID-19 disruptions to Vitamin A Supplementation delivery on child mortality and stunting in LMICs¹⁶, we compared the results of using several different effect sizes and analytical approaches (e.g the NI methods and LiST). In table 1, we can see that the different analytical approach results in a wide range of additional child lives lost across the eight sample countries in Africa and Asia attributed to decreases in VAS coverage as a result of COVID-19 disruptions.

Regardless of the methodology however, even the conservative number for number of additional child lives lost is substantial. We would be pleased to further discuss our decision to use a more conservative effect size for VAS. This change alone to GiveWell's model could reduce the VAS cost-effectiveness substantially. We are confident that even with a decrease in the effect size of VAS on mortality, that VAS will remain among the best value for money and essential interventions – especially if other benefits such as preventing blindness, strengthening immune systems, and reducing incidence of diarrhea, measles, and stunting are factored in.

¹⁵ Imdad, A, et al. (2022) Cochrane Review: Vitamin A supplementation for preventing morbidity and mortality in children from six months to five years of age. Cochrane Database of Systematic Reviews 2022, Issue 3.

¹⁶ Ahsan, S. et al. (Forthcoming) The modelled impact of COVID-19 disruptions to Vitamin A Supplementation delivery on child mortality and stunting in LMICs.



Country	Absolute percentage change in 2-dose Coverage	6-59m Population adversely impacted	Additional child (6-59m) lives lost		Range of additional child lives lost (Upper bound to lower bound)
			Additional child lives lost (NI methods - LiST)	Lives lost per 10,000 (VAS Table - LiST)	
*Country names hidden for this exercise.	+3%	- 194,627	(-50) - (-6)	(-0.0771) - (-0.0099)	
	-19%	463,444	20 - 183	0.0841 - 0.7509	
	-33%	2,917,100	113 - 1,746	0.1277 - 1.9791	
	-35%	7,770,835	116 - 952	0.0527 - 0.4334	
	-18%	8,142,968	269 - 1,210	0.1926 - 0.8678	
	-95%	20,145,341	278 - 5,937	0.1309 - 2.7997	
	-90%	32,326,816	1,384 - 11,746	0.3833 - 3.2534	
	-39%	11,438,741	2,469 - 12,880	0.8342 - 4.3522	
Africa			2,864 - 15,969	0.4674 - 2.6057	-100 4,900 9,900
Asia			1,777 - 18,635	0.2241 - 2.3506	
Total			4,641 - 34,604	0.3302 - 2.4619	

Table 1. Results of the modelled impact of COVID-19 disruptions to VAS delivery on child mortality.

Problem #5: Delivery platforms: VAS Campaign vs routine delivery:

The GiveWell cost-effectiveness model for VAS seems to favor the campaign delivery model of VAS versus routine health service delivery model. While scaling VAS over the years often depended on a campaign style delivery platform, many LMICs have transitioned or are in the process of transitioning to the delivery of VAS through routine health services.

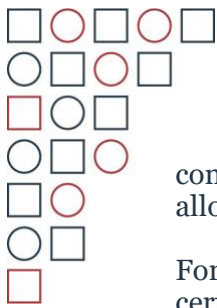
Each model has its advantages and disadvantages, and appropriateness in certain contexts. While some countries do not have a strong enough health system to consider delivering VAS through the routine health system, many countries do. Most often, a combination of approaches is most effective to ensure high coverage. Campaigns may allow for greater mobilization and coverage of children in remote communities, but often disrupt health services for a period of days or weeks across these geographies to administer the campaigns¹⁷. Routine health service delivery of VAS strengthens the existing health system rather than creating a parallel system, can leave children unreached. To be cost-effective, high rates of coverage need to be achieved, however no one-size fits all. For example, campaign-style approaches can be very helpful as mop-up for children missed through the routine contact points in a setting where VAS is integrated into the routine system, yet coverage is low.

Lastly, in contexts where VAS delivery has already transitioned to routine health service delivery, the cost of disruption by supporting campaigns can be detrimental and undermines longer term approaches to strengthen routine health systems and the delivery of VAS.

Problem #6: Lack of baseline coverage factored into model

The GiveWell model estimates the impact of VAS from a hypothetical \$100,000 investment. This approach may make the model comparable to other interventions in the model and may have served GiveWell when it was providing smaller amounts of funding, but it may now be providing an insufficiently detailed assessment of the

¹⁷ Gotuba, Horton and Greig (2017) Delivering Vitamin A Supplements to Children Aged 6 to 59 Months: Comparing Delivery Through Mass Campaign and Through Routine Health Services in Ethiopia. <https://journals.sagepub.com/doi/10.1177/0379572117708657>



context in countries of focus for VAS that can potentially receive millions in funding allocations.

For example, there is currently no assessment of whether the baseline coverage in certain districts/states/countries is low (0-20%) or much higher at 50-90%. As such, it may be possible that GiveWell is making funding allocations to organizations for achieving full coverage of VAS from a baseline of 0% when there is already a certain coverage level being achieved by governments or existing implementing partners. Thus, there is a risk of duplication of efforts and wastage of funds. The recommendation therefore is to take into account “additional coverage”.

Problem #7: Cost assumptions

As discussed above, the GiveWell model assumes a constant cost per child of over \$1 across country and district. As we know, there is significant variation in the cost of VAS delivery programs and other interventions across countries. The cost of program delivery of VAS depends on many factors, including the level of investment by governments and capability of the existing health system to deliver an intervention. The availability and profile of health workers, supply chains, and security context can also be key drivers of intervention cost. In the Investment Framework for Nutrition in Afghanistan analysis, we collected cost data from differing regions across the country and different implementing partners of nutrition interventions. In this example, we saw we saw a range in the annual cost per beneficiary of VAS from \$0.34 to 0.60¹⁸. This variation, in turn, drives the variation on cost and cost-effectiveness by region.

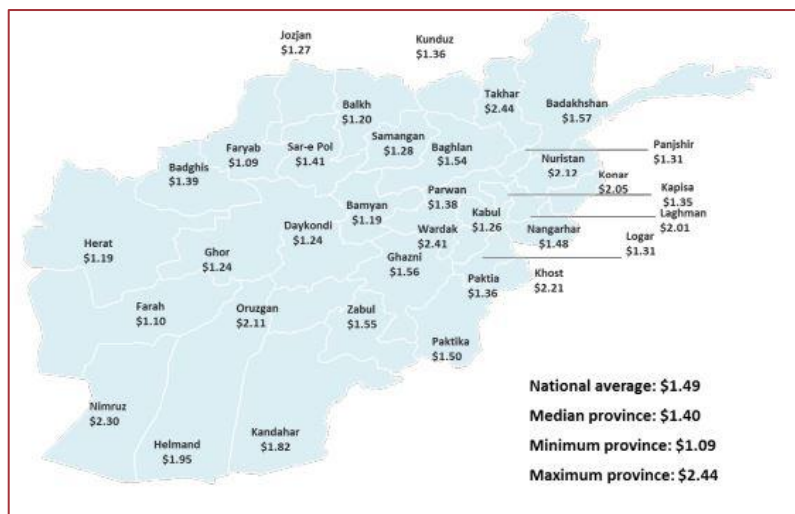
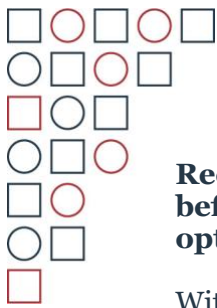


Figure 3. Annual per Capita Cost of BPHS Nutrition Core Interventions by region

As discussed earlier in this letter, given that this constant average cost estimate represents only the non-profit organization cost and that variation in cost components may be a key driver of the cost-effectiveness model of any intervention, it is likely that this lack of more detailed costing data is limiting GiveWell’s ability to achieve optimal value for money from its investments.

¹⁸ Walters et al. (2018) An investment framework for nutrition in Afghanistan. <https://openknowledge.worldbank.org/bitstream/handle/10986/30313/126287-WP-An-Investment-Framework-for-Nutrition-in-Afghanistan-PUBLIC.pdf?sequence=5&isAllowed=y>



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Recommendation #5: Conduct a country-level optimization analysis before making large funding for VAS (public health/micronutrient need, optimal mix of interventions, and costing) and other interventions.

With the increasing scale of investments made by GiveWell and partners into the millions and soon billions of dollars, it would be wise for GiveWell to invest a small amount of funds into conducting a detailed optimization analysis, in certain circumstances, to ascertain better context-specific estimates of the cost of VAS or other health and nutrition interventions such as fortification and multiple micronutrient supplementation. A country-level optimization analysis could include aspects of public health micronutrient gap analysis, assessing the optimal mix of interventions, and costing analysis of interventions and delivery platforms in various scaling scenarios¹⁹. In addition, this country-level optimization analysis could also include a sensitivity analysis to demonstrate the level of uncertainty in any investment based on assumptions with variation. This change alone could drastically change GiveWell's actual cost-effectiveness.

Summary of Recommendations

#1: Adopt a “Value for Money” approach

#2: Change to a two-stage value for money process: Interventions first, implementers second

#3: Application of generally accepted methodologies for economic evaluation in health and development

- A. Estimate Disability-Adjusted Life Years (DALYs) averted of interventions rather than only lives saved
- B. Incorporate benefit-cost analysis into decision-making
- C. Invest in field-level cost data collection and costing analysis

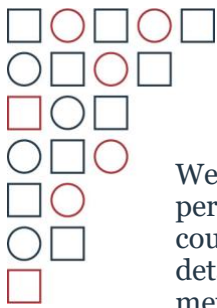
#4: Use the more conservative mortality reduction effect size for VAS

#5: Conduct a country-level optimization analysis before making large funding for VAS (public health/micronutrient need, optimal mix of interventions, and costing)

CONCLUSION

We sincerely feel that GiveWell's mission and approach to date to make cost-effective investments has been ground-breaking and innovative. However, GiveWell's cost-effectiveness model for the interventions selected is in a sense conducting analysis on what the health, nutrition and development community have already established as some of the most cost-effective or best value for the money interventions in existence today, and there few factors or data inputs within the model that would change this outcome.

¹⁹ Vosti et al. (2019) Strategies to achieve adequate vitamin A intake for young children: options for Cameroon.



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We feel that a GiveWell has earned the right to re-think its analytical model, and perhaps utilize a more nuanced value for money approach complemented by detailed country-level optimization analysis for its large investments that incorporates detailed public health analysis, costing analysis, and a generally accepted methodology for cost-effectiveness/benefit-cost analysis. This approach would provide GiveWell and partners with more informative and useful “data for decision-making” and confidence in its investments, rather than replicating the high-level cost-effectiveness analysis that is more useful for advocacy. As interventions and country contexts become more complex, we feel that it is important for this analysis to take place for GiveWell’s existing investments or emerging interventions with potential to be good value for money such as Multiple Micronutrient Supplementation, large-scale food fortification, breastfeeding promotion or SQ-LNS.

We hope that some of these ideas – and those of the other entrants to the innovative contest - can be of use to GiveWell. As the saying goes: “all models are wrong, but some are useful” is a helpful perspective that we take in our own improvement of our assessments. We are not motivated by the prize money of the contest (ironically the first author of this letter is a resident of the province of Quebec and therefore not even eligible for the prize, but the co-authors are). Rather, we are strongly motivated to provide a standing offer to GiveWell to work together on improving both of our models in the future as we of we share the same goal of ensuring that our investments achieve “save or improve lives the most per dollar” and support the achievement of the United Nations Sustainable Development Goals.

Sincerely,

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