



OUTPUT BASED FINANCIAL REPORTING OF COMMUNITY BASED CARE PROGRAMS IN MOZAMBIQUE

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ACRONYMS

CBC	Community-Based Care
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBC	Home-Based Care
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MOSW	Ministry of Women and Social Welfare
NGO	Nongovernmental Organization
OBFR	Output-Based Financial Reporting
OVC	Orphans and Vulnerable Children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
SCIP	Strengthening Communities through Integrated Programming
USAID	United States Agency for International Development

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EXECUTIVE SUMMARY

In Mozambique, which has one of the highest HIV prevalence rates in the world at 14 percent, a costing and capacity building exercise was undertaken by the United States Agency for International Development's Health Systems 20/20 project to analyze the costs and services within the community-based care (CBC) program. The CBC program's objective is to mitigate the impact of HIV in the community by providing a basic package of support to orphans and vulnerable children (OVC) and people living with HIV (PLHIV). The objectives of the exercise were to: (1) deepen CBC implementing institutions' understanding of the unit costs of CBC services and the components of those costs; (2) strengthen partners' capacity to regularly collect and use costing and service delivery data; (3) combine and analyze financial expenditure data with monitoring and evaluation (M&E) data to estimate unit costs by intervention; and (4) identify variations in unit costs and their causes across select partners in order to identify opportunities to increase efficiency of the use of the limited resources available for CBC services.

Site visits and key informant interviews were conducted with nine CBC partners across four provinces. Expenditure and M&E reports were reviewed by the Health Systems 20/20 team for each CBC partner. Key informants provided detailed information regarding the type and scope of services provided as well as the quantity of services. Unit costs for each service were estimated through an Output-Based Financial Reporting (OBFR) approach, which links financial and M&E data to give a detailed understanding of how programs turn their resources into services.

Results indicate the unit cost for delivering one home-based care (HBC) visit to a PLHIV ranges from US\$1.16 to US\$16.91, and one visit to an OVC ranges from US\$0.66 to US\$16.74 across the partners. Although all the partners deliver CBC in line with the national guidelines and protocols, two "models" of service delivery can still be observed: the first is an integrated program run by a single partner delivering OVC and HBC CBC and other types of care; in the second model, a prime partner supports sub-recipients' programs that deliver primarily or only CBC. The average cost of HBC and OVC visits in the first model is US\$2.32 and US\$1.29 (respectively), and US\$7.88 and US\$6.73 (respectively) in the second model of care. The differences in costs between the two models can be explained by differences in scale, with the Model A partners operating at the provincial level, compared to the district-level operations of the service delivery partners in Model B. There was little variation in costs among the partners executing Model A. However, there were significant variations in costs amongst the partners executing Model B, with the most expensive program costing approximately 16 times the cost of the least expensive program. Again, scale explained much of the variation in costs, along with a difference in the intensity of visits per beneficiary reported. In general higher costs were associated with smaller programs, while program structure and scope varied widely across partners and were large cost drivers. Large province-wide integrated programs benefited from economies of scale across shared administrative resources, unlike the smaller, more focused district-level organizations.

Several recommendations can be made for strengthening the CBC program and improving the efficiency with which the program uses its resources, as well as better understanding its impact and contributing to increasing its sustainability. In particular, recommendations include increasing the detail of M&E indicators to include visits to allow for more accurate costing and a better understanding of what beneficiaries actually receive; requiring OBFR to be part of annual reporting; seeking opportunities to leverage operations across sub-recipients in order lower units costs; and ensuring that any supplies needed are used efficiently and available consistently if they are deemed to be necessary. Finally, two further studies are recommended, one to determine how the CBC program actually improves OVC

access to health and educational support, and a second to determine measures of capacity building impact so that investments in building the capacity of local partners are made with clearly projected outcomes. It is essential that partners and funders understand the costs and cost drivers of services to support policy development, program planning and management, and to monitor the efficiency of resource use. OBRF is a basic approach to estimating costs and identifying cost drivers that is simple and fast enough to be conducted by partners on an annual basis.

I. INTRODUCTION

I.1 BACKGROUND

With one of the highest HIV prevalence rates in the world (14 percent), Mozambique has an estimated 510,000 orphans and vulnerable children (OVC) affected by the epidemic and over 1.5 million people living with HIV (PLHIV). To help address this challenge, the Government of Mozambique's community-based care (CBC) program aims to improve the quality of life and increase the lifespan of PLHIV and OVC, mitigating the impact of HIV. Although CBC is included as one of the key areas for national focus in Mozambique's Health Sector Strategic Plan and a minimum package of services for children is currently being piloted, there are still gaps in the understanding of what specific services are being delivered under CBC programs and how much these services cost.

Many stakeholders and sources of funding are involved with providing CBC services in Mozambique. The Ministry of Health (MOH) provides oversight of CBC to PLHIV and people living with other chronic conditions and is responsible for developing guidance and protocols for implementation by community care organizations. These visits are referred to as "Cuidados Domiciliários" or PLHIV home-based care (HBC) visits throughout the report.

The Ministry of Women and Social Welfare (MOSW) oversees the policies and protocols that guide home visits provided to OVC. These visits are referred to as "Visitas Domiciliárias" or OVC home visits throughout the report. These standard protocols and accompanying forms, provided by the MOH for CBC to PLHIV, and the MOSW for OVC visits, drive the types of CBC interventions and reporting mechanisms used by implementing partners. The result is that while variation exists in the structure and management of CBC and OVC programs, the basic interventions provided and reporting requirements are standardized across partners.

Major sources of funding for CBC services that include both PLHIV care visits and OVC home visits include the U.S. government and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). Through the Global Fund, local organizations receive funding to strengthen the capacity of community systems to increase access to quality CBC and OVC services. The U.S. government provides funding through its CBC implementing partners including Family Health International, Pathfinder International, World Vision, and several local organizations, to strengthen capacity to deliver CBC services.

In 2011, the United States Agency for International Development (USAID)-Mozambique requested Health Systems 20/20, a USAID-funded health systems strengthening project, to conduct a costing and capacity building exercise to ensure that the government of Mozambique, implementing partner organizations, and funders have an improved understanding of what specific services are being delivered and how much these services cost. Furthermore, the exercise would address limitations in partners' capacity to regularly collect expenditure and monitoring and evaluation (M&E) data and use them in combination, to provide financial management metrics in terms of cost by intervention.

This costing report provides an overview for technical staff, implementers, policymakers, and donors of the CBC services being provided in Mozambique, as well as how much these services cost. The report will discuss in more detail differences between CBC program design, implementation, and management, each of which can be shown to impact cost.

1.2 OBJECTIVES

The overall objective of the CBC costing activity was to strengthen programming and CBC interventions through determining what CBC services are being provided to PLHIV and OVC and at what cost. The execution of this activity strengthened the capacity of implementing partners to use economic and financial data to ensure efficient use of resources as they deliver CBC. The information on services and their unit costs can also be examined across different models of support and management structures to look at how resources are invested into CBC programs.

Health Systems 20/20 also identified the capacity gaps of CBC partners that may be limiting their ability to collect and use financial and M&E data for costing analysis, evidence-based planning, programming, and budgeting. To build CBC partners' capacity to use financial and M&E data, a mentorship approach was applied to tailor capacity building efforts to each partner's specific needs and allow close M&E of the partner's progress and use of costing information in their program management.

2. METHODOLOGY

Health Systems 20/20 developed and implemented an output-based financial reporting (OBFR) approach to conduct the costing of CBC services in Mozambique. This section will describe the data collection process as well as OBFR and how it is applied to ensure that implementing organizations and funders gain an improved understanding of what specific services are being delivered and how much these services cost per unit.

2.1 DATA COLLECTION AND VALIDATION

To understand the context and scope of CBC services, a review was completed of available reports and documentation of CBC services in Mozambique. Key policy documents included the Operational Manual developed by the MOH for HBC visits for PLHIV and other chronic illnesses, as well as the Operational Manual developed by the MOSW for home visits for OVC. Following the documentation review, nine U.S. government-funded implementing partners recommended by USAID were selected for inclusion in the CBC costing.

In October 2011, site visits and key informant interviews were conducted with CBC partners across four provinces (Lichinga, Maputo, Nampula, Zambézia). Expenditure and M&E reports were reviewed for each implementing partner. Key informants provided detailed information regarding the type and scope of services provided as well as the quantity of services. Unit costs for each service were estimated using an ingredients-based approach.

In November 2011, a two-day workshop was held in Maputo with all participating CBC partners as well as stakeholders including representatives from the Center for Disease Control, USAID, and the MOH. Participants were introduced to the OBFR approach and all partners reviewed the cost data and draft unit cost analysis produced by Health Systems 20/20. The workshop was a critical step in engaging the CBC partners and validating the cost data.

2.2 OUTPUT-BASED FINANCIAL REPORTING

OBFR links cost and M&E data to give a more detailed understanding of how programs turn their resources into services. The OBFR process is designed to ensure that implementing organizations and funders will have an improved understanding of what specific services are being delivered and how much these services cost per unit. Ultimately this improved understanding will strengthen the efficient use of resources through evidence-based planning, programming, and budgeting.

OBFR differs from M&E not only by including costs but also in terms of the specificity and detail provided on the unit being costed. For example, while two partners may be providing some form of HBC, each partner may provide different “components” as part of that service, that is each unit of service is actually different:

- Partner A visits the home twice a month using a paid community worker who can provide basic medical care including the provision of medication for pain and basic opportunistic infection.
- Partner B visits the home once a month using a volunteer who has no medical training and cannot provide drugs but has been trained to recognize when to refer a patient to a health facility or nurse.

These two services can both be referred to as “HBC,” and each visit would be reported as one person reached (and some partners may even specify that the person is reached with a home visit, although PEPFAR indicators do not require this level of detail). But clearly the service or “visit” being provided by the two partners in this example is different. Each service has a different level of resource intensity (skilled vs. less-skilled labor, provision of medication vs. no medication) which will almost certainly result in different costs. One could also reasonably argue that there is likely to be a different level of impact as well. While impact is beyond the scope of OBFR in this report, it is important to note that the first step in an impact evaluation such as cost-effectiveness requires the clear definition of the outputs of a program and the cost of producing the output, prior to determining the outcome or effect of a program.

An example of a service unit cost indicator used in OBFR would be:

300 PLHIV were reached with home care visits consisting of 12 visits a year (monthly visits) by a clinical community worker who provides any of the following: medication for pain or basic opportunistic infection, and referral for medical care if necessary, at a cost of US\$400 per year

Figure 2.1 illustrates the six process steps in OBFR and the anticipated outputs linked to each step. The six steps are summarized briefly below, but an OBFR Process Guide and accompanying materials are available.

FIGURE 2.1: OUTPUT-BASED FINANCIAL REPORTING



The first three steps of the OBFR methodology specify the output of the service. These steps define: Who receives the service(s)? What do they receive? What are the components of the service(s) they receive? and How often do they receive the service(s)? As noted in Step 3, there may be gaps between the service definition and the way in which M&E data are collected.

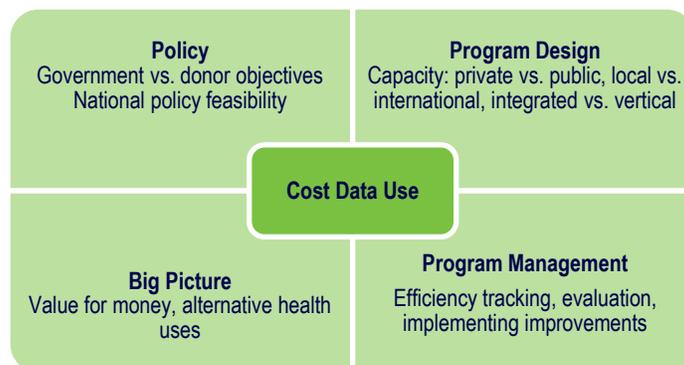
Steps 4 and 5 are used to determine the average cost of the output. This is conducted by identifying each input for each unit of service (labor, supplies, drugs, etc.) and attaching these inputs to actual expenditures as opposed to budget projections. Step 6 combines the outputs from the previous steps to arrive at the OBFR indicator. This indicator illustrates the program’s historical cost for delivering a single unit of service and can be used for policy development, program design, program management, and a wide array of other analysis and informed decision-making.

In terms of limitations, OBFR focuses on actual expenditures and therefore does not currently account for opportunity costs (e.g. volunteer time). Furthermore, while OBFR does provide nearly all of the costing information required for conducting cost-effectiveness analysis, it does not provide a cost per “outcome.” Rather it estimates the cost per “output” of a program. Further studies with extensive follow-up of beneficiaries would be required to determine the cost per outcome of a program or cost-effectiveness of a program.

2.3 USE OF OBFR DATA

OBFR data can be used for policy development, program design, and program management. The use of OBFR data is illustrated in the framework in Figure 2.2. A more extensive framework with discussion questions is presented in Annex C of this report.

FIGURE 2.2: COSTING DATA USE FRAMEWORK



For policy development, cost data can be used to guide discussions between governments and donors to weigh policy objectives against a changing donor environment. For example, cost data may inform how governments plan for reductions in PEPFAR funding, by estimating the resources required and informing how the government may be able to fill resource gaps to ensure coverage for policies enabling access to HIV/AIDS care. Cost data can also be used to help governments analyze the feasibility of certain policies from a financial perspective to determine if agencies have budgeted enough resources to meet their goals.

For program design, cost data can be used to inform decisions about how to structure the delivery of services. For example, cost data can reveal the differences between using a private sector nongovernmental organization (NGO) versus public sector facilities/staff to deliver similar services. The data can likewise help compare the costs of centralized or decentralized models of service delivery in a given context based on historical experience. Furthermore, the cost data allows practitioners to determine if integrated programs that cover a variety of services achieve economies of scale in comparison with vertical programs.

For program management, cost data can help managers evaluate efficiency. Consider the situation where similarly structured programs delivering similar units of service have vast differences in their unit cost indicators. This could lead to further investigations either of the lower-cost program's best practices or of the higher-cost program's cost drivers. The cost data can serve as a mode of comparison, coupled with analysis of the specific context and objectives of each program.

Beyond these uses, cost data can contribute to big picture discussions that respond to trends in HIV/AIDS programming and other health priorities. Cost data serves as one of the critical criteria that guides practitioners and policymakers in prioritizing certain interventions over others depending on the amount of financing available. Given the limited resources within the health sector, the cost data provides the basis for measuring how resources target particular populations (e.g., OVC and PLHIV) and whether a particular approach garners the most value for money. The OBFR data also provides evidence for demonstrating value for money or lays a foundation for impact evaluations.

2.4 CAPACITY BUILDING

The CBC partner workshop held in November 2011 served as an opportunity for partners and stakeholders to be introduced to the OBFR methodology and validate cost data. The partners were introduced to the basics of M&E and financial reporting as well as how to use OBFR to estimate their unit costs. Partners also discussed the ways in which they could use cost data in their own program management. In addition, the workshop introduced the CBC partners to Health Systems 20/20 mentors, based in Mozambique, who were paired with each CBC partner team to provide support over the following months. The local coaches from the Health Systems 20/20 team worked with community care partners over the next several months to address capacity gaps identified during the workshop. The goal was for each partner to cost an additional service or a modified version of a current service to demonstrate capacity to conduct unit cost estimation and OBFR.

3. CBC PARTNERS

This section provides a brief description of the CBC partners involved in the costing exercise, including an overview of the types of CBC interventions being delivered and the management structure of the different partners.

3.1 CBC INTERVENTIONS

The MOH and the MOSW provide the policy and guidance which dictates the type of interventions provided during HBC for PLHIV and other chronic conditions and OVC services. The package of community care services is described in the Operational Manual developed by the MOH for HBC visits for PLHIV and other chronic illnesses as well as the Operational Manual developed by MOSW for home visits for OVC. The result is that the basic structure and overall content of each CBC visit is fairly uniform across implementing partners. The differences between partners include the health status of the clients (i.e., some implementing partners have clients that suffer from more serious health conditions and require more intensive care), and the breadth of health messages covered across visits (i.e., some implementing partners have curriculums for volunteer home visits that cover a wider range of topics, but are inclusive of the standard guidance provided by the ministries).

The essential HBC services described in MOH guidance fall into five main categories:

- **Clinical care** – adherence support, referral system, assessment/management of opportunistic infection, basic physical care/instruction to family, nutritional status assessment
- **Prevention services** – health education regarding primary and secondary prevention, promotion of testing, disclosure support
- **Psychological care** – counseling, disclosure support, bereavement support
- **Social services** – food security, socioeconomic support, legal support (poverty certificate, inheritance protection)
- **Spiritual care** – counseling, comfort appropriate for the individual and family

For HBC visits to PLHIV and other chronic conditions, MOH policy describes the three standard kits that each implementing partner uses for HBC visits.

TABLE 3.1: KITS DESCRIBED IN THE NATIONAL POLICY

Kit	Description
Basic Care Package for Clients	Contains basic supplies for hygiene and care (e.g., soap, chlorine, male condoms and one Family Health Manual)
HBC Volunteer Kit	Contains a basic supply of medicine (e.g., paracetamol, oral rehydration solution, chlorine, benzine chlorhexidine) and materials (e.g., soap, condoms, thermometer, bandages)
HBC Nurse Kit	Contains a more comprehensive supply of medicines as compared to the Volunteer Kit (e.g., cotrimoxazole, amoxicilin, mebendazole, condoms, soap, compresses)

The MOSW minimum package of services provided to OVC during home visits includes the following categories:

- **Nutrition** – nutritional status assessment, nutritional education, support for regular access to adequate food and potable water
- **Health** – facilitate access to health services (through referral), health promotion and education
- **Psychosocial support** – emotional support, strengthen the family and community network for support
- **Education** – facilitate access to educational services, encourage staying in school, promote a supportive family and community environment for education
- **Housing** – facilitate access to housing
- **Legal protection and support** – facilitate access to official documentation such as identification cards
- **Economic strengthening** – map available resources within the community, support families to implement economic strengthening activities

3.2 DESCRIPTION OF PROGRAM STRUCTURES

Health Systems 20/20 collaborated with nine implementing partners to obtain cost and service delivery information. All nine receive funding from the U.S. government. Some receive funding from multiple donors.

The community care partners can be divided into three main categories or models based on program structure: (A) integrated programs, (B) prime programs with sub-recipients, and (C) local associations. Characteristics of each category of structure are described in Table 3.2.

TABLE 3.2: COMMUNITY CARE PROGRAM STRUCTURE

Model	Key Characteristics
A - Integrated	<ul style="list-style-type: none"> • Lead implementer is an international organization • Implemented by a consortium of partners • Provide an integrated package of services (e.g., health, agriculture, community empowerment) • Coverage is at the provincial level
B - Prime with sub-recipient	<ul style="list-style-type: none"> • Lead implementer is an international organization • Provide capacity building support to local sub-recipients • Local sub-recipients (civil society organizations) at the district level receive grants and capacity building support from the prime partner
C - Local association	<ul style="list-style-type: none"> • Implementer is a local association • Small levels of funding are received from multiple donors often for specific, short-term projects • Often lack sufficient staff and resources

The analysis presented in this report includes data from two integrated programs (Strengthening Communities through Integrated Programming [SCIP] 1 and 2), one prime and its sub-recipients (Sub-Recipients A through E), and one local association based in Gaza province.

4. RESULTS

This section will present the results of the data collection by describing the partners, their activities, and the unit costs of those activities. Partners are not named, although a list of all the partners whose data is presented here is available in Annex A. The results are presented in terms of the three models of service delivery described by the authors.

Overall, the approach to providing HBC and OVC care is similar across all the implementing partners visited because they follow the national protocols for delivering this care. Essentially, the care is provided through volunteers who are trained to provide care and support to the target groups. Each volunteer has a target number of households – on average, 10 households per volunteer was reported. Each household contains a PLHIV or an HIV-related OVC that the volunteer is required to visit at least twice a month. In each case the unit of service costed is the visit at which volunteers deliver very basic medical care using the HBC kits, or make referrals if necessary (typically the HBC volunteers inform their nurse supervisor who then follows up with the patient to provide care that is beyond the capacity of the volunteer to deliver). It is assumed for costing purposes that each patient on average receives two visits a month, but in reality some patients require fewer visits and others more. In addition to medical care, the HBC volunteer may spend time with the patient providing spiritual support, positive prevention counseling, and carry out minor household tasks including making the bed or assisting the patient to bathe if necessary. Across partners, the same types of HBC kits are provided: one for volunteers and one for nurses. Basic hygiene kits may also be provided to households with PLHIV and households with OVC.

Differences from this standard protocol are noted below in the individual partner result sections.

4.1 MODEL A – INTEGRATED PROGRAMS

Two of the service delivery partners (SCIP 1 and SCIP 2) provide OVC and HBC care as two elements of a larger program, hence the use of the term “integrated” programming. These programs use volunteers that deliver health information beyond HIV-related care. The unit costs of delivering HBC and OVC care in these programs are shown in Table 4.1. SCIP 1 provides HBC care at a cost of US\$73.27 per person per year, assuming that each person receives two visits per month (on average) and receives basic medical care or nursing care where necessary as well as other spiritual, preventive, and household care.

TABLE 4.1: UNIT COSTS (US\$ PER VISIT) OF PROVIDING HBC/OVC CARE THROUGH INTEGRATED PROGRAMS

	PLHIV HBC Visits		OVC Home Visits	
	SCIP 1	SCIP 2	SCIP 1	SCIP 2
Supplies	\$0.57	\$0.23	–	\$1.04
Training	\$0.94	\$0.84	\$0.22	–
Labor	\$1.06	\$0.16	\$0.01	\$0.46
Overhead	\$0.49	\$0.36	\$0.49	\$0.36
Unit cost	\$3.05	\$1.59	\$0.73	\$1.86
Unit cost per person per year*	\$73.27	\$38.04	\$17.43	\$44.72
Number of visits per month	13,296	1,734	111,624	41,492

*Assumes that on average each PLHIV or OVC is visited twice a month.

Supplies used in the HBC program are primarily the cost of the HBC kits. Variation in the use of nurses' kits (not used in SCIP 2) (and, potentially, the efficiency with which they are used) resulted in the differences in supplies costs. Despite having wide variation in the number of HBC visits made, the two programs appeared to use a similar number of volunteer kits, and therefore the analysis has to assume that not every volunteer in SCIP 2 receives an HBC kit. The difference in supplies for the OVC program is due to SCIP 2's distribution of hygiene kits when available to the households containing OVC. At a cost of US\$10 per volunteer kit, if every household received a kit this would amount to nearly half a million dollars, a substantial cost not covered by the SCIP 1.

Unlike the HBC kits, the basic care packages are not paid for by the program but are received from Populations Services International and are primarily focused on water hygiene and diarrheal disease control. Each basic care package costs approximately US\$7.07 including the cost of assembling and transporting the packages to the respective partners. In 2011, SCIP 1 received 15,000 basic care packages and SCIP 2 received 7,340. In addition, many of the OVCs reached by SCIP 2 are participating in a Young Farmer's Club program that is included in the supply cost category.

The SCIP 1 program has separate volunteers trained to deliver HBC or OVC care, whereas the volunteers in SCIP 2 are trained to provide both types of care. The training costs for SCIP 2 volunteers are captured under the HBC care as this is the more intensive of the trainings that volunteers are required to take and it is longer in duration. Therefore, the difference in training costs is not actually wide at the program level. Another difference between the two programs is that SCIP 2 was about to introduce stipend payments to HBC volunteers as per the national protocol and so those costs are included in the cost estimated here. SCIP 2 did not report paying nurses for their support, unlike SCIP 1 where nurses supervise volunteers and are a fundamental part of the program and the labor cost. SCIP 2 uses the same supervision structure for both its HBC and OVC programs since the volunteers do both, and because there are many more OVC visits, more of this labor cost has been allocated to the OVC program.

Overhead costs for each of the two programs work out to a similar amount per visit, and are driven largely by transportation costs that amount to 40 percent of monthly overhead for SCIP 1 and 70 percent for SCIP 2.

4.2 MODEL B AND C – NON-INTEGRATED PROGRAMS AND A LOCAL ASSOCIATION

Five of the partners visited are sub-recipients of a prime partner and one of the partners visit is a local association. The prime partner does not deliver service directly but supports and manages its sub-recipients who in turn deliver services directly through volunteers or informal networks of volunteers. Partners provide home visits for PLHIV and other chronic illnesses and OVC care using volunteers that are trained to deliver both types of care. One of the partners visited is a local association that delivers HBC services directly. Unit cost per PLHIV HBC visit ranges from US\$1.16 to US\$16.91 (Table 4.2).

TABLE 4.2: UNIT COSTS (US\$ PER VISIT) OF PROVIDING PLHIV HBC VISITS THROUGH NON-INTEGRATED PROGRAMS

	SUB A	SUB B	SUB C	SUB D	SUB E	Assoc
Supplies	\$0.50	\$1.39	\$1.50	\$0.87	\$1.05	\$0.17
Training	\$0.01	\$0.20	\$0.62	\$0.98	\$-*	\$0.42
Labor	\$0.05	\$3.26	\$3.08	\$8.64	\$4.03	\$7.79
Overhead	\$0.60	\$3.78	\$3.35	\$6.42	\$4.34	\$4.29
Unit cost	\$1.16	\$8.63	\$8.55	\$16.91	\$9.42	\$12.67
Unit cost per person per year**	\$27.77	\$207.12	\$205.20	\$405.95	\$226.15	\$304.12
Number of visits per month	1,080***	1,338	2,109	556	160	168
Number of people reached	199***	669	375	127	40	550

*While this sub-recipient may not have training expenditures in the year covered, this does not mean that in other time periods there won't be some training costs to add to this unit cost.

** Assumes that on average each PLHIV is visited twice a month; however, there will be variation in visit numbers due to variation in need.

*** 24 PLHIV need daily support.

An important observation to note is that only one sub-recipient, Sub-recipient A, stated specifically that some of its HBC beneficiaries required daily visits. Since these visits are conducted by the same volunteer, these daily visits drive the low unit costs for HBC visits seen for Sub-recipient A because each additional visit has a low marginal cost. This observation underlines the importance of understanding exactly how many visits are actually conducted as opposed to having to assume that all beneficiaries receive the same service on average.

Labor and overhead costs drive the differences between the sub-recipients, and these are discussed under the cost driver section. It should be noted that the high labor cost contribution for Sub-recipient D is because it has similar monthly salary expenditures and staff numbers as the other sub-recipients, but these are shared over relatively few beneficiaries. In addition it should be noted that Sub-recipient A had particularly low labor costs, relative to other sub-recipients, reporting just the program officers in addition to their 30 volunteers.

Table 4.3 shows the unit cost per OVC home visit across sub-recipients, which varies from US\$0.66 to US\$16.74 per visit.

TABLE 4.3: UNIT COSTS (US\$ PER VISIT) OF PROVIDING OVC HOME VISITS THROUGH NON-INTEGRATED PROGRAMS

	SUB A	SUB B	SUB C	SUB D	SUB E	Assoc
Supplies	\$0.00	\$0.22	\$0.28	\$0.66	\$0.00	\$2.56
Training	\$0.01	\$0.35	\$0.38	\$0.99	\$1.14	\$0.83
Labor	\$0.05	\$1.60	\$1.89	\$8.64	\$4.03	\$0.33
Overhead	\$0.60	\$3.78	\$2.05	\$6.45	\$0.53	\$5.73
Unit cost	\$0.66	\$5.95	\$4.59	\$16.74	\$5.70	\$9.43
Unit cost per person per year*	\$15.77	\$142.76	\$110.16	\$401.68	\$136.80	\$226.40
Number of visits per month	846	1,528	2,109	554	1,320	224
Number of people reached	423	95	328	151	30	1,680

*Assumes that on average each OVC is visited twice a month.

In summary, we see that across sub-recipients and the local association, the average cost of a PLHIV HBC visit is US\$8.46, and across the two integrated programs it is US\$2.32. For an OVC home visit, the average cost across sub-recipients and the local association is US\$9.56 and across the two integrated programs it is US\$1.29. The following section on cost drivers explains this variation.

The prime partner that manages the sub-recipients also has costs, but the units are different, since the activities that the prime partner carries out are fundamentally different from their sub-recipients. The authors recognize that from the donor viewpoint, the prime partner may be seen as an “implementer” that delivers services. However, from a cost estimate point of view, the reality is that the prime partner’s resources are turned into different outputs from its sub-recipients’, namely into supervisory (support) and capacity building activities to strengthen the implementing partners. This is a fundamental difference between the models of implementation (i.e., integrated and prime with sub-recipient programs) and outputs, where the prime with sub-recipient model has an additional output of 21 local organizations that are able to manage finances, provide M&E, and deliver services.

The prime partner provides direct funding to local organizations in seven provinces covering 52 districts. Each local organization takes the lead in supporting trained "activistas" to deliver integrated HBC and OVC services to identified families in their respective community and provide referrals to clinical and social support services. The prime partner is responsible for building technical and organizational capacity of the selected local organizations throughout the life of the project.

Since the costing study was initiated in the beginning phase of the prime partner’s new project, only two provinces are represented (Maputo and Niassa). Between the two provinces, the prime partner provided support to seven local organizations that received funding and initiated service delivery between February 2011 – January 2012. Organizations in Niassa province were further along in terms of implementation and required less trainings during this period. In addition, travel costs to Niassa were higher since the prime partner’s main office is located in Maputo.

TABLE 4.4: PRIME PARTNER UNIT COSTS OF SUPPORT FOR MAPUTO AND NIASA

	Capacity Building		Supportive Supervision/ Technical Assistance		M&E Support	
	Per CSO	Per Participant	Per CSO	Per Visit	Per CSO	Per Client
Training	\$6,516.55	\$223.61	\$806.08	\$67.17	\$806.08	\$2.16
Labor	\$9,509.03	\$3,26.29	\$6,940.80	\$578.40	\$5,482.29	\$14.71
Overhead	\$9,858.81	\$338.29	\$4,050.13	\$337.51	\$3,336.91	\$8.95
Travel	\$3,600.00	\$123.53	\$2,685.71	\$223.81	\$1,914.29	\$5.14
Unit Cost	\$29,484.39	\$1,011.72	\$14,482.72	\$1,206.89	\$11,539.56	\$30.96
Outputs	7 CSOs	204 participants	7 CSOs	84 site visits	7 CSOs	2,609 clients

Across Maputo and Niassa, seven CSOs (204 participants) received capacity building services and training from the prime partner in the last year, at an average cost of \$29,484 per training, or an average cost of \$1,011.72 per participant. A total of four trainings were conducted. Three trainings were provided to Maputo CSOs by the prime partner including a start-up workshop, a psychosocial support training and an M&E workshop. One training in the area of psychosocial support was provided to the CSOs in Niassa by the prime partner. Each province received a needs assessment. The prime partner conducted the needs assessment in Niassa, and a subcontractor to the prime partner conducted the needs assessment in Maputo.

The prime partner provided supportive supervision and technical supervision visits to seven sub-recipients by providing a total of 84 site visits per year, at an average cost of \$1,206.89 per visit. Supportive supervision consists of on-site visits by the prime partner's provincial staff or Maputo-based staff. A supervision visit is primarily observation and review of activities being implemented by a local organization and meetings with key stakeholders. A technical assistance visit is comprised of intensified one-on-one interaction with local organization staff and "activistas" to review processes used in implementation. Each technical assistance visit can include on-site job training, mentoring or one-on-one meeting to improve an issue identified. In this costing, technical assistance and supportive supervision visits have been combined.

Seven sub-recipients of the prime partner reached a total of 2,609 clients receiving M&E, quality control and oversight at an average cost of \$11,539.56 per sub-recipient. The prime partner is responsible for receiving M&E forms completed by each local organization. In Niassa, a field office is the first point of contact to receive and review monthly data collection forms prior to submitting to Maputo-based staff for final review and compilation. In Maputo, given proximity, the local CSOs submit monthly data collection forms directly to the M&E Lead. Local organizations receive orientation on the forms at various points. During the scope of work workshop a session on M&E is built in to review the purpose of each form, type of data to be collected and data flow. Follow-up meetings and technical assistance is provided to local organizations to support completion, comprehension and quality of data collection. The unit cost supports on-site and virtual support provided to local organizations in collecting routine monitoring data and data quality verification.

TABLE 4.5: PRIME PARTNER UNIT COSTS OF SUPPORT FOR MAPUTO AND NIASSA

	Capacity Building Per CSO		Supportive Supervision/Technical Assistance Per CSO		M&E Support Per CSO	
	Maputo	Niassa	Maputo	Niassa	Maputo	Niassa
Training	\$7,481.36	\$5,230.13	\$1,410.63	-	\$1,410.63	-
Labor	\$6,908.15	\$12,976.87	\$8,323.20	\$5,097.60	\$1,645.50	\$10,598.00
Overhead	\$7,036	\$13,621.93	\$4,759.84	\$3,103.84	\$1,494.45	\$5,793.53
Travel	-	\$8,400.00	\$850.00	\$5,133.33	-	\$4,466.67
Unit Cost	\$21,425.98	\$40,228.93	\$15,343.68	\$13,334.77	\$4,550.58	\$20,858.20
Outputs	4 CSOs	3 CSOs	4 CSOs	3 CSOs	4 CSOs	3 CSOs

Table 4.5 shows the increased costs associated with support to Niassa province due mainly to its location. As expected, support to Maputo requires less travel and less labor is required for capacity building and M&E Support. Labor is more in Maputo under the supportive supervision/technical assistance category due to the number of technical officers based in Maputo.

4.3 COST DRIVER ANALYSIS: EXPLAINING “BETWEEN” MODEL COST DRIVERS

It is essential when looking at unit cost data to understand the underlying factors that make up the unit cost in order for the estimates to be well understood and to ensure that the estimates are discussed and used appropriately. These factors, or cost “drivers,” typically account for the largest proportion of costs.

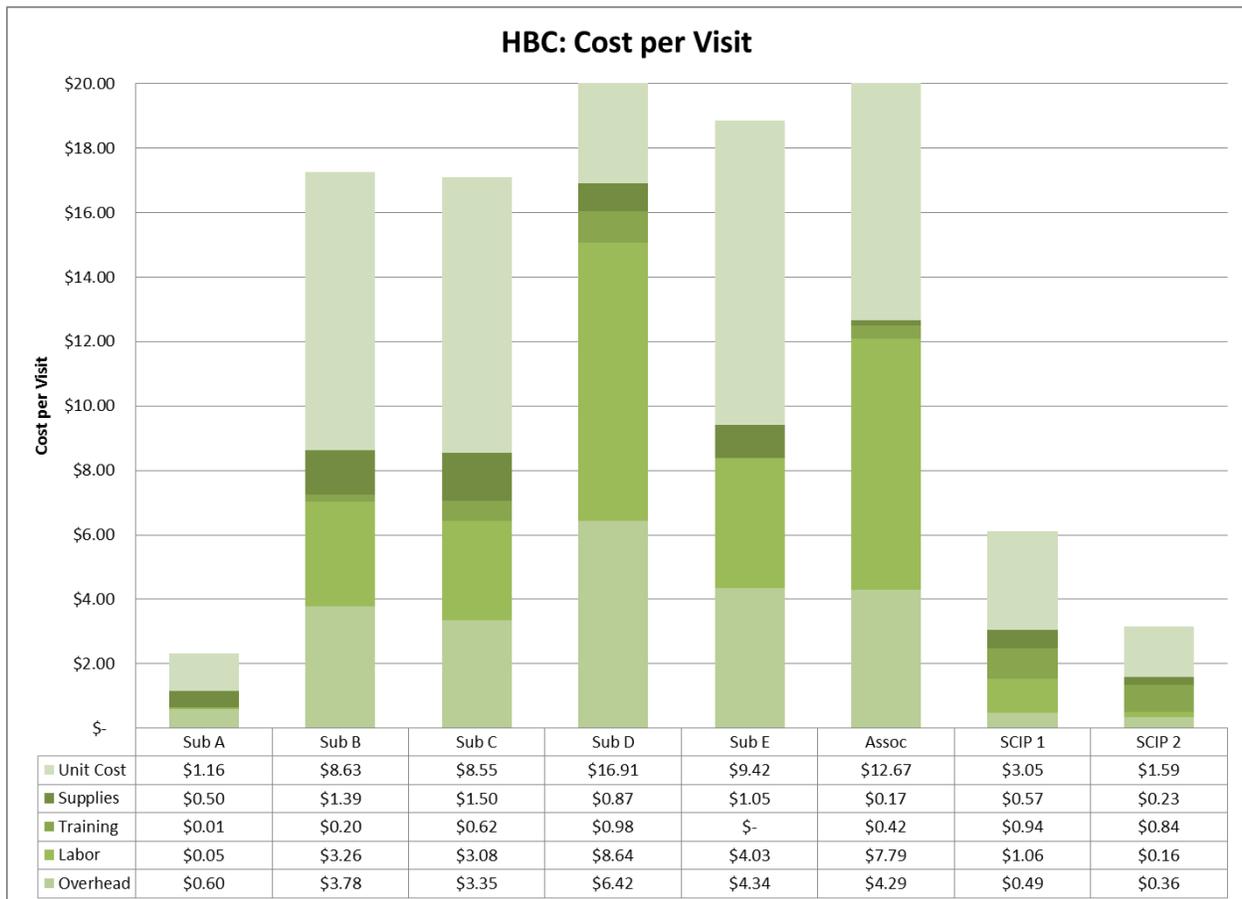
It should be noted that the two models of service delivery described and costed above have several important differences.

- **Duration** – the two integrated programs had been running for over two years at the time of data collection, while the sub-recipients’ programs were less than a year old at that time.
- **Scale** – while the overall scale of the two integrated programs and the prime with sub-recipient programs may appear similar when looking at the sub-recipients in terms of their prime partner (which is how their results are aggregated and presented to USAID), in reality they are operating on a very different scale from the integrated programs for OVC service delivery. The average number of OVC visits from each sub-recipient per year is estimated to be 1,271 visits, while the average number of visits across the integrated programs is 76,558.
- **Scope** – by definition, the integrated programs deliver other services beyond HBC and OVC, and therefore can leverage resources from those programs, in particular the types of resources for which expenditure is captured as overhead. The sub-recipients do not typically have this capacity, although at least two of the sub-recipients did receive funding from other sources to provide additional types of care.

All three of these characteristics play a major role in the capacity of each partner to benefit from economies of scale, which projects need to do if they are to operate most efficiently or at their lowest average cost. Another way of looking at this issue would be to say that these factors imply a different lowest average cost for each partner with a unique combination of characteristics, and a similar lowest average cost for those with the same combination of characteristics.

Looking at Figure 4.1, we can say that the cost drivers, that is, the factors accounting for the major portion of the unit costs, are different between the models. While overhead and labor account for much of the unit costs for the sub-recipients (first five bars), it is training, supplies and labor that account for the largest portion of unit costs in the implementing partners with integrated programs (last two bars). Given the variation discussed above in terms of scale and scope it can be reasoned that overhead and labor can be shared across all the services that integrated programs provide. Overhead can be shared across all the program’s services, and labor such as M&E officers and finance officers can work on more than just the HBC/OVC programs. However, this opportunity to leverage these resources is not available to the sub-recipient programs.

FIGURE 4.1: PERCENTAGE DISTRIBUTION OF INPUTS FOR UNIT COSTS (US\$ PER VISIT) OF PROVIDING HBC CARE ACROSS IMPLEMENTING PARTNERS



Furthermore, the integrated programs have a much larger target population, being provincial-level programs with very large numbers of PLHIV and OVC in need of care; as compared to the sub-recipient programs that are based at the district level where there is likely to be a relatively limited number of PLHIV and OVC. This smaller number of people needing care therefore limits the sub-recipients' and local association's capacity to grow and take advantage of the economies of scale that could lower their unit costs.

4.4 COST DRIVER ANALYSIS: EXPLAINING MODEL COST DRIVERS WITHIN THE SAME MODEL

The cost driver analysis for looking at differences between sub-recipients using the same model starts by also examining the issue of scale. Since overhead and labor account for the largest share of costs, these inputs are the focus of the analysis.

TABLE 4.6: MONTHLY OVERHEAD AND DIRECT LABOR EXPENDITURES FOR SUB-RECIPIENTS (US\$)

	Monthly Overhead	Monthly Direct Labor*	Overhead + Direct Labor	Total HBC and OVC Clients
SUB A	\$1,149	\$1,055	\$2,204	622
SUB B	\$5,570	\$2,448	\$8,018	764
SUB C	\$4,319	\$3,353	\$7,672	703
SUB D	\$3,571	\$2,005	\$5,576	278
SUB E	\$1,388	\$500	\$1,888	70

* Direct labor refers to staff directly responsible for the OVC or HBC programs, as opposed to non-direct staff such as partners' drivers or receptionists who are included in the overhead costs. Only a percentage of partner overhead (indirect costs) may be included in cost estimates of the OVC or HBC programs.

As the same volunteers typically provide HBC and OVC care among these partners, they are receiving the stipends which account for 50 percent of the direct labor costs (on average). There is little variation in overhead, although it is interesting to note that Sub-recipient A and Sub-recipient E have the same level of overhead despite having very different client numbers.

When comparing overhead and labor costs with the number of beneficiaries across sub-recipients we see that there are three sub-recipients which each reach between 600–760 beneficiaries, but have overhead and labor costs that vary between US\$2,204–US\$8,018. This seems to be quite a large cost variation for so little variation in output, but two possible reasons for this could be that in reality HBC visits happen more frequently than the protocol suggests due to need, or that the beneficiary numbers are not yet in a “steady” state because these sub-recipients were still in their first year of implementation at the time of this analysis.

4.5 CRITICAL ASSUMPTIONS AND ANALYSIS LIMITATIONS

As much as possible the OBFR approach to costing recommends that actual expenditures on inputs (labor, supplies, etc.) are linked directly to actual outputs wherever possible (visits, trainings, etc.) rather than being allocated. However, the approach recognizes that the service costed (e.g., volunteer trained) may not necessarily be a meaningful measure from the point of view of what the beneficiary receives. The OBFR approach will result in the costing of a service delivered that can be translated into what the beneficiary receives – that is, cost per visit produced by the HBC/OVC program. This unit can also be interpreted in terms of cost per person reached when we incorporate data about the number of visits each person receives. However, this analysis runs into a limitation at this point because it was not possible to use actual data on number of visits on average received by each beneficiary. Rather, the assumption had to be made that the volunteers had a given number of households assigned to them each of which they then visited, on average, twice a month. Given the findings for the cost of Sub-recipient A, we can see that this may be a very strong assumption that, if incorrect, will impact the costs estimated.

Given that the unit of cost was the visit, it would have been preferable to have had data on the actual number of visits rather than having to make an assumption. However, the M&E systems in place at all of the partners were not able to provide these data, so the analysis had to use the available data which tended to be the number of volunteers and the number of beneficiaries. Not having actual visit data constitutes a major limitation of this analysis.

5. DISCUSSION

This section presents a discussion of the results, structured as described by the Costing Data Use Framework in the Methodology section (Figure 2.2). This framework is described in detail in Annex C and is useful for further discussion of these results.

5.1 PROGRAM MANAGEMENT

Understanding the unit costs is fundamentally about understanding how resources are being turned into services, understanding what changes to the program will help it function more efficiently, and finally determining whether those changes, post-implementation, actually do result in efficiency increases. Focusing on the prime with sub-recipients model, the substantial variation between the partners – despite having overhead and labor costs that account for the majority of their unit costs, combined with wide variation in the number of beneficiaries reached – suggests inefficiency on the part of some partners. It is critical to note that all of these partners were in the early stages of their implementation, but this emphasizes the need for partners to (1) be able to cost themselves and produce unit costs for their own review, and (2) do so annually so that they can check to see that they are making efficiency gains as their targets increase.

5.2 PROGRAM DESIGN

The differences in cost and coverage of the models have implications for both USAID and partner governments' future program design. With the objective of building capacity, the prime with sub-recipient model is an evidence-based approach with known costs. The variation in costs may be considerable, but by examining the cause of variation and learning from the more-efficient partners, the average sub-recipient costs could be lowered. From the partner governments' point of view where resources are very limited, the integrated approach may be more attractive due to its lower unit costs and its potential to be leveraged to deliver other services such as family planning. Although the local capacity has not been built in the same way as the prime with sub-recipient model, the government could choose to contract the same service delivery partners as those currently administering the integrated programs. The costing information can be used to support such an approach or to cost the inclusion of such an approach in the national policy's operational plan when combined with policy targets and knowledge of the available budgetary resources.

Given the substantial efficiency gains that can be made by reaching a larger population of beneficiaries, it may be appropriate to consider ways in which the sub-recipients that are located close together might be able to share resources (such as supervisors) to lower their labor costs. From a longer-term perspective, the fact remains that small organizations that operate at a district level, such as the sub-recipients in Model B and the local association in Model C, will only ever be able to “grow” a limited amount due to target population size. Therefore, long-term planning must consider how to leverage the capacity currently being built in each of these organizations so that they can work together, perhaps with a local umbrella organization, to reach larger populations and to add on more services.

5.3 POLICY

Mozambique's OVC and HBC programs are predominantly donor-funded, and this has sustainability implications, particularly given the current global economic climate. Understanding the cost implications of the current programs is a first step in moving forward. The current policy documents lay out the protocols for delivering these services, but do not currently analyze the cost implications of service delivery targets. The cost estimates provided in this report can strengthen the current policies and be used in the development and costing of an operational plan for implementing the policies. In particular, the variation noted amongst the models and partners involved in HBC and OVC provide a more accurate picture of the cost of maintaining such programs given the variety of local capacity and need in Mozambique.

From the donor point of view, this analysis provides costing estimates and findings that can help country-level missions with their operational planning, but also with their country strategies as increasing emphasis is placed on the USAID Forward reform that is particularly designed to strengthen country ownership and sustainability (Annex B). The prime with sub-recipient model is clearly a strong approach to addressing at least three of USAID Forward's objectives, as it:

- Focuses on building partner country capacity (at the local NGO/civil society organization level) both in terms of service delivery and management.
- Builds competition in partner countries by strengthening several local institutions that can compete directly in future.

In addition, OBFR as a methodology helps USAID-Mozambique with the rebuilding of budget management (as recommended by USAID Forward) by introducing a costing approach that results in clearly understandable metrics describing what programs actually achieve, taking the guesswork out of thinking about value for money, which is necessary when separated M&E and expenditure data are the evidence for analysis.

5.4 BIG PICTURE

Without clear data on what beneficiaries actually receive as a result of interaction with volunteers, in particular OVC beneficiaries, it is very difficult to determine the actual benefit of the OVC programs. Understanding clearly whether identifying an OVC and conducting home visits leads to an improvement in that beneficiary's well-being is critical to determining the value for money of the OVC program. It may be that psychosocial care, the easiest service to measure since volunteers record the number of interactions (even though these are difficult to count at present), does improve OVC well-being. But it is likely that improving access to health and education services will make the most difference, and understanding whether this access is improved after identifying an OVC is absolutely critical before any discussion of "value for money" can occur.

6. RECOMMENDATIONS

Several recommendations for refining future cost estimates, increasing program efficiency, and evaluating program performance can be suggested from the costing results and discussion.

6.1 DISAGGREGATE M&E DATAS

It's critical to disaggregate M&E data to better understand what beneficiaries are receiving. Detailed information on visits is collected by volunteers, but this information is aggregated at every supervision step until it is limited to absolute numbers of beneficiaries reached and is stripped of a deeper understanding of what the beneficiaries receive. By disaggregating at a higher supervision level, the detailed data could be used to provide a more accurate unit cost estimate and also to identify the extent to which beneficiaries may be receiving services that vary by volunteer, geography, or some other yet-unknown criteria.

Some suggested specific metrics to leave disaggregated include:

- Actual beneficiaries per volunteer
- Actual visits per beneficiary, particularly for HBC where visits per beneficiary could be highly variable
- Counter-referral rates for health, education, and nutrition interventions

6.2 INTEGRATE/LEVERAGE ACROSS SUB-RECIPIENTS

Extending the costing analysis across more sub-recipients would provide more data that could assist with calibrating the “optimal” ratio of overhead/direct labor costs to number of beneficiaries, which would serve as a planning target to ensure that sub-recipients are operating efficiently at the lowest average cost per beneficiary.

6.3 CONDUCT ANNUAL OBFR EXERCISE

OBFR was designed to be a basic costing methodology that utilizes existing M&E and financial expenditure data. Although partners may see the value of understanding their cost structure, given competing demands on their time it may be useful for USAID to provide some incentive for partners to conduct OBFR. For example, requiring partners to report their unit cost data along with their M&E data would be a quick and evidence-based way for USAID to review and evaluate unit cost information at the same time as it reviews annual reports.

6.4 MONITOR INFORMATION ON SUPPLIES

Supplies have the most potential to impact unit costs after labor and overheads. It is important for partners to share information so that it is clear how many units of supplies (like hygiene kits and HBC kit refills) are actually supplied, needed, and used.

6.5 CONDUCT ADDITIONAL, TARGETED ASSESSMENTS

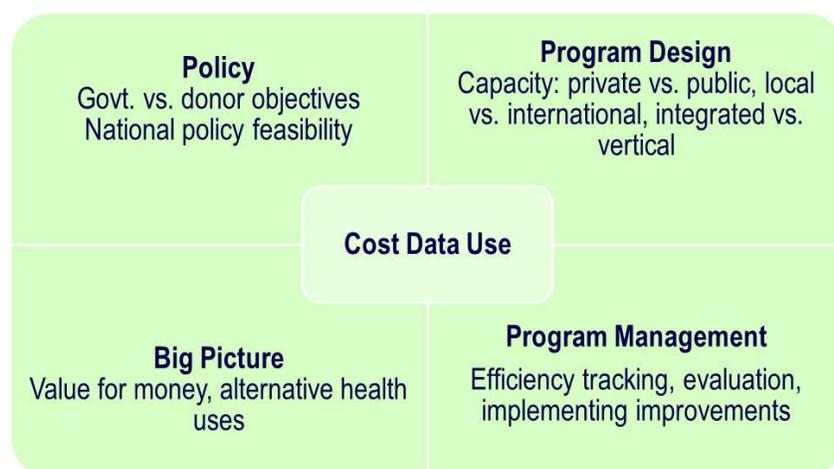
Two assessments are recommended to further strengthen the CBC program in Mozambique. Firstly, it is fairly urgent that an evidence-based evaluation be conducted to determine how the CBC program actually improves OVC access to health and educational support. For HBC, there are indicators capturing the number of HBC recipients who “graduate” from needing care, but this does not appear to be knowledge that translates into a reasonable objective for the program – an important issues when discussing the sustainability of the program. A second analysis is recommended to determine measures of capacity building impact so that investments in building the capacity of local partners are made with clearly projected outcomes. Understanding the costs of capacity building as it occurs alongside service delivery is the first step in operationalizing the USAID Forward principles for building strong country partner institutions and sustainable programs.

ANNEX A: LIST OF PARTICIPATING CBC PARTNERS

Participating Community Care Partners

- 1) *Associação Crista Interdenominacional para o Desenvolvimento da Comunidade (ACIDECO)*
 - 2) Christian Council of Mozambique (CCM)
 - 3) Comissão Diocesana de Saúde (CDS)
 - 4) Estamos
 - 5) Kupona
 - 6) Ogumaniha
 - 7) Reencontro
 - 8) Strengthening Communities through Integrated Programming (SCIP) Nampula
 - 9) Family Health International
-

ANNEX B: COSTING DATA USE FRAMEWORK



Area	Donor/U.S. Government	Government
Policy	<ul style="list-style-type: none"> How will the programs be structured in future? Does an integrated program achieve reasonable marginal costs? What are we willing to spend/invest to build local capacity vs. spend on service delivery? Is the absorptive capacity available for larger amounts of funding? How is universal access to services provided with potential budget reductions? 	<ul style="list-style-type: none"> In policy/strategy/operational planning, has the population been identified? And is the data being used to estimate a budget envelope? Or is there a budget envelope and is costing data used to: <ul style="list-style-type: none"> Prioritize? Choose interventions to serve the most? Choose interventions to serve the most vulnerable? Is the absorptive capacity available for larger amounts of funding? Which HIV/AIDS prevention services should be included in the national guidelines?

Area	Donor/U.S. Government	Government
Program Design	<ul style="list-style-type: none"> • Should international NGOs be used as primary recipients/grant managers with local partners as sub-recipients in order for the primary to develop the capacity of sub-recipients? • Have targets per partner been set to ensure that economies of scale are achieved and to promote efficiency of resource use or were other criteria used for setting partner targets? 	<ul style="list-style-type: none"> • How are targets met using the same models being used by donors like USAID? <ul style="list-style-type: none"> ◦ Using private sector NGOs? ◦ Using public sector facilities/staff? • Should budgeting be included for all the non-service delivery activities that are required by the programs e.g. M&E, Supervision, Capacity Building, others? <ul style="list-style-type: none"> ◦ And the capacity building required to conduct these non-service delivery activities?
Program Management	<ul style="list-style-type: none"> • How is efficiency evaluated? • Do findings from one partner suggest that another partner should be doing something differently? • How do we know that we have built capacity such that the program will function in the absence of: <ul style="list-style-type: none"> ◦ Donor funding ◦ International NGO grant management • Is an integrated program management approach – in which the management of several vertical programs is conducted by one set of financial and M&E staff – rather than a services received approach lowering the costs of these unit management activities? • What additional benefits do the beneficiaries receive and at what marginal cost using an integrated program? 	
Big Picture	<ul style="list-style-type: none"> • Prioritize within Prevention: <ul style="list-style-type: none"> ◦ Which prevention activities would be prioritized if there was US\$5 million available tomorrow? Direct service delivery, subsidizing services through local government, capacity building, peer education, etc. • Prioritize with HIV: <ul style="list-style-type: none"> ◦ Which HIV activities would be prioritized for support if there was US\$5 million available tomorrow? Prevention vs. ART vs. HBC of PLHIV vs. CBC of OVC. What data is available to support the decision? • Prioritize within Health Sector: <ul style="list-style-type: none"> ◦ If US\$80 per child is spent on OVC, what are we getting? ◦ Is what we are getting worth US\$80 when you can fully immunize a child with US\$40, or treat X cases of malaria with US\$40? 	

ANNEX C: USAID FORWARD REFERENCES

IMPLEMENTATION AND PROCUREMENT REFORM

(<http://forward.usaid.gov/node/317>)

Strengthen partner country capacity to improve aid effectiveness and sustainability by increasing use of reliable partner country systems and institutions to provide support to partner countries.

Strengthen local civil society and private sector capacity to improve aid effectiveness and sustainability, by working closely with our implementing partners on capacity building and local grant and contract allocations.

Increase competition and broaden USAID's partner base, by increasing the number of prime contract awards and percentage of total dollars obligated to U.S.-based small and disadvantaged businesses and small NGOs (while decreasing the number and value of large pre-competed contracts).

Use U.S. government resources more efficiently and effectively, by increasing the number of fixed-price contracts where feasible and appropriate, decreasing the use of "high-risk" procurement methods, and harmonizing procurement approaches with other U.S. government agencies working in the same substantive areas.

REBUILDING BUDGET MANAGEMENT

(<http://forward.usaid.gov/reform-agenda/rebuilding-budget-mgmt>)

Explicitly tie USAID's budget requests to key initiatives and country strategies, by including more up-front detail on program design and expected outcomes.

STRENGTHENING MONITORING, EVALUATION, AND TRANSPARENCY

(<http://forward.usaid.gov/reform-agenda/strengthening-monitoring-eval>)

Recognizing that the way in which development programs are monitored and evaluated is inadequate, we will change the agency's policies, structures, and processes that seek to establish USAID as "best in class" with respect to accountability and learning.

To accomplish this goal, we will:

1. Introduce a much-enhanced monitoring and evaluation process.
2. Link those efforts to our program design, budgeting, and strategy work.



