



OUTPUT-BASED FINANCIAL REPORTING OF COMMUNITY- BASED CARE PROGRAMS IN TANZANIA

August 2012

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CBC	Community-Based Care
CDC	U.S. Centers for Disease Control
CHBCP	Certification in Home-Based Care Provision
DoD	U.S. Department of Defense
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
HSHP-2	Health Sector HIV/AIDS Strategic Plan 2008–2012
HSSP III	Health Sector Strategic Plan 2009–2015
ITT	Interagency Technical Team
LGA	Local Government Authority
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MKUKUTA	National Strategy for Growth and Poverty Reduction
MOHSW	Ministry of Health for Social Welfare
MVCCs	Most Vulnerable Children Committees
NGO	Nongovernmental Organization
OBFR	Output-Based Financial Reporting
OVC	Orphans and Vulnerable Children
PLHIV	People Living with HIV/AIDS
PSW	ParaSocial Workers (also called volunteers)
TOT	Training of Trainers
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
USG	United States Government

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We would like to thank the staff at USAID/Tanzania for their support and assistance with this activity. Specifically we would like to thank Jacqueline Gayle, Elizabeth Lema, and Susan Monaghan at USAID for initiating the activity and providing oversight throughout the process. We are grateful for their foresight in developing an activity that goes beyond a costing report to encourage in-country capacity building for local organizations to learn to cost their own programs.

Finally we would like to express our sincere and deep appreciation to all of the Tanzanian implementing partners that contributed to this work. Despite busy schedules, they spent time with us and made highly commendable efforts to learn a new process and implement it. We are truly grateful to them for taking time out from the excellent and important work that they perform so diligently and we count ourselves fortunate to have had the opportunity learn from them and work with them.

EXECUTIVE SUMMARY

INTRODUCTION

In 2011, USAID|Tanzania requested Health Systems 20/20, a global USAID-funded health systems strengthening project, to conduct a costing and capacity building exercise to support the efforts of the Government of Tanzania, international donors, and implementing partner organizations to deepen their understanding of what specific services are being delivered through orphans and vulnerable children (OVC) and home-based care (HBC) programs, and how much these services cost. Furthermore, the exercise would address previously identified limitations in partners' capacity to regularly collect and combine financial expenditures and M&E data, to provide financial management metrics in terms of cost by intervention. USAID|Tanzania emphasized that both the OVC and HBC portfolios were going through substantial changes with the goal of focusing on increasing sustainability by leveraging other resources. The first phase in achieving such a goal would be gathering evidence on unit costs and program efficiencies to take steps that ensure that current resources are used efficiently and that implementing partners at both the prime and sub-recipient levels have the capacity to gather and use such evidence.

OBJECTIVES

Subsequent to discussion with USAID|Tanzania, CDC|Tanzania, and other members of the OVC Care Technical Working Group, the following questions and uses of the data were identified:

- Determine the unit costs and the extent of unit cost variation among programs.
- Determine what drives cost differences among similar programs.
- Discuss what partners are doing and what can be done to achieve cost-efficiency.
- Discuss characteristics of the more cost-efficient models of HBC/OVC programming given the variation in unit costs, context, program structure, and implementation approaches across programs and implementing partners. This discussion could involve analyzing different strategies such as direct service delivery versus use of sub-recipients.
- Discuss how these data can be used to assess whether partner budgets, targets, and budget/target relationships are realistic, in order to ensure more accurate budgeting for future activities.
- Link costing data to the Children's Policy in order to identify specific areas in which the data can support the development of operational plans at the district and/or regional level.

METHODOLOGY

Output Based Financial Reporting is an activity-based costing method that links financial expenditures and M&E data in order to provide a detailed understanding of how programs turn their resources into services than would a standard costing exercise, which may only determine the average unit cost of a service. Rather, OBFR focuses on identifying variations from which important lessons in efficiency or causes of inefficiency can be studied. 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.

RESULTS

16 partners are included in this analysis. These partners were trained on the OBFR methodology and worked with Health Systems 20/20 to produce the results presented. There was wide variation in partner capacity at the beginning and the end of the activity, where some partners may still need further support to complete an OBFR activity, while others appear to be capable of using OBFR independently. A summary of the results is presented below in three sub-sections: results for HBC-only programs, results for OVC-only programs, and results for HBC/OVC integrated programs.

HBC-only Partners

Four HBC-only partners are discussed, two providing services directly and one prime-partner-with-sub-recipient where the sub-recipient delivered services with the support of a prime partner. HBC service delivery to each client is comprised of an average of two visits per month by a trained volunteer; the number of visits varies depending on the condition of the client. A volunteer visit includes at least one of the following services to each patient: positive prevention, clinical health care services, psychological support, nutritional support, or social services. The three implementing partners had annual average unit costs per volunteer ranged from \$806 to \$1,059, with overhead expenses being the main cost driver. The sub-recipient partner had a unit cost of \$856, not including the costs of the support provided by its prime. The prime implementing partner, who was tasked with the capacity building and other support of this sub-recipient, had a supportive supervision unit cost per site visit (\$35,058) that was notably higher than any other prime partner, specifically those included in the OVC-only program analysis. This prime partner's high cost is partly due to scale (relatively few site visits that took place during the year that was costed compared to other primes), but it is mainly driven by labor expense, which accounted for almost 80% of the total unit cost.

OVC-Only Partners

The USAID-funded OVC-only programs are all structured as prime-partner-with-sub-recipients, and are funded through the Pamoja Tuwalee project. The prime partner services include capacity building, supportive supervision, and M&E quality control. Capacity building services are largely comprised of training workshops across a variety of thematic areas and an important finding is the lack of a standardized set of trainings to build the capacity of sub-recipients by prime partners. As such, unit costs per participant vary widely and comparisons have to be made with care. Much of the variation in prime partner M&E costs per sub-recipient is due to scale (based on number of sub-recipients supported). For example, one prime partner had only two sub-recipients and its unit cost per sub-recipient was higher (\$84,589) than for the other two primes, who worked with 17 and 29 sub-recipients, and had unit costs of \$11,994 and \$8,792, respectively. For supportive supervision, unit costs per site visit were similar: \$2,585, \$5,490, and \$6,436. The cost drivers for supportive supervision and M&E support, are split fairly evenly between overhead and labor expenses.

OVC service delivery, which is implemented by the sub-recipient partners, is targeted at both the child and the household. Each OVC should receive two visits per month by a community-based volunteer, and receive at least one of the following services per visit: economic strengthening, food and nutrition, shelter, educational/vocational support, health care, psychosocial support, and legal protection. With the exception of one partner, cost per volunteer of OVC service delivery is quite similar across sub-recipients: \$448, \$472, \$523 and \$100. The sub-recipient with the lowest unit cost reported a large number of volunteers (563), compared to the other sub-recipients' average of 64, which indicates that

implementing a model with a very large number of volunteers can reduce the cost per volunteer. One common cost driver across all sub-recipients is labor, accounting for at least half of costs per volunteer.

HBC/OVC Partners

Integrated partners include partners who run both OVC and HBC service delivery programs. One interesting comparison to note is that for both OVC and HBC programs, the integrated partners had a much higher unit cost per volunteer than did the partners who implemented HBC-only or OVC-only programs in the previous two sections. This may be due to the fact that the “integrated programs” are not actually integrated in terms of operational implementation and cost-sharing, but rather are one organization that implements two programs separately. For example, one partner uses two separate sets of volunteers in the same communities for its HBC and OVC programs likely leading to missed opportunities for program efficiencies. Partner HBC unit costs per volunteer were \$1,479, \$1,862, and \$2,553. OVC unit costs per volunteer were \$3,450, \$1,748, and \$1,374, and almost half of these unit costs are comprised by supplies expenses.

RECOMMENDATIONS

M&E system changes: Important information that can help determine the efficiency with which programs are operating is currently captured by volunteers in the community but is not recorded electronically in its raw form, only its aggregated form. This means that the data cannot easily be used for evaluation purposes, which is unfortunate given the effort being made to collect it. Using innovative technology to capture the data in detail electronically rather than manually may be one way of making it available for evaluation purposes. Ideally, cost per visit and the number of visits received by each beneficiary are the two units of analysis that should be estimated. These units can be linked directly to targets usually set in terms of numbers of beneficiaries, which then allows program budgets to be assessed in terms of targets: critical information for costing policies and designing programs.

Volunteer “chart review”: Given the point made above and the importance of understanding the workload of each volunteer and the services actually received by beneficiaries, it is recommended that a “chart review” of a sample of OVC/PLHIV using the volunteer as a unit of analysis be conducted to improve the understanding of how the program may impact individuals in the community.

Justifying service package with target population: A review of implementing partner packages, perhaps conducted by asking partners to complete a form listing simple service delivery descriptions with narrative around need criteria and assessment findings, should be conducted to provide understanding of why partners provide different packages of services and whether this is related to target population need (highly desirable) or merely due to partner capacity (not desirable). These data will support the development of an operational plan for the new Children’s Policy substantially.

Routine/annual reporting of service unit costs: It is recommended that the OBFR process be made an annual requirement for USAID/Tanzania’s implementing partners so that USAID can operate in line with USAID Forward principles and achieve the objectives that USAID Forward was designed to achieve. Specifically, partners should be able to describe and show the effectiveness of their efforts to increase program efficiency. They ought to be able to demonstrate lower unit costs over time as they gain knowledge and increase service delivery levels. These efforts then need to be widely disseminated across programs.

I. INTRODUCTION

I.1 BACKGROUND

Tanzania is a low-income country with a population is estimated at nearly 44 million, of which almost 75 percent live in rural areas, and 42 percent are under the age of 14. Tanzania has approximately 1.5 million people living with HIV/AIDS of which 10 percent are children. National data indicate that about two million children are classified as Orphans and Vulnerable Children (OVC) (CIA 2012).

Tanzania is currently implementing its third Health Sector Strategic Plan (HSSP III, 2009–2015), which was developed in line with the goals of the National Strategy for Growth and Poverty Reduction (MKUKUTA), the National Health Policy 2007, and the Millennium Development Goals (MDG), and which places the health sector as a priority of the government. Additionally, the country's national response to HIV care and support has been guided by the Health Sector HIV/AIDS Strategic Plan (HSHSP-2), which runs from 2008 to 2012 and focuses on the thematic areas of care and treatment and health systems strengthening (Ministry of Health and Social Welfare [MOHSW] 2012). With these plans in place, Tanzania has made significant headway on control and treatment of HIV/AIDS and malaria. Antiretroviral therapy (ART) coverage among people with advanced HIV infection is 80 percent (MOHSW 2009). With respect to total expenditures on HIV/AIDS, the Tanzanian government contributes 5 percent; the rest is contributed by development partners (MOHSW 2012). The report on the HIV/AIDS Public Expenditure Review for June 2010 estimates that of the total resources for HIV/AIDS, between 78 percent and 86 percent are off-budget expenditures. The government of Tanzania will need to take decisive measures to address this, especially now as it is faced with decreasing resources to finance national HIV/AIDS activities (Musau et al. 2011).

In preparation of the fiscal year 2010 PEPFAR Country Operational Plan for Tanzania, Health Systems 20/20 advisors conducted a costing exercise in August 2009 to understand the costs associated with community-based care (CBC) programs providing services to people living with HIV/AIDS (PLHIV) and OVC. One key finding from this study was that implementing partners did not have the capacity to produce expenditure data by intervention. It was recommended that financial reporting be done by thematic areas so that expenditures could be more easily compared to program monitoring and evaluation (M&E) data. In 2011, USAID/Tanzania requested Health Systems 20/20, a global USAID-funded health systems strengthening project, to conduct a costing and capacity building exercise to ensure that the government of Tanzania, international donors, and implementing partner organizations have an improved understanding of what specific services are being delivered through OVC and home-based care (HBC) programs, and how much these services cost. Furthermore, the exercise would address limitations in partners' capacity to regularly collect and combine financial expenditures and M&E data, to provide financial management metrics in terms of cost by intervention.

Health Systems 20/20 worked in Tanzania starting in November 2011 to conduct a situational analysis of OVC and HBC programs for the costing and output-based financial reporting (OBFR) activity. The primary objective of the first trip was to gather information from key stakeholders (i.e., MOHSW, UNICEF, Supply Chain Management System project) about the current environment in preparation for the data collection and capacity building workshop. Meetings were held with USAID/Tanzania to better understand the objectives and clarify any questions around the activity scope.

USAID/Tanzania emphasized that both the OVC and HBC portfolios were going through substantial changes and the goal was to focus on increasing sustainability by leveraging other resources. They were interested in strengthening the capacity of implementing partners at both the prime and sub-recipient levels. It was agreed among the Interagency Technical Team (ITT) staff members that all PEPFAR-funded partners (e.g., USAID, Centers for Disease Control [CDC], and Department of Defense [DoD]) would participate in the costing activity.

This costing report provides an overview for technical staff, implementers, policymakers, and donors, of the OVC and HBC services being provided in Tanzania and how much these services cost. The report will discuss in detail differences in program design, implementation, and management, each of which can be shown to impact cost. In addition, USAID was specifically interested in strengthening their implementing partners' capacity to manage their programs and sub-recipients, (particularly in the areas of estimating unit costs), providing these data to USAID, and using these data to monitor and improve the efficiency of their programs.

1.2 HEALTH SYSTEMS 20/20 APPROACH TO COSTING

A key part of the Health Systems 20/20 approach to conducting costing and sustainability analysis is a strong emphasis on first understanding what questions the users of the costing data require the data to answer beyond "What is the unit cost?" Secondly, costing data can have multiple uses at different levels of the health system that the original request may not have considered. Health Systems 20/20 has built upon its extensive experience with costing studies to develop a framework that can be used to help in-country stakeholders broaden the use of the costing data that are available. Finally, a fundamental driver of this approach is that implementing partners are best positioned to conduct their own costing analyses as a result of the technical support approach used by Health Systems 20/20, because the implementers have the best knowledge about the program. Additionally, for costing results to be effective at improving efficiency they need to be program-specific and timely, which are two characteristics that implementing partner costing can ensure. This approach, referred to as OBFR, is described in detail in Section 2, Methodology.

1.3 OBJECTIVES

The overall objective of this costing activity was to strengthen programming and implementation of OVC and HBC interventions by working with implementing partners to determine what services are currently being provided to PLHIV and OVC, and at what cost. The execution of this activity strengthened the capacity of implementing partners' ability to use financial and M&E data to ensure efficient use of resources as they deliver services to households. 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 these programs.

Subsequent to discussion with USAID/Tanzania, CDC/Tanzania, and other members of the OVC Care Technical Working Group, the following questions and uses of the data were identified:

- Determine the unit costs and the extent of unit cost variation among programs.
- Determine what drives cost differences among similar programs.
- Discuss what partners are doing and what can be done to achieve cost-efficiency.

- Discuss characteristics of the more cost-efficient models of HBC/OVC programming given the variation in unit costs, context, program structure, and implementation approaches across programs and implementing partners. This discussion could involve analyzing different strategies such as direct service delivery versus use of sub-grantees.
- Discuss how these data can be used to assess whether partner budgets, targets, and budget/target relationships are realistic, in order to ensure more accurate budgeting for future activities.
- Link costing data to the Children’s Policy in order to identify specific areas in which the data can support the development of operational plans at the district and/or regional level.

I.4 REPORT OUTLINE

Following this introductory section, Sections 2 and 3 will discuss the methodology and data collection approach used for the analysis. Next, results will be presented in three sub-sections: Results for HBC-only programs (Section 4.1), results for OVC-only programs (Section 4.2), and results for HBC/OVC integrated programs (Section 4.3). Finally, Sections 5 of the report will focus on a discussion of these findings and description of recommendations based on the findings.

2. METHODOLOGY

Health Systems 20/20 developed and implemented the OBFR approach to estimate unit costs, capture variations in unit costs, and assist with the strengthening of implementing partner/program capacity to collect and use costing data to manage their programs over time. All of these functions also support government and funders in the design and management of these programs, and strengthen their capacity to turn policies into operational programs. 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 OUTPUT-BASED FINANCIAL REPORTING

OBFR is an activity-based costing methodology that links financial expenditures and M&E data to give a more detailed understanding of how programs turn their resources into services than would a standard costing exercise, which determines the average unit cost of a service. The OBFR process is designed to ensure that implementing organizations and funders will have an improved understanding of what specific services are being delivered, by activity, 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, such that 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

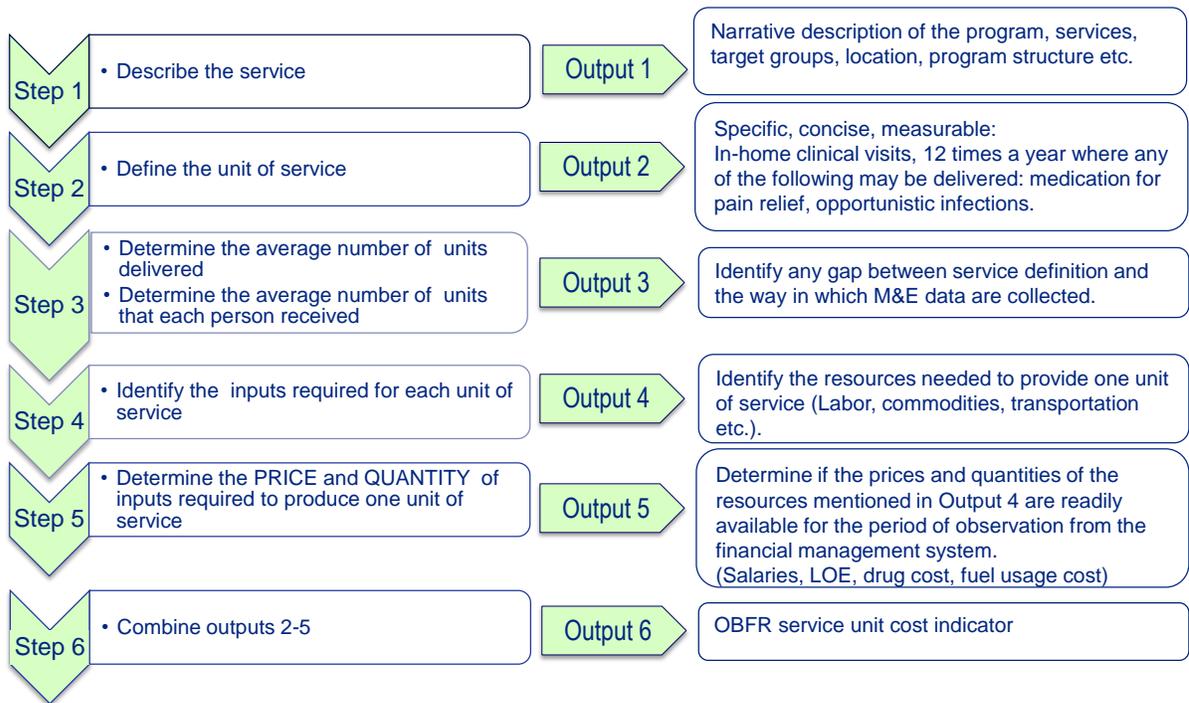
The two services above can both be referred to as “HBC,” and each visit would be reported as one person reached with care (and some partners may even specify that the person is reached with a home visit, although PEPFAR indicators do not require this level of detail). But clearly the service or “visit” being provided by each of the 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, 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. Finally, there may be good contextual and operational reasons for differences between program approaches that imply that a variation in costs, which is reasonable and should therefore be expected. For example, where there is less access to alternative care, training and equipping volunteers to provide care (and incurring the costs of doing so) may be critical for good program outcomes as compared to other settings where health facilities are easily accessible and volunteers need only make referrals for care.

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

Three hundred PLHIV were reached with home care visits consisting of 12 visits a year (monthly) by one of 15 clinical community volunteers who provides any of the following: psychosocial support, nutrition advice, educational support and/referral, and health referrals 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 with accompanying materials such as a worked example and exercises is available from the authors upon request.

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?
- How often do they receive the service(s)?

As noted in Step Three, there may be gaps between the service definition and the way in which M&E data are collected.

Steps Four and Five 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 Six combines the outputs from the previous steps to arrive at the OBFR service unit cost 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.

Limitations

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 (see above comment regarding opportunity costs), 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. Any other partner-specific limitations will be discussed during the results analysis.

2.2 PRIME PARTNERS AND SUB-RECIPIENT ACTIVITIES

The OBFR approach is designed to cost the specific activities carried out by the organization implementing it. The specificity is important because the point of the approach is to acknowledge that implementing partners may differ from each other contextually, and therefore have varying unit costs based upon differences in the environment in which they work, the target population that they reach, the length of time their program has been operating, and the scale at which they operate. They may also have varying costs because of the way they are managed which may result in them operating at different levels of efficiency. Using a costing tool rather than an OBFR approach would likely require users to "adjust" their data so that it fits into the tool, which may "erase" differences in the programs. However, the OBFR approach allows for the analysis of positive variation so that variations are clearly understood as being contextual or management-related.

As such, prime partners and their sub-recipients are treated as separate institutions, even though in practice both institutions participate in making the service delivery program possible. Under OBFR the prime that supports the sub-recipient to build its capacity is treated separately because the actual activities that the prime carries out are different from those of the sub-recipient (and therefore require different units to be costed). For example, the prime may have capacity building trainings for its sub-recipients on M&E and financial management. These activities would likely be counted in terms of the numbers of sub-recipient participants involved in the training. However, if a sub-recipient trains volunteers who reach the end beneficiaries of the OVC or HBC activities, then their activities would be counted in terms of numbers of volunteers (or beneficiaries, if solid data linking volunteers to beneficiaries is available). A complete description of the data collection and validation process used in the OBFR activity is given in Section 3, along with diagrams that illustrate the prime and sub-recipient relationships by program.

2.3 UNIT OF ANALYSIS

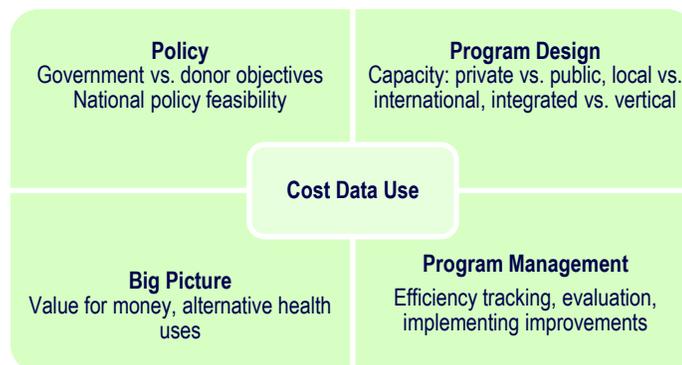
As mentioned above, the OBFR methodology costs the actual activities (expenditures and units of service delivered) that are carried out, to the extent possible, and thus focuses on services delivered, rather than program goals. This means that prime partners supporting sub-recipients that deliver the program services have their own activities costed: capacity building, supportive supervision, and M&E. In order to develop accurate and helpful service unit cost indicators, unit cost for capacity building was estimated per participant, supportive supervision was estimated per site visit, and M&E was estimated as the cost of support per sub-recipient.

For HBC and OVC service delivery, unit cost was per volunteer. Originally, per client and per visit were also considered as units, but based on partner discussions and validation, per volunteer was decided to be the most standardized and useful unit of information. The two reasons for this approach were that (1) due to the manner in which M&E data are aggregated for reporting purposes, it is very difficult to assess how many households, PLHIV, or OVC each volunteer visits on average and how often. This information is critical, because (2) anecdotally and in terms of the numbers of volunteers in relation to the number of beneficiaries (OVC or PLHIV), it can be concluded that there is wide variation in the numbers of beneficiaries that each volunteer covers. Therefore using the volunteer, a known and well-documented number, as the unit of analysis was considered the most accurate measure for describing costs.

2.4 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 A of this report.

FIGURE 2.2: COST DATA USE FRAMEWORK



The results from the analysis described in this report are organized by objective within this framework in Section 5, Discussion.

3. DATA COLLECTION AND VALIDATION

Data collection for the OBFR activity is closely linked with the capacity building aspect of the activity, and can be divided in two stages:

- Initial partner interviews and initial data validation
- Capacity building through a formal workshop and local coaches

The original organizations identified by USAID|Tanzania were all prime implementing partners, but varied in their service delivery structure (i.e., direct implementation vs. sub-recipient) and their program focus (i.e., OVC vs. HBC vs. integrated programs). USAID|Tanzania and Health Systems 20/20 agreed to ask each prime implementing partner to recommend and provide contact information for up to two sub-recipients to include in the data collection process. Figure 3.1–3.3 help to illustrate the relationship between the prime partners and sub-recipients, as well as which program each partner was responsible for, and what services they provide.

In this report, partners have been de-identified at the request of USAID|Tanzania. Prime partners that receive money directly from the United States Government (USG), whether it be from USAID, CDC, or DoD, are labeled with a letter (e.g., A, B or C). These partners may deliver service directly, as in the case of Partner A and Partner B in Figure 3.1 which deliver HBC services; or they may in turn give grants to sub-recipients who do the direct service delivery, as in Partner C who gives a grant to Partner C1. All sub-recipients are identified by their prime partner and a number (for example, Partner C1 in Figure 3.1).

The partners are presented in terms of whether they deliver HBC care only (as in Figure 3.1), OVC care only (as in Figure 3.2), or HBC and OVC care in an integrated program (as in the partners shown in Figure 3.3).

FIGURE 3.1: HBC PARTNERS



Figure 3.1 represents some of the prime and sub-recipient partners visited that belong to a large program called Pamoja Tuwale, which delivers care to OVC.

FIGURE 3.2: OVC PARTNERS

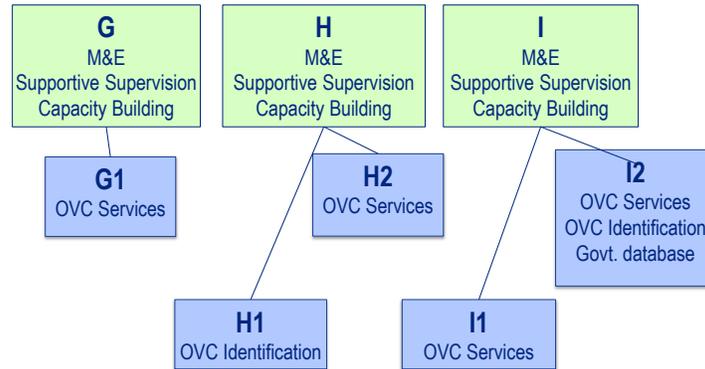
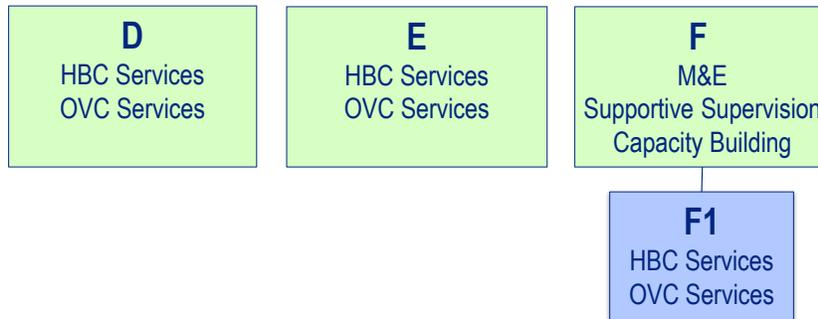


Figure 3.2 shows the three prime partners visited who run programs that deliver HBC care to PLHIV, as well as care to OVC and their households. Partner F provides funding and support with M&E, supervision, and capacity building to sub-recipient FI, which delivers the services.

FIGURE 3.3: HBC/OVC INTEGRATED PARTNERS



A list of all the partners included in this analysis is included in Annex C. All of the partners listed in the annex were involved during the initial data collection and OBFR workshop. However, following the workshop two partners were unable to continue with their participation and did not complete or validate their costing results, which are therefore not included in this analysis.

3.1 INITIAL PARTNER VISITS AND VALIDATION

Between December 2011 and January 2012, Health Systems 20/20 visited nine prime recipient partners and nine sub-recipient partners. At the initial visit, the Health Systems 20/20 team and a pair of local consultants/coaches explained the process to the personnel that were identified as critical to the process, (the program manager, the finance and accounting officer, and the M&E officer). These key informants were introduced to the OBFR process and provided preliminary data to the costing team in terms of existing financial and M&E reports, in order for a draft OBFR costing workbook could be put together by Health Systems 20/20. This workbook was then given to the partners during the OBFR workshop after in-depth coverage and training of the OBFR process. The partner was then asked to review the results/assumptions and complete the draft based on their updated knowledge of the OBFR

approach. Preliminary data also included 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 (that is, all inputs required to produce the service are identified in terms of quantity of units required and unit prices). Any assumptions used in the unit cost analysis were included in the initial OBFR costing workbook in order to be validated by the implementing partners.

3.2 CAPACITY BUILDING

The OBFR capacity building workshops for implementing partners were held just outside of Dar es Salaam in two sessions: February 8–10 and February 14–16, 2012, with about 35 participants each. These workshops 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, partners were paired with a Health Systems 20/20 coach, and the teams worked with their coach to identify institutional capacity gaps that might prevent them from institutionalizing OBFR as a routine annual process, and then outlined a work plan of activities that could mitigate these gaps. The local coaches from Health Systems 20/20 worked with partners over the next three to four months to address capacity gaps identified during the workshop. Gaps identified ranged from some basic process activities or coaching activities to those that could be considered further capacity building. Basic steps included activities such as passing the OBFR training on to staff within the program, and recording expenditure data in ways that simplified their abstraction and use for costing. However, some partners needed basic finance and accounting capacity building (for example, one partner needed training on the use of new software for tracking expenditures). Additional information about the on-the-job capacity building provided by coaches is included in Annex D.

4. RESULTS

This section presents the results of the data collection by describing the partners, their activities by service delivered, and the unit cost of those activities. The OBFR methodology costs the actual activities (expenditures and units of service delivered) that are carried out, to the extent possible, and thus focuses on services delivered, rather than program goals. This means that prime partners supporting sub-recipients that deliver the program services have their own activities costed: capacity building, supportive supervision, and M&E. Sub-recipient activities costed include HBC service delivery, OVC service delivery, and in some cases, OVC identification and procurement of educational supplies.

Results are presented below in three sub-sections: Results for HBC-only programs (Section 4.1), results for OVC-only programs (Section 4.2), and results for HBC/OVC integrated programs (Section 4.3). In addition, unit costs per client were derived in order to compare all partner unit costs in terms of prime/sub-recipient pairs (Section 4.4), and regionally (Section 4.5). Section 5 of the report will focus on a discussion of these findings and description of recommendations based on the findings.

4.1 HBC-ONLY PROGRAMS

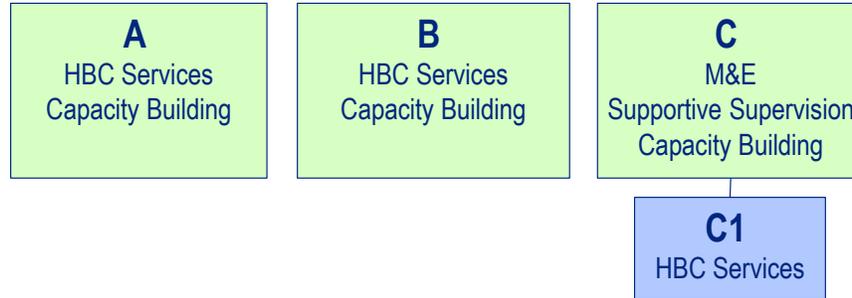
As previously mentioned, HBC programs are implemented through two types of structures: (1) a direct service delivery model in which a single partner provides service directly to the beneficiaries (“direct service delivery” program structure), and (2) a prime partner supporting a sub-recipient that provides this service delivery (“prime/sub” structure). HBC service delivery to each client is comprised of an average of two visits per month by a trained volunteer; the number of visits varies depending on the condition of the client. A volunteer visit includes at least one of the following services to each patient, as well as members of the household with clearly defined relationships and long-term commitments, based on patient needs (these activities occur as part of the volunteers’ work but cannot be separated out as distinct activities because they are not reported as part of M&E):

- Positive prevention: provide counseling, water treatment products, and condoms to prevent new infections.
- Clinical health care services: provision of drugs for opportunistic infections, insecticide-treated nets for malaria prevention, and basic nursing care or health facility referrals.
- Psychological support: provide counseling to PLHIV and their families, establish support groups, and provide spiritual services.
- Nutritional support: nutrition assessment and counseling.
- Social services: community mobilization and leadership development through ward meetings, household economic strengthening.

Two partners implementing HBC programs, identified in Figure 4.1 as A and B, use a direct service delivery model to implement HBC services, and also provide HBC-specific capacity building services, such as training and mentorship, to their volunteers, local government authorities (LGAs), and occasionally other community members. Partner C (the prime) uses the prime/sub structure: the prime provides capacity building and supportive supervision to sub-recipients, as well as M&E of activities; and the sub-recipients then provide the same service delivery found in the other HBC programs. Cost

information was collected from C1, one of the three sub-recipients that the prime supported during the costed year.

FIGURE 4.1: HBC-ONLY PROGRAM PARTNERS



The per-volunteer cost of providing HBC household visits is presented in Figure 4.2. Total cost per volunteer is similar across the three partners, with a variance of about US\$250. Partner A spent about US\$118 per volunteer on supplies, which included items such as HBC kits, T-shirts, boots, and bicycles. Partner A also had a large overhead cost per volunteer, about half of which is attributable to transportation expenditures, which are significant given the large number of volunteers. Details of transportation costs were not provided. Partner B's training cost per volunteer was driven by biannual volunteer meetings and quarterly supervision meetings in each of the five districts covered during the costed year. However, during data collection interviews, the partner noted that they had recently cut the days of a three-week HBC service delivery training in half and structured it more like a refresher course, in order to cut down on costs. It should be noted that during the costed year, Sub-Recipient C₁ was receiving support from Partner C, thus this partner's unit cost does not include any expenditures for training or supplies. However, C1 covered more clients with fewer volunteers than the other two partners, for a comparable cost per volunteer, which may indicate cost efficiency.

FIGURE 4.2: HBC-ONLY PROGRAM PARTNERS: COST PER VOLUNTEER (US\$)

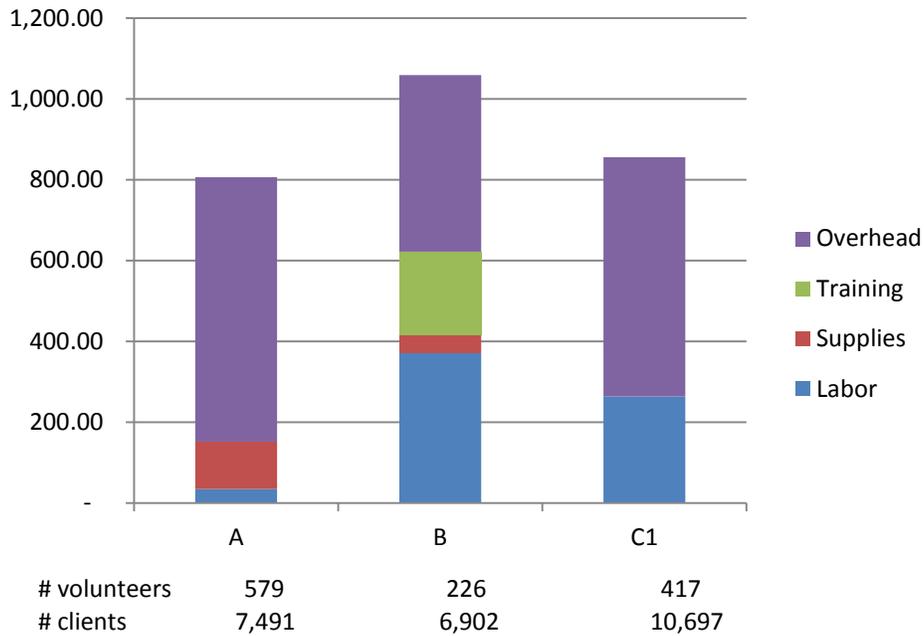
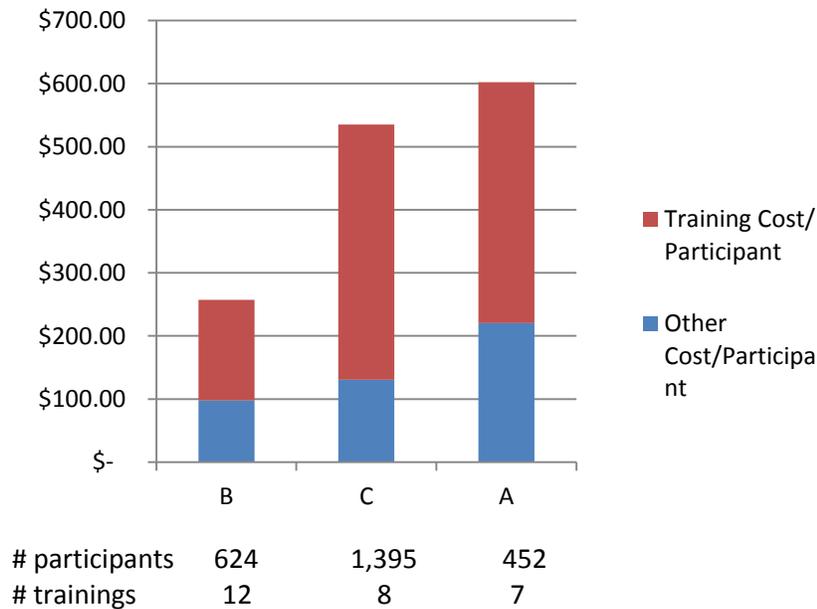


Figure 4.3 indicates that the per-participant cost of HBC capacity building was considerably less for Partner B, which has trained 624 participants through a total of 12 training sessions, than for the other two partners. Partner A again had a large overhead cost per participant, with transportation driving almost US\$100 of the unit cost. Partner C has a high unit cost, especially given the number of participants trained, but it is important to note that this is also a prime implementing partner, and capacity building activities is one of the three services they provide. HBC service provision training workshops and refresher courses were conducted for all sub-recipient volunteers, as well as some community members and LGAs. However, partners A and B trained about 54 and 65 participants each per training, respectively, while Partner C trained about 175 participants per training.

FIGURE 4.3: HBC-ONLY PROGRAM PARTNER CAPACITY BUILDING: COST PER PARTICIPANT (US\$)



In addition to capacity building services, Partner C also provided supportive supervision and M&E services to sub-recipients. Supportive supervision is comprised of one-on-one interactions, mentoring, and site visits to the sub-recipient home offices as well as district-level government officials and community committees, when appropriate. Partner C provided supportive supervision at a cost of about US\$35,058 per site visit, for a total of 16 site visits across three sub-recipients. While Partner C is the only prime implementing partner for HBC-only programs, this cost per site visit is notably higher than any other prime partner supportive supervision unit costs (which will be discussed later under OVC program results section), which average at about US\$4,840 for an average of 80 site visits each. Partner C’s cost is partly due to the small scale of site visits during the costed year, but is also primarily driven by labor expense. Labor accounts for about US\$27,840 of the total unit cost. The partner allocated 60 percent of labor expenditures to the supportive supervision service (with the remaining 40 percent split evenly between capacity building and M&E services). Partner C’s M&E services included collecting and compiling M&E reports from all three sub-recipients, verifying the data quality of the M&E reports, and providing technical assistance on M&E when needed. This was conducted at a unit cost of US\$75,398 per sub-recipient. Prime implementing partners’ M&E unit costs are primarily driven by scale (that is, the number of sub-recipients), which will be discussed under the OVC program results section.

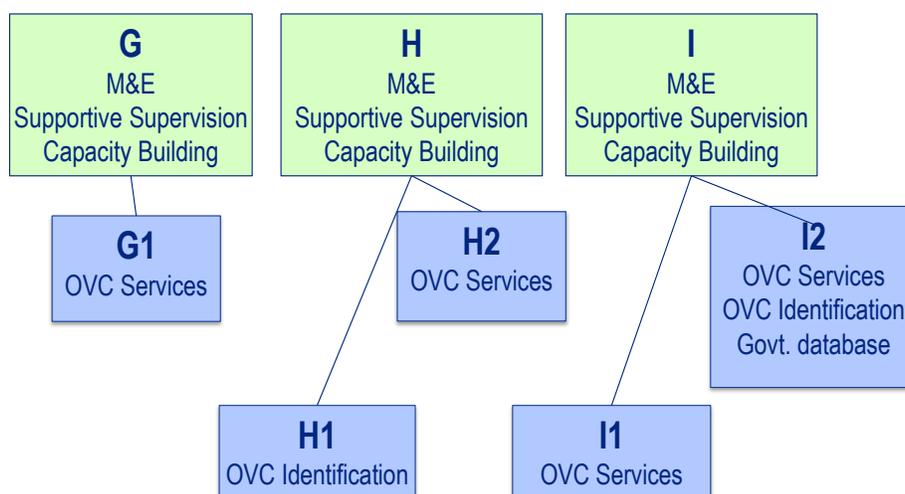
4.2 OVC-ONLY PROGRAMS

The USAID-funded OVC-only programs are all structured similarly in a prime partner-with-sub-recipient set-up, and are funded through the Pamoja Tuwalee project. The Pamoja Tuwalee project model includes a focus on building the capacity of local NGO partners to improve and expand high-quality comprehensive care in a sustainable manner; mobilize communities to reach large numbers of children and households in rural areas with comprehensive, essential services; and work with the MOHSW and

local MVCCs to develop a cadre of desperately needed, skilled village-based social workers. It is important to note that the costed year for the implementing partners in Figure 4.4 aligned with the first year of implementation for the Pamoja Tuwalee project. As such, many partners are still in the scale-up stage, causing variations in service unit cost indicators that cannot be accounted for in this exercise. Notwithstanding this limitation, the analysis presented here can serve as a useful baseline for the programs. Prime partners had a wide range of numbers of sub-recipients in the costed year, and sub-recipient expenditures included many start-up costs. Partner H was responsible for implementing the previous USAID-funded OVC project, which caused a delay in their expenditures under the current program. As such, the partner decided it would be more accurate and useful to use expenditure information for the first six months of Year 2 on the project. Additionally, corporate management of Partner H would not allow for the provision of any disaggregated expenditure information. Partner H2 did not begin OVC service delivery of household visits, but rather, all expenditures in the costed year were spent on OVC identification.

The OVC implementing partner relationships are diagrammed in Figure 4.4. In each of these three partnerships, the prime partner (labeled G, H, and I) provides capacity building and supportive supervision services to sub-recipients, and also undertakes M&E of program activities. During the costed period, Partner G was working with two sub-recipients, whereas partners H and I were working with 29 and 17 sub-recipients, respectively. As a part of this costing exercise, the prime implementing partner suggested and provided contact for up to two of their sub-recipients, to provide a fuller understanding of Pamoja Tuwalee service delivery costs. These sub-recipients are labeled G₁, H₁, H₂, I₁, and I₂.

FIGURE 4.4: IMPLEMENTING PARTNERS WITH OVC-ONLY PROGRAMS (PAMOJA TUWALEE PROJECT)



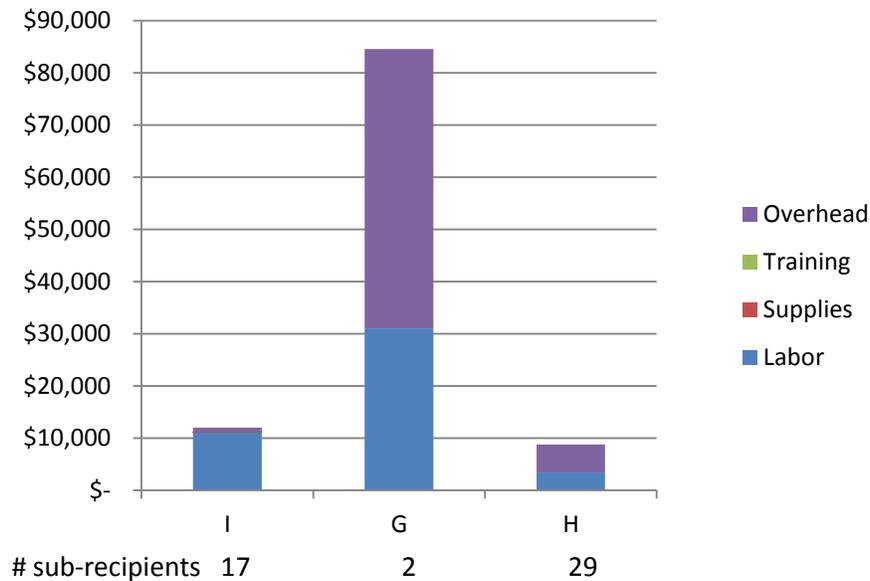
4.2.1 OVC-ONLY PROGRAMS – PRIME PARTNERS

The three OVC Pamoja Tuwalee prime implementing partners (G, H, and I) all provide the following services to their respective sub-recipients: supportive supervision, M&E oversight and quality control, and capacity building.

Monitoring and evaluation

Figure 4.5 shows the prime partners' M&E unit costs per sub-recipient. The primes' M&E service consists of collecting and compiling M&E reports from sub-recipients, verifying the data quality of the M&E reports, and providing technical assistance on M&E when needed.

FIGURE 4.5: OVC PRIME PARTNERS: M&E COST PER SUB-RECIPIENT (US\$)

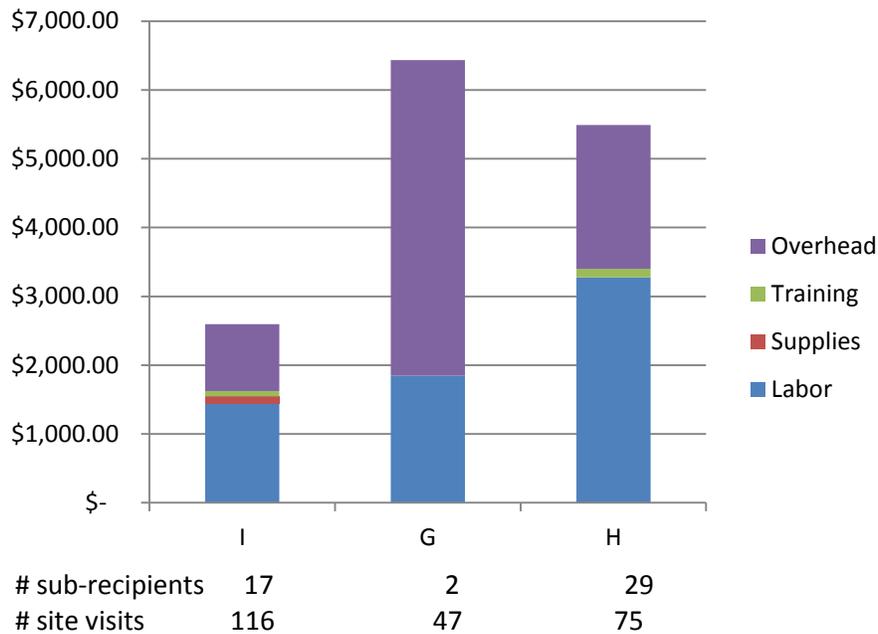


Much of the variation in M&E costs per sub-recipient is due to scale (based on how many sub-recipients have been brought on to the program). Since Partner G has only two sub-recipients, the cost per sub-recipient is considerably higher than for the partners I and H, working with 17 and 29 sub-recipients respectively. If Partner G were to cover 20 sub-recipients, the unit cost would be right on par with the other two partners' unit costs. The M&E activities are only comprised of labor and overhead costs, with training and supplies falling under supportive supervision and capacity building. Prime partners allocated differing percentages of total labor and overhead costs to M&E: Partner G allocated 25 percent of both labor and overhead to M&E; Partner H allocated 20 percent of labor and one-third of overhead to M&E; and Partner I allocated 50 percent of labor and overhead costs to M&E.

Supportive supervision

Figure 4.6 shows the prime partners' supportive supervision unit cost per site visit. Supportive supervision includes the technical assistance and oversight provided to sub-recipients. Supportive supervision is comprised of one-on-one interactions, team mentoring, and site visits to the sub-recipients home offices (as well as district-level government officials and community committees, when appropriate).

FIGURE 4.6: OVC PRIME PARTNERS: SUPPORTIVE SUPERVISION COST PER SITE VISIT (US\$)



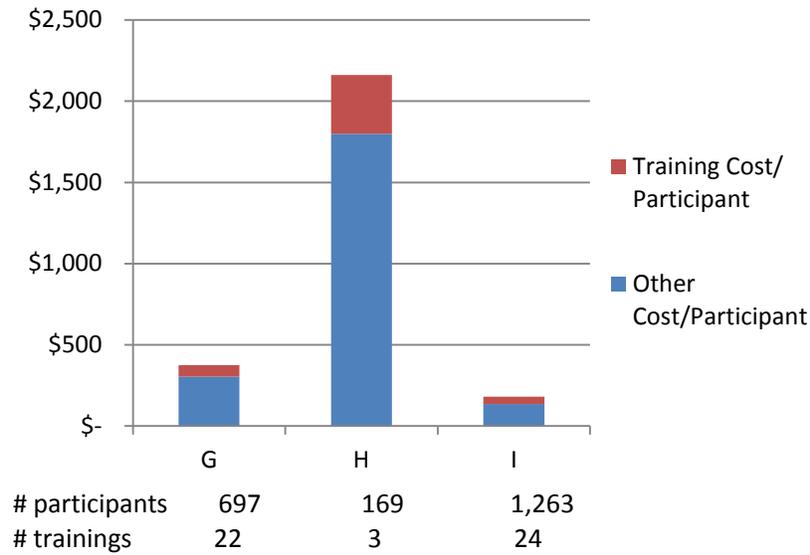
The cost drivers for supportive supervision, like the M&E activities, are mainly labor and overhead costs. Partners determined the following allocations to supportive supervision: Partner I assigned 25 percent of total labor and overhead costs; Partner G assigned 35 percent of labor and 50 percent of overhead costs; and Partner H assigned 50 percent of labor and one-third of overhead costs to supportive supervision. Scale in number of annual site visits is still apparent, but the variance in unit costs is not as wide as in M&E activities.

Capacity building

Figure 4.7 illustrates the unit cost per participant spent on capacity building services by the three prime implementing partners under the Pamoja Tuwalee project. “Training cost/participant” represents all expenditures spent on the actual training workshops (including facilities, catering, materials, and per diems), while “other cost/participant” represents supporting program costs (including labor, overhead, and supplies). Capacity building services are largely comprised of training workshops across a variety of thematic areas. It is interesting to note that there does not appear to be a standardized set of trainings provided, but rather it is decided at the discretion of the prime partners.

Partner H’s unit cost is over quadruple the amount spent by the next-most-expensive implementing partner, Partner G. Scale has a substantial impact on the unit costs per participant, as Partner H only trained one-quarter the number of participants as Partner G. As discussed earlier, this may be due to the fact that Partner H experienced a slow program start-up period, and only included financial expenditures from the first six months of the fiscal year.

FIGURE 4.7: OVC PRIME PARTNERS: CAPACITY BUILDING COST PER PARTICIPANT (US\$)



While this section only discusses the capacity building services of the three OVC-only prime partners, there were a total of eight implementing partners providing capacity building services. A full analysis of capacity building costs is included in Annex F. It is interesting to note that, compared to the HBC prime partners, the OVC prime partners spent a higher proportion of capacity building unit costs on “Other,” which includes labor, overhead, and supplies. These details can be reviewed in Annex F. Training workshops were compared by thematic areas (i.e., HBC services training, OVC services training, and economic strengthening trainings). This allows a better comparison of partners’ unit costs on workshops that are similar in content.

4.2.2 OVC-ONLY PROGRAMS – SUB-RECIPIENTS

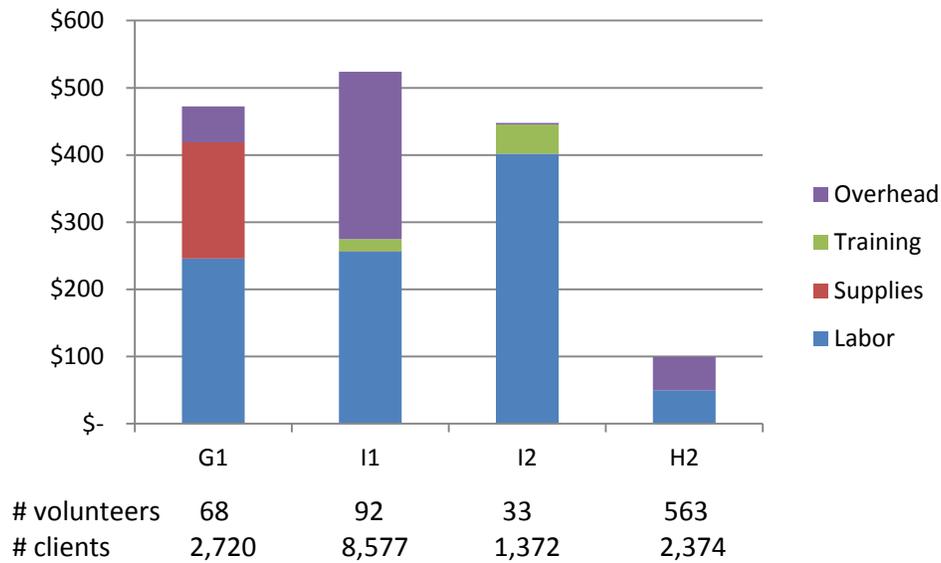
OVC services are targeted at both the household and child. Each OVC should receive two visits per month by a community-based volunteer, at least at the beginning of the process, according to the partners. After some time, depending upon the household need, the frequency may lower or the child may be capable of contacting the volunteer when they need assistance. It is not uncommon for multiple OVC to live in the same household, in which case, one volunteer visit to the household will be recorded as multiple OVC visits. OVC volunteers work closely with MVCCs (Most Vulnerable Children Committees), and linkages or referrals to other organizations are made for services not provided by the implementing partners. Each volunteer visit includes at least one of the services provided in the standard OVC service package. A package of OVC services includes those listed in Table 4.1:

TABLE 4.1: OVC SERVICE DELIVERY PACKAGE

Economic Strengthening	Program may organize small groups for group loans and provides oversight on payback mechanisms; program provides capacity building training workshops on economic strengthening or income-generating activities.
Food and Nutrition	Includes assistance in the form of food goods (cash, in-kind) provided to OVC household, such as grains. Volunteers provide counseling to the household on providing nutritional meals.
Shelter and Care	Volunteers make note of structural damage/needs of the house, and inform the local MVCC. Upon occasion, program may provide payment for necessary construction services to the household.
Education and Vocational Training	Depending on the needs of the OVC, programs may provide school uniforms, books, tuition fee waivers, or transportation stipends.
Health Care Referral	Volunteers provide basic hygiene counseling and health care referrals.
Psychosocial, Social, and Spiritual	Volunteers provide counseling and support in psychosocial, social, and spiritual needs. Also advocate for additional support to be received by the MVCCs.
Protection and Legal Support	Program provides legal support for birth certificates and inheritance rights. Program provides referral to legal counseling and protection services.

Figure 4.8 shows that with the exception of Partner H₂, for which low unit costs can be attributed to scale, costs per volunteer of providing OVC services is quite similar across sub-recipients. However, despite the similarity of the services sub-recipients report providing, the contribution of each input to the total cost per volunteer varies greatly. One common characteristic across all sub-recipients is the fact that labor is an important driver of costs, accounting for about half of costs per volunteer or more. Partners G₁, I₁, and I₂ all report spending approximately US\$500 per volunteer, despite the fact that the number of volunteers fielded varies somewhat (from 33 to 92) and the number of clients varies greatly (from 1,372 to 8,577). A review of the four sub-recipients seems to indicate that implementing a model with a very large number of volunteers can reduce the cost per volunteer, since H₂ managed to field its 563 volunteers at a cost of only US\$100 per person.

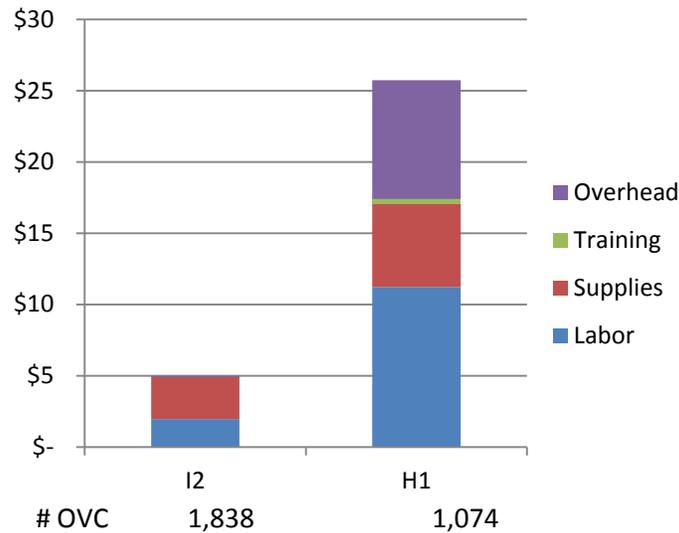
FIGURE 4.8: OVC SUB-RECIPIENTS: COST PER VOLUNTEER (US\$)



Partner G1 provides educational supplies packages to some of the OVC covered by their program. Details of this supplies package is discussed in further detail in Section 4.2.3. Partner I1’s overhead contributes to the total unit cost at a higher proportion than the other sub-recipients. Over 85 percent of Partner I1’s overhead expenditures are attributed to travel, but no further detail is provided. Partner I2’s high labor cost can also be attributed to scale, as this partner uses half of the number of volunteers as the next-smallest program.

Additionally, it is important to note that Partner I2 was the only OVC sub-recipient that split overhead and labor costs across three different activities: OVC service delivery, OVC identification, and government OVC database updates. Partner I2 developed a unit cost for each of the three services provided. Partner H2, as discussed earlier, had a slow program start-up, and the only service provided by this partner in the costed year was OVC identification. As such, identification services for partners I2 and H2 have been compared in Figure 4.9. OVC identification service was a secondary service provided by Partner I2, but the only service provided by Partner H2, which may partially explain why identification expenditures were five times as much for Partner H2 than for I2.

FIGURE 4.9: OVC SUB-RECIPIENTS: OVC IDENTIFICATION COST PER CLIENT (US\$)



4.2.3 EDUCATIONAL SUPPLIES PACKAGES

Two of the four partners that provide educational packages reported costs with enough detail to determine unit cost per OVC client; this is shown in Figure 4.10 and Table 4.2. Partner E spent approximately double the amount of Partner G₁ based on these packages. In this case, implementing on a larger scale does not appear to help decrease expenditures per student, since Partner E spends a lot per client despite serving considerably more clients both at primary school and secondary school levels. Further information on educational supplies packages, including tables of supply costs and illustrative items included in the packages, are presented in Annex E.

FIGURE 4.10: EDUCATIONAL SUPPLIES: COST PER CLIENT (US\$)

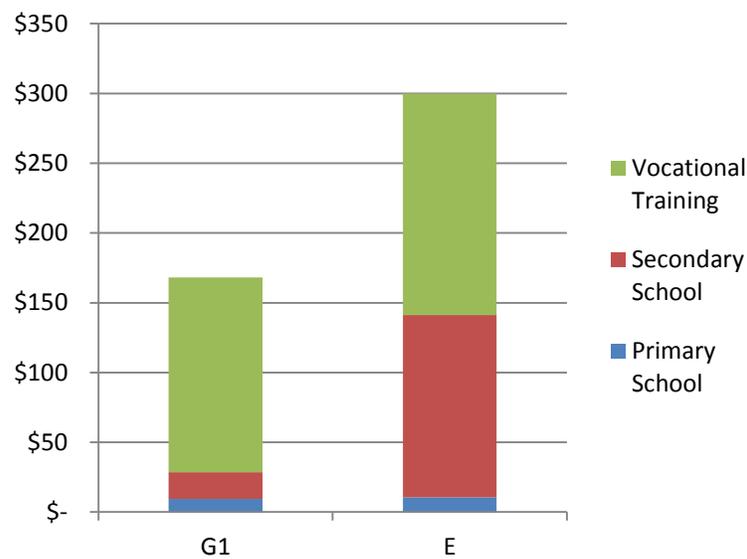


TABLE 4.2: EDUCATIONAL SUPPLIES: COST PER CLIENT (US\$)

		G1	E
	# clients	200	6,000
Primary School	cost/ client	\$ 9.52	\$ 10.49
	# clients	150	1,398
Secondary School	cost/ client	\$ 19.05	\$ 130.71
	# clients	50	120
Vocational Training	cost/ client	\$ 139.68	\$ 158.73

4.3 HBC/OVC INTEGRATED PROGRAMS

A few of the implementing partners included in the costing activity have both HBC and OVC programs, which they deliver with varying degrees of integration. As is the case with HBC programs discussed above, integrated programs operate through two different structures. Two programs, labeled D and E in Figure 4.11, operate as stand-alone partners and provide service delivery directly to beneficiaries. HBC services are provided through house visits by volunteers, in the same way the above HBC-only programs are structured. OVC services are also delivered through community-based volunteers, and cover the seven core areas: health and hygiene counseling and referrals, educational support, psychosocial support, shelter and home protection, legal protection and referrals, food and nutrition counseling, and economic strengthening support. Staff working within the OVC programs are also trained to improve their OVC service delivery and care quality.

FIGURE 4.11: IMPLEMENTING PARTNERS WITH INTEGRATED HBC/OVC PROGRAMS



OVC services are targeted at both the household and child. Each OVC should receive two visits per month by a community-based volunteer, at least at the beginning of the process, according to the partners. After some time, depending upon the household need, the frequency may lower or the child may be capable of contacting the volunteer when they need assistance. It is not uncommon for multiple OVC to live in the same household, in which case, one volunteer visit to the household will be recorded as multiple OVC visits. OVC volunteers work closely with MVCCs (Most Vulnerable Children Committees), and linkages or referrals to other organizations are made for services not provided by the implementing partners. Each volunteer visit includes at least one of the services provided in the standard OVC service package, as illustrated in Table 4.1 under the OVC-only section.

In the third program, prime Partner F provides capacity building and supportive supervision to sub-recipients, and also undertakes M&E of program activities. Cost information was collected from only one of the prime’s 12 sub-recipients (labeled F₁).

Overall program expenditures shown in Figure 4.12 and Figure 4.13 reported across integrated partners do not suggest that the unit cost per volunteer is consistently higher for HBC programs or OVC programs. Partner E has a considerably higher cost per volunteer for the HBC program than the OVC program. The cost driver for this is the labor expenditure, which is discussed further below. On the other hand, the opposite is the case with Partner D, where the cost driver is the supplies expenditure, as Partner D procures and distributes food, educational support, and sanitary supplies.

Figure Figure 4.12 indicates that for integrated programs providing both OVC and HBC services, supplies are a major driver of cost per volunteer spent to provide OVC household visits. Partner D supplies expenditures are about half educational supplies, while the other half includes food and nutrition. Almost all of Partner E’s supplies expenditures were spent on educational supplies packages. (For more information on educational supplies packages, please refer to Annex E). OVC household visit cost per volunteer varies somewhat, from approximately US\$1,400 to US\$3,500 per volunteer. For partners E and D, which receive direct funding and also implement OVC services directly, the difference in the per-volunteer unit cost (US\$1,374 vs. US\$1,450) can be partially attributed to scale, as the programs are implemented through 450 and 62 volunteers, respectively. Partner F1 is a sub-recipient and operating on an extremely small scale in the district of Sumbawanga.

FIGURE 4.12: OVC INTEGRATED PROGRAM PARTNERS: COST PER VOLUNTEER (US\$)

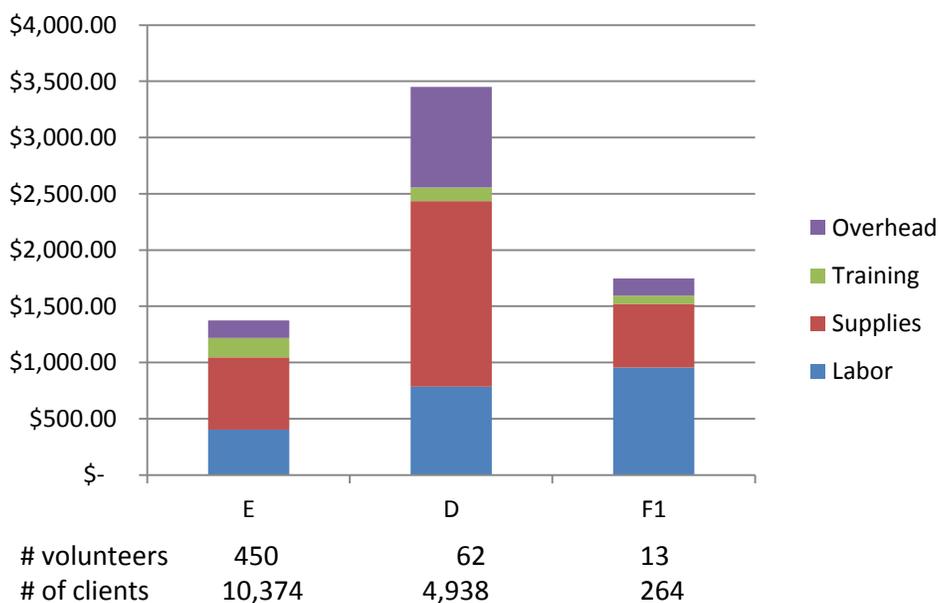
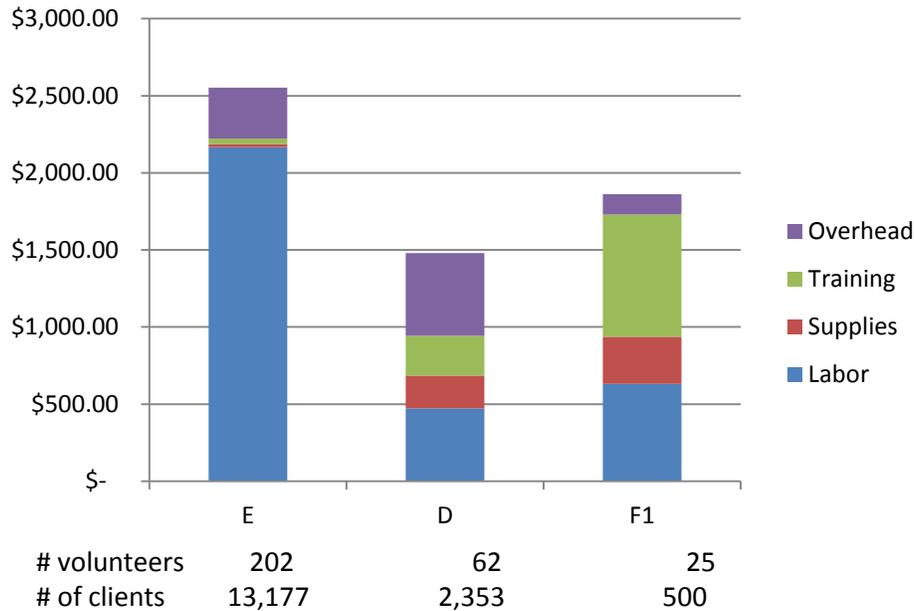


FIGURE 4.13: HBC INTEGRATED PROGRAM PARTNERS: COST PER VOLUNTEER (US\$)



In Figure 4.13, expenditures on HBC household visits among integrated programs varied somewhat less than those for OVC visits, ranging from approximately US\$1,500 to US\$2,500 per volunteer. These activities were undertaken with varying proportions of expenditures toward the four input categories. Although labor was a large percentage of cost across all three partners, costs attributable to the broad types of inputs were quite inconsistent among programs. Partner F1, although a sub-recipient, spent a significant proportion of the unit cost on training, which is interesting to note because it is usually the responsibility of the prime partner to provide the training and capacity building. Partner F1 delivered one 28-day HBC training to 10 volunteers.

Partner E’s management team determined that labor allocation would be based on the overall funding level and longevity. In other words, it allocates indirect labor across its programs by percentage allocation of the value of the program funding, rather than by the LOE of the indirect staff. Thus, the organization allocates more labor costs (i.e., executive director, accountants, grounds keepers) to the HBC program than to the OVC program. In addition, the HBC program uses nurses to provide home visits to patients when necessary, whereas in the OVC program, only volunteers are used.

4.3.1 INTEGRATED HBC/OVC PROGRAM USING THE PRIME/SUB STRUCTURE

Prime Partner F works through 12 partner nongovernmental organizations (NGOs) located in four districts and 52 wards in the Rukwa region, and works across both HBC and OVC programs. This partner builds capacity by providing a variety of training sessions on improving the quality of HBC and OVC care, income-generating activities, paralegal support, computer skills, and evidence-based project management. The capacity building service is implemented at a unit cost of about US\$242 per participant to 330 participants. These training sessions are provided to MVCCs, households of OVC clients,

volunteers, local government staff, and program staff. Supportive supervision service was provided to sub-recipients in order to build the quality and sustainability of the HBC and OVC activities, at a cost of about US\$710 per site visit, for a total of 48 site visits throughout the year. This unit cost is significantly less than the OVC prime partners, but Partner F is also located outside of Dar es Salaam and oversees very small local organizations. Partner F's M&E oversight and quality control is implemented at a unit cost of about US\$2,375 per sub-recipient. This unit cost is also very low in comparison to the other prime partners.

4.3.2 INTEGRATED PROGRAM SUMMARY

One interesting comparison to note is that for both OVC and HBC programs, the partners who implemented both programs had a much higher unit cost per volunteer than did the partners who were HBC-only or OVC-only. This may be due to the fact that the “integrated programs” are not fully integrated in operational implementation and cost-sharing, but rather organizations that implement both programs separately. For example, Partner E’s HBC and OVC programs are implemented separately, with different volunteers for each program, even in the same communities. Partner E also implements voluntary counseling and testing and HIV prevention activities as well, so the potential for a most cost-effective integration is available. Additionally, for the OVC programs, the partners that do not fall under the Pamoja Tuwalee project spend more per volunteer on supplies. For example, Partner D’s cost of supplies is three times more expensive than the entire amount spent by the Pamoja Tuwalee sub-recipients. The direct comparison for HBC and OVC programs that are integrated vs. stand-alone is made in Figure 4.14 and Figure 4.15.

FIGURE 4.14: ALL HBC PROGRAM HOUSEHOLD VISITS: COST PER VOLUNTEER (US\$)

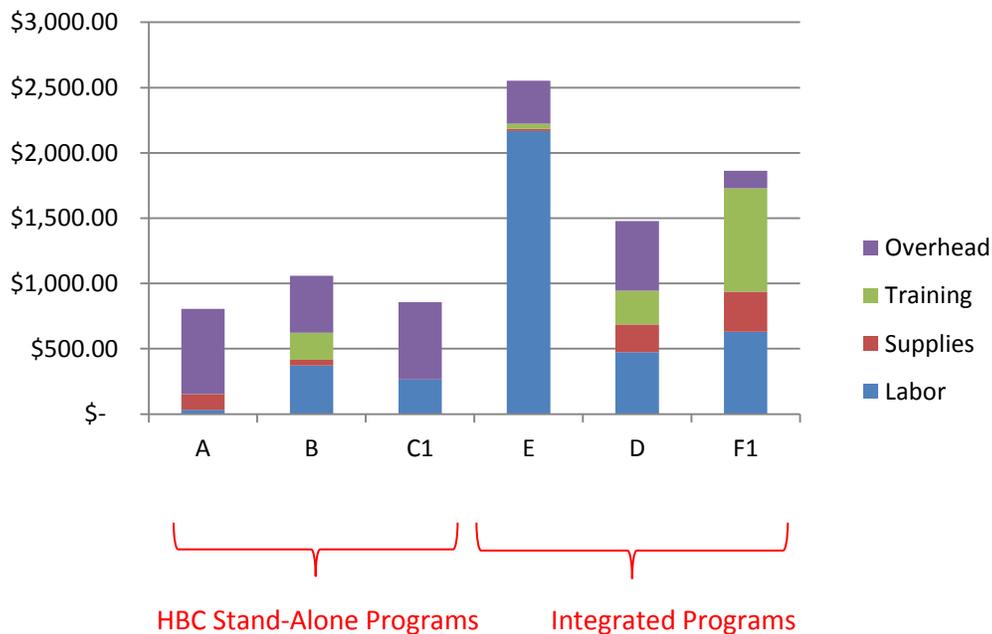
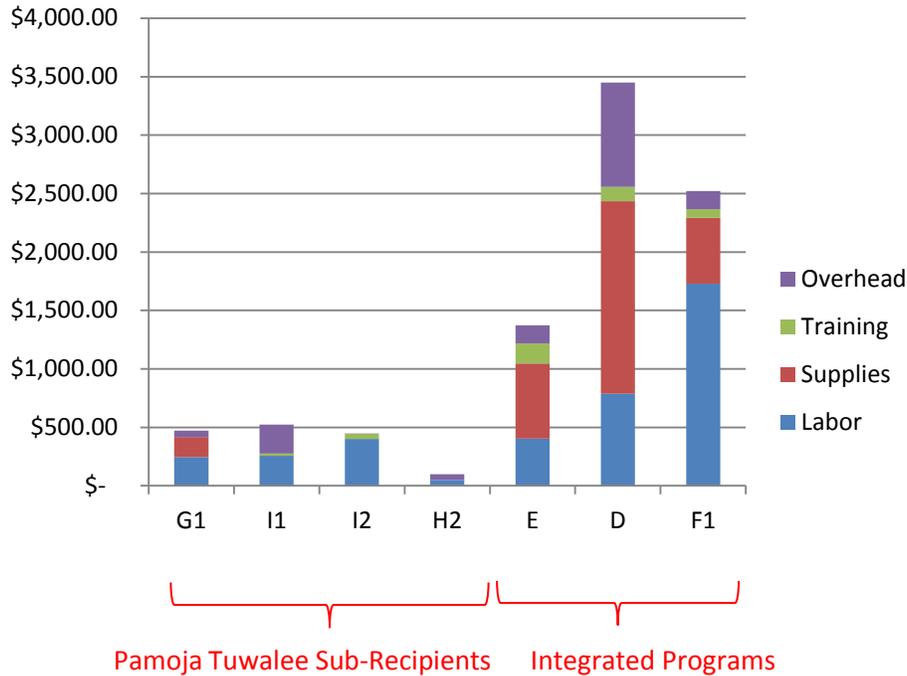


FIGURE 4.15: ALL OVC PROGRAM HOUSEHOLD VISITS: COST PER VOLUNTEER (US\$)



4.4 PRIME/SUB-RECIPIENT PAIRING

The partner pair of C/CI implements an HBC-only program, partner pair F/FI implements both OVC and HBC programs, and the remaining three partner pairings fall under the OVC-only Pamoja Tuwalee project. Partner G's labor and overhead costs per unit stand out due to issues of scale, as the number of clients covered by the prime is one-sixth the amount of the second-smallest client cache. On the opposite side of the spectrum, all of Partner F's prime costs are barely visible in Figure 4.16, due to the large number of clients covered by the prime.

FIGURE 4.16: OVC PROGRAM: PRIME/SUB-RECIPIENT PAIRS, COST PER CLIENT (US\$)

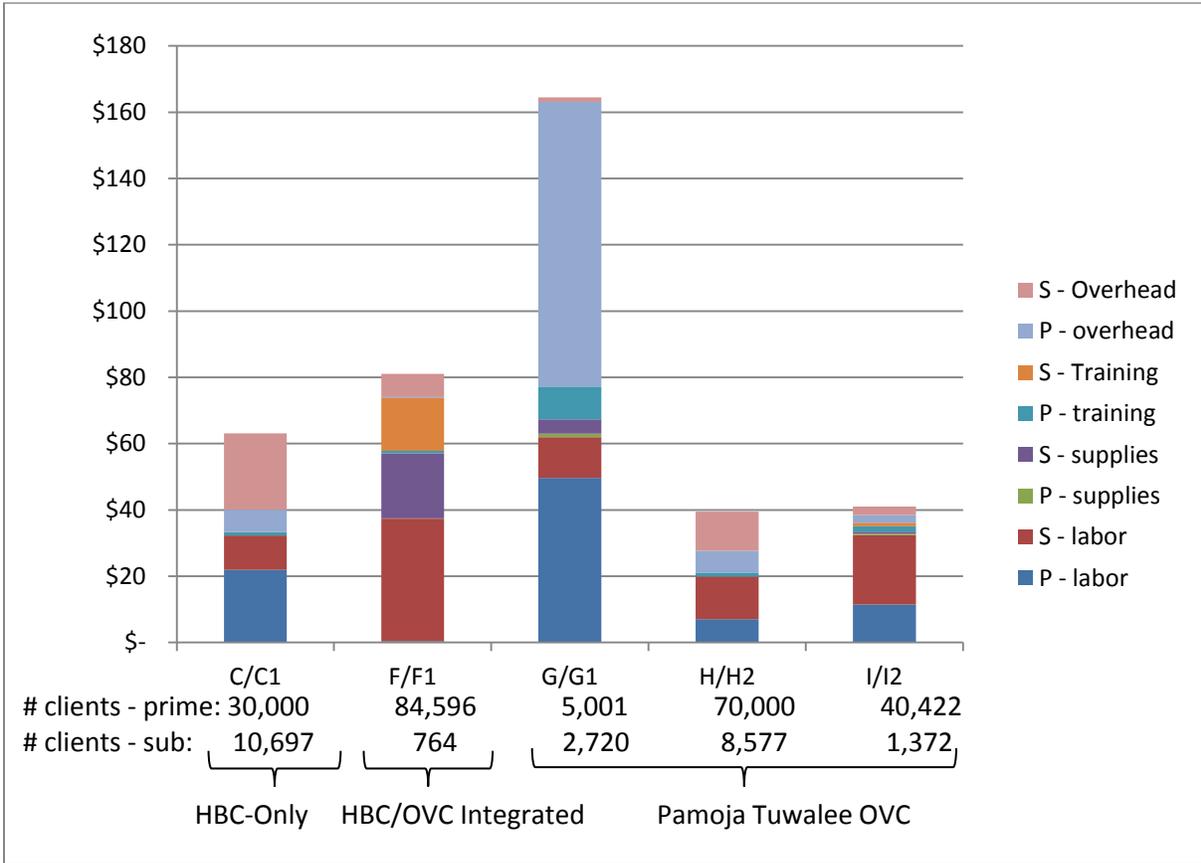
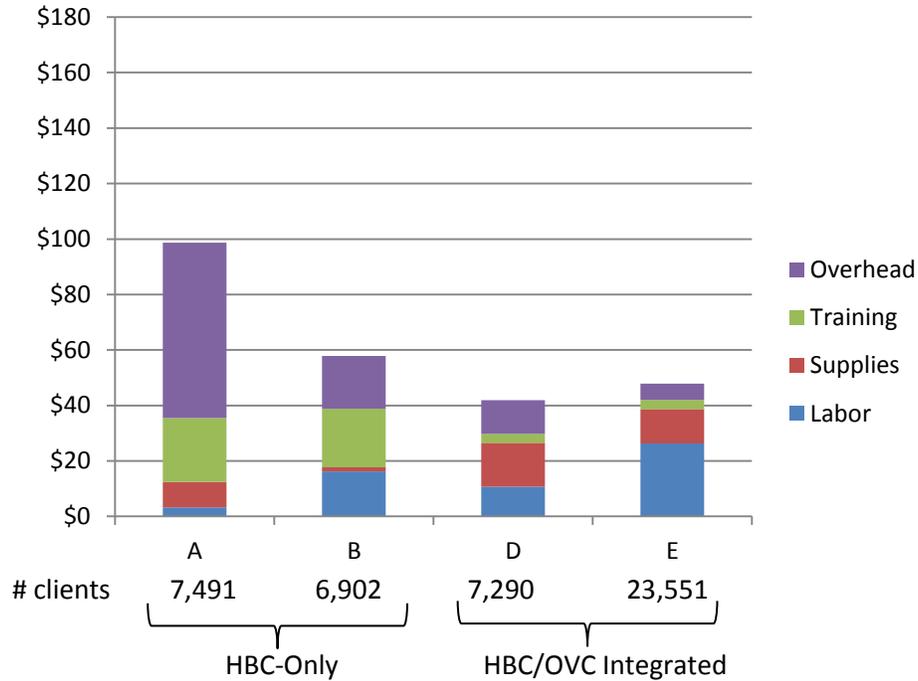


Figure 4.16 and Figure 4.17 show that the range of costs across the prime/sub programs is US\$40 to US\$80 (with the exception of a single outliers, G/GI, operating on a much lower scale) while the range of costs across the direct service delivery partners is US\$40 to US\$100. Considering that in the former, case costs are being added for two partners to make a single cost per beneficiary, this is an important and interesting finding. The cost of building institutional capacity does not radically increase the cost of service delivery.

**FIGURE 4.17: HBC AND INTEGRATED STAND-ALONE PROGRAMS:
DIRECT SERVICE DELIVERY,
COST PER CLIENT (US\$)**



4.5 REGIONAL VARIATION OF COSTS

It might be expected that where transportation costs could have a large impact on overall unit costs, the location of partners would impact overall costs; the rationale being that urban-located partners may incur relatively high transport costs. However, Table 4.3 does not suggest that partners in Dar es Salaam (US\$14–US\$145) have much higher costs than other partners (US\$3–US\$79); there is substantial overlap in costs, and five of the Dar es Salaam-based partners have costs below US\$25. Rather, it appears that costs are more likely to be driven by scale and whether the partner is a prime or sub-recipient.

TABLE 4.3: COST VARIATION BY REGION/LOCATION

Partner	Head Office in Dar es Salaam? (X if Yes)	Regional Coverage	# Clients	Cost per Client (US\$)
A	X	Kilwa, Lindi, Nachingwea, Newala, Tandahimba	7,491	\$98.63
B	X	3 districts in Lindi (Nachingwea, Kilwa, and Lindi Urban), and 2 of Mtwara region (Newala and	6,902	\$57.91

		Tandahimba)		
C	X	Arusha, Kilimanjaro, Shinyanga, Dar es Salaam (3 districts in 20 wards)	30,000	\$45.04
CI	X	Kilimanjaro Region (Moshi Urban, Moshi Rural, and Hai districts), Shinyanga Region (Shinyanga Urban, Shinyanga Rural, Kahama districts), Tanga Region (Tanga Municipal, Korogwe, Lushoto districts)	10,697	\$33.46
D		Rungwe, Chunya, Mbeya rural, and Mbeya urban	7,290	\$41.92
E	X	Dar es Salaam (3 districts of Ilala, Temeke, and Kinondoni) and Pwani Region (5 districts of Kibaha, Kisarawe, Mkurunga, Rufiji, and Bagamoyo)	23,551	\$47.82
F		Rukwa Region (Sumbawanga municipal, Sumbawanga rural, Nkasi, and Kalambo districts), Katavi Region (Mlele, Mpanda districts)	84,596	\$1.69
FI		Sumbawanga	764	\$79.38
G	X	Dar es Salaam, Morogoro, Coast, Ugunja, and Pemba regions	5,001	\$146.56
GI	X	N/A	2,720	\$17.95
H	X	Southern zone (Lindi and Mtwara), and Lake zone (Mara, Kagera, Tabora, and Mwanza)	70,000	\$14.74
H1		Bunda, Lilawe districts	8,577	\$3.72
H2	X	Lindi Rural (10 wards), Kigoma urban and rural, Serengeti (Mara); headquarters in Dar es Salaam	2,374	\$24.72
I	X	Iringa, Njombe, Dodoma, and Singida regions	40,422	\$15.93
II		Kongwa district, 16 wards	8,577	\$5.74
I2		Dodoma Municipal and Bahi	1,372	\$25.05

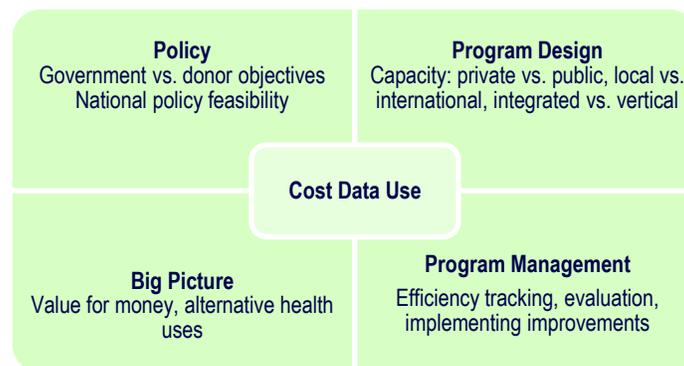
5. DISCUSSION

As discussed in the introduction, the following objectives were identified for this activity:

- Determine the unit costs and the extent of unit cost variation among programs.
- Determine what drives cost differences among similar programs.
- Discuss what partners are doing and what can be done to achieve cost-efficiency.
- Discuss characteristics of the more cost-efficient models of HBC/OVC programming given the variation in unit costs, context, program structure, and implementation approaches across programs and implementing partners. This discussion could involve analyzing different strategies such as direct service delivery versus use of sub-recipients.
- Discuss how these data can be used to assess whether partner budgets, targets, and budget/target relationships are realistic, in order to ensure more accurate budgeting for future activities.
- Link costing data to the Children’s Policy in order to identify specific areas in which the data can support the development of operational plans at the district and/or regional level.

These issues are addressed within the Cost Data Use Framework described in the Section 2, Methodology, and summarized below in Figure 5.1.

FIGURE 5.1: COST DATA USE FRAMEWORK



5.1 PROGRAM MANAGEMENT

- Determine the unit costs and the extent of unit cost variation among programs.
- Determine what drives cost differences among similar programs.
- Discuss what partners are doing and what can be done to achieve cost-efficiency.

When using the data produced by the OBFR process for program management, the data should be considered in terms of not only the final unit cost but also in terms of the cost components and cost drivers. Overall we see that HBC program costs range from US\$750 to US\$2,500 per active volunteer per year. This is quite a considerable range. Furthermore, there is a clear distinction between the range of costs in the stand-alone programs (US\$750–US\$1,000) and the range between the integrated HBC/OVC programs, with the integrated programs costing considerably more per volunteer (US\$1,500–US\$2,500). While program structure is clearly the principal explanation for the overall range of costs, it is necessary to look at the component costs to understand the program-level causes. While many direct costs of care cannot be managed away, overhead costs can to a certain extent be affected by management intervention. In this case we saw that the partners with the largest overhead costs, both proportionately and in absolute terms, are in fact the lower-cost stand-alone programs. Since overhead does not drive the difference, we look to the next cost component in terms of size – labor. The labor costs for one integrated partner are extremely high and, as previously discussed, this is due to the approach taken by that partner in allocating its labor costs, rather than because their HBC program actually has particularly large labor expenditures. The labor costs of the other two integrated partners are relatively high but not extremely so. As it turns out, it is the cost of supplies that drives the difference between these two integrated partners and the lower-cost stand-alone partners. The integrated partners procure and deliver a wide range of supplies for both their HBC and OVC programs, including educational supplies, food/nutrition supplies, and other sanitation commodities.

For OVC programs, the cost per volunteer ranges from US\$100 to US\$500 among the stand-alone Pamoja Tuwale partners, and between US\$1,400 and US\$3,500 for the integrated programs. However, the Pamoja Tuwale partners are in the first year of implementation, so a comparison between these two groups is inappropriate. For the integrated programs the main cost drivers are supplies and labor. Specifically, educational support (including tuition costs as well educational materials) appears to be more widely procured and distributed by partners in the integrated program as compared to the stand-alone programs.

Therefore, while it is tempting to say that integrated programs are more expensive because of their structure and scale, it would not be entirely correct to do so. This is because supplies, whether provided to a few or to all beneficiaries, are a direct cost that would be incurred per beneficiary whether the program is integrated or not and regardless of whether the program reaches tens or hundreds of beneficiaries. The lesson to be learned here is that integrated programs do not appear to be leveraging any economies of scale that one might think an integrated program could benefit from, but rather appear to be single organizations that happen to run two, separate community-based programs.

5.1.1 ACTIVITIES TO IMPROVE EFFICIENCY

Partners specifically raised the issue of how OBFR can help them track improvements in efficiency within their programs. Efforts that the partners are making in improving efficiency are described briefly in Table 5.1.

TABLE 5.1: PARTNERS' EFFICIENCY ACTIVITIES

Partner	Approaches for Increasing Program Efficiency
I	<ul style="list-style-type: none"> Operating through regional offices has cut costs significantly and improved the working relationships with their sub-recipients. This activity could not track the efficiency effects of this change due to time constraints, but the partners could potentially track this if they continue to outsource program management to regional offices and a second costing is done next year. Some of their sub-recipients are being partially supervised by the LGA, which has cut back on travel costs (and some labor). Historically, this partner spent money on supplies for educational support and also implemented economic strengthening activities; under Pamoja Tuwalee, clients have been generating money on their own for educational supplies. Data have already begun to come in suggesting that clients generated TZS133,000,000 in the first six months of this fiscal year.
H	<ul style="list-style-type: none"> Beginning to plan their program so that technical teams are located in the field (to be implemented since interview took place) – to affect cost drivers such as travel expenses. Focusing on increasing the amount of private donations and community revenue generation.
G	<ul style="list-style-type: none"> Cost-sharing with school venues and other government facilities for trainings (as well as the International Youth Fund). Trying to use government staff as facilitators for national curriculum. Developing technical staff capacity so they are multi-disciplinary (i.e., covering M&E, OVC support, and economic strengthening), and then move them to the regional level. Advocate with government in order to use underutilized government space where feasible (to reduce rent costs).
C	<ul style="list-style-type: none"> Starting to integrate all volunteers to provide all the partner's services, instead of different volunteers for different services (OVC, HBC) – huge cost right now is volunteer allowances. Working with the district-level LGA to take more ownership.
A	<ul style="list-style-type: none"> Outsourcing supervision responsibilities to LGA. Currently running assessments to identify available services to more effectively link clients (thus offering the same services, but with increased impact). Has a separate Care & Treatment Center activity – so if an HBC client has missed check-ups three months in a row, the HBC volunteer will conduct a Care & Treatment Center-specific visit.

5.2 PROGRAM DESIGN

- Discuss characteristics of the more cost-efficient models of HBC/OVC programming given the variation in unit costs, context, program structure, and implementation approaches across programs and implementing partners. This discussion could involve analyzing different strategies such as direct service delivery versus use of sub-recipients.

Program design is typically discussed under several headings including structure, scale, and service package.

5.2.1 PROGRAM STRUCTURE

As previously discussed, program structure does not appear to have an impact on costs despite the fact that a superficial review of the data might suggest that stand-alone programs are providing community services at lower costs per beneficiary than integrated programs. Another program structure observed among these partners is the prime/sub and direct service delivery programs. Again, however, there did not appear to be an association between costs and structure (although obviously there will be some increased cost due to institutional capacity building and supervision in the prime/sub structure, which is due to the funder requirement, in this case USAID, wants to build the capacity of local partners). With the exception of a single partner that was still in its startup phase and had a very low number of beneficiaries, all the prime/sub pairs reached had a cost per beneficiary of between US\$40 and US\$80.

5.2.2 PROGRAM SCALE

The most important observations regarding scale for the programs analyzed in this report were the differences in scale due to the early phase that some partners/programs were still going through, the ratio of volunteers to beneficiaries, and the ratio of support activities to sub-recipients (e.g., number of training participants per training or number of site visits per sub-recipient).

Early on in the OBFR process it was clear that a cost per beneficiary could not be used to examine cost drivers because the cost per beneficiary measure was so highly sensitive to changes in assumptions of the number of visits each beneficiary receives. This number had to be an assumption because of the limitations of the M&E systems. The assumption commonly made by partners that each OVC beneficiary/household was visited twice a month was clearly inaccurate in practice, even if it was correct in terms of protocol. For example, among three HBC stand-alone projects, the first reached 10,000 beneficiaries with 450 volunteers, while the second reached nearly 5,000 beneficiaries with only 62 volunteers, and the last reached 264 beneficiaries with just 13 volunteers. The implied volunteer-per-beneficiary ratios are 22, 78, and 20, respectively. If a visit takes 30 minutes, this would mean that at best each volunteer in the first program would be spending 22 hours a month making visits, while for the second program's volunteers this figure would be 78 hours. For OVC stand-alone programs these ratios were 65, 37, and 20. This level of effort is asking a lot of volunteers and doesn't include any other community work that they may carry out. In general, partners agreed that there is significant variation in numbers of volunteers and beneficiaries; however, the variation between partners is very significant and a closer study of this level of effort is highly recommended.

5.2.3 SERVICE PACKAGE

Significant variations in unit costs have been explained by variation in the services being delivered that have direct costs (as opposed to the indirect costs such as overhead that typically tend to be affected by structure and scale). Service packages analyzed here include actual service components (such as what is provided as "educational support") as well as the activities that are carried out by the program that support beneficiaries indirectly such as capacity building of local partners and local government.

Variation in service package should ideally be because different beneficiaries require different types of support and receive different levels (intensity) of support. However, due to the limitations of the way in

which support delivered is captured by M&E systems, this level of variation is impossible to assess. The M&E data are aggregated so early after the point of capture, rather than stored on a per-visit basis, that it is only by choosing a sample of volunteers and reviewing the forms that they fill out over a period of time that variation in beneficiary need and support received can be examined. Such an exercise was beyond the scope of this activity but it is strongly recommended by this report. Essentially, partners should be able to explicitly explain why their package of care includes or does not include paying OVC tuition. This would help to justify the variation in cost as being necessary rather than being a result of inefficient programs. While M&E reporting is limited to the USG-required indicators, OBFR-style reporting, by linking costs to actual service descriptions, allows for a more clear explanation of not just what the components of each unit cost are, but what the service being costed actually is, rather than describing the “cost per beneficiary” as if all beneficiaries receive the same services.

5.3 POLICY

- *Discuss how these data can be used to assess whether partner budgets, targets, and budget/target relationships are realistic, in order to ensure more accurate budgeting for future activities.*

The costing data provided in this analysis can be used to support the government of Tanzania’s current efforts to finalize a new strategic plan for OVC under the Children’s Policy. In the previous strategy document, it was found that the unit costs to support operational planning for that policy were not available. In this economic environment, having a costed strategy is key to obtaining financial support both within a country and from external donors.

5.3.1 USAID FORWARD

- *Implementation and Procurement Reform:*

USAID Forward fundamentally requires increased focus on building and using local capacity. Building local capacity requires investment by USG in-country, and this analysis provides detailed information on the cost of doing this by separating the functions of training and support supervision from the service delivery aspects of programs.

- *Strengthening Monitoring and Evaluation:*

While PEPFAR M&E indicators have been very successful at tracking the “process” of delivering care since PEPFAR’s start, they were not designed to explicitly track the efficiency with which funding has been used at the program level. OBFR allows implementing partners, both local and international, to track their programs’ efficiency by giving them the capacity to measure their unit costs over time in such a way as to easily identify cost drivers and changes in costs. This is important for providing partners with data to use for program management and also to demonstrate to their funders exactly what their resources are being used for and what actions partners have taken to effectively increase their program efficiency.

- *Rebuilding Budget Management:*

To date, implementing partners have reported their M&E and their financial data separately on an annual basis to the USG. Costing studies have frequently been requested by USG and conducted by external partners “in isolation” and without necessarily leaving behind effective capacity with the local partners. USAID/Tanzania has shown initiative with this activity by specifically requesting that partner capacity to manage programs be strengthened rather than just requesting a costing activity. The next step for this activity, addressed in the recommendations below, is to institutionalize OBFR-type reporting so that the

analysis is conducted annually and the results are used by both partners and the USG. This will allow the USG to have up-to-date cost data that can be used to support its procurement and partner management processes. In the future, partners submitting budgets can be assessed based on these data as to whether their budgets and service delivery targets actually match each other in a functional way.

5.4 BIG PICTURE

OBFR provides only limited information on the impact of the programs in which it is used. In this context, the OBFR measure clarifies the scope and scale of the functions and activities being carried out by the implementing partners in more detail than a top-down allocation of costs may provide. However, the approach provides no information on program impact or cost-effectiveness until the effectiveness of the programs described here are measured. For example, baseline and endline studies in the target populations may provide impact measures. These measures could then be combined with the cost data in this report to give a cost-effectiveness analysis, by activity. This report provides some information that could inform such a cost-effectiveness analysis, in that it highlights the need to track beneficiaries and interventions more closely, particularly since detailed information is already being collected by volunteers at each visit.

5.5 RECOMMENDATIONS

- *M&E system changes*

Important information that can help determine the efficiency with which programs are operating is currently captured by volunteers in the community but is not recorded electronically in its raw form, only its aggregated form. This means that the data cannot easily be used for evaluation purposes, which is unfortunate given the effort being made to collect it. Using innovative technology to capture the data in detail electronically rather than manually may be one way of making it available for evaluation purposes. Cost per visit and the number of visits received by each beneficiary are the units of analysis that should be estimated ideally. These units can be linked directly to targets usually set in terms of numbers of beneficiaries which then allows program budgets to be assessed in terms of targets: critical information for costing policies and designing programs.

- *Volunteer “chart review”*

Given the point made above and the importance of understanding the workload of each volunteer and the services actually received by beneficiaries, it is recommended that a “chart review” of a sample of OVC/PLHIV using the volunteer as a unit of analysis be conducted to improve the understanding of how the program may impact individuals in the community.

- *Justifying service package with target population*

A review of implementing partner packages, perhaps conducted by asking partners to complete a form listing simple service delivery descriptions with narrative around need criteria and assessment findings, should be conducted to provide understanding of why partners provide different packages of services and whether this is related to target population need (highly desirable) or merely due to partner capacity (not desirable). These data will support the development of an operational plan for the new Children’s Policy substantially.

- *Routine/annual reporting of service unit costs*

It is recommended that the OBFR process be made an annual requirement for USAID/Tanzania's implementing partners so that USAID can operate in line with USAID Forward principles and achieve the objectives that USAID Forward was designed to achieve. Specifically, partners should be able to describe and show the effectiveness of their efforts to increase program efficiency. They ought to be able to demonstrate lower unit costs over time as they gain knowledge and increase service delivery levels. These efforts then need to be widely disseminated across programs.

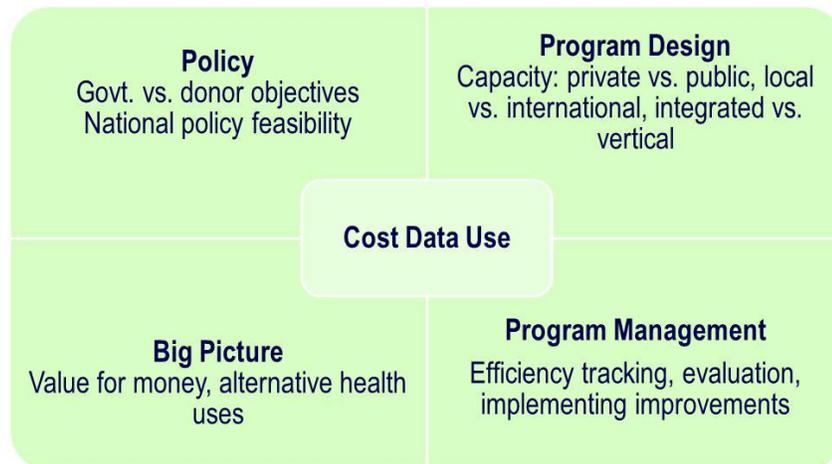
5.6 CONCLUSIONS

This analysis provides an overview of the costs and outputs of a subset of USAID-funded CBC programs. Variations in costs, cost drivers, program structure, and service package delivery have been identified and discussed.

Strong and effective CBC programs are a major priority for global HIV programs as well as USG-funded programs. Understanding the cost of strengthening programs at the institutional level is critical to having effective and efficient programs at a national level. Although the number of partners covered in this report is small relative to the total number of partners in CBC programs funded by the USG in Tanzania, important lessons can be learned and assumptions corrected about what drives the unit costs of supporting and delivering care to Tanzanian OVC and PLHIV.

ANNEX A: COST DATA USE FRAMEWORK

Figure A-1: Cost 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 on how to structure the delivery of services. For example, cost data can reveal the differences between using a private sector NGO versus public sector facilities/staff to deliver similar services. The data can likewise help to 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 serve as one of the critical criteria that guide 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 provide the basis for measuring how resources target particular populations (e.g., PLHIV) and whether a particular approach garners the most value for money. The OBFR data also provide evidence for demonstrating value for money or can lay a foundation for impact evaluations.

Table A-1: Cost Data Use Examples

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 are 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? The goal is to standardize the list of prevention services delivered by partners.
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 subs? ● 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? ● 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? ● And the capacity building required to conduct these non-service delivery

Area	Donor/U.S. Government	Government
		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 \$5 million available tomorrow? Direct service delivery, subsidizing service delivery through local government/partner, capacity building, peer-to-peer education, condom distribution, etc. ● Prioritize with HIV: <ul style="list-style-type: none"> ○ Which HIV activities would be prioritized for support if there was \$5 million available tomorrow? Prevention vs. antiretroviral therapy vs. community-based care of PLHIV, community-based care of orphans and vulnerable children. What data are available to support the decision? ● Prioritize within Health Sector: ● If \$80 per child is spent on orphans and vulnerable children, what are we getting? <ul style="list-style-type: none"> ○ Is what we are getting worth \$80 when you can fully immunize a child with \$40, or treat X cases of malaria with \$40? 	

ANNEX B: DEFINITIONS

The following, listed in Table B-I are the working definitions for terms used in this analysis and report:

TABLE B-I: LIST OF DEFINITIONS

Term	Definition
Labor	Staff time expensed for any aspect of delivering program services.
Supplies	All physical items used by the program that will incur a direct cost (kits, pharmaceuticals, other materials).
Training	All costs associated with training of staff to deliver program services. Training course specific to implementing partners are described in the text. Training subjects ranged from financial management to peer education.
Overhead	Costs of resources which apply to more than one department or program and are allocated across all relevant programs.
Capital costs	Expenditures incurred in the purchase of major capital assets required by the program, such as equipment, buildings, land, etc. Capital assets typically have a continuing benefit to the organization and are used in the production of other goods or services.
Indirect costs	Costs shared across several programs or services; they include any expenses that are not directly tied to the operation of a specific program. Indirect costs can include general administration and management expenses, infrastructure costs, and other costs that are incurred for the benefit of all the programs within the organization (e.g., marketing costs, advocacy expenses).
Cost drivers	Measurable factors that help determine the relationship between the indirect cost and each service area, and may vary for different cost items, i.e., the variables that cause a particular indirect cost to grow or decrease.

ANNEX C: LIST OF PARTNERS

Table C-I lists the partners, alphabetically, that participated in this activity during initial data collection and who attended the OBFR workshops.

TABLE C-I: LIST OF PARTNERS

Partner	Funding Agency	Program
Africare	CDC	HBC
Africare	USAID – Pamoja Tuwalee	OVC
Axios	USAID	HBC
BAK AIDS	USAID – Pamoja Tuwalee; PACT sub-recipient	OVC
CHIYOWONET	USAID – Pamoja Tuwalee; PACT sub-recipient	OVC
FHI360	USAID – Pamoja Tuwalee	OVC
KIHUMBE	DoD	HBC/OVC
PACT	USAID – Pamoja Tuwalee	OVC
PASADA	USAID	HBC/OVC
Pathfinder International	CDC	HBC/OVC
Red Cross of Tanzania	CDC; Pathfinder sub-recipient	OVC
RODI-SHDEPHA	DoD	HBC/OVC
Sharing Worlds Tanzania	USAID – Pamoja Tuwalee; Africare sub-recipient	OVC
SHDEPHA-Sumbawanga	DoD; RODI sub-recipient	HBC/OVC
UMWEMA	USAID – Pamoja Tuwalee; Africare sub-recipient	OVC
WAMATA	USAID – Pamoja Tuwalee; FHI360 sub-recipient	OVC

ANNEX D: CAPACITY BUILDING ACTIVITIES

During initial data collection of financial expenditure data, and through conversations in the OBFR training workshops held in February 2012, it was found that some of the partners involved in this costing exercise would need additional capacity building in the area of accounting and financial management. These partners' accounting and reporting systems were comprised of analytical cash books, monthly financial statements, and bank reconciliations recorded in excel workbooks. In some cases, the original receipts for payments made were kept in physical cash books as source documents.

The OBFR Coach (Bernard Kilembe) working with these partners undertook mentoring and capacity building activities in addition to the original OBFR scope. The coach visited the offices of these partners to review the existing accounting and reporting systems, install QuickBooks software, train the partner staff responsible for using this new system, and assist in the entering of data (voucher receipt and income) for the period of October 2011 through the June 2012. Training in QuickBooks included project accountants, field officers, and project coordinators.

The QuickBooks accounting software was chosen in collaboration with partners for its simplicity and accuracy. The software requires double entry of each transaction, for quality control, and then populates this information throughout the program to allow for the easy compilation of multiple reports for further analysis and manipulation. QuickBooks will drastically reduce the partners' burden of preparing reports and arithmetic errors. It follows the International Financial Reporting Standards (IFRS) and General Accepted Accounting Standards (GAAP).

Further recommendations by the OBFR coach included a follow-up with partners to review the data entry process, having higher-level managers explore the possibility of full integration and adoption of QuickBooks or another financial package, and for project accountants to impart skills and knowledge on the use of the accounting systems to the full organization, which will facilitate reporting to donors and sub-recipients.

ANNEX E: EDUCATIONAL SUPPLIES PACKAGES

TABLE E-I: EDUCATIONAL SUPPLIES DETAILS, BY PARTNER

PASADA				Cost/OVC	Cost/OVC
	Qty.	Unit Cost	Total Cost	(TZS)	(USD)
Primary School				16,525	10.49
Education materials	6000	8,208.33	49,250,000		5.21
School uniforms	6000	8316.67	49,900,000		5.28
Secondary schools				205,868	130.71
school fees	1600	120,187.50	192,300,000		76.31
bus fares	1195	79,832.64	95,400,000		50.69
Vocational Training				250,000	158.73
Grants	120	250,000	30,000,000		

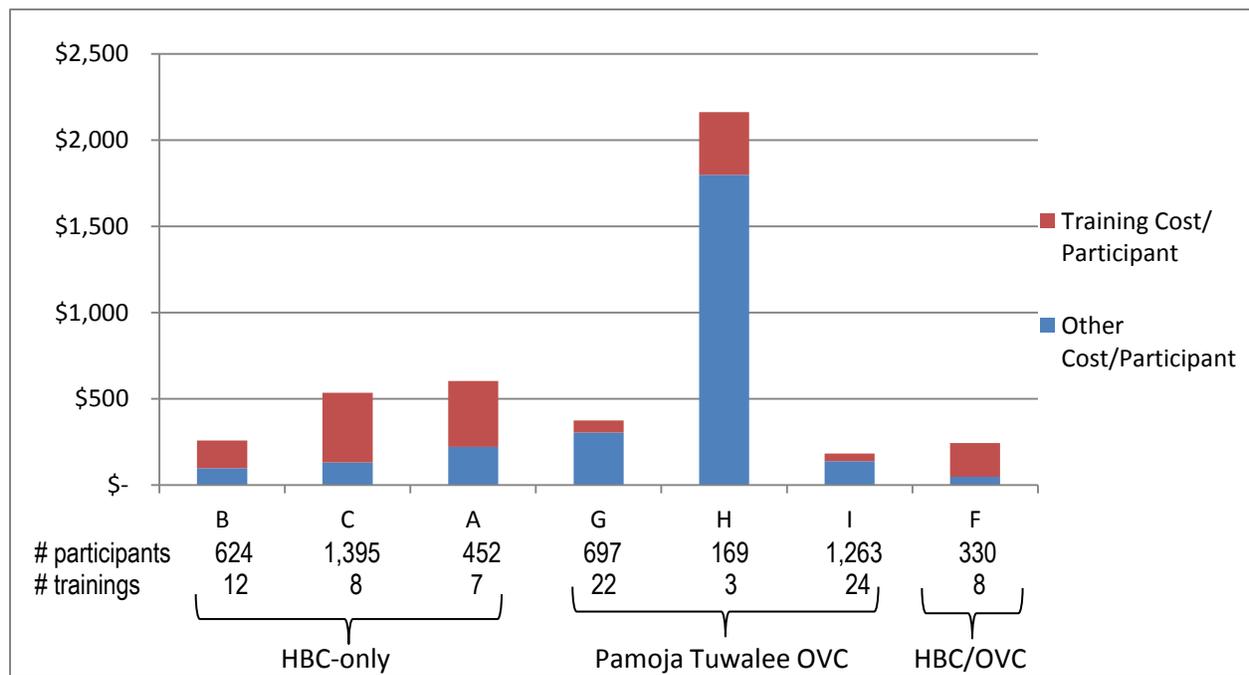
WAMATA				Cost/OVC	Cost/OVC
	Qty.	Unit Cost	Total Cost	(TZS)	(USD)
Primary School				15,000	9.52
Scholastic Materials (books, pencils, math sets)	200	5,000	1,000,000		3.17
Uniform	200	10,000	2,000,000		6.35
Secondary School				30,000	19.05
Scholastic Materials	150	10,000	1,500,000		6.35
School fees	150	20,000	3,000,000		12.70
Vocational Training				220,000	139.68
Fees	50	100,000	5,000,000		63.49
Scholastic Materials	50	20,000	1,000,000		12.70
Seed funds	50	100,000	5,000,000		63.49

SDEPHA List of Comprehensive Scholastic Supplies and Unit Costs		
Primary Schools		
Uniform		8,500
Shoes		10,000
Exercise book		9,000
pen & pencil		2,000
Health insurance facility		2,000
sweater		15,000
sox		1,500
school bag		10,000
ruler		500
mathematical set		1,500
medical support		10,000
food support		20,000
Secondary Schools		
school fees		20,000
Contribution for watchman & academic		15,000
uniform		25,000
shoes		18,000
exercise book		3,000
5 pens		1,500
health insurance Facility		5,000
counter book		40,000
Mills cost		60,000
T-shirt		7,000
Furniture		10,000
Sports Gear		25,000
Ruler		500
House Renovation		5,000
Vocational Education Training Authority Colleges		
School fees		150,000
contribution to Watchman		5,000
Uniform		25,000
Shoes		20,000
Sweater		15,000
Sox		1,500
T-shirt		7,000
Overall		40,000
Sports Gear		25,000
Mathematical set		1,500
exercise book		20,000
Pen & pencil		3,000
tool kit		150,000
ruler		500
health insurance facility		10,000
registration cost		5,000
High Schools		
School fees		70,000
Other school contribution		30,000
Registration cost		5,000
shoes		20,000
Bus Fare		200,000

ANNEX F: CAPACITY BUILDING COSTS DETAIL

As mentioned in Section 4.2.1, the below chart compares the unit cost per participant across all partners that provided capacity building services. It is interesting to note the high proportion of “Training Cost/Participant” to “Other Cost/Participant” for HBC-only and HBC/OVC partners, whereas for the Pamoja Tuwalee OVC partners, the “Other Cost/Participant” accounts for the majority of the unit cost. This may be accounted for in part with two reasons: first, under the structure of the OVC programs of Pamoja Tuwalee, one of the prime partners’ main responsibilities is the capacity building of the sub-recipients, thus causing “Other Cost/Participant” to be high because of overhead and labor costs; second, the Pamoja Tuwalee project was in the first year of implementation in the costed year of this exercise, which may mean that capacity building activities, and thus “Training Cost/participant” will be scaled up in future years of program implementation. However, it is also interesting to note that among the other four partners, Partner C and F are primes providing capacity building services to sub-recipients, while Partner A and B are direct implementers, and all four have very similar unit costs.

FIGURE F-1: CAPACITY BUILDING BY PRIME PARTNERS, COST PER PARTICIPANT (US\$)



Another important finding in this costing exercise was the lack of standardization on types of trainings provided by partners. Thus the total expenditures spent on trainings are not perfectly comparable. To account for this, trainings were stratified by thematic area, and unit costs per participant were found for each type of training. Conversations with partners determined that this information would be most helpful in terms of future program planning and budgeting. The four types of trainings that were most

prevalent included: OVC and HBC service delivery trainings (for volunteers, LGA, or other community members, M&E trainings, and Economic Strengthening trainings.

Figure F-2, below, shows all the OVC service trainings, which varied greatly. The cost per day of these trainings ranges from US\$2,535 to US\$12,176, and cost per participant ranges from US\$308 to US\$2,214. ParaSocial worker (PSW) trainings, which are all undertaken by Partner H, are particularly costly per day of training and per participant. An extension of this study could analyze whether the model implemented by Partner H involves spending more to undertake capacity building trainings for OVC, or if PSW training tends to be a more expensive type of training in general. Alternatively, these higher costs may be driven by the fact that Partner H has only trained 169 participants through three training sessions, which is considerably fewer than partners G and I. On the other hand, HBC service trainings, illustrated in Figure F-3, are much lower and more consistent.

FIGURE F-2: CAPACITY BUILDING – OVC SERVICE TRAININGS, COST PER PARTICIPANT (BY PARTNER)

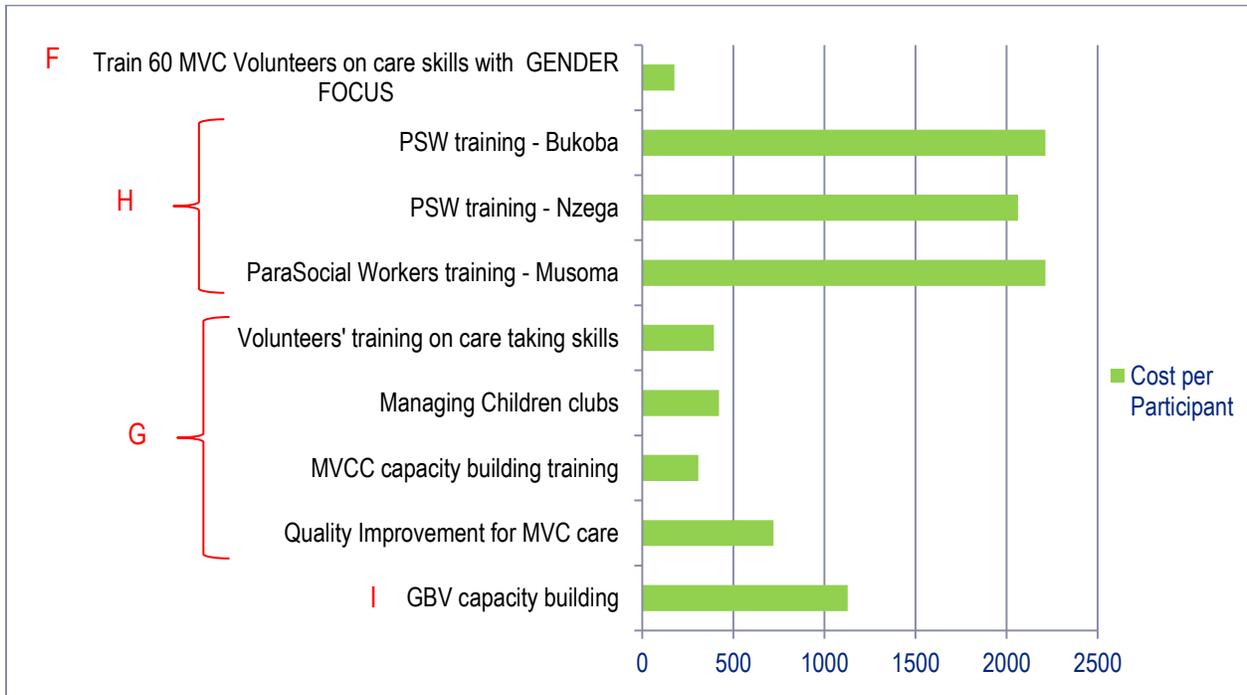


FIGURE F-3: CAPACITY BUILDING – HBC SERVICE TRAININGS, COST PER PARTICIPANT (BY PARTNER)

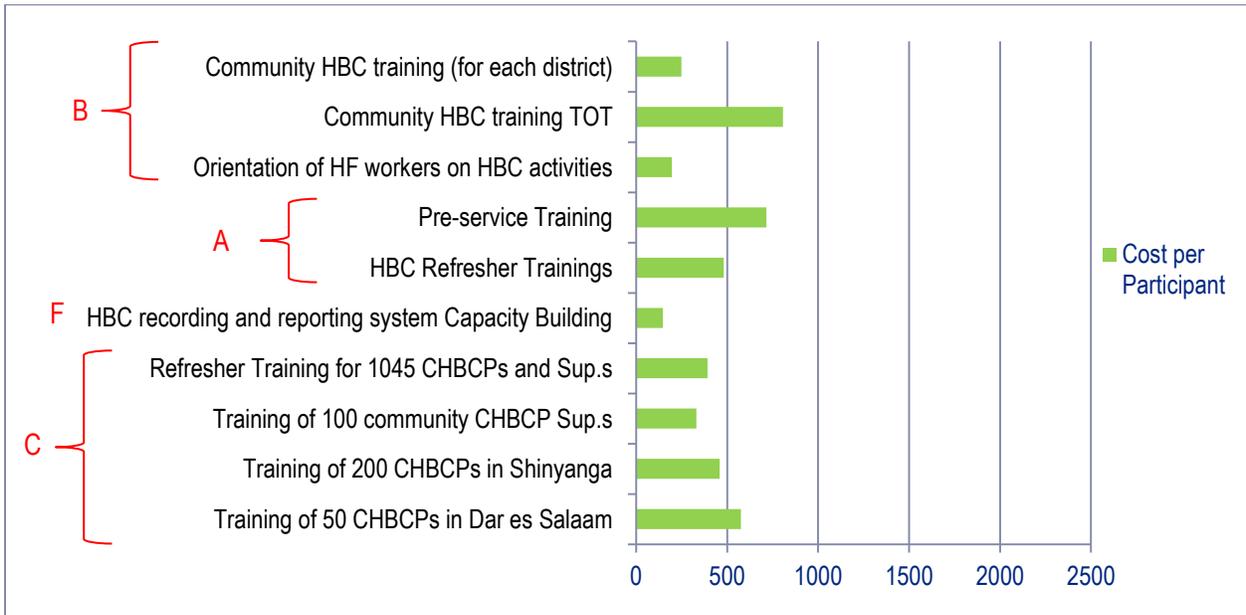


FIGURE F-4: CAPACITY BUILDING – M&E TRAININGS, COST PER PARTICIPANT (BY PARTNER)

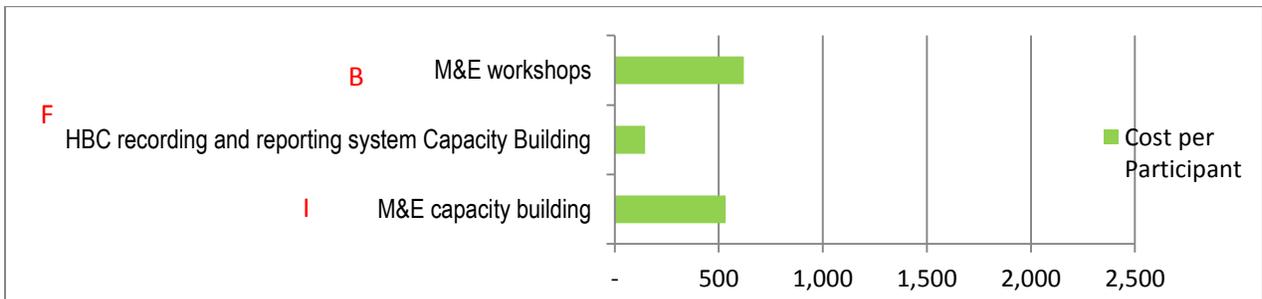
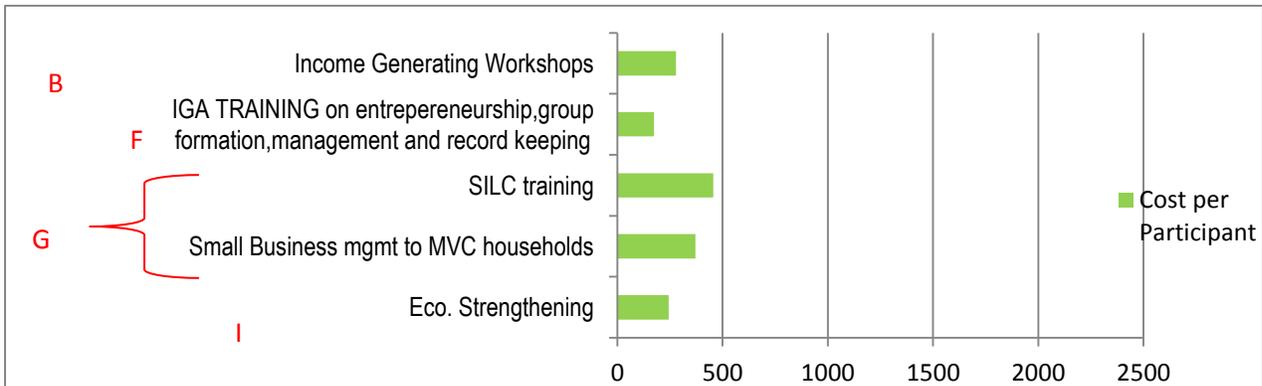


FIGURE F-5: CAPACITY BUILDING – ECONOMIC STRENGTHENING TRAININGS; COST PER PARTICIPANT (BY PARTNER)



ANNEX G: BIBLIOGRAPHY

Central Intelligence Agency (CIA). 2012. The World Factbook. Accessed 13 Aug 2012 at <https://www.cia.gov/library/publications/the-world-factbook/geos/tz.html#>

Ministry of Health and Social Welfare (MOHSW). 2009. *National AIDS Control Programme*. Dar es Salaam, Tanzania.

Ministry of Health and Social Welfare (MOHSW). 2012. *Country Progress Reporting – Part A: Tanzania Mainland*. Dar es Salaam, Tanzania.

Musau, Stephen, Grace Chee, Rebecca Patsika, Emmanuel Malangalila, Dereck Chitama, Eric Van Praag, and Greta Schettler. July 2011. *Tanzania Health System Assessment 2010*. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.



