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Results and Value for Money: A Performance Review of the Human Development Portfolio in Mozambique

Jeremy Clarke and Muriel Visser-Valfrey

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Summary

1. Over the period 2005-10 DFID Mozambique (DFIDMoz) spent around £ 74 million on the Human Development (HD) portfolio in Mozambique. The main result from this investment has been a significant contribution to basic services supplied by the Government of Mozambique (GOM) which is likely to have had a positive impact on progress toward health, education and HIV and AIDS service delivery targets and development outcomes.

2. The contribution to service delivery outputs cannot be directly attributed to DFID because the majority of the funds provided have been mixed with those of GOM and other donors. However it is possible to allocate a share of the combined output to DFID and on that basis over a five year period 2005-9 DFID spending has achieved :

Health, HIV and AIDS

- 118,000 children fully immunised
- 117,000 institutionalised births (i.e. giving access to emergency care for new mothers)
- 126,000 mothers receiving family planning advice and services
- 19700 HIV and AIDS sufferers receiving ARVs
- 50 health centres refurbished or reconstructed

Education

- 289,000 children in the early grades (years 1-5) of primary
- 138,000 girls in the early grades of primary
- 50,000 adults on literacy programmes
- 570 new primary teachers
- 637 new classrooms for early grades of primary
- 92,000 pupils in upper primary (years 6-12)

3. The provision of finance has had some equally important additional benefits to GOM which are harder to measure. Financial aid to Health and Education, respectively by DFID and other donors has indirectly led to strengthening of the service delivery institutions by enabling Government to improve infrastructure, equipment and enhance recurrent financing at the point of service delivery

4. DFID has provided much more than money and during 2005-10 a high priority was given to influencing other donors and Government using DFID advisors and technical assistance. . This effort has paid off with clear evidence of achievement in several areas. The initial aims were to: promote new policy ideas for the future development of the HD sectors; strengthen sectoral institutions and improve their capacity; and to enhance aid effectiveness. Total DFID staff time allotted to the HD portfolio has been around 6 person years totalling around £950,000.

5. GOM is clear that, together with other donors, DFID has led by example and facilitated efforts to improve donor coordination and alignment. There have been important aid effectiveness benefits from increased predictability of donor flows into the sectoral budgets which has improved GOMs ability to plan ahead and to ensure continuity of service delivery in health and education. In Education, donor contributions to pooled funding have increased from US$ 30 mill to US$ 124 mill.

These benefits are particularly significant when so much of Government spending depends on donor support.

6. Results from a major influencing effort to align the vertical Global Fund for AIDS Tuberculosis and Malaria (GFATM) with GOM plans and systems were less successful as GFATM was ultimately unable or unwilling to channel funds directly to GOM. PEPFAR is however better coordinated as a result of DFIDMoz influencing efforts which have helped leverage US$ 2-3 mill funds annually over 5 years (US$ 10-15mill in total) which are now more directly aligned to GOM plans. However PEPFARs main programmes remain off budget and separately managed and delivered.

7. DFIDMoz has played an influential and supportive role in the donor groups for Health, HIV/AIDS and Education. Other donors have valued the professional input and argued for an ongoing "critical mass" of donors to support the dialogue in each of these key areas. DFIDMoz and other donors have been able to support the development of sector plans in all three sectors, including the major human resource development plan in Health. Abolition of user fees for health services is also being examined. The health human resource development plan is being partially implemented due to limited availability of resources. Abolition of user fees is still under consideration due to a concern about dealing with additional demand if fees are abolished.

8. Ideally, consideration should be given to whether DFID has made cost effective and optimal investment choices between the alternative health, HIV/AIDS and education programmes that were available in Mozambique during 2005-10. Our examination of the portfolio suggests that the kind of interventions that were chosen by DFID Moz in health and HIV and AIDS over 2005-10 were broadly consistent with cost effective options identified in research by WHO and other international bodies. DFIDMoz support to the priorities in the Education Sector Plan have contributed to an increase in government funding for teacher salaries and to an important expansion in access to primary and secondary education, allowing more children to complete higher levels of education which will contribute to a better trained workforce. DFIDMoz support has also funded important education reforms which aim at improving education quality and the efficiency of the system.

9. Nevertheless, the largest proportion of DFIDMoz funds were channelled through GOM systems and budget formats prevent the line Ministries from properly tracking unit costs and improving value for money. The engagement of DFIDMoz and the donors with the Ministry of Education to analyse the unit costs of school construction is an example of good practice which needs to be replicated elsewhere. It is possible that this will lead to substantial resource savings to GOM.

10. Discussions with the donor groups and an on line survey conducted in the context of this study revealed there is wide interest in pursuing efforts to improve the capacity of Government to track costs and measure performance and value for money. This was seen as a high priority, not least to enhance domestic accountability. There is a willingness to collaborate on this work and also to consider how best to meet the increased demand for performance information from donor headquarters (HQs) and taxpayers.

11. DFIDMoz is working to improve its internal results management systems and the HD results framework is quite well aligned with the Sectoral Performance

Assessment Framework (PAF) of GOM . More needs to be done to align DFIDs progress reporting on the Millennium Development Goals (MDGs) with the Government of Mozambique's Poverty Reduction Strategy (PARPA). Similarly, work is needed to further develop value for money indicators and suggestions are included in the report.

12. The visit revealed the limitations of current DFID methods for assessing results from its programmes. Some suggestions are made about valuing health and education benefits or adopting entirely different marginal benefit models. More work is needed by DFID HQ to find ways to capture less easily quantifiable benefits from programmes. DFIDMoz has been in the forefront of efforts to examine influencing but need help to define better indicators. They also need to find ways to capture the benefits from financial aid to sectors that arise in the form of system, productivity and quality improvements.

1. Introduction

1.1 The UK Government is placing a high priority on securing value for money for aid expenditure and it is critically important for DFID to demonstrate the results and impact from the major bilateral development programmes. DFIDMozambique therefore wants to assess the performance and results from its past investments in Health, HIV and AIDS and Education over the period 2005-10. This report will feed into future strategic and resource allocation decisions to be made as part of the next Country Strategy for Mozambique.

1.2 The Health, HIV and AIDS and Education sub-sectors make up a coherent set of programmes supporting the achievement of DFIDMoz strategic objectives for the human development related MDGs in Mozambique. These sectors also account for a major proportion of the spend in the country programme and include a variety of aid modalities.

1.3 The scope of the work requires an examination of the overall outputs arising from the expenditure that has taken place. The methodology for doing this has been developed by the Economist group in DFID and has been drawn upon for this purpose (see annex 1). The authors also agreed to supplement this with a review of key documents and a limited interview programme with key Government Ministries and sector donors in Mozambique. All the key DFIDMoz staff were also interviewed. A set of case histories of DFIDMoz influencing efforts were prepared and are set out in annex 2 and survey of donor attitudes and perceptions around monitoring and value for money was carried and is presented in annex 3.

1.4 The main report has seven main sections. The second provides background and the third describes the results framework being used in the HD sector in Mozambique. Section 4 examines DFID's spending and the performance of the HD portfolio over 2005-10 and section 5 sets out the results achieved to date. Section 6 considers how the methodology for assessing results could be extended and the following section 7 provides an overview of DFIDMoz influencing efforts in HD. Section 8 sets out some suggestions on value for money indicators.

2. Background

The overall development framework for Mozambique

2.1 The five-year Social and Economic Plan (PES) is the main planning document of the Mozambican government. The country's medium term objectives are laid out in the country's poverty reduction strategy document known as PARPA.

2.2 PARPA II (2006-2011) focuses on education, health, basic infrastructure, agriculture and rural development, good governance, and macroeconomic and financial administration. The PARPA II – compared to its predecessor PARPA I- puts an increased focus on conditions for sustained economic growth, support to small and medium enterprises, and development of internal revenue collection systems and methods for allocating budget funds. PARPA II also highlights the importance of increasing donor alignment and harmonization and of decentralization.

While the PES and PARPA are seen as key documents they also have acknowledged weaknesses. The PES contains insufficient prioritization of actions, and the PARPA is slanted towards donor priorities around poverty reduction and the MDGs.

DFID support to Mozambique in Human Resource Development (HD)

2.3 DFIDs support to Mozambique is outlined in the Country Assessment Paper (CAP) for 2008-2012, and the office is organized to reflect alignment with the pillars of the PARPA. Three programme pillars exist within DFID - Human Development, Regional Linkages, Growth and Infrastructure, and Governance. A fourth Aid Effectiveness team concentrates on budget support.

2.4 The human development pillar - which is the focus of this report - consists of financial aid and technical assistance in three areas of focus (health, education and HIV/AIDS). A common strategy and approach is adopted across sectors as set out in the CAP. In each of the sectors DFID aims to promote:

- capacity for service delivery;
- accountability in service delivery (in particular by promoting civil society involvement);
- responsive pro-poor policies as a complement to universal approaches to service delivery;
- improvements in aid effectiveness at sector level.

2.5 Over 2005-10, DFID support to the health sector was mainly through sector budget support (by contributing to the Common donor pooled fund known as PROSAUDE) and programmatic funding for malaria bed nets, medicines and condoms. There was an important Mother and Child Health project and DFID has also provided technical assistance for policy reform. In education the majority of funding is channeled to the education sector pool fund FASE, with some smaller financial contributions being used for the funding of technical assistance support to the sector. In HIV/AIDS the financial contribution is split between pooled funding to the Common Fund (CF) of the National AIDS Council (NAC), and pooled funding to a separate Rapid Results Fund (RRF) which will give grants for implementation of priority programmes, support to RENSIDA (a network of associations of HIV positive

persons), and to MONASO (a network of civil society organizations working on HIV/AIDS). Technical assistance is provided across the three sectors, for example through a WB HIV/AIDS advisor and a UNAIDS advisor, and in the MoE through intermittent consultancy support to strengthen data bases and monitoring capacity.

2.6 A breakdown of the main programmes under each of these areas is provided in the table below[1] and a profile of their spending by programme and project is set out in annex 1.

Sectors/areas of focus	Main programmes
Health	PROSAUDE (2007-2013) – Sector Budget Support to the Health Sector. Around £7 million per year, complemented by technical support to the sector. Insecticide Treated Nets (2005-2010) – funding to separate entity to procure and supply bed nets. Total funding of £ 8.5 million .
Education	FASE – Support to the Education Sector Pool Fund (2007-2016). Total funding £ 45 million complemented by selected areas of technical support to the sector.
HIV/AIDS	CNCS CF (2009-2012) – Funding to the National AIDS Council, approximately £ 360.000 per year. HIV/AIDS Rapid Results Fund (RRF) (2008-2012) – Funding to UNDP for a common fund, with a portion of the £ 2.4 million DfID contribution earmarked for CSO support. MONASO (2006-2010) – Funding to a Network of HIV organizations. Total of £ 1.65 million disbursed for activities by NGOs. RENSIDA (2007-2011) – Funding to associations of HIV positive people. Total of £ 550.000for four years.

2.7 DFID has long term commitments to education (until 2016) and to health (until 2013). An in principle decision has been made to exit from the health sector in 2012, at the end of current funding commitment. However this may come up for review in light of the change in Government in the UK, the need to respond to newly defined priorities, and the importance of ensuring that sector funding remains at current levels.

2.8 DFID is the fifth largest donor to Mozambique. DFID's bilateral aid framework has almost doubled from a budget of £45m in 2006 to one of £81 million in 2009. DFID funding to Mozambique is provided through a mix of instruments General Budget Support (GBS), Sector Budget Support (SBS), project support and Technical Assistance (TA). GBS was targeted to reach 70% and accounts for the majority of spend. Currently DFID GBS spending is at 55% (2009) down from 63% in 2007, and 65% in 2008.

Government spending over 2005-2010

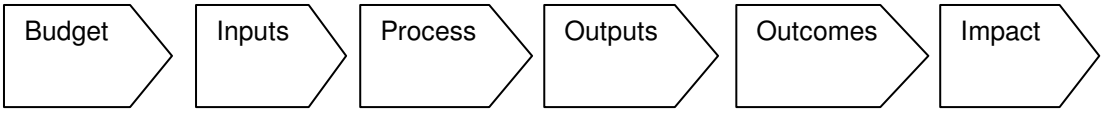
2.9 The overall Mozambique Government budget grew from 46 billion Mt in 2004 to 91 billion in 2009, representing close to double the level of five years before. Budget execution levels are typically around 70 percent, with variations across sectors. In 2009, education represented 21 percent of the state budget, and health 10-11% percent.

[1] Smaller programmes, as well as programmes prior to 2005, are not shown in the table.

2.10 Mozambique is highly dependent on aid. Over half of the government budget is funded by external resources. ODA represented 29% of GNI in terms of total aid commitments in 2007. External resources consist of approximately 80% grants, the remainder is loans. The high proportion of external resources means that in practice GoM income through taxes and other revenues covers recurrent expenditure (of which a substantial portion goes to salaries in the civil service) while aid provides for non salary recurrent and capital expenditure. As a result of aid dependence, donors play a dominant role in all stages of the policy process in Mozambique . The fact that a substantial portion of aid is still channeled in the form of projects which are off-budget, gives donors an even stronger role, in that negotiations take place directly with line Ministries.

3. Capturing and Presenting the Results

3.1 The terms of reference require a performance and value for money assessment based on the available data collected routinely by Government and by DFIDMoz. Ideally this requires a results based management system that can capture each link[2] in the chain:



3.2 Our report will aim to examine all of the key links in the results framework drawing on existing reviews[3] , original data analysis and some limited interviews with Government and donors . DAC donors including DFIDMoz, understand that it is reasonably straightforward to examine the inputs they provide (money, expertise and staff time) and the immediate outputs from their work but much harder to trace the effects in terms of development outputs and MDG outcomes. Clearly, the further along the results chain one looks, the harder it is to identify or attribute outcomes and impact to individual donors.

3.3 This report therefore aims to make an overall assessment of the contribution made by DFID as a one of a group of donors working with Government to make progress to achieve the MDGs. There is a focus on the financial and staffing inputs at the early stages of the results chain and we also seek to compare the investments made with the outputs specifically achieved by DFID. This involves both examining financial flows and how they were used in programmes and projects and also the influencing efforts of DFID staff that were designed to change policy or promote institutional reform and improved aid effectiveness.

3.4 The Government has been developing a performance assessment structure for health, HIV and AIDS and education at the outcome end of the results chain. The PARPA includes a matrix of key indicators, identified and agreed with Government, development partners and civil society. These indicators are taken from the sector Performance Assessment Frameworks (PAFs). The PARPA indicators are monitored through PES, and also through annual budget support and sector dialogue.

[2] Chart provided by Value for Money Department DFID
[3] In particular we have drawn on the Country Programme Evaluation for Mozambique; the Health Influencing Study : Mozambique Case study ODI, 2009 and the Sector Budget Support Case Study also by ODI 2010

Discussions are on-going as to whether a third PARPA will be developed, or whether this should be integrated with the five year Government Plan.

3.5 The monitoring and results reporting structure has been evolving over time and provides a reasonable accountability chain to the donor community which our discussions and survey work (see annex 3) suggests is broadly meeting their requirements. Since 2000 the sectoral PAFs have reportedly improved accountability and given donors the assurance to move beyond self managed projects to support pooled donor funds like FASE or Sector Budget Support arrangements in Health.

3.6 The links between the early stages of the results chain are less clear. One of the difficulties is that Government does not record its own spending on a programme by programme basis which makes it difficult to monitor the costs of service delivery, to manage resources to maximise value for money or even just to link spending to changes in sectoral outputs. There are particular challenges in identifying resource flows into the Health sector because so much of the sectoral spend is off budget and hard for GOM to track and monitor (see annex 1). This has also made it difficult for the consultants to separately identify the resources spent specifically on HIV and Aids prevention and treatment.

3.7 The scope of Sector PAFs is broad with a mix of output and outcome indicators. The coverage of indicators reflects the data available from line Ministry management information systems and national statistical surveys. The quality, reliability and coverage of this data is in line with other poor Sub Saharan countries that face similar capacity constraints. Nevertheless, there are significant limitations which GOM and donors recognise and which provides a basis for ongoing dialogue aimed at further developing the results framework over the longer term. Issues include:

- limited data on health or education system costs and efficiency .
- over reliance on treatment data to measure service delivery and outcomes in health [4].
- over reliance on enrolment rather than retention data to measure service delivery and outcomes in education.
- no direct measures of the quality of service provision in health and education.
- limited data on access to health and education services.
- lack of differentiation between outputs and outcomes with relatively few outcome measures e.g. disease prevalence in health; learning outcomes in education.

3.8 The Government has established a hierarchical reporting structure which uses the PARPA to track selected indicators from the HD sectors. For example, there are five indicators included in the PARPA reviews that are drawn from the health PAF which itself covers a much wider range of indicators. Government and donors have been discussing that this is too narrow an approach and it is likely that in future the Health Sector will report on overall progress rather than just a few select indicators.

DFID Mozambique Results Framework

3.9 In line with the rest of DFID, the Mozambique office has been developing a results and performance assessment framework and we examined the report for Human Development for 2009/10. This framework is linked to the objectives in the

[4] This is particularly the case with HIV and Aids where the Sector PAF monitors ARV treatments (including for pregnant women) but there is little or no information about the effectiveness of behaviour and preventative interventions. Even data on condom distribution is patchy and is difficult to separate as the Ministry records all family planning methods together.

Country Strategy and has included a range of results based indicators that are drawn from the standard indicators provided by DFIDHQ and from the existing programme and project documents.

3.10 A critical requirement for an effective results chain is to have a clear "line of sight" and a logic chain between DFIDMoz inputs and the objectives of the Government of Mozambique. The DFIDMoz HD results framework does have a clear link to the Sectoral PAF and includes several identifiable indicators and data sources drawn directly from it. There is therefore a coherence between the DFIDMoz and Government programmes and results frameworks. Indeed, the fact that the DFIDMoz HD results framework relies on data from the GOM monitoring and reporting systems means it suffers from the same deficiencies (see para 3.6 above). There are minor ways that the DFIDMoz framework could be improved: for example, by strengthening the indicators used for Education and to differentiate more consistently between inputs and outputs.

3.11 The HD results framework is designed to lead into the higher level analysis of development outcomes related to the MDGs. The links between the sectoral HD and the outcome or MDG level results framework developed by DFIDMoz is less clear because the narrative concentrates more on the inputs provided rather than the outputs achieved. There is also a less obvious linkage between the MDG level reporting and the objectives and indicators in the PARPA.

3.12 DFIDMoz has been at the forefront of efforts to measure and monitor the results from its influencing effort and the ODI case study in Mozambique last year [5]was an important contribution to the Health Portfolio review. In that case, a survey tool and outcome mapping approach was used to trace DFIDs contribution. We have used a similar but more truncated approach to assess the results of DFIDMoz influencing in HD (see Annex 2). It will be important for DFIDMoz to find a simple light touch monitoring tool to capture and report on these efforts in future. A presentation was made to the office on a range of possible tools.

3.13 Another area of ongoing work is the development of a response to DFIDHQ interest in developing value for money indicators. This is not an area where DFIDMoz can currently report results but their engagement in a donor dialogue around the unit cost of school construction shows the potential to develop suitable VFM indicators. The experience in the HD sectors is discussed in more detail later in the report and specific proposals on possible VFM indicators are put forward in section 8.

[5] See DFID Influencing in the Health Sector : Mozambique Case Study DFID Working Paper 33 Nov 2009

4. Spending and Portfolio Performance Assessment

4.1 Over the period 2005-10 DFID has invested a rising proportion of the Mozambique bilateral programme in the Human Development Sectors. Table 1 shows a total of £ 74 mill has been spent over the period and that by 2008/9 this amounted to 23% of the annual aid disbursed. The majority of these resources have gone into the Health sector.

Table 1: DFID Spending in Health, HIV and AIDS and Education: 2005-10

	2005/6	2006/7	2007/8	2008/9	2009/10	Total
Health inc HIV& AIDS	10.488	5.919	15.173	10.68	9.811	52.071
Education	2.063	6.321	4.514	4.540	4.560	22.0
Sub total	12,551	12.24	19.69	15.22	14.37	74.071
DFID country programme	56.54	56.273	67.58	65.495	n.a.	n.a.
HD as % of country programme	22	22	29	23	n.a	n.a.

Source: DFIDMoz for sector data and UK Aid statistics for Country Programme

4.2 It is also important to examine how DFIDMoz used its own staff. The table below indicates the amount of time DFID staff spent on influencing other donors and Government. The rest of their time was spent supporting internal DFID work, for example, contributing to strategy, funding submissions and programme management and reviews.

Table 2: Proportion of DFID staff time spent on Influencing (% Full time equivalent - FTE)

	2005	2006	2007	2008	2009	2010
Post						
Senior Health Adviser			0.2	0.5	0.5	0.5
GFATM &Health &HIV/AIDS Adviser			0.7	0.8	0.6	0.5
Education Adviser	0.2	0.2				
Sector Management Adviser	0.05	0.05	0.3	0.4	0.4	0.5

Total FTE equivalent	0.25	0.25	1.2	1.7	1.5	1.5
Total cost £ mill *	0.042	0.042	0.210	0.238	0.210	0.210

***Unit cost assumes average G7 at £ 140,000 per annum in 2009**

4.3 Influencing is clearly a significant component of the time spent by DFID staff and the results from this work are discussed in more detail in section 7. The total cost of the direct DFID inputs undertaken over 2005-10 were £ 952,000 which is small in relation to overall programme costs. Indirect influencing costs were also incurred as DFID used consultants to undertake studies and analysis or to work with other donors to ensure their aid was more effectively coordinated or delivered in the sector as planned.

4.4 In assessing performance and value for money it is important to consider the economy, efficiency and effectiveness of resource use and in particular to compare costs with the benefits or outputs that may have been achieved. It is not possible to determine whether resource have always been used in a least cost way as DFIDMoz does not systematically monitor unit costs across its HD portfolio. However competitive tendering processes have been followed in relation to DFID self managed programmes and projects which have helped ensure that commodities and services have been procured at competitive prices.

4.5 DFID Moz has also been actively working with Government of Mozambique to improve procurement and public financial management systems across Government and directly with the Ministries of Health and Education. GOM is constrained from analysing unit costs by the format of the budget but DFIDMoz has potential to help GOM track and control costs better in future. This is needed to ensure that financial aid provided through Common Funds is used in ways which maximise value for money. There are some good examples of best practice in cost control which DFID and the donors have been pursuing for example in relation to school construction in education and this could be pursued more systematically in future.

4.6 It is also important to consider whether DFID has made optimal investment choices between the alternative health, HIV/AIDS, and education programmes that were available in Mozambique. It is clear that the kinds of interventions that were chosen by DFID Moz over 2005-10 are consistent with cost effective options identified in research. For example WHO CHOICE data suggests that provision of bed nets and essential medicines, vaccination programmes, mother and child health and condoms for prevention of sexually transmitted diseases including HIV are typically some of the most cost effective expenditures that can be made on health[6]. All of these were supported by DFIDMoz directly or indirectly by GOM through the pooled funds. Similarly, in the Education Sector, DFID funds have mainly gone into the Common Donor Fund (FASE) which has been used by the Ministry of Education largely to finance additional spending in basic and secondary education including for primary teacher training. In HIV/AIDS DFIDMoz has used its focal donor position to influence GoM to strengthen policy and priority setting. The priority strategies that have been identified in the recently approved Prevention Strategy are in line with those that UNAIDS has identified as being cost effective and include Prevention of

[6] See Cost Effectiveness of Health Interventions in Africa Region East (includes Mozambique)

Mother to Child Transmission (PMTCT), condom distribution, and male circumcision, among others.

4.7 However, the critical questions are the extent to which DFID inputs actually delivered results and whether these results could have been achieved at lower cost. It is not possible to be definitive about this because DFID funding was part of a broader effort by GOM and donors and all these resources and inputs have contributed to the observed outcomes. In the next section we have analysed the total spending and total outputs from the sector and allocated a proportion of this to DFID. This approach can provide an indication of the results from the investments made and the analysis has been further deepened by document reviews and a limited number of interviews. In addition, there are some clear positive trends in health and education service delivery, and some very recent indications of progress in stemming the spread of HIV, which indicate that overall results are being achieved as a result of the collective effort of the GoM and development partners.

4.8 One proxy for assessing the outputs achieved is to assess the performance of the HD portfolio as assessed in DFID programme and project annual reviews . Table 3 gives a useful snapshot of performance for key health programmes and projects over the period in question. The table suggests that the health portfolio is performing well after a dip in 2008/9 when average review scores were hovering around 2.7 (purpose level objectives only likely to be partly achieved).

Table 3: Portfolio performance Health and HIV and AIDS

	2005/6		2006/7		2007/8		2008/9		2009/10	
	PS	OS	PS	OS	PS	IS	PS	IS	PS	IS
Bednets					2	80%	3	60 %	2	75%
Prosaude Common Fund					2	68.75 %	2	68 .7 5 %	2	68.75 %
Monaso					3	62.5%	3	62 .5 %	2	75%
Essential medicines	2	2	na	na	2	2 output score				
Maternal health	3	3	3	3						
Average score	2.5	2.5			2.25	70%	2.7	64 %	2	73%

Notes:
PS is Purpose Score ie the extent to which the project purpose is likely to be achieved
IS is the impact score given as a % impact likely to be realised
OS is the output score ie the extent to which project outputs are likely to be achieved
Scores rated as follows:
1 Likely to be completely achieved
2. Likely to be largely achieved
3. Likely to be partly achieved
4. Only likely to be achieved to a very limited extent
5. Unlikely to be achieved

4.9 The situation in Education was as follows:

	2005/6		2006/7		2007/8		2008/9		2009/10	
	PS	OS	PS	OS	PS	IS	PS	IS	PS	IS
Common Fund FASE					2	75%	3	60%	2	75%
TA					2	75	3	60%	2	75%
Secondary Distance Learning		3	3							
Average score					2	75%	3	60%	2	75%

Section 5: Comparing Investment and Results

5.1 The results from DFIDMoz spending need to be assessed in terms of the improvements in health (including HIV and AIDS) and Education outputs and outcomes that have been achieved in Mozambique. As section 1 pointed out, Mozambique has established a performance reporting system that can be used to assess the progress that has been made over 2005-10. Despite the limitations of the data there are clear improving trends in service delivery including overall outputs of services and access to primary health care and education. A growing number of children are being vaccinated and attending primary school and more people are using bed nets , getting access to treatment for malaria, TB and HIV and AIDS treatments etc. Progress is also being made in extending the coverage of HIV prevention efforts. Annex 1 sets out the trends in education, health and HIV/AIDS in detail drawing on the latest reports from Government.

Service Delivery Outputs from DFID Support

5.2 In reality, improvements in service delivery and health, education, and HIV/AIDS outcomes are due to a joint effort by Government, all the external partners and also the non state NGO and private sectors. However it is possible to get a presentation ally useful indication of the contribution being made by DFID through:

(i) calculating the total spending in health and education sectors from all sources.
(ii) working out the proportionate share of this spending that can be accounted for by DFID spending.
(iii) using that share of sectoral spend to allocate the same share of quantifiable outputs from the sector to DFID

5.3 Annex 1 sets out such a calculation for education and health (including HIV and AIDS) and indicates that between 2005 and 2009 DFID accounted annually for around 5% of total health spending and 1.5% of education spending. On that basis, we have calculated that DFID can claim the following contribution has been made by its spending:

Table 4: Health Sector Outputs Contributed by DFID 2005-9

	2005	2006	2007	2008	2009	Total
DPT3 and Hb coverage 0-12 months nos of children	37,906	40,883	40,195	40,000*	40,000*	**198,984**
Children under 1 year totally immunised . Numbers of children	17502	22180	26165	25987	25987*	**117,821**
Numbers of Institutionalised Births	21203	21759	23546	25296	25300*	**117104**
Numbers of new mothers using family planning (QAD)	20986	21000*	28438	25902	29992	**126,318**
Number of HIV and AIDS infected persons receiving ARVs (QAD)	795	n.a.	4410	5947	8510	**19662**
Number of Health Centres rehabilitated or constructed	1.65	n.a.	3.75	22.1	22.1	**50**

*study estimate

Table 5: Education Sector Outputs Contributed by DFID 2005-9

Indicator	*2005*	*2006*	*2007*	*2008*	*2009*	*Total*
No. of pupils in EP1 (grade 1-5)	50,956	53,907	57,946	61,649	64,495	**288,953**
Of which girls in EP1	*23,949*	*25,336*	*27,814*	*29,591*	*31,602*	***138,294***
No. of pupils in EP2 (grades 6 and 7)	8,017	8,625	10,418	11,720	11,584	**50,364**
Of which girls in EP2	*3,287*	*3,709*	*4,584*	*5,274*	*5,444*	***22,298***
No. of pupils ESG1 (grade 8-10)	4,676	5,780	6,922	7,978	10,036	**35,391**
No. of pupils ESG2 (grades 11 and 12)	672	893	1,232	1,579	2,126	**6,501**
No. of adult literacy pupils	8,915	10,533	9,210	10,521	11,047	**50,225**
Number of new teachers for primary education	60	107	116	141	146	**570**
No. of classrooms EP1	129	105	113	135	155	**637**
No of classrooms EP2	18	23	23	24	40	**128**

5.4 The estimates in tables 4 and 5 above are calculated solely on the basis of the spending by DFID on sector budget support and projects specifically directed to the sector and they do not include any contribution attributable to GBS. DFIDMoz has separately calculated that the UK share of spending on GBS amounts to 2.2 % of total Government expenditure across all sectors of Government. This would add an additional contribution to the above calculation. To estimate the sectoral outputs from GBS, DFIDMoz could take an additional 2.2 % of the total quantifiable outputs in the HD sector as shown in annex 1. Taken together this would give a better picture of the overall DFID contribution.

5.5 The approach in table 4 and 5 focuses exclusively on aspects of sectoral service delivery output that can be quantified . Because of data limitations it cannot capture improvements in the quality of services or increased access to them. More over there are other potential benefits from the financial aid and technical assistance that has been provided by DFIDMoz which are not fully captured by this approach. This includes changes to policy, capacity and systems which in the medium to long term are likely to produce quantitative and qualitative outputs and outcomes. It also includes leveraging by DFID of additional resources from other donors coming into the sector, which has been the case both in HIV/AIDS and Education (see Annex 2).

5.6 Discussions with Government suggested that in conjunction with other donors DFID added considerable value including in : analysis of new policy ideas and options; institutional reforms in the HD sectors ; and improvements in aid effectiveness for example in terms of improved predictability of aid and reduced transaction costs from working with multiple donors and aid delivery systems. These aspects have been assessed on the basis of interviews and a document review and are discussed further below.

Aid Effectiveness Outputs

5.7 Both the Ministries of Health and Education, and the National AIDS Council emphasised to us the important benefits that had emerged from DFID and donor willingness to support common fund or pooling arrangements. In the case of the health common fund – ProSaude - funds are channelled through Government systems and in the case of FASE, the donors in education hold funds in a joint account. For the HIV/AIDS response, donors have also contributed to pooled funding arrangements. In education and health a single set of procedures are used for the management, disbursement and reporting on the use of the funds. Government is clear that there have been important benefits from increased predictability of donor flows into the sectoral budgets which has improved the ability to plan ahead and to ensure continuity of service delivery in health and education. These benefits are particularly significant when so much of Government spending depends on donor support.

5.8 Government perceives DFIDMoz to have been one of the leading donors who have encouraged others by their action. The Director of Education mentioned DFIDMoz pivotal role, together with the Netherlands, in establishing the Education Common Fund FASE and the Ministry of Health underlined how DFID support for Prosaude had been an important signal of support to other donors. Government also stressed how these arrangements had reduced transaction costs for them, and had increased ownership.

5.9 Both Government and HD donors are monitoring the outputs from aid effectiveness by examining the predictability of aid flows and the numbers of donor visits. A Health Sector Partners report in 2006[7] highlighted that most partners (13 out of 18) had joined the Common Fund providing multi year predictable commitments. Disbursement rates for donors were high (above 90%) and that most occurred on time. Delays in disbursements averaged only 4 weeks. A more recent report [8] confirms this pattern showing that although only 50% of partners actually disbursed within the month they originally indicated, the majority of the slippage was minor (into the following month) and followed up promptly. DFID has a very good track record in terms of disbursement.

5.10 Donors did rather less well on reducing the administrative burden on GOM as there were as many as 59 missions in 2005 in Health (mostly by WHO) . There are also few delegated cooperation arrangements. Despite all the progress with improved coordination (67% of the donors said they did this) two of the major donors still programme and deliver their support separately as vertical funding (e.g. GFATM) or off budget and through non state providers (US Government through PEPFAR). The continued use of separate delivery channels by GFATM and PEPFAR continues to impose additional administrative and delivery costs. DFID efforts to improve this situation are discussed in the next section.

Policy outputs

5.11 Along with other donors, DFIDMoz aims to engage in policy dialogue with Government around longer term sectoral development issues as well as reviewing performance against the indicators in the overall and sectoral PAFs. Dialogue takes place through regular meetings to review the overall poverty reduction plan (PARPA) and also at sectoral levels with the line Ministries concerned . Interviews with GOM, donors and DFIDMoz suggest that sectoral policy and challenges have tended not to be substantively discussed at PARPA meetings . Sectoral meetings between line Ministries and donors reportedly tend to focus on reviewing trends against the health and education indicators in the PAF and only occasionally on the substantive issues and options for overcoming specific constraints in the Health and Education sectors. The Health and Education donor groups have managed to focus on some key areas by supporting separate discussions directly with the Minister of Health and Education around specific policy issues [9].

5.12 DFIDMoz has used its position as the focal donor and Health Partner Group representative, and as focal donor on HIV/AIDS and partner in the education sector to push forward a number of initiatives with potential longer term benefit for the development of the health and education systems and for the HIV/AIDS response in the country. In most cases the inputs were DFID advisory staff time and consultants. These are discussed in more detail in the next section and in the case histories in Annex 2. Specific examples include:

[7] Health Sector Partners Performance Report (ACA v) April 2006
[8] Spreadsheet provided by Health Partners Group –Delays in Disbursement Plan Nov 2009
[9] The previous Education Adviser made the point that DFIDMoz had made a big effort to link the Education Sector and PARPA/GBS policy dialogue and that this required a more integrated and multidisciplinary approach that brought together Governance, economic and human development advisers.

- Supporting the development of a Health sector strategy within the Ministry of Health which focussed on basic services. GOM now has a more clearly defined strategy which can help inform resource allocation.

- Promoting the International Health Partnership (IHP) as a compact around mutually agreed commitments including the predictable resourcing of the health sector.

- Human Resource Development Plan in Health. This sets out workforce and financing requirements. Although it has not helped GOM to raise more donor finance it has provided a sound basis for improving the effectiveness of the workforce.

- Abolition of Health User Fees. GOM has been assisted to consider the implications of such a policy on demand and the overall financing of the sector. The policy is yet to be enacted.

- Strengthening of the National AIDS Response through establishment of a pooled Common Fund for the response, including mobilization of funding from other donors such as the Global Fund and the World Bank.

- Support to the NAC to develop a communication strategy for the AIDS response as well as a prevention strategy. Both have been integrated into the national strategy for the coordination of the response to the prevention and treatment of HIV and AIDS.

- Setting up a common fund in Education and leveraging donor contributions so that the funding going into the Pool fund has increased from 30 million USD in 2005 to 124 million in 2009.

- Reform of pre-service teacher training (resulting in a doubling of the capacity for teacher training and an increase in the proportion of trained teachers in the system)

- Improved management of primary and secondary school construction and greater awareness of unit costs and quality considerations.

Institutional Development Outputs

5.13 Along with other donors, DFID Moz aimed to use technical assistance flexibly to strengthen the Ministries of Health and Education to enhance planning, budgeting, financial management and procurement. In practice, relatively few opportunities have arisen to do this.

5.14 The Ministries of Health and Education have yet to set out a comprehensive programme for institutional reform or capacity building of sectoral institutions although the new Human Resource Development plan in Health provides a good starting point. There have been some individual areas of improvement including better sector plans and information systems. DFIDMoz is currently supporting an Education Planner which is providing that Ministry with valuable analysis of programme costs, service delivery and improved planning and resource allocation decisions.

5.15 There are several constraints. Budgeting and financial systems cut across all Ministries and programmes to improve them are led by the Ministries of Finance and Planning rather than the line Ministries. The Government wide financial management reform programme SISTAFE has reportedly made good progress in ensuring budget execution and improved accountability but it has yet to change the budget format to allow a clearer link between programme costs and service delivery outputs. This makes it very difficult for line Ministries to monitor programme costs or to consider different service delivery scenarios.

5.16 Line Ministries also face difficulties in introducing organisational changes and addressing their workforce needs as any plans need to be consistent with Government wide wage bill and numbers ceilings. Financial constraints on workforce numbers have limited the options for reorganisation and improvements. Education is an interesting counter example in this respect, however, because the sector has been able to effectively argue for more resources for staff, while at the same time reducing the pay level of teachers by reforming the teacher education system and thus employing more teachers with the same budget. The Ministry of Health could potentially have achieved more in terms of capacity building had it been more receptive to external technical assistance over the last five years.

5.17 DFID Moz played a major role in supporting the National AIDS Council. Technical assistance and support from DFID helped the Council to refocus on its core functions on coordination and facilitation. Reforms to the funding mechanisms for the National AIDS Response have relieved the CNCS of the burden of grant management. . As a result the National AIDS Council is gradually become more effective, although considerable challenges remain.

5.18 Financial aid to PROSAUDE and to FASE in Health and Education, respectively by DFID and other donors has indirectly led to strengthening of the service delivery institutions by enabling Government to improve infrastructure, equipment and recurrent financing at the point of service delivery. Discussions with Health and Education that additional donor financial resources has enabled:

Health

- Upgrading and improvement of clinics and health centres.
- Sustained training of health professionals and deployment to isolated areas.
- Better staffed, equipped and supplied health centres and clinics

Education

- Improved supervision and inspection
- Training of district level staff
- New and upgraded schools and classrooms
- Increased supply and stock of text books
- Improved teacher training and earlier deployment

5.19 In the area of HIV and AIDS, DFID also supported the development of a Common Fund arrangement to channel grants to local organisations for work on prevention, care and support. The CF was initially managed by the National AIDS Council. As a result of management constraints in CNCS, the donor grant component of the CF has been reduced and most grant funding is now channelled through a separate Rapid Results Fund which is managed by UNDP. The Common Fund has helped to open up alternative ways of providing services and DFIDMoz also encouraged the National AIDS Council to contract out the management

arrangements as an innovative way of improving the speed and efficiency of grant management. Although progress has been slow, the arrangement could have important long term benefits in building the capability of NGO service providers and advocacy.

6. Extending the Analysis of Results

6.1 DFIDMoz are already applying the simple "share of sector output" model set out in the last section to determine the results from its spending in the health sector. Several of the indicators included in their performance assessment framework for DFID report on achievements in output terms. It is possible in principle to extend this analysis by attaching monetary values to the outputs to obtain an overall value of the benefits to Mozambique. At least one of the main donors in the health sector said that they attempted to undertake analysis of project and programme costs and then to consider the benefits in terms of DALYS (Disability Adjusted Life Years) or QALYS (Quality Adjusted Life Years).

6.2 QALYS are controversial but are being used for example in the National Health Service (NHS) in the UK to assess the value for money of a health intervention. For example, if an intervention gives a person an extra year of (good quality) life that counts as one QALY. DFIDMoz should be cautious in developing such an approach because it requires reliable data on the quantity of increased health outputs and a reliable QALY measure for interventions in the Mozambiquan context. It is also more appropriate to apply the approach to specific projects and interventions directly funded by DFID where outputs can be more directly attributed rather than a general programme such as financing the pooled fund.

6.3 QALYS are most often used to compare the cost of an intervention with the number of QALYs saved. However if the information were available on the benefits of specific interventions in terms of QALYs it would be possible to use the output data in table 4 above to give an indication of the monetary value from DFID spending. For example, if we claim that in 2009 DFID funded the following number of vaccinations then their economic benefit to Mozambique could be assessed as:

	Numbers covered in 2009 by DFID input	QALYs per fully immunised child	Total Benefit in Numbers of QALYs	Value of each QALY based on per capita income (US$)	Total benefit from immunisation in US$
Full immunisation of children under one year	25,987	Z	25987 x Z	380	25,987 x Z x 380

6.4 In general though, donors may be better advised to invest more in basic research in specific health related interventions. For example, recent work has been done

which illustrates the costs and benefits of cholera vaccination in Beira in Mozambique. Researchers used economic and epidemiological data to assess the relative returns to three different strategies (with and without user fees; school based vaccination for children; and mass vaccination for all). For a wide variety of parameters vaccination produced positive returns and especially for small school based programmes.[10]

6.5 There are other planning models which can be useful to focus planned spending on critical areas to maximise results. The Marginal Bottlenecks for Budgeting model (MBB) has been tried in several sub Saharan African countries to identify the main bottlenecks and constraints on service delivery.[11] The aim is to improve the targeting of additional marginal resources for health on community, facility or outreach packages to overcome specific problems rather than on provision of funds for identified health interventions. In Mozambique the critical constraints could well include availability of trained staff or access to facilities. The analysis would reveal where spending could best be targeted to get the best results in terms of impact on the MDGs.

6.6 If such an approach were adopted in the health sector in Mozambique it would allow GOM and donors to target spending more effectively and to maximise results in terms of health outcomes. It would also allow a clearer link to be established between expenditure related to overcoming bottlenecks in the health system and the service delivery and health outcomes. There would seem to be potential to develop this approach in Mozambique provided the analysis is not constrained by the lack of programme based budgeting.

6.7 Using the MBB might be a practical way for DFIDMoz to better capture the benefits and results to the Mozambiquan health system arising from its support to the pooled fund. There is no reason why a similar approach could not be adopted for financial aid to education through FASE. Another option could be to focus on defining proxy measures that would capture health system improvements for example:

Health system improvements	Benefit	Indicators	Valuation
Improved efficiency of delivery	Same service level but at reduced overhead costs	Overhead costs for delivering key services and treatments	Cost savings in MT
Improved productivity	More treatments or teaching contact with same staff and resources	% increases in treatments Number of classes or shifts and contact hours	n.a.
Quality of services being delivered improves	Better health and education outcomes	Test results in Education. Treatment success rates in Health	n.a.

[10] See Marc Jeuland et al A Cost-Benefit Analysis of Cholera Vaccination In Beira Mozambique

[11] See Marginal Bottlenecks : A New Costing and Resource Allocation Practice to Buy Health Results Agnes Soucal et al World Bank, WHO , UNICEF and Institute of Tropical Medicine Amsterdam 2002

6.8 In the education sector DFIDMoz is already monitoring key outputs of the investments. However, as for Health, the analysis around education could be extended to look into more detail at outcomes and impact, both from an economic perspective as well as from a social development (health, democracy) perspective. This will require the strengthening of capacity and systems to make the link between inputs (the amount of money), outputs (directly attributable to DFIDMoz) and the outcomes and impact.

6.9 A number of possibilities could be explored:

- Examining how acquisition of basic cognitive skills such as literacy, numeracy and critical thinking relate to economic indicators such individual earnings, the distribution of income (including regional distributions) and economic growth. This data is not currently available so any initiative would require developing measurement instruments for these cognitive skills and examining trends across a representative sample of the population

- Examining the relationship between years of schooling and indicators of individual earnings, distribution of income and economic growth. This may be more feasible than the last option because it will not require the development of a separate measurement tool. However it is likely to be less accurate as levels of schooling do not always correspond to levels of cognitive skills. Studies from other countries have shown that each additional year of schooling brings an incremental benefit.

- Examining the relationship between years/levels of schooling of mothers and the levels of education attained by their children (disaggregated by gender). The 2009 Mozambique Multiple Indicator Cluster Survey (MICS) showed that the schooling of mothers is a strong determinant of a child's chances of completing primary education. Children of mothers with a secondary education were more than three times as likely to complete primary education (58% as opposed to 16%) as those who had completed primary education. Similar analysis could be done for other levels of education and these results can then be related back to the indicators around earnings and economic development.

- Examining how years of schooling is related to selected health and nutritional outcomes. The MICS data clearly showed that mothers' level of education was an important factor in the level of chronic malnutrition among children under five. Almost one in two children of mothers who had not gone to school were found to be chronically malnourished, compared to one in four of those who had secondary level of more. The analysis also highlighted that the difference in levels of chronic malnutrition between those who had no schooling and those who had completed primary education was relatively small (49% of mothers who had never been to school where malnourished compared to 43% of mothers with primary education). Other selected indicators which could be monitored include HIV prevalence and fertility, as these both have important implications for economic development.

6.10 Many of the gains that are outlined above will depend on progress in terms of education quality. This underscores the importance of support to strengthen the capacity of the country to collect and use such data. Monitoring of education quality is currently done through proxy indicators (such as percentage of children

who complete schooling within the required number of years) and - for the region - through the results of the Southern and Eastern Africa Consortium for Monitoring Educational Quality assessment (SACMEC) studies. However both approaches are not entirely satisfactory and offer only a very limited understanding of the issues. The interviews conducted during the consultancy suggested the need for enhanced capacity in Mozambique (in the Ministry of Education, research institutes and Universities) to produce more useful information on the quality of primary education.

7. The Contribution from Influencing

Approach to influencing

7.1 This report has examined a number of examples of DFIDMoz influencing in the HD sectors which are discussed in detail in Annex 2. From these examples a number of common influencing objectives can be identified:

(i) Policy strengthening and priority setting for better service delivery in Health, Education and HIV/AIDS. This has included efforts at strengthening the overall sectoral policy as well as a focus on specific areas within sectors (such as on the teacher training and human resource policies in Education, human resource development in health, and the communication strategy for HIV/AIDS)
(ii) Enhancing aid effectiveness by encouraging donors to align with government priorities and to harmonize procedures and approaches through joint mechanisms (SBS and pooled funding)
(iii) Promoting longer term predictable funding to sectors through long term financial commitments (to education for ten years, and to health for five)
(iv) Mobilizing additional financial resources (in the case of education and health) and making better use of existing financial resources (across the three areas)

7.2 While this has been the overall approach, within HD sector the emphasis on the different objectives has varied. There have also been varying levels of joint action and coordination with other partners around the influencing agenda. In health, DFID has focused on all the objectives but emphasized aid effectiveness with a focus on getting partners to join PROSAUDE (e.g. the Global Fund on AIDS Tuberculosis and Malaria) and mobilizing additional resources (e.g. from PEPFAR) . In HIV/AIDS influencing focused on establishing joint funding mechanisms to encourage a more coherent funding approach by partners. In Education, DFID initially supported the setting up a pooled fund but has since focused more on advocating for changes on specific areas of policy where efficiency gains could be made (such as school construction, teacher training) rather than on influencing of specific partners.

Examples of DFID areas of influencing around aid effectiveness

In the health sector an important area of focus for DFID has been getting GFATM and PEPFAR to align and harmonize with PROSAUDE. Efforts have been partially successful, with PEPFAR funding being better coordinated with Government priorities. An additional US$ 2-4 mill has been allocated to institution building as a result.

In the Education Sector, DFID and the Netherlands played in an important role in negotiations around FTI Catalytic Funding being provided through the FASE pool fund rather than through separate modalities.

In HIV/AIDS DFID used its lead donor role to lobby other partners to join common funding mechanisms. Recently this has resulted in the establishment of the Rapid Results Fund (RRF) which is managed by UNDP.

7.3 Corporate influencing priorities were pursued by DFIDMoz in the Health sector where these were considered relevant to the local context and consistent with the priorities of Government. Examples included the International Health Partnership and more recently the Abolition of User Fees. The UK Prime Minister's commitment to Education was a foundation for a 10 year funding commitment to education, but overall there has been a less strong focus on specific corporate priority agendas. HIV/AIDS is a corporate priority but influencing priorities have mostly concentrated on addressing local issues related to critical capacity and management constraints in the response, and on better prioritization of actions.

Planning of influencing

7.4 Influencing strategies by DFIDMoz have been generally coherent and objectives have been both explicit and implicit. There are examples where influencing objectives have been incorporated into log frames, annual plans and monitoring frameworks. DFIDMoz experienced some difficulty in defining suitable indicators for influencing and DFIDHQ will need to consider further what can be done to address this. HD Advisers also have implicit influencing objectives for the use of their time but this was not always recorded because of time constraints and because of the need to maintain flexibility to respond in an opportunistic way. One example was the influencing of the World Bank to redirect resources for HIV/AIDS to a newly established joint funding mechanism (see Annex 2).

Examples of technical inputs by DFID

- Using lead/focal donor position to advance an agenda – e.g. on the human resource strategy in the health sector and in influencing of the GFATM and PEPFAR. In HIV/AIDS the lead donor position of DFID was strategically used to promote better prioritization of the response and to lobby for a re-focussing of the National AIDS Council on Coordination rather than implementation.
- Supplying technical input into certain studies or discussions, for example DFID has funded technical expertise to education on construction and education modelling for decision making.
- Funding of long term TA within certain agencies, such as is the case for the HIV/AIDS specialist funded by DFID in UNAIDS and in the WB office in Mozambique.
- Participating in sector working groups and using this to advance a specific agenda .

Modalities/strategies for influencing

7.5 Broadly speaking influencing across the sectors has involved a combination of the following:

- **Technical input:** DFID advisory time (especially as the lead or "focal" donor) and technical assistance. Influencing takes place through the Donor Partner Groups but also by providing inputs into key sectoral working groups.
- **Using funding** to help establish mechanisms that encourage other donors to make funds available in a flexible way that leverages additional resources. Annex 2 highlights how DFID support for PROSAUDE and FASE had a strong signalling function for other donors. In HIV and AIDS, MONASO and RENSIDA leveraged additional funding for CSOs. Funding can potentially be used to facilitate policy change. DFID has offered to support the Ministry of Health to compensate for loss of resources should it move forward with the abolition of user fees.
- **Leading by example**, for example in predictability, by making a 10 year commitment to support the education sector, and by introducing a five year rolling budget support arrangement. DFID has also stated it will not engage in parallel projects.
- **Cross Cutting Influencing** by supporting a mix of aid instruments DFID has been able to share its experience and expertise across sectors. For example, experience with the health sector PROSAUDE process was fed into the revised

Memorandum of Understanding (MoU) for FASE, and DFIDs support for education policy fed into the discussion around priorities for GBS.

- **An HQ influencing role.** DFIDMoz has worked closely with DFIDHQ to influence other major partners when the issues that need to be addressed transcend the individual country level. DFIDMoz efforts to influence GFATM were closely linked with efforts to influence decisions at Board level. In relation to FTI, DFID's understanding of the Rwanda experience and its relationship with the World Bank was important in moving things forward (the World Bank did not want to use FASE for FTI funding).

The DFID Moz contribution

7.6 The analysis of the influencing cases in Annex 2 and discussions with GOM confirm that DFID is valued as much for the professional inputs and expertise it provides as for its financial contribution. Government underlined the important role DFID and the Health Partner Group had played in providing support for policy development in the Health sector and specifically in taking forward the International Health Partnership, the Human Resource Development Plan and exploring the issues and options around user fees. There was also a recognition of the efforts to align the vertical fund GFATM and to mobilise additional resources from PEPFAR even though these had not succeeded.

7.7 GOM and development partners also highlighted the value added from DFIDs ability to provide technical assistance in a flexible and timely way. A good example is the DFID funded Education planning consultant whose work will feed into the next application for FTI funding by Mozambique and into the next education sector strategic plan which is currently under preparation. In HIV/AIDS, consultancy support for the development of the prevention strategy was seen as adding value particularly because DFID was able to identify senior experts with the right mix of skills.

7.8 Government and development partners stressed the importance of DFID senior level staff with relevant expertise to effectively influence and contribute ideas. This was also seen as important for building the relationship with Government. There was also a concern that DFID staff should have more exposure to the field and should be less inward looking. Both observations were also recorded in the DFIDMoz Country Programme Evaluation (CPE).

Influencing as a joint effort

7.9 DFID has also worked in a supportive role to enhance influencing. For example, in the education sector the World Bank and Spanish have led the discussion around school construction and unit costs, but informants underscored that DFIDs additional inputs had contributed to generating the necessary additional weight and technical expertise to pressure Government into examining unit costs. Had DFID been the only partner to do this, or had one or two other partners tried to do so then the process may have been less successful.

7.10 Where DFID plays a supportive role in generating this kind of "critical mass" the question is whether DFID support is essential or not. The answer is necessarily context specific. Key donors like the Netherlands and DANIDA are exiting the Education sector. Other donors in the sector are replacing international experts with local staff. DFIDs continued support in that sector is seen as vital by donor partners because of the changing make up of the donor group i.e. a critical mass of a certain calibre and level of expertise is considered necessary (see Annex 2).

7.11 DFID has scored very well on local annual assessments of the progress of Programme Aid Partners (PAP) against the Paris principles and has ranked at the top of the list of the G19 donors. DFID leadership as donor focal point has been valued by donor groups and by Government partners. However, there were some concerns that DFIDHQ agendas could drive donor discussions[12] excessively (e.g. on health user fees) but it was acknowledged that DFIDs role in the Donor Partner Groups had been to share and discuss these agendas openly and to work within the donor consensus especially in relation to the policy dialogue. It was also apparent that DFIDHQ influencing priorities around for example GFTAM and User Fees were issues already being considered by GOM. One informant distinguished between a legitimate advocacy role for any individual donor and the need for donors to work in a harmonized way.

Outputs from influencing

7.12 This study shows that DFID influencing has had a demonstrable impact in a number of areas. Specific examples are discussed in detail in Annex 2, and include:

- DFID has played a key role in the establishment/furthering of SBS and pooled funding modalities across the three sectors (PROSAUDE, FASE, and the common funds for HIV/AIDS). In the case of education, the level of external funding has increased.. In health and HIV/AIDS funding is better aligned with priorities and transaction costs for Government have reduced to some extent.
- DFID funding has had a signalling function, e.g. in the HIV/AIDS common funds where other donors later joined mechanisms supporting CSOs and provided additional funding
- In some cases, the outputs from DFID influencing have resulted in cost savings or improved resource reallocation. For example in education, DFID has worked with other donors to influence unit costs for construction which could potentially reduce secondary school costs from US $ 5 mill to US$ 3 mill and ensure better value for money at primary level. DFID has successfully lobbied to ensure that the HIV/AIDS workplace policy is funded and also managed to ensure that US$ 20 mill of World Bank funding was re-programmed in the sector rather than being re-allocated to non-HIV/AIDS priorities.
- DFID has had some success in encouraging non-like minded partners to align (for example the GFATM and PEPFAR in health, and the FTI CF in Education). Results here have been mixed. In health alignment was not achieved, but there is evidence of better coordination with non like-minded partners, in particular with PEPFAR who have now allocated US$ 2-3 mill per annum for education capacity building and training of state institutions and personnel. In education DFID played an important supportive role in getting the FTI to join FASE but some changes had to be made to the new MoU that may have reduced alignment with Government systems.

7.13 Some of the influencing efforts have yet to come to fruition. DFIDMoz support of the IHP and human resource development plan in the run up to the 2008 UN summit did not elicit the expected additional financial commitments for Mozambique from the US Government (PEPFAR). In practice, PEPFAR decisions have been more influenced by the new administration and the current economic downturn.

[12] This concern was also raised in the recent Country Programme Evaluation

7.14 Influencing is not an exact science and it is difficult to predict progress and outcomes exactly. This report also shows that influencing can be risky and have unforeseen consequences. The reversal out of PROSAUDE by GFATM has had significant implications for the sector (see Annex 2). This was not the fault of DFIDMoz but of GFATMs failure to adapt its procedures as promised. With the benefit of hindsight it might have been possible for DFID to examine the specific changes in GFATM business processes that were needed but in practice this was unlikely to have happened as throughout the process DFID received strong signals and constant high level reassurance from the most senior levels of the GFATM that changes would be made. The case study on GFATM in annex 2 highlights important lessons that can be applied across different influencing efforts. These include:

- The need to consider the risks of failure at the outset of an influencing exercise and to systematically assess the adverse consequences in advance.
- The need to assess the mechanism and managerial processes by which the proposed policy change will take place and to address any barriers at this level (i.e. a high level commitment does not automatically bring about organizational change).
- The importance of understanding the precise nature of the change that needs to take place. For example, whether it requires a wholesale change in the business processes of the organisation or if changes to procedures can take place locally at country level.

7.15 The focus on establishing a CF for the National HIV/AIDS response is a further example. The fund was established with the intention of harmonizing donor support and aligning behind Government priorities in the sector. However the management burden on the National AIDS Council was heavy and likely underestimated (hence the importance of understanding the change that the management of the CF would require within the CNCS) and the lack of confidence of partners that resulted are in part a consequence of this.

Value for Money

7.16 The direct influencing costs incurred by DFID were less than £1mill. There were also some small associated technical assistance costs. Where DFID influencing was carried out jointly with other donors they will also have incurred resource costs in support of the influencing efforts. Even if we assume that the overall cost of donor influencing efforts was around three times higher at £ 3 mill over 2005-10 it seems likely that the benefits in terms of cost savings, resource allocation and mobilization and aid effectiveness are more than sufficient to justify the influencing effort.

8. Assessing Value for Money Using Unit Costs

8.1 A key aspect of ensuring value for money is measuring unit costs of activities undertaken and of programmes supported by aid. DFIDMoz is responding to the challenge to develop unit cost indicators in its main programmes. Whilst this is relatively straightforward where DFID controls and manages the funds and arranges procurement (e.g. for bed nets or condoms) it is much less straightforward where resources are provided into a common or pooled donor fund. These resources are then channelled directly to Government and it is for the line Ministries to monitor and exert cost control and to examine unit costs.

8.2 Unfortunately the lack of programme budgeting in Mozambique makes it difficult to routinely measure the costs of individual programmes and activities. However it is possible for line Ministries to use their own information systems to track costs and to identify anomalies. For example, the Ministry of Education can use procurement programmes to assess the unit cost of school construction or textbook production and distribution and the Ministry of Health should be able to track the unit costs of drugs procurement and of clinic rehabilitation and upgrading. It is less easy to track the costs of some treatments because they include a mix of staff time, drugs costs and facility overhead costs.

8.3 The recent experience with secondary school construction in the Ministry of Education demonstrates how important a donor dialogue about unit costs can be. This is an excellent example of good practice. As the case history in Annex 2 indicates, DFIDMoz played an important part together with other donors in focussing GOM on the high costs of complex secondary schools and then in examining the costs of primary school construction.

8.4 There is potential for donors to help Government to develop the capacity to examine unit costs and value for money more systematically. The current TA being provided by DFID to the Ministry of Education should enable the Ministry to better track the costs of school books, teacher training and other aspects of the system. As well as basic costs of construction and materials provision, it should also be possible to track the costs of supervision and inspection per school and the costs of teaching a pupil for a year. All of these types of measures can provide an effective way to improve the use of resources in the sector.

8.5 In the Health Sector a similar approach could be used. WHO has already developed several costing models that can help Governments track the cost of different treatments and integrated primary health care facilities and services. [13] WHO has also recently developed an estimate of unit costs for patient services in Mozambique including for the cost per visit for primary care facilities i.e. health centres at different levels of population coverage. These estimates include depreciated capital items but exclude drugs and diagnostics. Unit costs are as follows:

[13] See for example WHO Costing Tools for the Health MDGs

Mozambique: Cost Per Visit at Health Centre for a 20 minute visit

Population coverage	US $ 2005
50%	5.95
80 %	7.01
95%	10.64

Source : WHO

8.6 During the mission we discussed the importance of cost analysis in Government as a way of improving value for money in the HD sectors. There was a lot of interest from the Health Partners Group in considering how this could be built into the existing performance assessment framework and how the donor group could work on the issue collectively. It was recognised that this was required both to assist Government to get maximum value for money but also to ensure that results were being better communicated to the taxpayer.
8.7 There is also room to do more to measure key efficiency ratios including average numbers of visits per clinic or staff and overhead costs per facility in health etc or in education the administration cost per district or school and pupil teacher ratio by grade. A more systematic survey of donor attitudes to measuring performance and value for money was also carried out and the results are summarised in the box and presented in annex 3.

Summary of main findings from donor survey

- Overall, education and health donors think the sector PAF provides good /very good coverage of performance in their sector (health, education and/or HIV/AIDS)
- Most respondents stated the sector PAF was a good instrument for providing feed back to agency headquarters.
- However, most respondents indicated that the sector PAF is only of limited value in assessing value for money (VfM)
- The majority of donors (over two thirds) were in favour of joint work to develop VfM assessments

8.8 The foregoing analysis suggests that DFIDMoz and the donor partner groups in HD could explore options to work with the line Ministries to :

- Identify main cost centres in each sector and the data required to measure and monitor unit costs.
- Track unit costs nationally and in different parts of the country
- Compare unit costs in Mozambique to regional and international norms wherever possible
- Define suitable efficiency ratios and monitor them .

8.9 DFIDMoz will need to develop suitable value for money indicators in the HD sectors in order to meet requirements from DFIDHQ. This would be best done by drawing on the data already collected by GOM either in the PAF or in the internal information systems of the line Ministries concerned. Examples of the kind of unit costs and efficiency measures to focus on in health could include:

Health	Cost centre	Unit costs	Efficiency Ratios
	Construction cost	Per clinic	
	Bednets	Procurement cost per net and delivery cost to point of use	Numbers distributed per target group

	Drugs	Procurement cost per batch and delivery cost to point of use	% availability per clinic and % stock outs
	Vaccinations	Cost of dose and treatment per person	Numbers treated per health staff
	Overhead and staffing costs	Per health centre or clinic or patient	Staff cost per treatment
	Outpatient and in patient	Cost per patient visit	Visits per facility, consultations per staff member

8.10 For education, indicators could include those listed below. It should be noted that in the education sector some VFM data of this kind is being collected with technical input funded by donors including DFIDMoz, but more work is needed to improve the reliability and in particular to ensure that the analysis of unit costs is fed into the decision making.

Education	Cost centre	Unit costs	Efficiency Ratios
	Construction cost	Per classroom completed, by type of construction (community, contractor, mixed, etc) and by level (primary, secondary) Per training institution (e.g. teacher training)	Numbers of classrooms constructed Better quality classrooms Higher completion rate of school construction (currently classrooms are not always completed)
	Books	Procurement cost per set of books by level of education (lower primary, upper primary, lower secondary, upper secondary) and delivery cost to point of use	Numbers and cost of books per school or pupils receiving a full set of books Numbers of books per set
	Teachers	Cost to train one teacher for a specific level of teaching (primary, secondary)	Numbers of teachers trained for given level of spending
	Pupils	Cost of producing one graduate at primary level Cost of producing one graduate at secondary level	Numbers of pupils trained at different levels Numbers of pupils completing
	HIV/AIDS pupils and teachers	Cost of enrolling and supporting one orphan per year per level of education Cost of training and support to each teacher per year	% of HIV and Aids staff and pupils on school roll Turnover and vacancies of teachers and nos retained in the

			system
	Personnel expenditure (non teaching staff)	Salaries and Non-recurrent personnel expenditure by average grade at each level of work (national, provincial, district, school)	Wage bill for a given level of school numbers

Conclusions

There are four main points:

- DFID investment in health, education and HIV and AIDS have generated a range of benefits including improved policy, aid effectiveness and institution building in addition to increasing the quantity of services to poor people in Mozambique.
- DFID has worked effectively with other donors in accordance with the Paris principles.
- Influencing has generated improvements to aid effectiveness and in policy areas appreciated by GOM. There are several examples of successful influencing of other donors and with other donors of the Government.
- DFID needs to work with other donors and Government to enhance capacity for the measurement and monitoring of unit costs in the line Ministries of Health and Education.

ANNEX 1: Part A - Health and HIV & AIDS Resource Mobilisation and Outputs 2005-10

1. The Context

1.1 Mozambique remains one of the poorest countries in the world and its health status reflects the high levels of poverty. Malnutrition is a major problem and infant mortality remains high. The burden of disease reflects a high level of infectious and communicable diseases including HIV and Aids. Malaria remains the biggest single problem and is responsible for 40% of all outpatient attendance and 30% of childhood mortality.

1.2 Health problems are compounded by lack of access and about 30% of the population are unable to access a health facility within 30 minutes of their home. Some progress is being made in the health sector. As rates of immunisation increase the level of childhood diseases is falling. There has been some reduction in infant mortality as a result. Health service facilities are being improved throughout the country and there is a discernable effect on mother and child services including an increased number of institutionalised births. Maternal mortality was once one of the highest in the region but has been falling in the last five years reaching 408/100,000 live births.

1.3 GOM gives priority to basic health services in rural areas and has been trying to improve facilities, drugs supply and the quality and availability of staff. Health remains a priority area for development assistance and Government remains aid dependent with around half sectoral funding coming from external sources. There are x donors currently operating in the sector. Trends in health sector performance and outputs are shown in the table below:

2. Performance Trends in the Sector 2005-10

Table 1: Selected Health Sector Performance Indicators

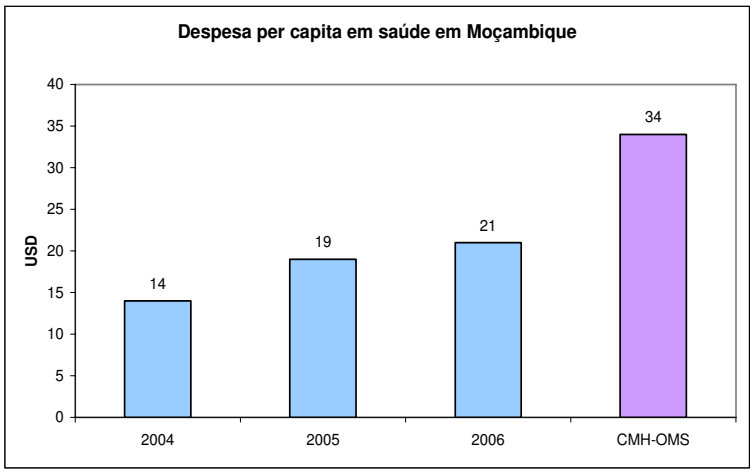
	2005 result	2006 result	2007 result	2008 result	2009 result	2010 target
Indicator						
Infant mortality	100			94		
U5 mortality (Demographic Health Survey and MICS)	145			138		
DPT3 and Hb coverage 0-12 months (DFID Moz)	94 % =758135	100% =817657	98% =803899	Est = 800,000	Est = 800,000	
Children under 1 year totally immunised (DFID Moz)	44% =350041	55% =443590	64% =523300	62.7 % =519745	Est =520000	
Institutionalised Births (DFID Moz)	49% =424066	48% =435175	52 % =470911	55% =505925	Est =506,000	
Numbers of new mothers using family planning (QAD)	419,726	n.a.	568,760	518,045	598,440	
Malaria – pregnant women that receive at least one treated bed net (QAD % and DFIDMoz numbers)	18%	41% =1,196,041	82% =2,834,140	77% Est 2,600,000	Est 2,600,000	
TB % of those treated counselled for HIV and Aids (QAD)	24%	n.a.	68%	79%	84%	
TB rate of cure with treatment (QAD)	78%	n.a.	82%	82%	82%	

Number of HIV and Aids infected persons receiving ARVs (QAD)	6360 men 9540 women = 15900	n.a.	88211.	43,616 men 75, 321 women =118,937	63,306 men 106,892 women =170,198	
Ratio of Medical staff to population (QAD)	21317	n.a.	17115	15,871	13,721	
Ratio of all Health staff to population (QAD)	1617	n.a	1381	1310	1261	
Number of Health Centres rehabilitated or constructed	33	n.a.	75	442	442	
Number of facilities fully equipped with basic services of water and electricity (RAE)	n.a.	10%	30%	50%	50%	

Source: DFIDMoz and Government of Mozambique QAD and RAE documents

3. Spending in the Health Sector 2005-10

3.1 Overall spending per capita in the health sector has been rising over time but is still well below regional levels. As the Fig shows total spending in the sector from all sources has reached US$ 34 per capita in 2006 although Government meets only US$ 21 of this.



Fonte: MISAU - DPC, CNS 2004 - 2006.

3.2 Overall DFID spent £ 52 mill on health including HIV and Aids over 2005/6-2009/10. The majority of these funds were spent on financing the health system with essential supplies (drugs and bed nets) and general financing into the common pool which Government used to meet the needs of the wider health system. Around £ 7.7 mill was spent directly on HIV and Aids with some related spending under the Maternal and HIV/Aids programme. The patterns of spend is set out in table 2 below.

3.3 DFID also accounted for a significant proportion of total health sector spending over the period. Using Government data that collects together all spending in the sector over 2005-8 it is possible to calculate that DFID spending varied between 3-7 % per annum of total spend (see table 3 below). Over 2005-8 total spending by Government and donors was MT 41.65 bill and spend by DFID was MT 2.11 bill or 5% of the total.

Table 2 DFID Spending on Health 2005-10

	2005/6	2006/7	2007/8	2008/9	2009/10	
Essential medecines	1.0					
Maternal Health and HIV/Aids	6.8	2.189	1.179	0.33		
Pro Saude Common			10.4	7.0	7.0	

Fund				+0.26 TA	+0.2 TA	
Bednets	0.452	1.469	2.425	1.807	1.839	
Sub total	8.252	3.658	14.00	9.40	9.04	44.35

	2005/6	2006/7	2007/8	2008/9	2009/10	
Social Marketing of condoms	1.716	1.716				
Common Fund			0.5		0.36	
Monaso	0.1	0.348	0.316	0.360	0.367	
Rensida	0.02	0.153	0.212	0.046		
HIV Prevention			0.024	0.873	0.044	
TA to CNCS World Bank and UNAIDS	0.400	0.044	0.121			
Sub total	2.236	2.261	1.173	1.28	0.771	7.721
Total DFID Spend on Health	10.488	5.919	15.173	10.68	9.811	52.071

Table 3 : Proportion of Health Sector Spending Accounted for By DFID

All in Meticais Billions

	2005	2006	2007	2008	2009	
1. State Budget	2.704	2.808	3.302	3.588		
2. Common Fund	2.756	2.574	3.250	1.924		
3. Vertical Funds	3.380	3.666	3.900	7.800		

4. Total Health sector spend	8.840	9.048	10.452	13.312		
5. DFID Spend on Health MT (£ mill)*	0.524 (£10.488m)	0.296 (£ 5.919m)	0.758 (£15.17m)	0.534 (£10.68m)	0.490 (£ 9.811m)	
% of health sector spend by DFID	5.9	3.3	7.3	4.0		

*exchange rate of £ 1 =Mt 50

Source : Mocambique Contas Nacionais De Saude Jan 2010 see Table 4 Page 13

Outputs in the Health Sector

4.1 On the basis of this assessment we can extract some of the key quantitative indicators in table 1 and "claim" that proportion of the outputs for DFID. Table 4 sets out this calculation:

Table 4: Health Sector Spending –Outputs Claimed By DFID

	2005 result	2006 result	2007 result	2008 result	2009 Result	Total
Indicator						
DPT3 and Hb coverage 0-12 months (DFID Moz)	94 % =758135	100% =817657	98% =803899	Est = 800,000	Est = 800,000	
DFID 5% Contribution	**37,906**	**40,883**	**40,195**	**40,000**	**40,000**	**198,984**
Children under 1 year totally immunised (DFID Moz)	44% =350041	55% =443590	64% =523300	62.7 % =519745	Est =520000	
DFID 5% Contribution	**17502**	**22180**	**26165**	**25987**	**25987**	**117,821**
Institutionalised Births	49% =424066	48% =435178	52 % =470911	55% =505925	Est =506,000	

(DFID Moz)						
DFID 5% Contribution	**21203**	**21759**	**23546**	**25296**	**25300**	**117,104**
Numbers of new mothers using family planning (QAD)	419,726	n.a.	568,760	518,045	598,440	
DFID 5% Contribution	**20986**	**Est 21000**	**28438**	**25902**	**29992**	**126,318**
Number of HIV and Aids infected persons receiving ARVs (QAD)	6360 men 9540 women = 15900	n.a.	88211.	43,616 men 75, 321 women =118,937	63,306 men 106,892 women =170,198	
DFID 5% Contribution	**795**	**n.a.**	**4410**	**5947**	**8510**	**19662**
Number of Health Centres rehabilitated or constructed	33	n.a.	75	442 est	442 est	
DFID 5% Contribution	**1.65**	**n.a.**	**3.75**	**22.1**	**22.1**	**50**

Conclusion

On the basis of this analysis DFID has made a considerable contribution to the outputs of the sector over the period 2005-8. However the analysis is indicative only as it does not deal directly with the attribution issue. Clearly the specific outputs identified here are not traceable to specific DFID projects and programmes but rather they are a useful technique for summarising DFIDs overall contribution to the sector for communication to the public and DFID management.

Annex 1 Part B– Education

The context

The education system in Mozambique has seen grown impressively between 2005 and 2010. The growth has been important at all levels of the system, but has been particularly strong in secondary education (see table 1), where the number of students has increased by 165% for lower secondary (grades 8-10) between 2004 and 2009 and almost three fold in upper secondary (grades 11 and 12) over the same period. Non-salary spending per pupils has increased. The vast majority of school provision is provided by the state, with the private sector accounting for no more than 2 percent of the pupils at lower primary level, although private sector provision is somewhat more important at higher levels of the system (secondary and university level).

In spite of these achievements considerable challenges remain. Access to secondary education is still predominantly an urban phenomenon, high repetition and drop-out rates reduce the efficiency of the system, and there are concerns about the quality of the graduates at different levels. As will be noted below there is also an emerging additional challenge of reducing levels of funding to the sector which threatens sustainability and continuity of the achievements.

The developments in the education sector have been guided by the Second Education Sector Strategic Plan (ESSPII) for 2006-2010. The main aims of this plan are to:

a) Provide all children with access to seven years of schooling (EP1 and EP2) by 2015
b) Generate conditions for the expansion of post primary education

Through these priorities the GoM seeks to respond to the growing demand for further education by primary school completers. Ultimately the aim is to produce a well trained human resource base to which will contribute to sustainable and long term growth and development in Mozambique.

In recognition of the weaknesses in the system, the ESSPII has prioritized a number of key reforms aimed at ensuring a more efficiency and effective use of the resources in the system. This has included a strong focus on teacher training, curriculum, and school construction, as well a drive to promote decentralization (to increase implementation capacity), institutional development, and improved harmonization and alignment among partners supporting the sector. Over recent years the MoE has prioritized capacity development at district and local levels with the intent of influencing quality of the system through better management and supervision. In line with this priority, funds are being decentralized to district and local levels, resources (vehicles and other means of transportation, equipment for district offices) are being made available, and strategies are being put in place to train district officers.

Support to the education sector is provided by a total of 24 development partners. The past seven years have seen a major shift from donors funding parallel projects to a harmonized approach where the majority of resources to the sector are now channeled through FASE (a joint pooled fund established in 2003). This is a reflection of the maturing sector dialogue. Ten development partners (DPs) and the Fast Track Initiative's (FTI) Catalytic Funding (CF) are now channeling funding through FASE.

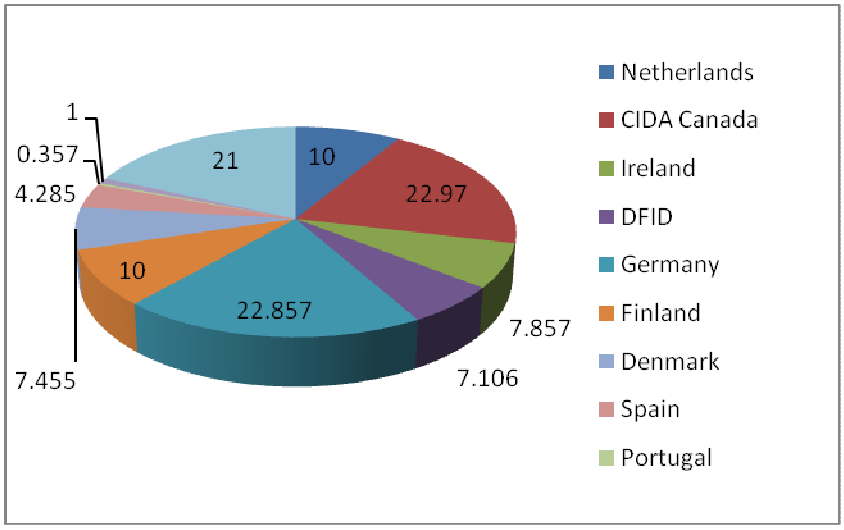


Figure 1 - Funding to the Education Sector Pool Fund in Million of US $ by Donors (2009)

In 2009 the largest contributors to FASE was the FTI/CF, the Netherlands, Germany and Canada. Commitments to FASE totalled USD 123 million in 2009, although this is expected to fall to around USD 77 million in 2012 due to the withdrawal of the Netherlands from the education sector and the likely withdrawal of DANIDA, the end of CF's, and also the reduction of budgets of some partners as a result of the economic crisis (Irish Aid). This is a situation that is of great concern to the MoE as this would mean that key areas of spend (teacher training, school books and others) would need to be curtailed with corresponding expected impacts on further expansion and on quality issues in the system.

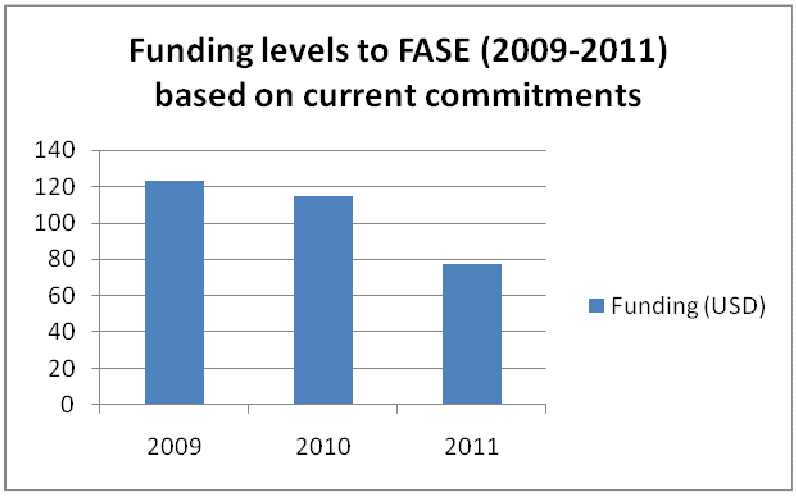


Figure 2 - Funding levels to the Education Sector Pool Fund (FASE) for 2009-2011 (source MoE, 2010)

Performance trends in the sector 2005-2010

Table 1 below provides an overview of selected education outputs.

Table 1 - Progress on Selected Education Outputs (2005-2009)

Indicator	*2005*	*2006*	*2007*	*2008*	*2009*	*Growth factor*
No. of pupils in EP1 (grade 1-5)	3,397,047	3,593,806	3,863,087	4,109,925	4,299,638	1.27
Percentage of girls EP1	*47.20*	*47.50*	*47.70*	*47.90*	*48.5*	
No. of pupils in EP2 (grades 6 and 7)	534,491	574,983	694,556	781,314	772,240	1.44
Percentage of girls EP2	*41.3*	*43.4*	*44.4*	*45.2*	*46.5*	
No. of pupils ESG1 (grade 8-10)	311,716	385,320	461,480	531,854	669,052	2.14
No. of pupils ESG2 (grades 11 and 12)	44,768	59,513	82,146	105,257	141,714	3.15
No. of adult literacy pupils	594,365	702,203	613,973	701,370	736,439	1.24
Number of new teachers for primary education	4000	7143	7717	9400	9721	2.43
No. of classrooms EP1	8598				10365	1.20
No of classrooms EP2	1212				2693	2.22
Per pupils spend through direct support to schools (USD)	1				2.5	2.50
Source: MoE financing educ sector 2009, and for 2009 data the statistical summary						

Table 2 below shows progress on selected indicators of sector outcomes.

Table 2 - Progress on Selected Indicators of Sector Outcomes (2005-2009)

Indicator	*2005*	*2006*	*2007*	*2008*	*2009*
Net grade 1 enrollment rates	55	59.6	66.1	69.6	74
Net grade 1 enrollment rates for girls	*55.1*	*59.8*	*66.5*	*69.8*	*74.6*
Primary school completion (EP2) - gross (%)	**34**			**46 (d) 40.6 (n)**	**54.2 (d) 49.2 (n)**
Primary school completion (EP2) girls - gross (%)	*28*			*39.4 (d) 34.1(n)*	*48 (d) 42.9 (n)*
Primary school completion (EP2) - net (%)					
Transition rates EP2 to ESG 1 (%)	**74**	**73.2**	**75.4**	**71.4**	**67**
Transition rates EP2 to ESG 1 girls (%)	*74.4*	*72.8*	*72.8*	*70.9*	*66.7*
Pupil teacher ratios primary EP1	*74*	*76*	*73*	*71*	*68*
Pupil class ratio primary EP1	49.5	49.6	50.1	50.2	50.1
Class teacher ratio primary	1.49	1.54	1.46	1.45	1.38
Percentage of pupils who complete a full primary cycle in 7 years					
Adult illiteracy rates	53%				48.10%
Number of new teachers for primary education	3901	7143	7717	9400	9721
% of new primary school teacherswith training	30%			95%	100%

Comments on the trends

The trends above point to important gains in quantitative terms but also to some gains in efficiency.

- Important increases in the number of students at each level of the system, in particular in upper primary (EP2) and secondary levels (ESG1 and 2)
- Gradually reducing teacher:pupil ratio. Because of the double shift system, this disguises the actual teacher:class ratio (which is also dropping)
- Greater number of pupils enrolling at age six years, which will mean better chances at continuing through the education system, in particular for girls.

- Improving gross, and net enrolment rates and a closing of the gap between these two point to some gains in efficiency
- Improved transition rates from lower primary to upper primary and from upper primary to secondary. Pupils who complete a full primary cycle in principle have the opportunity to carry on to study either in basic technical education or to continue on to secondary level
- Increasing per pupil spend, which is expected to contributed to quality improvements in the medium term as students have better conditions (books, and other teaching aids) to learn.
- However (not shown) repetition and drop-out rates, after a period of reduction, appear to now be on the increase and there are concerns that quality gains are very small and will need greater attention in the coming years.

Resource mobilization and spending

Around 50% of the overall GoM budget is funded by external sources (loans and grants). For education this percentage is somewhat lower (35-40%), and is expected to decline to about 25% in 2010.

Table 3 - Spending in the Education Sector (2005-2009)

Spending in the Education Sector							
All values in MZM thousands							
	2005	2006	2007	2008	2009	Totals (2005-2009)	Growth factor (2008/2005)
Overall GoM expenditure totals	36,910,897	44,820,000	56,643,600	64,201,200	91,447,431	294,023,128	2.48
GoM expenditure on educ as proportion of total expenditure	*19.59%*	*19.42%*	*21.04%*	*23.14%*	*20.71%*		
OGE Spend on Education	**7,232,676**	**8,705,399**	**11,920,185**	**14,858,849**	**18,940,437**	61,657,546	2.62
Donor spending on education							
FASE	*813,652*	*1,331,907*	*1,792,089*	*2,745,029*	*3,301,100*	9,983,777	4.06
Off budget donor funding	45,667	89,605	116,247	114,187	96,410	462,116	2.11
Sub total donor spending	**859,319**	**1,421,512**	**1,908,336**	**2,859,216**	**3,397,510**	10,445,893	
Total GoM and Donor Spending on Educ.	**8,091,995**	**10,126,911**	**13,828,521**	**17,718,065**	**22,337,947**	72,103,439	2.76
State budget as % of total	89.38	85.96	86.20	83.86	84.79		
DfID funding (pounds)	2,062,626.00	6,321,147.00	4,514,065.00	4,540,413.00	4,560,348.00	21,998,599	
DfID funding (MZM thousands)	103,131	316,057	225,703	227,021	228,017	1099929.95	2.21
DfID funding as % of total	1.27	3.12	1.63	1.28	1.02	**1.53**	

N.B. This does not include the contribution which parents make to the education costs of their children (parallel payments, school uniform, school supplies)

Education is a priority under the PARPA and has received an increase in nominal funds. The share of funds going to education also increased until 2007 (21.6%) when it started to show a small decrease to 18.5% in 2008 and 19.3% in 2009 (source: MoE, 2010).

The GoM funds to the Education Sector are mostly used on recurrent costs (94% of the 2008 budget was for recurrent expenditure, and only 6% for capital expenditure). The largest portion of recurrent cost is related to the payment of teacher and staff salaries. And over half of the education budget is to pay for recurrent expenditure at primary level (grades 1 through 7) where the bulk of the students are.

A number of trends can be discerned from the table above:

- Government budget has more than doubled between 2005 and 2010 due to economic growth

- External funding through FASE has grown even faster, increasing by a factor 4
- Most of the external support to the sector now uses national systems. While in 2003 (the year FASE started – data not shown above) only 5% of funding was going through FASE (numbers not shown) this has increased to 80% in 2008 (check).

It is clear that the increased resources to the sector have played an important role in the expansion of the systems and in some of the gains outlined above. The MoE, through increase in internal and external funding has, for example, dramatically increased the number of new teachers who are hired into the system annually.

DfID contribution to service outputs

Important results have been obtained over the period. Using the 1.53% of spending in the sector which is DfIDs contribution over 2005-2013, the following outputs can be attributed directly to DfID:

- As a result of joint efforts, the lower primary system grew by 27% over five years, allowing more children to start school and to stay in school. In 2009, funding by the Government and donors allowed 902.000 more children to receive primary education in grades 1-5 compared to 2005. Over the period DfID funding directly paid for 288,953 children to benefit from lower primary education, of these 138,294 were girls.
- As a result of joint efforts, the capacity to receive children in grades 6 and 7 (upper primary) increased by almost 50% between 2005 and 2009. In 2009, 237.749 additional children were enrolled in upper primary in 2009 compared to 2005. Over the period 2005-2009, DfID funding paid for 50,364 to benefit from upper primary education.
- Between 2005 and 2009 the capacity to train primary school teachers more than doubled. As a result, all new primary school teachers recruited by the MoE in 2009 had at least one year of teacher training, against 30% of teachers in 2005. Over the medium term this will contribute to better quality teaching. As a result, over 37.000 new primary school teachers were trained and employed between 2005 and 2009. DfID funding directly paid for the training of 570 teachers. At a pupil teacher ratio of 1:70, this means that an additional 42.000 children were able to go to school directly because of DfID funding.
- The number of adult literacy pupils increased by 25% over 2005-2009. DfID paid directly for over 50.000 adult literacy pupils over the period.
- DfID funding also paid for 655 new classrooms at lower primary level, and for 125 new classrooms for grades 6 and 7.

Indicator	***2005***	***2006***	***2007***	***2008***	***2009***	***Total***
No. of pupils in EP1 (grade 1-5)	50,956	53,907	57,946	61,649	64,495	**288,953**
Of which girls in EP1	*23,949*	*25,336*	*27,814*	*29,591*	*31,602*	***138,294***
No. of pupils in EP2 (grades 6 and 7)	8,017	8,625	10,418	11,720	11,584	**50,364**
Of which girls in EP2	*3,287*	*3,709*	*4,584*	*5,274*	*5,444*	***22,298***
No. of pupils ESG1 (grade 8-10)	4,676	5,780	6,922	7,978	10,036	**35,391**
No. of pupils ESG2 (grades 11 and 12)	672	893	1,232	1,579	2,126	**6,501**

No. of adult literacy pupils	8,915	10,533	9,210	10,521	11,047	**50,225**
Number of new teachers for primary education	60	107	116	141	146	**570**
No. of classrooms EP1	129	105	113	135	155	**637**
No of classrooms EP2	18	23	23	24	40	**128**

Table 4 - Outputs directly funded by DFIDMoz between 2005-2009

Other changes in the sector which DfID funding has contributed to

- Establishment of FASE which brings together most donors contributions in a fully harmonized and aligned manner and which has enhanced government capacity for planning and monitoring, and has produced clear efficiency gains. FASE funding has increased from 30 million USD in 2005 to 125 million USD in 2009. While not all this funding is additional, it is funding that the MoE can directly manage according to its priorities.
- Improved estimation of unit costs for school construction, and improved capacity for supervision in this area (see influencing example)
- Guaranteed funding for the HIV/AIDS workplace policy in the sector

Conclusion

DfID has made an important contribution to the sector. Its contribution to spend is small, but because of the size of the sector the outputs are nonetheless important. In addition, DfID has made, through its influencing, an important contribution to efficiency and effectiveness in the sector.

Annex 2: Part A - Health Sector: Influencing By DFID

1. Context

1.1 Only two thirds of the population of Mozambique is covered by health services and since 2000 Government has given a high priority to the development of the Health Sector. There is a health sector strategic plan and GOM priorities have been to extend coverage especially of basic facilities , treatments and drugs . Since 2005 the Government has identified shortages of human resources as the main constraint on further progress against the MDGs. Mozambique faces a health workforce crisis with only 1.26 health workers per 1000 population which is among the bottom 5 ratios in the world. GOM is keen to address these constraints and to influence donors to mobilize more resources for the sector and put aid funding through the budget or to use common funds wherever possible. It nevertheless tolerates off budget spending provided by vertical funds and the large bilateral US Government programme PEPFAR.

1.2 In Mozambique, donors play a critical role in the sector with over 50% of the total sector spend funded by international aid. Donors fall into two camps. The first group including the EC, DANIDA, Dutch, Canadians and DFID have been at the forefront of influencing other donors in terms of alignment and harmonization. Before 1998, the sector was highly fragmented with donors providing aid on a project by project basis but a Sector Wide Approach (SWAp) was adopted in 2000. Between 1998 and 2008 three common funds were set up including the main ProSaude pooled fund arrangement supported by DFID. Prosaude has expanded steadily in size .The second group of donors are made up of the US Government (PEPFAR) and the Global Fund for Aids, TB and Malaria (GFATM) who continue to provide off budget support often through projects. The World Bank is planning to support a major health project in the Northern Provinces which will also require separate management arrangements.

2. Approach to influencing by DFID in the Sector

2.1 DFIDMozambique has sought to ensure coherence between DFID corporate influencing agendas which they have tried to pursue and the priorities of Government of Mozambique. DFIDMoz influencing objectives have often originated from DFIDHQ and then been contextualized to match the local situation. On other occasions the DFID Mozambique team have seized opportunities to link their influencing efforts with the priorities of Ministers and senior management.

2.2 Broadly speaking the influencing objectives for DFIDMozambique in the health sector have been :
(i) to help mobilise additional resources from donors for the sector through demonstrating the extent of the financial and human resource requirements

(ii) to encourage greater aid effectiveness by lending support to the common fund and joint donor procedures and by encouraging other donors to align and harmonise
(iii) to improve access to health services and service delivery by encouraging GOM to adopt new policy and improve sector management.

Influencing objectives of individual health programmes and projects have sometimes been explicit and some times implicit. The Prosaude submission contained explicit influencing objectives embedded within the log frame in relation to aid effectiveness and resource mobilization objectives. Advisers had implicit influencing objectives and a coherent strategy for the use of their time but this was not always recorded.

2.3 DFID has worked through the Health Partner Group including by acting as the focal or lead donor. Development partners are represented on the Joint Coordination Committee which meets 8 times a year and is Chaired by the Permanent Secretary. There are several donor working groups supporting this Committee.

3. DFID influencing in Health.

Example 1: Global Fund: Promoting Alignment and Harmonisation

Objectives of DFID Influencing

3.1 DFID is a major contributor to the Global Fund and an important corporate objective is to influence the organisation to encourage harmonisation with other donors working in the health sector and alignment with national priorities of developing countries. DFID aimed to do this through its representation on the Board and through efforts at country level working through the bilateral programmes in Mozambique, Zambia and elsewhere.
3.2 Achieving alignment of donors and moving more aid on budget remains a very high priority for Government. Interviews with the Ministry of Health (MISAU) suggested that they perceived important benefits from influencing GFATM to join the common donor fund (PROSAUDE). These included: greater predictability and flexibility because Government could control and allocate funds as well as reduced transaction costs as GOM could avoid separate monitoring and reporting arrangements.

Influencing Inputs

3.3 The HD team in DFID Mozambique gave a high priority to influencing GFATM and an adviser was appointed in 2007 with a remit to work on GFATM related issues with MISAU. The adviser worked with the rest of the PROSAUDE donors and the overall DFID input varied between 0.5 to 0.8 FTE per annum. The rest of the donor group also provided support as well.

3.4 Considerable effort was put into developing a relationship with the Ministry and liaising with the Global Fund portfolio manager to ensure that GFTAM procedural requirements for applications and reporting on results could be re engineered to allow alignment with PROSAUDE . Initially these efforts seemed successful because GFATM signed the MOU in 2006 that set out procedures for the common donor fund (PROSAUDE) and provided personnel to liaise with MISAU and the donors about the adoption of suitable procedures.

3.5 The Global Fund did in fact deposit funds into the PROSAUDE common fund over 2006-8 but these were eventually withdrawn at MISAUs request in mid 2008. The GFATM Board had previously indicated that there were no barriers in principle to using the PROSAUDE Fund providing management and reporting requirements were met . GFATM said they were willing to review the tools they were using for applications and performance reporting but in practice they did not . MISAU were also unable to provide sufficient reporting on the utilisation of PROSAUDE to meet GFATM requirements. In order to avoid further disbursement delays GFATM left PROSAUDE and put their funds into a separate account which they managed and monitored directly and funding was kept off budget. These decisions were made between GFATM and MISAU. The PROSAUDE donors and DFID were not invited to engage and could not therefore influence the outcome.
3.6 The process of integrating the Global Fund into PROSAUDE proved to be problematic and transaction intensive with seven separate disbursement requests being made, all of which failed. The Ministry of Health reported that the failure of GFATM to disburse also left a gap in their planned drugs supply of around US $ 40 mill in late 2008 which was only partially filled by funding from the US Government. There was a US $ 10 mill drug stock out and it is possible that this has led to disrupted treatments for some people during this period.

Achievements of DFID Influencing

3.7 The original influencing objectives have not been achieved since GFATM remains outside PROSAUDE and continues to operate as a separate off budget and vertical programme. In addition the adverse consequences from the reversal of the decision to join the common fund have been significant. However this set back was not caused by the influencing effort itself but by the lack of progress in changing GFATM procedures. There have been some gains as the Global Fund remains a signatory of the PROSAUDE code of conduct and is making more effort to ensure programmes are in line with national priorities and plans of other donors. There are also prospects for further improvements in coordination by integrating planning and management in a stand alone unit within MISAU.
3.8 This outcome does not mean that this influencing effort by the donors and DFID should not have been attempted. The potential aid effectiveness gains remain large and this is readily acknowledged by Government. Drawing GFATM into PROSAUDE could have generated considerable savings from reducing the transaction costs to Government and the overhead costs associated with delivering GFATM outside Government and through projects.
3.9 The current position is that the donors are supporting the establishment of a PMIU within health to manage the GFATM funds. This will help ensure funds are disbursed more smoothly and that reporting requirements can be more easily met. Overall, DFIDs influencing objectives were not achieved but there are important lessons to be learned:

- The need to consider the risks of failure at the outset of an influencing exercise and to systematically assess the adverse consequences in advance
- The need to assess the practicalities of alignment and doing the groundwork in advance i.e. to determine the precise procedural changes and their acceptability to GFATM
- The importance of changing GFATM policy and business processes for the whole organisation first rather than trying to achieve this through specific country level efforts.

Example 2: Mobilising Resources from PEPFAR and the Global Fund

Objectives of DFID Influencing

4.1 The International Health Partnership (IHP) is an effort to promote a Compact between developing counties and donors around mutual obligations to deliver improved health and increased development assistance. The IHP is supposed to shift health sector donors towards supporting national priorities and strategic plans aligned to the budget and offering long term predictable financing.

4.2 In 2007 UK Ministers became personally committed to supporting the IHP and DFIDMoz saw this as an opportunity to link Corporate and country level influencing efforts. DFIDMoz therefore used its influence as a member of the Health Partners Group (HPG) to support Government to follow the IHP process including helping to facilitate the development of a national health human resources (HHR) plan (see details in following example). The influencing effort was systematic but objectives were more implicit than explicit as there was no separately designed log frame or influencing project.

4.3 The aim was to use the IHP process as a mechanism to encourage non-aligned donor partners such as GFATM and the United States Government (USG) through PEPFAR to coordinate their efforts more directly with donors financing the PROSAUDE Common Fund and to contribute more resources. It was hoped that PEPFAR would become more aligned with national priorities and that they would increase the level of their support.

4.4 The main opportunity for this arose through the 2008 UN MDG summit at which the Government of Mozambique made speeches setting out its priorities in Health and the resources required. DFID and the donor group also encouraged Government to use the IHP and the related HHR plan costings to highlight the need for more resources in their negotiations and dialogue with PEPFAR and the Global Fund

Influencing Inputs

4.5 Most of the influencing effort was undertaken directly with MISAU by the DFID Health Adviser acting as the focal donor and representative of the wider donor group. It often took the form of advice and briefing for the Minister of Health as a basis for lobbying other donors to sign the Compact or to ensure Mozambique was able to set out clearly its plans and its financing requirements. Specific efforts involved:

- Active and direct negotiation with development partners in Mozambique to sign the Compact;
- Coordination with the IHP process and DFID HQ to achieve a high international profile for the national health strategy, lobbying of development partners in their capitals;
- Support to Government in the international dialogue including its presentation at the UN Summit in 2008

4.6 The Government of Mozambique Health Sector Strategy is set out in the Health Sector Strategic Plan 2007-12 (PESS) which focuses on primary health care, equity and better quality of care. Under the IHP process, the donor group and DFID promoted the signing of a Compact between the GoM and all development partners

in Mozambique which committed them to supporting the national health plan. Initially, not all development partners were positive about this especially the USG, EC and the WHO, because they considered the existing partnership arrangements were adequate. However, DFID, negotiated with each development partner to ensure that the Compact would be acceptable to all of them.

4.7 DFID also worked with the donor group to facilitate work by Government on the Human Resources for Health (HRH) plan which set out workforce requirements and additional resources required to sustain an effective delivery system up to 2015 (see detail in the next example). The IHP process and the HRH plan were key inputs that provided the analysis and evidence underpinning the national health strategy and the financing plans in the sector. These were both drawn on to make the case for additional funding at the UN summit in 2008 and separately with GFATM (the round 9 proposals) and PEPFAR.

Achievements

4.8 The successful adoption of the IHP in Mozambique has made a contribution to improving the organisation and coordination of donor efforts around agreed and well defined national priorities. Not all those involved initially saw the IHP process and the Compact as value for money but the majority are supportive and positive.
The US is now an active member of the Health Partner Group and a supporter of IHP. They highlighted the coordination benefits from the IHP process and how the efforts of DFID and the donor group have helped bring PEPFAR more directly into the discussion of national priorities and promoted better donor coordination.

4.9 The existence of the IHP has also influenced PEPFAR to redirect and channel more resources into areas of Government priority. USAID have confirmed that US$ 2-4 mill a year is now being allocated by PEPFAR to help strengthen the health sector institutions including skills development and training. Over a five year period that amounts to US$ 10-20 mill funding that has been directed toward national priorities which would not have been possible without the IHP or the work done on the HRH plan.

4.10 The IHP has been less successful in mobilising any substantial increase in PEPFAR funds. DFID had hoped that GOM could use the IHP to mobilise additional PEPFAR resources for health following the UN summit in 2008. USAID have confirmed that this has not happened and that in practice decisions on PEPFAR funding are decided on the basis of US political priorities and have been affected by the current economic crisis.

4.11 Similarly the IHP process has yet to yield any benefits in relation to increased resources from GFATM. The round 9 application from GOM was unsuccessful and it is not yet clear whether an application for round 10 will go ahead. However DFID continues to work with MISAU on the longer term resource requirements to examine options for longer term financing of the sector and to strengthen the case for additional external support.

Example 3: DFID Support for the Human Resource Plan

DFID Influencing Objectives

5.1 Institutional and capacity constraints are arguably the biggest challenge facing health service delivery in Mozambique. There are a range of interlocking institutional issues but improving the numbers, quality , motivation and distribution of the health workforce has been seen as central by Government and donors.

5.2 The donor group and DFID initially engaged in supporting work on human resources in the sector to produce a better analytical and evidence base for policy dialogue with Government. The objective was to assess the challenges, consider the options and develop a Human Resources for Health (HRH) plan which could be approved and then implemented by Government. Later, as discussions of the IHP commenced, donors also began to see the potential of using the HRH for supporting the case for additional external sources in order to help finance the planned expansion and improvements to the health workforce.

5.3 DFID included explicit influencing objectives in the ProSaude programme log frame around facilitating the development of the HRH plan. Indeed the Senior Health Adviser was recruited specifically because he had expertise in this area.

Inputs

5.4 The Human Resources donor working group initiated the initial work on the HRH plan after . Government abandoned an existing draft plan. The working group was chaired by the MoH and co-chaired by one of the development partners. DANIDA took the lead within the Human Resources working group and, with the MoH, developed the terms of reference for the development of the new plan. There were several background studies co-funded by DANIDA and DFID.

5.5 The Ministry of Health was engaged through the Director of Human Resources and they played a critical role in ensuring the process went forward. The development of the plan started in late 2007 and culminated in September 2008 with the launch of the National HRH Plan at the UN Summit in New York.

5.6 DFID played a key role in persuading the GoM to respond, take the lead and agree to broader consultation (even if this was not carried out to everyone's satisfaction). DFID also paid for a consultancy for the MoH to do the costing of the plan. This was intended to be the basis of a resource mobilisation exercise, both within Mozambique and also in terms of mobilising external funding.

5.7 A validation of the costing of the plan was also funded by DFID (using the Resource Requirement Tool (RRT) developed by the WHO) as it was necessary for its inclusion in the Round 9 application for the GFATM.

5.8 DFID may have played a leading role within the working group, but others played equally important parts. After all, the working group had been operational on the HRH issue before DFID took it on as a policy priority.

Achievements of DFID Influencing

5.9 The HRH plan was approved by Government in 2008 and since that time MISAU has been implementing it within the constraints of the funding available. Discussions with MISAU and donors indicate that the following changes have taken place as a result of the influencing effort:

- GOM took full ownership of the HRH plan and is taking it forward. There is a sound basis for future developments in the sector and although it is too early to see results the plan provides a good basis for future monitoring.

- There is a greater recognition by GOM of concerns about the inequality of service provision and staffing support between Provinces and Districts. This issue is also now part of the policy dialogue.

- GOM is continuing to take action to allocate more newly trained staff to the least well served areas of the country. This policy started before the HRH plan was approved but it has been reinforced by it. Up to 30% of new medical graduates are now posted to Zambesia the least well served Province.

Example 4: Influencing New Policy: Abolition of User Fees

DFID Influencing Objectives

6.1 Since 2004 DFID has adopted a positive stance towards policies to abolish user fees on the grounds that it will help increase access to health services by poor people. It is recognised that this policy has significant risks including how to respond to sudden increased demand and associated additional resource requirements. DFID has corporate influencing priorities to persuade the World Bank to support free healthcare and since 2009, has been committed to support its introduction in any developing country where the Government wishes to do so.[14]
6.2 Government reported that they were trying to move to free health services but slowly. They already have free services for pregnant women and children. However GOM is still wary about abolishing user fees because they wanted greater assurance that they could respond to increased demand.
6.3 DFIDMoz encouraged the Health Partners Group to consider working on the issue so that Government could be provided with the evidence from other countries and could consider the options. The aim was to respond to an existing Government interest and to help ensure optimal policy making in this area. DFIDMoz objectives were implicit as they did not have a defined log frame with influencing objectives nor was the effort projectised .

Inputs

6.4 The Senior Health Adviser devoted time to briefing and advising MISAU and the Health Partners Group on policies for the abolition of user fees on Mozambique. A consultancy study was undertaken to examine the evidence and options for adopting such a policy in Mozambique. DFID also lined up additional financial support to enable Government to meet a predicted surge in demand of 30% for services and consequent shortfall in sector funding that might occur. This additional funding was explicitly linked to the agreement and implementation of a policy to abolish user fees.
6.5 DFID engaged actively with the Health Partners Group throughout. Some donors were concerned that DFID was overly driven by the priorities of UK Ministers but in general, the influencing effort was seen as legitimate advocacy of a relevant policy that the Government of Mozambique was potentially interested in pursuing. The process and content of dialogue with Government was discussed and agreed with

[14] Sept 2009 UK Prime Minister announced US$ 5.3 bill package to deliver on this pledge with £ 250 mill from DFID

the wider donor group. Some donors would still like to see more debate in the donor group about this and other policy options. They had concerns about the wider impact on the health sector of abolishing user fees.

Achievements of DFID Influencing

6.6 Government has yet to decide its position on user fees so it is premature to judge the outcome from the influencing effort. Concerns about the longer term financing of the system remain and this has sparked a wider dialogue on sector financing. However there have been several achievements to date:

- Government of Mozambique is better informed about the evidence and experience and therefore better equipped to make a well informed policy choice
- An approach to abolishing user fees has been considered and a plan developed should Government decide to proceed
- Government is more aware of the risks associated with abolishing user fees and has some assurance that additional funding is available from DFID to help mitigate these.

Conclusion

7.1 The influencing examples and interviews suggest DFID has worked effectively to lead and support the Health Partners group efforts to influence Government policy and other donors to align and harmonise procedures and to mobilise resources for the sector. The HRH plan is a good basis for GOM to address the challenge of workforce issues and to develop a longer term financing plan.

7.2 The overall results from the influencing efforts have been mixed. Non like minded donors including the US Government and GFATM are better able to coordinate their programmes and to design them to support national priorities than in the past. More funding is directed at Government priorities including for capacity and systems development. However neither have been able to align with national systems for managing financial resources and both remain off budget with all the additional overheads that implies. Nor has their yet been any success in mobilizing additional resources from these sources. However the potential for this to be achieved still remains

Annex 2: Part B - Influencing examples in HIV/AIDS

DfID has put an important emphasis on HIV/AIDS, both through its support to the health sector, as well as through its support to the National Aid Council (CNCS by its Portuguese acronym). DfID has also indirectly supported the HIV response in other sectors (e.g. in education where DfID has lobbied for funding to the HIV/AIDS workplace policy through FASE).

Example 1: Strengthening of the National HIV/AIDS response

Objectives of DfID influencing

The CNCS was established in 2000 by the GoM to coordinate and facilitate the national HIV/AIDS response. However from its inception the CNCS has faced a number of important challenges including capacity constraints, weak internal management and external oversight, poor acceptance of its coordinating function by other government institutions, and a tendency to focus on implementation as opposed to a facilitating and coordinating function. These challenges were exacerbated by a poor understanding of the key drivers of the epidemic in Mozambique and a corresponding lack of clear prioritization within the HIV/AIDS response.

In this context DfID influencing has focused on strengthening the capacity of the CNCS to coordinate the response. The key strategy pursued by DfID was to establishment mechanisms for joint funding of the response by donors so that the CNCS would have the resources at its disposal for its internal functioning and to provide grants to implementing organizations.

Influencing inputs

Most of the influencing was undertaken directly by DfID as a member of the donor group and importantly as focal donor on HIV/AIDS on two occasions (exact dates to be inserted). The influencing took the form of participation and leading by the AIDS Adviser of DfID on meetings among donors, and meetings with the National AIDS Council. A number of specific meetings were organized with certain multilateral and bilateral partners to further the agenda. Over the past three years approximately 15% of the AIDS Advisor's time was spent in direct interactions with the CNCS and a further 15% was spent influencing relevant donor partners. In addition, DfID brought in and funded specific technical expertise to design the grant management mechanisms that were set up and subsequently reformed.

Achievements of DfID influencing

DfID provided key support in the early years (2003/4) to the establishment of a common CNCS managed fund for the HIV/AIDS response. The fund brought together 8 donors. DfID's played a key role as a focal donor at the time, and also provided key technical input to the design of the CF. DfID played a lead role by lobbying other donors to join the CF, including the traditionally less harmonized players such as the WB and the GFATM.

However, while the establishment of the fund gave the CNCS some independence in terms of functioning and decision making and contributed in principle to a more coordinate approach to the response, the management of a large number of small

grants in a challenging context (lack of capacity at grant recipient level, weak banking systems, long distances, poor communication) put a heavy burden on the institution. It also meant that the CNCS was spending much of its time and energy on implementation, detracting from its principal facilitation and coordination role.

This resulted in a loss of confidence among partners in the capacity of the CNCS, a reduction of GoM funds to the CNCS (as a result of perceived lack of capacity to spend) and threats from the WB to re-allocate funding from the WB MAP project to other non-HIV/AIDS priorities (see influencing example below).

DfID lobbying with other donors – among others through its role as focal donor in 2008/09 focused on addressing this problem. This resulted in a decision to establish a separate pooled fund (the Rapid Results Fund – RRF) in 2008. The RRF is administered by UNDP but managed by a committee in which government and donors are represented. The objective is to ensure that the HIV/AIDS response receives funding for priority areas, while removing the burden of management from the CNCS so that it can effectively carry out its coordination and facilitating role.

DfID's influencing was therefore instrumental in the negotiations around the CF and in the establishment of the RRF. DfID also played a major role in getting other donors to fund the HIV/AIDS response: DANIDA and PEPFAR and GF money went to the CNCS CF, and in rallying partners around the new RRF. Finally, at DfIDs insistence the RRF includes an earmarked budget for CSO granting so as to ensure adequate resources to these organizations.

However, while it appears that a solution to onward granting for agencies/organizations delivering services and support in the context of the HIV/AIDS response may now have been found, the overriding perception is that the HIV/AIDS response is now more fragmented, and that the issues around the CF have affected the reputation of the CNCS.

Context	*Anticipated change*	*Change that took place*	*Outcomes so far*
• Poor capacity for coordination of the National AIDS response • Funding insufficiently aligned with established priorities	• NAC effectively and efficiently coordinating the national AIDS response, including decisions around funding. • Better alignment of funding with priorities	• CF for HIV/AIDS established at CNCS • Most funding from CF for HIV/AIDS re-directed to RRF established in 2009	• CNCS able to flexibly access funds for management costs • Earmarked funds from RRF going to Civil Society and other priorities • More funding for CSO's

Example 2: Influencing the WB to redirect resources

Weak management capacity and external constraints (including the capacity of grantees to provide accounts) were affecting the capacity of the National Aids Council (CNCS) to disburse funding provided by multiple donors into a join HIV/AIDS fund. The WB had made an allocation of 20 mln from its WB MAP funding to the CF which was not being disbursed. Confidence of partners in the CNCS was diminishing and the WB was threatening to withdraw its funding from the CF and reallocate the money to other priorities outside of HIV/AIDS.

Objectives of influencing
The main objective of DfID influencing was to avoid that the WB MAP funding would be re-allocated to other non-HIV/AIDS priorities.

Influencing inputs
DfID worked with other partners to establish an alternative to the CF which would relieve the CNCS of the burden of management. The Rapid Results Fund (RRF), managed by UNDP, was established as an alternative to the CF. DfID used its position as focal donor for the HIV/AIDS response to lobby other partners to support the RRF. In addition DfID played a major backstage role in supporting the government in its negotiation with the WB MAP program to re-allocate USD 20 mln which had not been spent from the CNCS CF to RRF.

Achievements of DfID influencing
As a result of DfIDs actions, the 20 mln USD which would have been otherwise re-allocated were retained in the sector were re-programmed to the RRF and are now in the process of being disbursed.

Context	Anticipated change	Change that took place	Outcomes so far
• Peak capacity of the CNCS to manage the CF • Attempt to outsource the management of the CF to a grant agency had failed • Funding for the HIV/AIDS response not being disbursed through the CNCS CF • Major donors expressing concern and moving to reallocate unspent funds to non-HIV related priorities	• Funding to the HIV response being disbursed • NCS relieved of the burden of managing a multitude of small grants, and better able to focus on its function of coordinating the HIV/AIDS response • Better alignment of funding with priorities	• Establishment of the Rapid Results Fund (RRF), under UNDP management and with joint decision making by donors and government	• 20 million USD of WB MAP funding (which would have been lost to the response) channelled to the RRF • Earmarked funds from RRF going to Civil Society and other priorities • Other donors putting funds into the RRF

Example 3: Strengthening policy and strategic choices

For much of the earlier part of the decade the AIDS response has been limited by the fact that there has been insufficient understanding of the pandemic and by weak policy and insufficient strategic choices. There has been a major move over the past three years to strengthen the area of policy and strategy so as to make the response more effective. This has been possible in part, because research conducted more recently has highlighted what the main drivers pandemic are.

Objectives of influencing
DfID in its role as focal donor for the sector in 2008/2009 has put major emphasis on strengthening policy and strategy. The main purpose of DfID influencing was to produce a coherent policy on communication to guide activities around HIV/AIDS and to ensure that this policy and other policies (e.g. the prevention policy) would inform priority setting of the new National HIV/AIDS Policy.

Influencing inputs
DfID used the time of its AIDS advisor to provide support to promoting this activity and to ensuring that the outcome fed into discussions around priority setting. In addition DfID provided external technical expertise to the drafting of the communication strategy.

Achievements of DfID influencing
DfID played a lead role in developing a communication strategy for the response. This strategy, which was carefully negotiated among the major actors in the sector, defines priority national HIV communication objectives and includes a national HIV campaign focused on adolescents and young people. DfID funded critical inputs from experienced consultants who worked closely with the Communication Working Group of the HIV/AIDS response. The consultancy support was critical in bringing together partners and in seeking consensus on the key elements of the strategy.
DfID also played an important facilitating role in the development of the prevention strategy. This strategy was approved in 2009 by the President of Mozambique and guides and prioritizes actions around prevention. It identifies the major drivers of the epidemic: multiple concurrent partnerships, gender and economic inequalities, high population mobility, alcohol and drug abuse, and failure to discuss sexuality, sex and AIDS inside the family. It also highlights agreed upon priority areas of action for partners in the response (counseling and testing, condoms, high risk groups, early detection and treatment of sexually transmitted infections, male circumcision, prevention of mother-to-child HIV transmission, access to anti-retroviral treatment; and bio-safety) and is widely considered as having been critical to improving and targeting the response.

The prevention and communication strategy highlighted the importance of specific approaches and have provided arguments for key external partners (CDC, UNAIDS and DfID) to push for ensuring that certain less popular or more political strategies are now part of a new National HIV/AIDS Strategy, which incorporates the priorities of the communication and prevention strategies and the priorities of the overall AIDS response in a single document. This included, for example, lobbying for the unpopular but cost effective promotion of male circumcision which would otherwise have been left out of the strategy.

As a result of these efforts, partners in the AIDS response agree that there is more clarity on priority strategies, with potential impact for cost effectiveness (i.e. money spent on approaches that are most likely to produce results such as: reducing multiple concurrent partnerships, Preventing Mother to Child Transmission (PMTCT), targeting high risk groups.

Context	*Anticipated change*	*Change that took place*	*Outcomes so far*
• Poor understanding of the drivers of the HIV epidemic • Conflicting messages around HIV prevention	• Greater clarity, capacity, and consistency around priority interventions for HIV prevention • Improved prioritization of interventions	• Development of a policy on HIV prevention outlining priorities and strategies • Development of a national communication policy around HIV/AIDS • Integration of prevention and communication priorities in the new national HIV/AIDS policy	• Better targeting of resources to priorities of the response

Annex 2: Part C - Education: Influencing by DFID

Context

In 1992 after a decade and a half of internal war, Mozambique faced the enormous challenge of re-building its school network, re-integrating large numbers of displaced pupils, and building up its human resources. In the years since, there has been a strong focus on expansion of the system, mainly at primary level, but also increasingly at secondary to meet growing demand.

In response to the early post-war challenges, the MoE developed a first series of strategy documents for the sector in the early 1990's covering the various sub-sectors .These formed the basis for the drafting of a first education strategic plan in 2000. The first plan focused on three key strategic areas which were a) access b) quality and c) capacity building. An important critique of this plan was the lack of a clear strategic focus and prioritization. The follow up strategic plan for education and culture (2005-2009) retained the key priorities but was seen as more comprehensive and coherent. It included the entire education sector and sought to: a) extend access to all school age children; b) provide educational opportunities for out of school youth and adults; and c) improve quality and relevance to ensure that increasing numbers of children had access to post-primary levels.

A third five year strategic plan is currently under preparation and will be informed by an independent evaluation. The priorities will likely continue to be broadly the same, but with a stronger focus on efficiency and quality.

Dialogue in the sector has matured considerably over the years. Annual reviews involving key government and donor partners and a selection of civil society partners examine progress against an agreed-upon set of indicators and are informed by joint field visits to assess progress. The annual reviews discuss major strategies and progress on cross cutting issues such as gender and HIV/AIDS. Three education indicators have been selected for progress monitoring through the PARPA (enrollment for girls at age 6, primary completion for girls, and teacher pupil ratio at primary). While it is acknowledged that these present a limited picture, the indicators are judged to be adequate as they provide a measure of efficiency and equity and (in the case of the third indicator) also reflect human resource and overarching government and managerial issues.

Since the late 1990's donor and education sector coordination has been an important focus. On the donor side the emphasis has been on strengthening the policy dialogue, on promoting a comprehensive approach to education issues (rather than a sub-sectoral focus), and on harmonization and alignment. The establishment of a pooled fund for the sector (FASE) in 2002 has harmonized donor procedures and promoted alignment with government systems. The government, through the MoE's Department for Planning, has been keen to push this agenda and has been a strong coordinator. A recent review of mutual accountability (Hadley, 2008) identified that in the education sector "unlike in many other sectors, there is fairly strong consensus regarding key education policy priorities between GoM and donors which has allowed

the sector to establish a clear strategic plan with buy-in from participating donors" (p.16). It also highlighted the good integration between the education plan and national planning, with the PARPA Performance Assessment Framework (PAF) drawing on the education sector PAF.

Over the years a number of bilateral donors have played a prominent role in the sector, including the Netherlands, GTZ, SIDA, CIDA, DANIDA, Finland, and DFID. After a number of years of increasing financial contributions, the sector currently faces an emerging crisIs. Key long-term partners (first SIDA, then the Netherlands and DANIDA) have left or are leaving the sector, and financial commitments to FASE for 2011 are 40% below those of 2010 with no certain solution in sight.
DFID is considered an important partner in the sector. DFIDs role in the sector was – according to external stakeholders – strongest between 2003 and 2007. For external partners DFID's current role has been mainly as a predictable and reliable financial partner – something which in the context of emerging decreasing financial commitments to the sector and exiting by some longstanding partners is seen as very important. DFID is also considered an important partner in the dialogue around the implementation of the strategic plan.

Approach to influencing by DFID

DFID Mozambique has sought to support the overall influencing agenda of other like-minded donors in the sector, in particular of the Netherlands, and has worked very closely with the latter.
DFID influencing objectives for the education sector have focused on:

1) Strengthening the linkage between macro level dialogue (GBS) and sectoral dialogue (SBS and pooled funding)
2) Enhancing aid effectiveness by supporting the establishment of a joint donor fund for education (FASE) which is harmonized and aligned, and by encouraging other donors to channel their funding through FASE
3) Strengthening policy and strategies in specific areas such as in teacher training and human resources
4) Strengthening implementation capacity for example by focusing on capacity for supervision of school construction
5) And enhancing efficiency and cost-effectiveness by advocating for strategic choices around the financing of policy priorities and for a better understanding of unit costs

DFID has coordinated its influencing role in the education sector through the donor group, and has been strongly coordinated with other likeminded donors. DFID has also sought to make its voice by participating actively in key education sector working groups (on gender, institutional development, secondary education, construction, and teacher training) and by providing technical input at various levels.

Examples of DFID influencing

Example 1: Setting up a common fund and leveraging donor contributions

Objectives of influencing
DFID has, with the Netherlands, sought to improve predictability, ownership and funding levels to the education sector by supporting the establishment of a pooled fund for the sector (FASE for the Portuguese acronym). Prior to this funding to the

education sector was provided through stand alone projects. Achieving this was a high priority for DFID in light of its commitment to the Paris agenda.

Influencing inputs
DFID provided technical input into the discussions by the MoE and the donors into the design of FASE and the formulation of the Memorandum of Understanding (MoU). This input was provided by its human development advisor (who at the time was an education expert) into the education donor group. DFID also participated very actively in the overall Education partners forum where details of the common fund were worked out.
DFID separately brought in in-house technical expertise and its experience in SBS and GBS models in Mozambique (health sector), as well as from other countries as an important input in the design of FASE and in the drafting of the Memorandum of Understanding (MoU) between partners.

Achievements of DFID influencing
FASE was established as a pooled fund in 2002. FASE has gone from channeling around 5% of direct external funds to the sector to over 70% at present. The number of signatories has increased from six to 15 (check) partners. Funds are on budget, come in through the treasury, are channeled using government systems, and are accounted for using government procedures15. Progress is assessed annually by all partners against an agreed upon set of indicators. DFID itself has made a ten year commitment to FASE.

Benefits of FASE are various, including:

- Increase in on-budget funding (from MZM 823.557 in 2005 to 4.345.056 in 2009 – a fivefold increase)
- Improved predictability of donor funding (longer term commitments and a clear calendar for disbursement)
- Greater government ownership and decision making capacity around priorities in the sector
- Reduced transaction costs for the MoE (the MoE no longer needs to meet with donors individually for discussions around project design and monitoring)

FASE has contributed to improving capacity in the sector, and has promoted decentralization. Both are expected to enhance quality of the system. For example, the MoE now transfers funds for supervision and management down to districts and school clusters, making it possible for supervision and support to be carried out at this levels with expected returns in the medium term (3-5 years from now) being better quality education.
FASE has also produced important savings for the MoE. Examples of this include that the MoE uses the funds of FASE to pay newly trained teachers while they await nomination by the State (previously teachers would wait up to two years for their nomination - in the process substantial numbers of teachers would resort to other employment opportunities and be lost to the sector).

[15] In order to access funding from the Fast Track Initiative (FTI) the MoU had to be modified in 2008 to include a technical addendum on procurement which has to comply with World Bank (WB) rules. Alignment with Government processes was reduced as a result. However, some partners argue that while this represents a set back it has improved the scrutiny of procurement processes and is likely to have improved utilization of funds. On the other hand, and as a result of the new procurement procedures, school book provision was delayed.

Finally FASE has enhanced government ownership of what were previously donor managed activities. For example the World Bank initiated Direct Support to Schools is now channeled through FASE, is co-funded by other FASE donors, and uses government systems to allocate funds directly to school on a per pupil allocation basis . The funds are managed by parent teachers committees. Since the establishment of this system in 2003, the amount of money per pupil has increased from 1 USD in 2005 to 2.5 USD in 2009. This Direct Support system has been progressively modified to allow greater discretion at local level in decision-making around priorities (the narrow list of permitted purchases has been progressively expanded). Today funds are used among other priorities to: support the purchasing of school supplies (pencils, notebooks); to support orphans and vulnerable children (OVC), to finance HIV prevention activities, and to fund school uniforms for girls. The existence of these funds at local level is thought to have impacted – together with other measures - on the improved NER for girls at primary level from 23.9% in 2005, to 37% in 2008 (latest statistics, expected NER in 2009 is 41.9%).
FASE funds have also been used to generate a system of incentives for the placement of teachers, including female teachers, in rural areas. Potentially this will lead to a better distribution of teachers according to needs, greater motivation of teachers to move to rural areas, recruitment of more female teachers, and better placement. The MoE recognizes that the hiring of female teachers may encourage greater girls' participation in primary education.

Context	*Anticipated change*	*Change that took place*	*Outcomes so far*	*DFID inputs*
• Funding to education being provided through parallel projects • MoE little overview or control over priority setting on external funding • Poor capacity for planning	• More predictable funding • Improved priority setting by government for education • Greater levels of funding to the sector	• Establishment of a pooled donor education fund which uses government systems and for which progress is monitored annually against agreed upon indicators	• In-budget funding increased five-fold in five years • External funding to the sector more than doubled in five years • Greater ownership by GoM • Reduced transaction costs for GoM • Decentralization of spending to district and school levels • More efficient recruitment of newly trained teachers	• Advisory time of DFID team • Experience from other sectors where DFID is active (health)

In conclusion, DFID has played an important role, together with a small number of other partners, in ensuring scaled up and more predictable funding to the education sector. DFID was important but could not have done this alone.

Example 2: Enhanced financing to and improved management of the education system

Objectives of Influencing
DFID, with other donors, actively engaged in the discussion around the management and financing of the education sector. The main objective was to linkage macro level dialogue around GBS with sectoral priorities and to use this to a) influence funding to the sector, in particular for teacher training and recruitment, and b) reshape the public sector reform agenda, making what had been a top down approach more relevant to the needs of the sector. The expected benefits of the influencing were to contribute to further expansion of the education system and to enhancing quality).

Influencing inputs
DFID lobbied closely on a number of fronts. At macro level, the DFID economist engaged actively in the PARPA and GBS fora, using inputs from the sector level. The specific objective of this lobbying was to bring to the macro dialogue concrete examples from the sectors (education, but also health) and to link this with the implications for the spending agenda. A major focus was therefore on making the PARPA and BS dialogue more committed to the sectors.
At sector level, DFID engaged closely with the dialogue around the need for improved management of teachers and the reform of the established pre-service teacher training model. Most of the influencing effort at this level was undertaken directly by the DFID Human Development Advisor, but also involved engagement of the DFID economist in sector level discussions. DFID commissioned a study on the status of teachers which was conducted by VSO and highlighted challenges to the teaching profession (in terms of a wide range of issues such as teacher pay levels, support, training, etc.), most especially with regards to motivation.
DFID also lobbied with a number of influential donor institutions and government organizations. A particular focus was on the International Monetary Fund (IMF) and the World Bank (WB) to remove the cap on teacher recruitment. In addition, DFID worked closely with the Human Resource Department of the MoE to promote a shift from a technical and pedagogical focus on teachers to a more overarching managerial and financial focus.
An important early influencing input was in the aforementioned discussion around PARPA indicators for education. DFID lobbied very strongly for the inclusion of an indicator around pupil teacher ratio, as this would imply a stronger government commitment and funding to reforms in the sector. In particular DFID wanted to ensure that implications of sectoral priorities would be discussed at macro level including with the Ministry of Finance (MoF) which would have to foot the bill for the additional teachers.

Results of influencing
After an initial push back from the MoF, the pupil teacher ratio indicator was adopted in the PARPA. In order to meet the growing demand for teachers and to bring down the teacher pupil ratio, the MoE adopted a new model of primary pre-service teacher training which was introduced in 2008. The model involves recruiting tenth grade teachers, providing them with one year of pre-service training and then following up with intensive in-service training for a further year. This model has allowed the MoE to increase its capacity for pre-service teacher training. Teacher Training Colleges are now producing between 10 and 12 thousand new teachers yearly, against approximately 4000 before the reform. Before this reform, only 40% of the newly

recruited teachers had formal teacher training, the remaining 60% were being recruited with no training at all.
The model has reduced the wage bill per teacher (as teachers with one year of training are recruited in a different category), allowing the MoE to recruit more teachers for the same budget. The MoE has in parallel been able to argue effectively with the MoF for an increase in the budget for teachers. The increase in the number of teachers, in parallel with the adoption of a policy of reducing the number of double shifts, has contributed to reducing the PTR from 74:1 to 68:1 between 2005 and 2009. It has also contributed to a reducing class:teacher ratio from 49:1 to 38:1 over the same period.
Finally the focus on teacher management and the issues raised in the VSO study have stimulated the MoE to provide some incentives for teachers working in rural areas. This is being funded through FASE.
There are, however, some concerns about the new teacher training policy that has been adopted. In practice the MoE has not been able to guarantee the in-service training which was supposed to complement the pre-service training period. As a result new teachers are less well trained under the new policy (although more are being trained), which is likely to have implications for the quality of education. The MoE will be re-examining options for teacher training in the light of the new Education Sector Strategic Plan (2011-2016) which is in the process of being prepared, and may revert to a different model.

Context	*Anticipated change*	*Change that took place*	*Outcomes so far*
• Only 40% of teachers at primary level have any pre-service training (2005) • Teachers face considerable challenges due to lack of support for placement and installation and lack of supervision • Dialogue at macro (PARPA and GBS) level insufficiently linked to the needs and priorities at sectoral level	• Increase in the budget for teacher recruitment by the MoF • Stronger linkage between sector priorities and macro level decision making • Reduction in the pupil teacher ratio • Increase in the annual proportion of teachers recruited with pre-service training • Greater understanding of the constraints faced by teachers leading to decision making by the MoE on management and working conditions	• Pre-service teacher training model revised from two years to one year of pre-service training (with the second year as an in-service component) • Incentives for teachers in rural areas to be paid from FASE • Study examining teaching in Mozambique produced highlighting key challenges • DFID internally changed its way of working to a whole team approach with economists and sector staff becoming involved in priority issues	• Year on year increase in the budget for teacher recruitment • Capacity for pre-service teacher training increased from 4000 teachers per year to over 11000 • All teachers recruited in 2009 and 2010 have at least one year of teacher training • Small percentage increase in the number of female teachers • A few incentives in place for teachers working in rural areas

Example 3: Unit costs in school construction

Objectives of DFID influencing
School construction is monitored as one of the E-PAF indicators but progress has been disappointing due to various internal and external constraints (poor capacity within the MoE, sensitive issues around contracting, poor capacity for implementation at local level owing to lack of service providers at local level). DFID has sought to support the efforts of other partners to strengthen supervision of school construction and to influence discussions around models and unit costs, so as to bring about an increase in the number of quality classrooms that are constructed at primary and secondary levels.

Influencing Inputs
DFID input consisted of staff time to participate in the working group on construction in the education sector. This input was provided mainly by an engineer working for DFID Mozambique. In addition the education sector advisor for DFID also participated in selected meetings.
The construction WG (in which the WB and the Spanish Cooperation have played an important role) has effectively raised the issue of unit costs to the attention of the Ministry of Education. DFID has been important in providing support through its construction engineer who participated in a series of visits to schools around the country to determine what the challenges were and who also provided inputs into the working group discussion. This work has raised a number of issues including:

- That the model for low cost school construction (based on community construction 'brigades' (local artisans and small enterprises) was not being effectively monitored or supervised, with some classrooms being of poor quality
- That the ceiling per primary classroom at USD 12.000 was not sufficient and was contributing (together with the first point) to constructions not being completed

Outcomes of influencing
Through its involvement in the WG DFID and other donors contributed to a revised model of classroom construction which will rely on small officially registered companies (to avoid difficulties in recovering funds when the constructions are not completed and to guarantee better quality), and which will include an international procurement of key structural elements of the construction (beams, pillars, doors, windows, roofing) which will be delivered on site and which will be put together by the local contractor, who will also be responsible for supplying the remaining elements of the construction (walls, floors, etc). Studies of this model, to be launched this year, point towards a unit cost of 18.000 per classroom, however the MoE – which wants to make a maximum effort to reach its targets in classrooms constructed - is currently piloting an alternative which is budgeted at 14.400.
In conclusion, through dialogue and technical support the WG members are contributing to better quality construction, improved supervision of works, improved completion rates of primary classroom construction efforts (in other words less schools that are not completed), as well as to a more careful weighing and consideration of unit costs by the MoE. DFID has provided important technical input into this group to support other key partners (the Spanish Cooperation, DANIDA and the World Bank who have been driving this agenda).

Context	Anticipated change	Change that took place	Outcomes so far
Poor quality of school construction Poor supervision of construction High numbers of schools not completed	Better management of school construction Improved quality of construction	Establishment of improved norms and models for school construction Improved supervision and monitoring of school construction	Unit costs in primary education increased to ensure quality construction (from USD 12.000 per classroom to a pilot testing mixed mode construction (imported and local materials) at USD 14.400.

Example 4: Financing of the HIV/AIDS Workplace Policy

Objectives of DFID influencing

DFID sought to ensure that the underfunded HIV/AIDS Workplace Policy receive priority funding through FASE. This is an example of an opportunistic influencing opportunity, which was not systematically planned by DFID but where there was a clear strategy of the DFID education sector advisor.

The HIV/AIDS workplace policy for the sector was developed in 2007 to protect the rights of HIV positive teachers and staff (average HIV prevalence among adult population is estimated at 16%, with large geographical differences including 26% prevalence in the southern provinces of Maputo and Gaza). The workplace policy includes a strong focus on prevention, training and sensitization of managers and staff, as well as measures to ensure fair treatment of HIV positive teachers, and implementation of regulations around access to ARVs.

With HIV/AIDS being an important cause of death and absenteeism the underfunding of the workplace policy would potentially have meant less teachers being fit for work, and teachers being 'lost' to the system due to absenteeism and death.

Influencing inputs

Through its participation in key working groups under the Strategic Plan (the secondary education group, construction group, and the overall education dialogue), DFID was able to contribute to the dialogue around financing of the priorities by raising questions around the high unit costs for the construction of secondary schools. The expansion of so called 'complex' secondary schools in urban areas (district and provincial capitals) is a priority of the Government. However, a detailed examination of the construction costs revealed that the models that were being used were overly expensive (on average costing 6 to 7 million USD per school).

DFID inputs were mainly in the form of staff time of the DFID education advisor. The strategy included going through the FASE budget and reports and calculating unit costs of school construction. This evidence was then used in a discussion around priority setting in the sector.

Outcomes of influencing

Raising this issue in the context of the WGs enabled DFID to:

a) Influence the MoE policy on secondary school construction, resulting in a reduction in the budget per 'complex' school and re-consideration of the models for expansion at secondary level. The WG efforts have – in the opinion of some senior MoE officials – been helpful in managing the political pressure behind this construction effort
b) Ensure that some of the 'savings' made in secondary construction as a result of this dialogue be re-programmed for other priorities in the ESSP, including for the implementation of the newly approved (2009) Workplace Policy on HIV/AIDS.

Context	*Anticipated change*	*Change that took place*	*Outcomes so far*
• Workplace HIV/AIDS policy without essential funding for implementation	• Funds made available for the workplace policy to ensure protection and rights of teachers and staff	• Funds redirected from expensive secondary school construction model to finance the HIV/AIDS workplace policy	• Crucial activities could now be carried out (e.g. identification and training of district level implementers) • Workplace policy in the process of being implemented

Annex 3: Value for Money (VfM) Survey – Overview of Results

Background

In mid 2010 DfID Mozambique commissioned an internal consultancy to provide inputs into an assessment of the value for money (VfM) of DfID's funding to Mozambique. The purpose of the consultancy was to enhance DfIDs capacity for targeting efforts and financial contributions to areas where impact is likely to be greatest in the three areas of its Human Development Portfolio (Health, Education and HIV/AIDS).

As monitoring of progress in Mozambique is to a significant extent based on collective dialogue and frameworks, the approach to the assignment was to obtain inputs from key donor and government partners in the relevant sectors. This was done in part through interviews and meetings with agencies during the field work for the consultancy. In addition, a short survey of donor perceptions on the dialogue and monitoring in education and health was conducted.

This report presents the main finding of the education and health survey. The findings will be integrated in the overall consultancy report which will be finalized in July 2010. This report was prepared as an annex and was also emailed separately to all those who responded to the survey.

Summary of main findings

- For just over half the respondents the sector PAF provides a good or very good coverage of performance in their sector (health, education and/or HIV/AIDS
- Almost two thirds of respondents felt that the sector PAF was a good to very good instrument for providing feed back to agency headquarters
- However, most respondents indicated that the sector PAF is only of limited value in assessing value for money
- Finally just under two thirds of respondents indicated that they felt that donors should work together on developing VfM assessments and indicators in a harmonized manner for the sectors concerned.

The survey

The survey contained a total of 12 questions and was posted on-line using Survey Monkey. An email was sent out to donors in the education and health sectors requesting their collaboration in filling out the survey. Fifteen responses had been received one week after the survey was posted.

Respondents background

Over three quarters of the respondents of the survey had been working for their agency in Mozambique for three years and more (one respondent emailed separately to indicate that this was a second posting). Respondents were asked to indicate what sector they worked in (response options: *"health", "education"* and *"HIV/AIDS"*). More than half of the respondents covered two sectors of the three. In total the responses represented six persons working on education, seven on health and seven on HIV/AIDS, with a further 3 respondents indicating that they work also in another (non specified) sector. Over 50 percent of the respondents had participated

in at least three or more annual reviews in the sector which they were currently working in[16].

Overview of the main findings of the survey

a) On the Performance Assessment Framework (PAF)

Three questions in the survey related to the Sector Performance Assessment Frameworks (PAF). The first questions asked respondents to indicate how comprehensive the PAF is *"in assessing the results achieved in the sector"*. Just over half of the respondents indicated that they felt that the PAF provided a *"good"* or *"very good"* coverage. The responses are shown in figure 1 below.

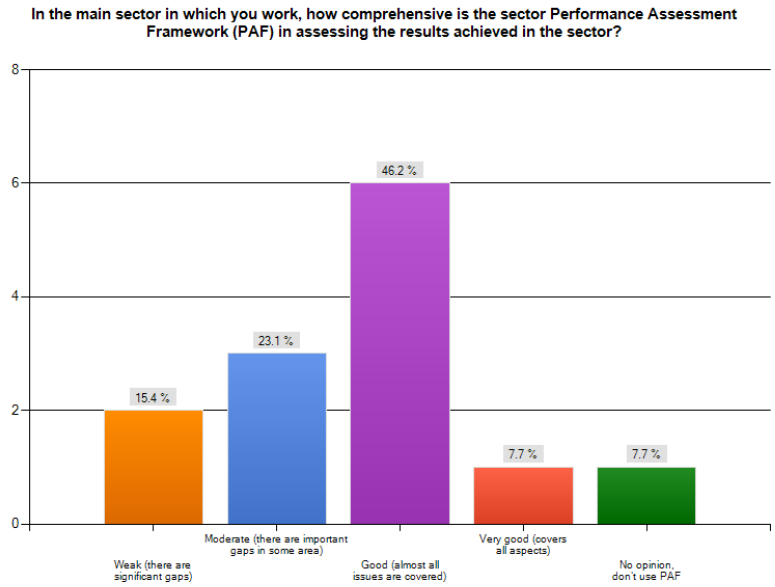


Figure 3 - Comprehensiveness of the PAF in Assessing Sector Results

Respondents were also asked to indicate how important the PAF is in reporting back to their agency headquarters on annual progress.

[16] Respondents who worked in more than one sector were asked at the start of the survey to *"please chose one of these sectors and use your experience in that sector to answer the remaining questions in this survey*".

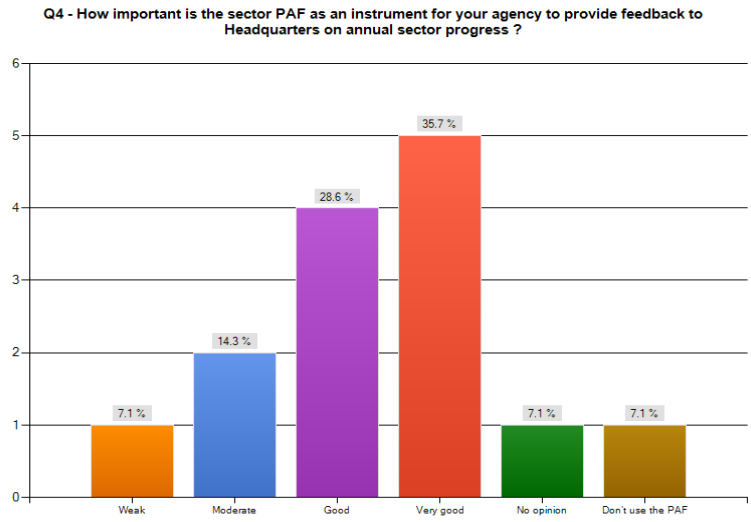


Figure 4 - Use of PAF for Feedback to Agency Headquarters

As can be seen from Figure 2, almost two thirds of respondents felt that the sector PAF was a *"good"* or *"very good"* instrument. Three respondents indicated that the PAF was either *"weak"* or only of *"moderate"* use.

The survey also sought participants' opinion on the usefulness of the PAF indicators in terms of providing *"an overall assessment of value for money, i.e. that funds are used efficiently and to maximize benefits at least cost"*. The responses are reflected in figure 3 below and indicate that the majority of respondents (51%) were of the opinion that the sector PAF is of *"weak"* or *"moderate"* value to assessing value for money.

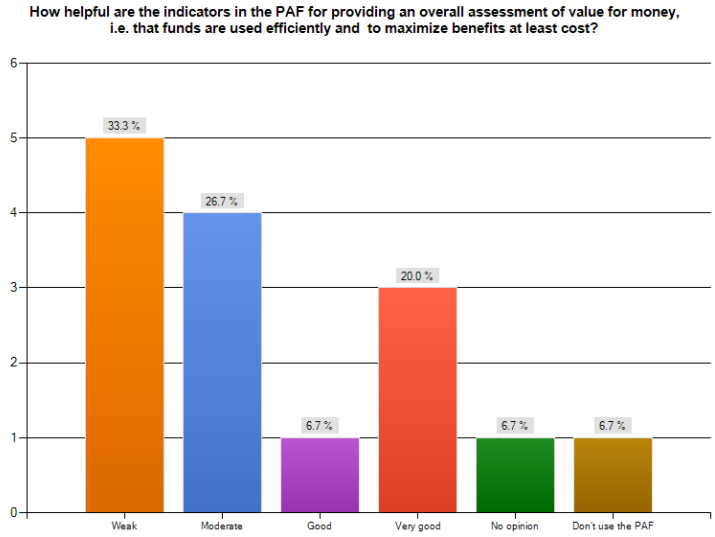


Figure 5 - Respondents Opinion on Usefulness of PAF Indicators on VfM issues

Respondents were asked to indicate *"what other instruments/means (their agency) use to track and report on the efficiency of spending and the impact of its financial contribution to the sector"*.

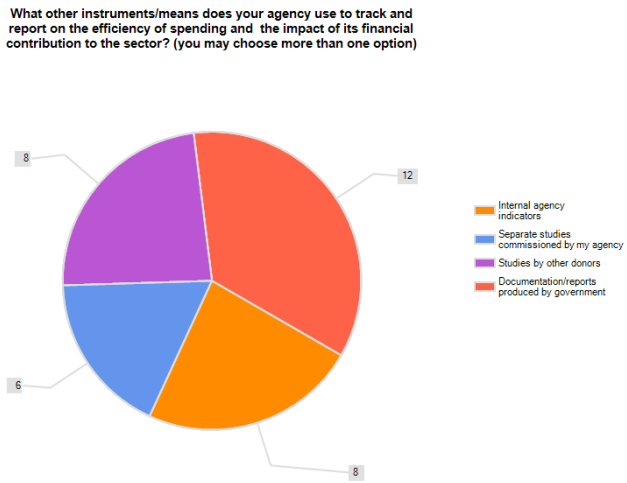


Figure 6 – Other Instruments Used for Reporting on Efficiency and Impact of Spending

Figure 4 shows that *"documentation and reports produced by government"* are an important additional source of information as are *"separate studies"* commissioned by the agency. Examples of additional documentation to the PAF which are considered useful were provided by a number of respondents and included the National AIDS Spending Assessments (NASA), internal assessment on sector track records, the National Health Assessment, and Public Expenditure Tracking Surveys (PETS).

b) On the Policy Dialogue

Respondents were asked to indicate at what levels they thought the policy dialogue was the most effective. Response options are listed in Figure 6 below.

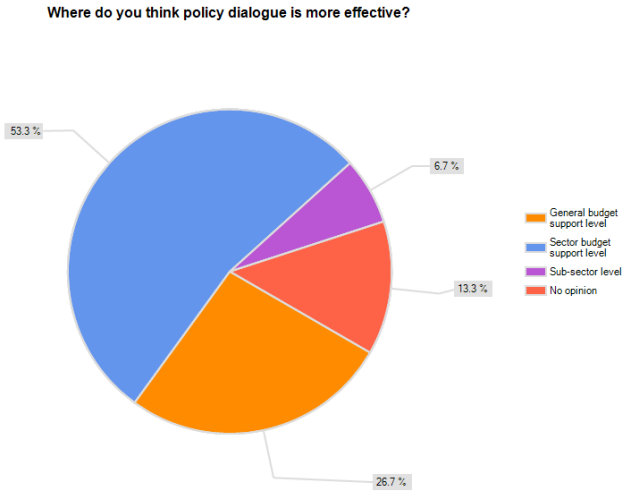


Figure 7 - Effectiveness of Sector Dialogue

As can be seen from the Figure, just over half of the respondents indicated that the policy dialogue was most effective at *"sector budget support level"*. Reasons provided by respondents for their choice for the level of sector budget support included the fact that the dialogue at this level *"involves experts with sector experience"* and that GBS level sector dialogue *is "very formal and does not follow up specific issues in depth, therefore (providing) limited scope for drawing conclusions and making recommendations that could make a change to policy"*. However one of the respondents noted that there are issues also with sector budget support

discussions: *"At sector level - there is more scope to debate policy, however there is limited scope to influence financing either within the sector - as there is a lack of financial information (no programme budgets) or to the sector - as Ministry of Finance and other key ministries are not participating in the sectoral policy dialogue and ability of sectors to influence MFO in terms of resource allocation seems limited".*

c) On improving performance monitoring at GBS level

In an additional open question respondents were asked to provide suggestions on how to make performance monitoring at GBS level more effective. A total of nine respondents provided suggestions with some overlapping opinions. Three respondents indicated that it was essential that the sector assessment at GBS level not be based solely on a small selection of indicators, but rather on a more comprehensive assessment of the sector. As one respondent suggested the sector should be *"asked to produce an overall assessment of sectoral performance identifying 2 or 3 key challenges. The key challenges and how to overcome them should then be the focus on the sector specific performance issues in the GBS policy dialogue"*. Other suggestions included:

- Ensuring that the working groups are more technical
- Developing specific studies to feed into discussions at working group level
- Improving the capacity of the National Statistics Institute (INE) and feeding the data into discussions
- Enhancing the level of joint work between partners and the GoM, including by making the suggestions that emerge from GBS dialogue more practical to follow up

On improving performance monitoring at SBS level
Respondents were also asked to provide suggestions on ways in which performance monitoring could be improved at sector level. The main suggestions included:

- Strengthening of planning and budgeting capacity, including in areas such as Public Financial Management (PFM) and Monitoring and Evaluation (M&E)
- Focusing the working groups on more technical inputs, and proving these with specific studies to feed their discussions
- Focusing on indicators which can be monitored more easily to increase quality and data reliability
- Collecting/insisting on programme budget data so that allocation of resources against priorities and the impact of marginal changes in the budget can be assessed on a year-by-year basis. This would require calculating the real value of project based financing, and a better understanding of unit costs.
- Strengthening the quality and quantity of inputs into the sector including through more specialised donor agency representatives in SBS discussions and by bringing interdisciplinary expertise into the mix, including in areas such as: economics, construction, statistics, and social sciences.

d) On future joint VfM work

Finally respondents were asked how useful they thought it would be for *"donors to work together on developing VfM assessments and indicators in a harmonized way"*. The results in Figure 5 below show that a majority of respondents (61.5%) felt that this would be "very" useful, with just over one quarter indicating that it would be *"somewhat useful".*

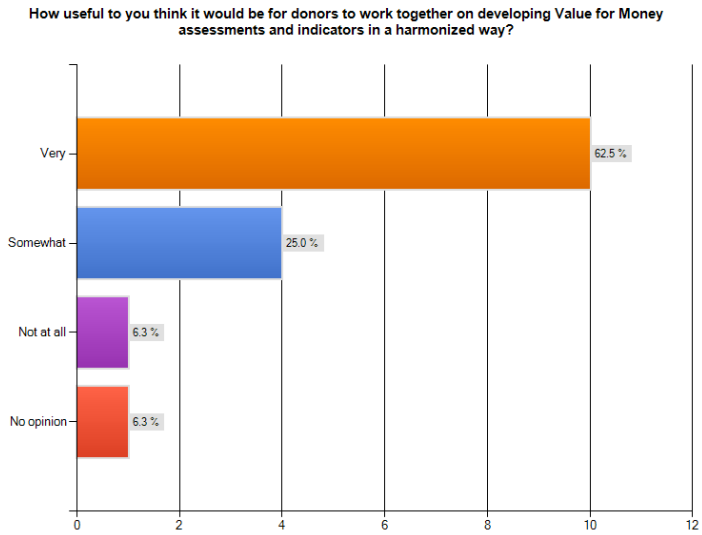


Figure 8 - Usefulness of Future Joint Work on VfM Assessments and Indicators

Summary of main findings

- For just over half the respondents the sector PAF provides a good or very good coverage of performance in their sector (health, education and/or HIV/AIDS
- Almost two thirds of respondents felt that the sector PAF was a good to very good instrument for providing feed back to agency headquarters
- However, most respondents indicated that the sector PAF is only of limited value in providing an overall assessment of value for money
- In terms of sector dialogue, just over half of the respondents felt that the dialogue was most effective at sector level. Follow up questions on sector versus general budget support dialogue highlighted weaknesses at both levels related to structures, mechanisms for dialogue and the level and kind of expertise involved. Selected suggestions for improving both GBS and SBS dialogue were provided and highlighted the importance of:
    a. A whole sector assessment approach, as opposed to a focus on a selection of indicators
    b. A careful matching of expertise to the nature of the dialogue, and a greater level of technical discussion at GBS level
    c. A review of monitoring indicator i.e. simpler indicators with greater reliability
    d. Further capacity building for monitoring at sectoral level, and better national capacity for information gathering
    e. Focusing on programme based budgeting, allowing for allocation of resources against priorities and marginal changes in budgets to be used for assessments/decision making
- Finally just under two thirds of respondents indicated that they felt that donors should work together on developing VfM assessments and indicators in a harmonized manner for the sectors concerned.

Group Disclaimer

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