Appendix

Social Return on Investment (SROI) methodology and sensitivity analysis of the case studies

SROI Methodology

It is a methodology that allows a deeper understanding of the social, health, environmental and economic values created by the process of social contracting by a range of stakeholders identified as primary beneficiaries. It is a framework to measure and account for the value created by a programme or series of initiatives, beyond financial value. It incorporates social, health, environmental and economic costs and benefits (SROI Network, 2012). SROI is a participatory, beneficiary-led approach which uses financial values defined by programme beneficiaries themselves to represent social, health, environmental and economic outcomes, thus enabling a ratio of benefits to costs to be calculated. For example, a project ratio of 1:4 indicates that a donor investment of $1 delivers $4 of social value to the direct beneficiaries of the programme (Tong et al, 2012).

The usual stages of SROI analysis include: (i) establishing scope and identifying key stakeholders; (ii) mapping project outcomes with the stakeholders using the theory of change; (iii) assigning a financial value to the project outcomes; (iv) establishing project impact from the project end line evaluation; (v) calculating inputs to the project; (vi) calculating the SROI (SROI Network, 2012).

Social contracting in the area of HIV can create significant social returns, going beyond improving the health status of PLHIV or reducing the incidence and prevalence of HIV in a particular country and in the region. In order to study the social returns created by social contracting, we adapted and implemented the Social return on investment (SROI) methodology to the context of HIV in the wider EECA region. In this section we elaborate on the SROI methodology, while the next section presents the sensitivity analysis around case studies from three countries where we have conducted a rapid implementation of the SROI methodology in the context of HIV Social Contracting.

Stage 1: Establishing scope and identification of stakeholder groups

The SROI usually starts with establishment of scope and identifying the key groups or stakeholders that are to be included in the analysis. In the context of HIV in the EECA region, there are a few main beneficiaries: PLHIV, caregivers of PLHIV, people who inject/use drugs, sex workers, MSMs (men who have sex with men) and transgender people, NGO workers that provide services to marginalised groups and other community workers.

Stage 2: Mapping project outcomes with the stakeholders using the theory of change

Following the identification of the beneficiaries, the SROI methodology then maps the beneficiary-defined outcomes against relevant indicators, which are usually available through the end of the project evaluation or other repositories (e.g. health centres utilization data). Mapping the outcomes of an activity done through social contracting can help understand how increasing community action on HIV prevention, care and impact mitigation can lead to tangible changes in the lives of beneficiaries. More specifically, SROI analysis enables to measure the value of the impact of activities on beneficiaries’ lives, and to see how a series of programmatic activities led by community or implementing programme partners have led to certain measurable outputs, which in turn have led to measurable changes in beneficiaries’ lives.
The relationship between the project activities, outputs, outcomes, and impact can be assessed using the theory of change, and represented through impact maps (SROI Network, 2012).

The graph below gives examples on the link between the activities, outcomes, and ultimately impact of projects conducted under the auspices of social contracting, with particular reference to HIV-related projects in the EECA region. As the case studies in the next section will reveal, in most cases, the projects target either PLHIV or some (or all) of the key populations via counseling activities.

Stage 3: Assigning a financial value to the project outcomes

The theory of change allows to identify some of the project outcomes going beyond simple outputs. The next stage in the SROI analysis is to identify the outcomes of a social contracting project/activity and to attach an appropriate financial proxy to them. For example, if an activity involved counselling of key populations at higher risk of HIV on safe sex practices, the project outcomes could include the number of HIV infections that could be averted as a result of the counselling. By the same token, the financial proxy for this outcome could be the price of ART (which should be administered in case the infections were not averted) (Graph 1).

Stage 4: Establishing project impact from the project end line evaluation

Another important aspect of an SROI approach is that it allows researchers to isolate the impact of a particular activity on the project outcomes. To look at this in more depth, there is a need for a closer look at the outcomes by measuring: (i) attribution; (ii) deadweight; and (iii) drop-off.

Attribution estimate

i. Attribution—an assessment of how much of the outcome was caused by the contribution of others (organizations or people): “who else contributed and what is their claim in achieving the outcome?”

Understanding attribution is an important step in the estimation of the impact of a project, and failing to do so would result in an overestimation of the benefits attributable to an HIV-related project, as we would effectively be claiming 100 percent of the credit for any changes that have taken place. This is a key difference between an SROI approach and many other evaluation techniques. Usually this is done by consulting with the beneficiaries about who else was carrying out similar activities in the target areas (government agencies, other NGOs, individuals, community groups etc.), and who may have influenced or contributed to the outcomes or changes experienced (The SROI Network, 2012).

Given the nature of the HIV-related projects in the EECA region as well as the concentrated nature of
the epidemic, we expect that most of the improvement in beneficiaries’ lives to come through the project itself. In other words, the NGOs/CSOs working in the area are fairly focused, with limited but focused mandate, catering to key populations (e.g. people who inject drugs, sex workers, MSM and TG) and which would not have been otherwise included in activities by other projects.

**Stage 5: Calculating Inputs to the project**
The next step in the SROI is identifying the project inputs. These are fairly easy to obtain and usually include the standard set of costs that have been incurred in running the project. For example, this could include: (i) staff costs; (ii) equipment and supplies; (iii) administrative costs; (iv) travel, training; and (v) implementing partner budget allocation. In addition, there are some other, ‘hidden’ costs that could be associated with the implementation of an HIV-related project. This could, for example, include the caregiver’s time spent on carrying for PLHIV or co-infected beneficiaries of a project (The SROI Network, 2012).

**Stage 6: Calculating the SROI**
After all of the steps above are done, the final part includes taking the monetary value of the activity outcomes, dividing it by the activity inputs and expressing the SROI in terms of the ratio mentioned in the beginning of the methodology section above.

**Sensitivity analysis**

**Bosnia and Herzegovina**
In order to see how stable results are to various changes in the assumptions, conduct a few sensitivity analysis tests. In the case of BIH, first, we increased the attribution rate to 20 percent. The **final ratio that we obtained in this case** is 3.12 to 1—which is fairly comparable to the baseline scenario. Second, we applied a more gradual drop to the effect of the counselling (75 percent in year 2, 50 percent in year 3, 25 percent in year 4, 10 percent in year 5). The result that we get in this case, is obviously slightly higher than our baseline 4.1 to 1, but it is still comparable to our main set of results. Third, we reduced the financial proxy for the PLHIV as some of them might not be fit enough/well enough to contribute, so we only applied 50 percent of the annual minimum wage. In this case, our SROI ratio drops to 3.1 to 1, which is again comparable to the main set of results.

**North Macedonia**
In the case of North Macedonia to see how stable results are to various changes in the assumptions, we also increased the attribution rate to 20 percent. The **final ratio in this case** is **1.37 to 1**—which is fairly comparable to the baseline scenario. Second, we applied a more gradual drop to the effect of the counselling (75 percent in year 2, 50 percent in year 3, 25 percent in year 4, 10 percent in year 5). The result that we get in this case, is obviously slightly higher than our baseline 2.03 to 1, but even then, it is still comparable to our main set of results.

**Belarus—Red Cross**
Similarly, for Belarus—Red Cross, to see how stable our results are to various changes in the assumptions, we increased the same attribution rate to 20 percent. The final ratio that we obtained in this case is **1.4 to 1**—which is fairly comparable to the baseline scenario. Second, we applied a more gradual drop to the effect of the counselling (75 percent in year 2, 50 percent in year 3, 25 percent in year 4, 10 percent in year 5). The result that we get in this case, is obviously slightly higher than our baseline.
1.9 to 1, but even then, it is still comparable to our main set of results. Third, we reduced the financial proxy for the PLHIV as some of them might not be fit enough/well enough to contribute, so we only applied 50 percent of the annual minimum wage. In this case, our SROI ratio drops to 1.4 to 1, which is again comparable to the main set of results.

Belarus—Pozitivnoe Dvizhenie
As with the other 3 cases above, for Belarus Positive Dvizhenie, the sensitivity analysis tests conducted were also included. First, increasing the attribution rate to 20 percent. The final ratio in this case is 2.3 to 1—which is fairly comparable to the baseline scenario. Second, reducing the financial proxy for the PLHIV as some of them might not be fit enough/well enough to contribute, so we only applied 50 percent of the annual minimum wage. In this case, our SROI ratio drops to 1.3 to 1, slightly lower compared to the baseline scenario.

References