

Appendix

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

SROI Methodology

Social return on investment (SROI) is a methodology that allows a deeper understanding of the social, health, environmental and economic values created by a range of NGOs implementing projects under social contracting. 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.¹ SROI is a participatory, beneficiary-led approach which uses financial values defined by programme beneficiaries themselves to represent outcomes, thus enabling a ratio of costs to benefits to be calculated. For example, a project ratio of 1:4 indicates that a donor investment of 1 USD delivers 4 USD of social value to the direct beneficiaries of the programme.²

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.³

Social contracting in the area of HIV can create significant social returns, going beyond improving the health status of PLHIV or reducing the incidence

in a particular country and in the region. In order to study the social returns created by social contracting, we adapted and implemented the SROI methodology to the context of HIV in the wider Eastern Europe and Central Asia (EECA) region.⁴ 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 analysis 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: people living with HIV (PLHIV), caregivers of PLHIV, people who inject/use drugs, sex workers, men who have sex with men (MSM), transgender people, NGO workers that provide services to marginalized 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

1 The SROI Network, *A Guide to Social Return on Investment*, 2012, <https://socialvalueuk.org/resource/a-guide-to-social-return-on-investment-2012/>.

2 Banke-Thomas et al., *Social Return on Investment (SROI) methodology to account for value for money of public health interventions: a systematic review*, BMC Public Health, 2015, 15:582, <https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-015-1935-7>.

3 The SROI Network, *A Guide to Social Return on Investment*, 2012, <https://socialvalueuk.org/resource/a-guide-to-social-return-on-investment-2012/>.

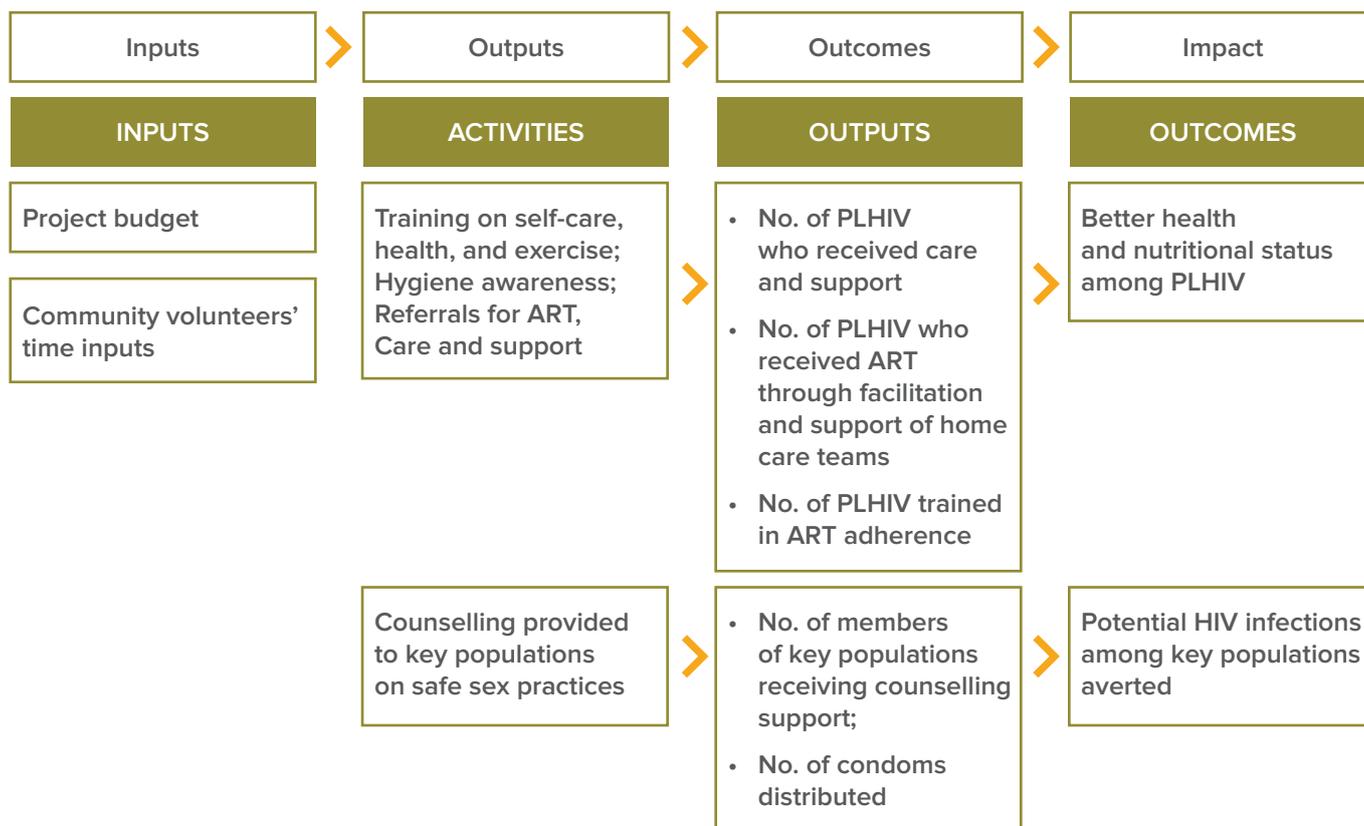
4 <https://www.eurasia.undp.org/content/rbec/en/home/about-us/about-the-region.html>

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.⁵

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 testing and counselling activities.

Graph 1. Theory of change map for an SROI analysis (Applied to selected HIV-related projects in the EECA region)



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 the 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 to adjust financial value of the outcomes by measuring and applying: (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?”

Accounting for 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 the estimation of attribution 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.⁶

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 working in the area are fairly focused, with limited mandate, catering to key populations (e.g. people who inject drugs, sex workers, MSM and transgender persons) and which would have not been otherwise included in activities by other projects.

Deadweight estimate

- ii. Deadweight—the percentage of the outcome that would have happened even if the project activity had not taken place.

As in the case above, given the nature of the HIV epidemic and response in the region, it is expected that some of the activities and outcomes would have not happened without the existence of the project.

Drop-off estimate

- iii. Drop-off—this measures the reduction of the outcome after the intervention has been implemented, i.e. the value by which the effect is decreasing over time. For example, after an intervention has been implemented, it is expected that some of its effects will continue. For example, if a project provides employment opportunities for people from marginalized groups, it is expected that some of them will continue to have their employment after the work is finished. However, with time more beneficiaries may be losing their jobs; the drop-off rate reflects the percentage of such beneficiaries.

Even when the contribution of the project to a given outcome has dropped off completely, this does not necessarily mean that the beneficiaries are no longer benefiting from the project activity. It simply means that the relative importance or influence of

the project activity on that outcome has diminished. For example, as we mention above, if a project has counselled some of the key populations on safe sex practices, it is expected that the knowledge obtained through the counselling would be retained for a few years after the activity has ended.

Stage 5: Calculating inputs to the project

The next step in the SROI analysis 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's own contribution. 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 caring for PLHIV or co-infected beneficiaries of a project.⁷

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 section.

Sensitivity analysis

Bosnia and Herzegovina

In order to see how stable results are to various changes in the assumptions, a few sensitivity analysis tests should be conducted. In the case of BiH, first, we increased the attribution rate to 20 percent. When doing this, we obtain a ratio of 1:3.1, which corresponds to the lower bound of the sensitivity analysis (see Table 3 in the Policy Brief) and is fairly comparable to our main finding. Second, we applied a more gradual drop-off (25 percent in year 2, 50 percent in year 3, 75 percent in year 4, and 90 percent in year 5). The result that we obtain in this case (1:4.1) corresponds to the upper bound of the sensitivity analysis (Table 3 in the Policy Brief) and is still comparable to our main findings. Third, we reduced the financial proxy for the outcome of the applied intervention relevant for PLHIV. Rather than taking the value of the total annual wage, we have applied 50 percent (as the health of PLHIV is unpredictable, even with continuous subsistence support, applying a full financial proxy to the outcome relevant to PLHIV may lead to over-estimation). In this case, the ratio obtained is 1:3.1, which corresponds to the lower bound of the sensitivity analysis (see Table 3 in the Policy Brief). This is again comparable to the main findings.

6 *Ibid.*

7 *Ibid.*

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 obtained in this case is 1:1.4, which represents the lower bound of the sensitivity analysis (see Table 3 of the Policy brief) and is fairly comparable to our main findings. Second, we applied a more gradual drop-off (25 percent in year 2, 50 percent in year 3, 75 percent in year 4, and 90 percent in year 5). The ratio in this case is 1:2.0 and it corresponds to the upper bound in the sensitivity analysis (see Table 3 in the Policy Brief). It is, however, still comparable to the main findings.

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 obtained in this case is 1:1.4, which corresponds to the lower bound of the sensitivity analysis (see Table 3 in the Policy Brief) and is comparable to our main findings. Second, we applied a more gradual drop-off (25 percent in year 2, 50 percent in year 3, 75 percent in year 4, and 90 percent in year 5). The ratio in this case is 1:1.9 and it corresponds to the upper bound in the sensitivity analysis (see Table 3 in the Policy Brief). Even then it is still comparable to the main findings. Third, we reduced the financial

proxy for the outcome of the applied intervention relevant for PLHIV. Rather than taking the value of the total annual wage, we have applied 50 percent (as the health of PLHIV is unpredictable, even with continuous subsistence support, applying a full financial proxy to the outcome relevant to PLHIV may lead to over-estimation). In this case, the ratio obtained is 1:1.4, which corresponds to the lower bound of the sensitivity analysis (see Table 3 in the Policy Brief). This is again comparable to the main findings.

Belarus—Pozitivnoe Dvizhenie

As with the other three cases above, for Belarus Positive Dvizhenie, the sensitivity analysis tests conducted were also included. First, increasing the attribution rate to 20 percent changed the ratio to 1:2.3, which is the upper bound of the sensitivity analysis (see Table 3 in the Policy Brief). Second, we reduced the financial proxy for the outcome of the applied intervention relevant for PLHIV. Rather than taking the value of the total annual wage, we have applied 50 percent (as the health of PLHIV is unpredictable, even with continuous subsistence support, applying a full financial proxy to the outcome relevant to PLHIV may lead to over-estimation). In this case, the ratio obtained is 1:1.3, which corresponds to the lower bound of the sensitivity analysis (see Table 3 in the Policy Brief). This is again comparable to the main findings.