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# Better Health Systems Strategies that Work

Exploring the impact of Health Systems 20/20 worldwide

## Output-Based Financial Reporting: Linking Financial Data with Monitoring & Evaluation Data

### RISING DEMAND TO MEASURE PERFORMANCE AND COSTS

Last year, more than 20 countries asked Health Systems 20/20 for support in collecting and analyzing costing data. Donors and governments used to ask: Does this project work? But now they want to know: How much more can we get out of what we have? Increasingly cost conscious, they are seeking more specific financial information that will allow them to understand the true cost of providing health services, what services are really being provided, and how much it will cost to sustain them.

In response, Health Systems 20/20 applied costing techniques to program monitoring to produce an approach called Output-Based Financial Reporting (OBFR). OBFR focuses on responding to specific questions rather than producing high-level aggregated unit costs. OBFR intentionally builds in-country capacity to ask the right costing questions, to conduct simple but effective analyses, to recognize the limitations of costing data, to understand how to use it for policy questions and program design, and to answer program management questions.

### HOW DOES OBFR WORK?

OBFR links cost data with a program's existing monitoring and evaluation (M&E) data to provide a detailed understanding of how programs turn resources into outputs, such as health services. The OBFR process is designed to ensure that implementing organizations and funders will have a deeper understanding of what specific services are being delivered and how much these services cost per unit, leading to evidence-based planning, programming, budgeting, and, ultimately, the more efficient use of resources.



*“Normally, we receive the financial reports and M&E reports separately, so we should be able to use this tool to train our partners to improve their narrative reports. What I’ve learned from the workshop will also improve my financial reports. I will use the OBFR to better describe activities and services, and the donor can see how we’re different from other groups.”*

**Mr. Kennedy Zachariah Panja, Program Officer, RODI, Tanzania**

OBFR differs from basic M&E reporting not only by including costs, but also by increasing the specificity and detail provided on program outputs. As the six steps in the OBFR process imply (see Figure 1), it takes time and effort to verify that the correct question is asked at the outset to obtain useful, actionable answers. OBFR demonstrates that “What is the unit cost?” is rarely the right question. Rather, there are countless “right” questions, depending on the country context, program needs, donor and government priorities, and a myriad of other factors.

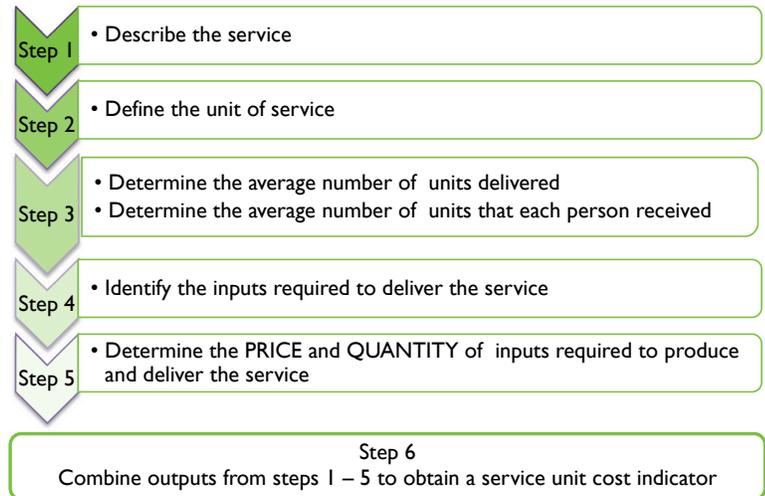
For instance, if a project is spending \$240 annually on community-based care (CBC) for a child with HIV, what does that cover – tuition, a school bag? Nutritional counseling or food? How many children? Are there other outputs beyond “children served,” such as building the capacity of local community care providers? Knowing what was bought, as well as what was spent, is far more useful to the donor, the program, and the governments who need to advocate for and fund these programs.

The OBFR process begins with a discussion around the objectives of the programs, with a view to drilling down to a clear description of who the program beneficiaries are and what they receive. Beneficiaries in this sense could be orphans and vulnerable children (OVC), pregnant women, or local non-governmental organizations. Next, there is a thorough review of both financial and M&E data along with program work plans and objectives. The financial review focuses on collecting expenditure information and categorizing that information into labor, supplies, overheads, and miscellaneous (e.g., training) expenses. The M&E review focuses on how the services delivered or received are counted by the organization so that an output unit cost describes costs in terms of what the program actually produces. For example, services could be described in terms of the care received or the supervision and training a local organization requires to deliver that care. These steps ensure that the service unit cost gives the program’s historical cost for delivering a single, specific unit of service that is more informative than a mere “dollar per beneficiary” value.

## OBFR IN MOZAMBIQUE AND ETHIOPIA

USAID missions in Africa have expressed interest in knowing more about the costs involved in delivering HIV/AIDS programs in order to better measure the efficiency of community-based programs. To implement USAID Forward principles, missions are increasingly supporting the institutional strengthening of their NGO partners’ capacity to integrate cost data into their M&E reporting. Health Systems 20/20 developed and delivered a two-day OBFR workshop in Mozambique, Tanzania, and Ethiopia for NGO implementing partners, followed by a program of approximately six months to support them as they began to implement OBFR. Building the in-country capacity to capture and understand true program costs is critical to ensuring the long-term sustainability of health programs.

**FIGURE 1. OBFR FLOWCHART**



During the OBFR workshops, Health Systems 20/20 staff worked closely with participants to identify the right costing questions that would result in useful recommendations for their programs (see Table 1)

**TABLE 1. THE LINK BETWEEN COSTING OBJECTIVES AND RECOMMENDATIONS**

	<b>Mozambique</b>	<b>Ethiopia</b>
Costing Objective	Identify variations in unit costs and their causes across select partners to identify opportunities to increase efficiency of the use of the limited resources available for CBC services.	Costing data will support decision-making around the standardization of peer education models by providing evidence cost, process and implementation variations across models.
OBFR Recommendation	<ul style="list-style-type: none"> <li>• Increase detail of M&amp;E indicators to include visits to allow for more accurate costing and a better understanding of what beneficiaries actually receive.</li> <li>• Make OBFR part of annual reporting.</li> <li>• Seek opportunities to leverage operations across sub-recipients to lower unit costs.</li> <li>• Ensure needed supplies are used efficiently and available consistently.</li> </ul>	<ul style="list-style-type: none"> <li>• Requiring unit costs to be determined by target population and by curriculum length would help ensure that the cost data are understood and used correctly for decision-making</li> <li>• Make OBFR part of annual reporting</li> </ul>

In **Mozambique**, Health Systems 20/20 was asked to cost CBC for people living with HIV (PLHIV) and OVC. Site visits and key informant interviews were conducted with eight of USAID’s CBC partners across four provinces, and each partner’s expenditure and M&E reports were reviewed. Key informants provided detailed information regarding the type, scope, and quantity of services provided. Following these visits, program staff attended a workshop to learn the OBFR process and validate the draft results. The unit cost for delivering one home-based care (HBC) visit ranged from \$1.95 to \$16.91 and one visit to an orphan or vulnerable child ranged from \$0.55 to \$16.74. CBC program structure and size varied widely across partners and drove costs variations. Large, provincial-wide programs benefited from economies of scale unlike the smaller, district-level organizations. Service delivery costs were lower among international NGO partners compared to local partners who also needed institutional strengthening activities provided by international partners. These findings are important to a donor seeking long-term sustainability outputs as well as short-term benefits for PLHIV. Knowing the additional cost is due to strengthening activities rather than inefficient service delivery can be vital information when donors and governments are using cost data as evidence in policy making and program design.

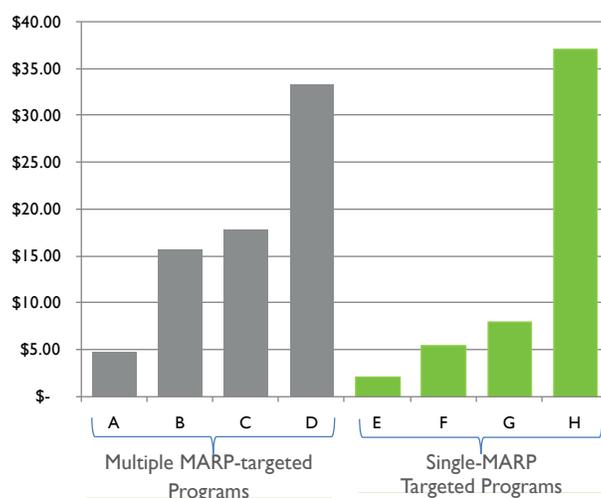
In Ethiopia Health Systems 20/20 worked with the Federal HIV/AIDS Prevention and Control Office of Ethiopia, implementing partners, and USAID to identify the true costs of providing four different models of curriculum for peer education for HIV prevention among most at risk persons (MARPs). Variations in unit costs per beneficiary were seen to be associated with different target populations because there is variation in the way programs are managed and implemented that have cost implications, see Figure 2 showing different unit costs per beneficiary reached between partners delivering the same curriculum model. Also, unit costs tended to be higher in programs that targeted multiple MARP populations (e.g., CSWs, migrant workers, and PLHIV covered together in one integrated program.)

It was also observed that programs adapted the same curricula according to the target population. For example, one program using Model A delivered the curriculum in 10 sessions to CSWs, but in four sessions to migrant workers; in other words the same program delivered the same curriculum model at a different unit cost for each of the two MARP populations reached. These findings mean that at a program design level, when standardizing a program output at the national level, it is important to recognize that there will still be variations in costs at the program delivery level depending upon the number and mix of beneficiaries targeted. This information is critical for government, donors and implementing partners.

## CONCLUSION

The old “spreadsheet tools producing tables of costs” approach to costing a health program is inadequate to address what country stakeholders and donors need in today’s environment. The response to a request for a costing activity must include building a common understanding of why they want it and what they want to do with the information. The response should build local capacity to ask the right questions at the outset and integrate cost data into M&E reporting over the long term. Understanding how resources are turned into outputs is a major step towards ensuring good stewardship of scarce resources at every level of program implementation.

**FIGURE 2. UNIT COST PER HIV PREVENTION PEER COUNSELING BENEFICIARY**



### About the Better Health Systems: Strategies that Work Series

The Better Health Systems briefs explore Health Systems 20/20 strategies and tools, why they work, and how they contribute to better health systems. Collectively, the series will distill valuable lessons learned in an effort to share the project’s wisdom with our partners and colleagues. For more information, please visit [www.healthsystems2020.org](http://www.healthsystems2020.org).

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### About Health Systems 20/20

Health Systems 20/20 is USAID’s flagship project for strengthening health systems worldwide. By supporting countries to improve their health financing, governance, operations, and institutional capacities, Health Systems 20/20 helps eliminate barriers to the delivery and use of priority health care, such as HIV/AIDS services, tuberculosis treatment, reproductive health services, and maternal and child health care.

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