

Policy Brief

Social Return on Investment for HIV services

Photo: UNDP

Introduction and background information

HIV situation in brief

The estimated number of people living with HIV (PLHIV) in the region of Eastern Europe and Central Asia (EECA)¹ between 2010 and 2019 has nearly doubled from 0.8 million to 1.7 million, while HIV prevalence rose correspondingly from 0.4 percent in 2010 to 0.9 percent in 2019.² Injecting drug use has traditionally been the predominant mode of HIV transmission in EECA, with 48 percent of infections occurring among people who inject drugs (PWID) as of 2019.³ In addition, the prevalence of HIV has been high among other key populations at higher risk of HIV infection, such as sex workers, men who have sex with men (MSM) as well as the prison population⁴ (Table 1). However, recently, heterosexual transmission has also been on the rise.⁵

Table 1.
EECA: HIV prevalence among the adult population and selected key populations at higher risk of HIV

	population (age 15–49)	people who inject drugs	sex workers	MSM	prison population
Albania	<0.1	1.4	0.7	2.0	0.5
Armenia	0.2	1.9	0.6	1.9	0.3
Azerbaijan	0.1	6.9	3.5	1.1	1.9
Belarus	0.5	30.8	7.0	9.8	8.5
Bosnia and Herzegovina	—	—	—	—	—
Georgia	0.4	2.3	0.9	16.2	0.1
Kazakhstan	0.3	7.9	1.4	6.5	3.6
Kosovo ⁶	—	—	—	—	—
Kyrgyzstan	0.2	14.3	2.0	6.6	11.3
Moldova	0.7	13.9	3.9	9.0	3.8
Montenegro	<0.1	0.5	0.5	12.5	0
North Macedonia	—	—	—	—	—

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

2 UNAIDS, <http://aidsinfo.unaids.org/>, retrieved on 10th of October, 2020.

3 UNAIDS, *Global AIDS Update 2020. Seizing the Moment—Tackling entrenched inequalities to end epidemics*, https://www.unaids.org/sites/default/files/media_asset/2020_global-aids-report_en.pdf.

4 It is important to note that these are not mutually exclusive categories and there is some mobility between groups.

5 ECDC, *HIV/AIDS Surveillance in Europe 2019*, <https://www.ecdc.europa.eu/en/publications-data/hivaids-surveillance-europe-2020-2019-data>.

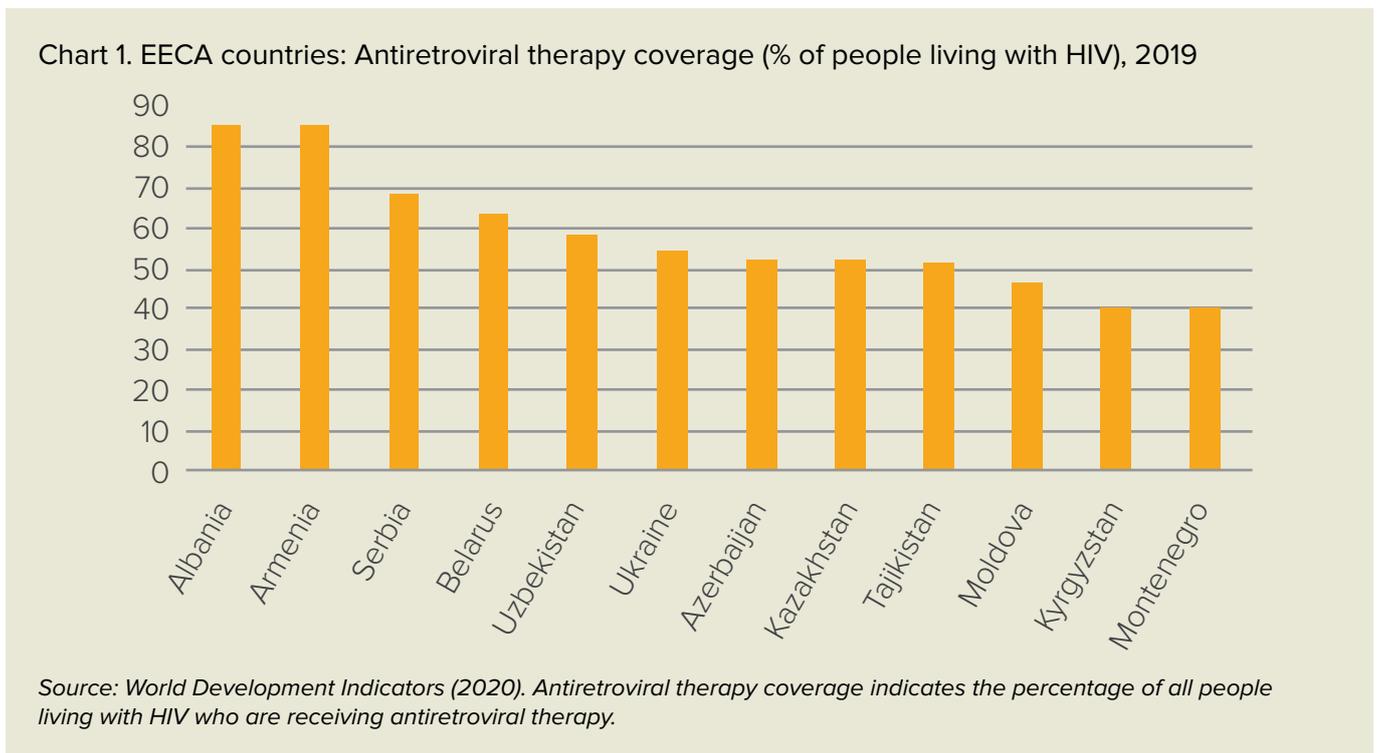
6 References to Kosovo shall be understood to be in the context of Security Council resolution 1244 (1999).

	population (age 15–49)	people who inject drugs	sex workers	MSM	prison population
Serbia	<0.1	1.8	1.6	8.3	—
Tajikistan	0.2	12.1	2.9	2.3	—
Turkey	—	—	—	—	—
Turkmenistan	—	—	—	—	—
Ukraine	1	22.6	5.2	7.5	7.2
Uzbekistan	0.2	5.1	3.2	3.7	0.5

Source: UNAIDS, <http://aidsinfo.unaids.org/>, retrieved on 10th of October, 2020.

Data suggests that antiretroviral treatment (ART) coverage in the region is low. In over half of the countries in the region, just about half (or less) of

PLHIV are receiving antiretroviral therapy. Albania and Armenia are notable exceptions, with over 80 percent of PLHIV receiving ART (Chart 1).



The HIV epidemic in Eastern Europe and Central Asia has been exacerbated by frequent co-infection with sexually transmitted infections (STIs), tuberculosis (TB), hepatitis B, hepatitis C, and other infections. EECA houses nine of the world’s 30 countries with the highest burden of multidrug-resistant TB (MDR-TB). MDR-TB prevalence is particularly high among new cases across the countries in the region.⁷ Among people living with HIV, TB co-infection is associated with a higher morbidity and mortality; and among people with TB, HIV co-infection is associated with increased TB transmission to the general population.⁸ Moreover, the disrupt-

tions of services and supplies caused by the on-going COVID-19 epidemic threaten to further exacerbate the HIV epidemic in the wider EECA region.⁹

Social contracting—definition

These worrying trends clearly suggest that more action is needed in order to halt the further spread of the epidemic as well as to further address the inequities in access to prevention, ART and care services among PLHIV and other key populations. This is becoming a pressing issue particularly since availability of donor financing across the countries

7 ECDC, *Tuberculosis surveillance and monitoring in Europe 2019*, <https://www.ecdc.europa.eu/en/publications-data/tuberculosis-surveillance-and-monitoring-europe-2019>.

8 Corbett, E.L., Watt, C.J., Walker, N., et al., *The growing burden of tuberculosis: global trends and interactions with HIV epidemic*. Arch. Intern. Med. 163, 1009–1021 (2003), <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/215525>.

9 <https://eeeca.unfpa.org/en/news/helping-most-vulnerable-survive-double-pandemic-hiv-and-covid-19-eastern-europe-and-central>

in the region is decreasing. Over the last few years, the World Bank has re-classified most of the countries in the region as lower or upper middle-income countries. As a result, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and other international support for HIV programmes in the region has been decreasing, yet domestic funding for HIV prevention is not meeting the funding gap.¹⁰ Moreover, while there has been some progress in domestic funding for ART, less progress has been seen in funding of prevention activities, which based on UNAIDS recommendations should receive approximately one quarter of the overall investments in the HIV response.¹¹

Against this background, social contracting could provide a basis for efficiently delivering HIV/TB services using governments (both, national and local) funds. It is defined as the process by which government resources are used to fund entities that are not part of government (e.g., NGOs) in order to provide services. Regardless of the terminology used, social contracting mechanisms typically involve a legally binding contract, in which the government agrees to pay an NGO for services rendered and the NGO agrees to provide agreed deliverables in exchange.¹² Thus, social contracting is different from the other NGOs funding streams and could be also described as ‘public financing and procurement of NGO-delivered services’. The process of social contracting is particularly important for the EECA region, where NGOs are the principal vehicle for service delivery to key populations. This is mainly influenced by a few factors: trust, improving navigation around the existing state provided services, as well as overcoming legal and other barriers.¹³

Social contracting in EECA—conditions for effective social contracting

The existing evidence suggests that there are a few conditions for an effective social contracting mechanism.¹⁴ The first condition is the **existence of legal and administrative systems** permitting and facilitating social contracting. Currently, across the region, all countries fulfil this condition, either through the existence of a **clear national social contracting legislation** or via streamlining social contracting through **the usual legislation on public procurement**.¹⁵

The second condition is the existence of **strong national leadership and funding from national authorities**. In **Ukraine**, for example, there has been a steady increase of state budget support on step-by-step plan, from 20 percent to 50 percent to 80 percent of all expenses of HIV services for key populations since 2018.¹⁶ Moreover, the **Ukrainian financing model** encourages **coupling of funding from both national and sub-national budget sources** as an important way to ensure sustainability. For example, Kyiv and Odessa which signed up to UNAIDS’ Fast Track Cities initiative in 2016, are now implementing a range of innovations, including funding from private sources, decentralisation of treatment and social contracting to reach its target of 82 percent of people living with HIV in the city on treatment by 2021.¹⁷

The third condition, **allocating budget resources for HIV-specific activities**, ensures transparency, fairness and effectiveness in funding allocation. Since 2017, **North Macedonia** has had a practice of **passing a national budget** with specific lines for HIV-programme funding, implying that the services provided

10 UNAIDS, *Prevention Gap Report*, 2016, <https://www.unaids.org/en/resources/documents/2016/prevention-gap>.

11 UNAIDS, *Global AIDS Update 2020. Seizing the Moment—Tackling entrenched inequalities to end epidemics*, https://www.unaids.org/sites/default/files/media_asset/2020_global-aids-report_en.pdf

12 UNDP, *Guidance note for the analysis of NGO social contracting mechanisms—The experience of Europe and Central Asia*, 2019, https://www.eurasia.undp.org/content/dam/rbec/docs/NGO_socialcontracting_EN.pdf

13 Open Society Foundations, *A global consultation on social contracting: working toward sustainable responses to HIV, TB, and malaria through government financing of programmes implemented by civil society*, 2017, http://shifhivfinancing.org/wp-content/uploads/2018/06/Social_Contracting_Report_English.pdf.

14 Hecht, R. et al., *Donor Transitions from HIV Programs: What Is The Impact On Vulnerable Populations?* Health Affairs, 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20181213.623294/full/>.

15 AETS Consortium, *Social Economy in Eastern Neighbourhood and in the Western Balkans: Synthesis report*, March, 2018. https://ec.europa.eu/growth/news/social-economy-eastern-neighbourhood-and-western-balkans-2018-06-04_en; EHRA, *Ensuring sustainability of services for key populations in the EECA region: Taking stock of budget advocacy efforts to date*, Initial meeting of regional analysis and dialogue, December 2020. https://harmreductioneurasia.org/wp-content/uploads/2021/01/Budget-Advocacy-Partners-Dialogue-Dec-2020_REPORT_Eng.pdf

16 UNAIDS, *Independent evaluation to the UN system response to AIDS in 2016–2019*, 2020, <https://www.unaids.org/en/resources/documents/2020/evaluation-of-the-UN-system-response-to-AIDS-2016-2019>.

17 Open Society Foundations, *A global consultation on social contracting: working toward sustainable responses to HIV, TB, and malaria through government financing of programmes implemented by civil society*, 2017, http://shifhivfinancing.org/wp-content/uploads/2018/06/Social_Contracting_Report_English.pdf.

to PLHIV and key affected populations are well prioritized by national or local governments.¹⁸ Moreover, since 2017, there has been a practice of social contracting between the Ministry of Health and NGOs on HIV prevention programmes.¹⁹ According to data from the 2019 budget, about half of the HIV related prevention activities have been implemented by NGOs (see Box 1 below, which further illustrates the progress achieved in the case of North Macedonia).

Box 1. Social contracting: the case of North Macedonia

The case of North Macedonia illustrates some of the necessary steps that lead to improvement in the social contracting mechanisms. The watershed for North Macedonia was 2017, when Government decided to ensure sustainability, allocate funds and establish long-term contracting mechanisms for NGOs. Moreover, since 2018, the national budget allocates resources for HIV services for key affected populations (according to the latest figures about 50 percent of all budget resources for HIV are awarded to NGOs). Three years earlier, there were some significant activities that took place and paved the way for the 2017 watershed: (i) building consensus among stakeholders and political will; (ii) strong coalition of service delivery organizations; (iii) advocacy strategy; and (iv) funding for advocacy. Currently, 14 NGOs across 10 towns in the country are supported and their work mostly revolves around prevention interventions targeting the marginalized communities. Finally, the case of North Macedonia illustrated some of the key enablers for this progress in the area of social contracting thus including: political will, existing practice of social contracting in the area of social services as well as institutional capacity of the key government entity.

Finally, the fourth condition for an effective social contracting mechanism is a need for **technical and managerial capacity of NGOs** involved in the social contracting process.²⁰ In that respect, the Drug Policy Network Southeast Europe has been involved in improving NGO capacity across South-eastern Europe (**Serbia, Montenegro, Bosnia and Herzegovina**) in areas such as: technical assistance in the field of budget advocacy as well as budget advocacy and monitoring.²¹ Further in this area, there has been a regional consultation on social contracting to develop good practice/normative standards.²²

Social contracting in the EECA—challenges

Despite these achievements in the major areas that are *sine qua non* for an effective social contracting mechanism, there are some challenges across the countries in the region. First, despite the existence of legislation for social contracting, there are additional barriers to accessing HIV-related services.²³ For example, in Belarus, while there are some changes to the national legislation allowing for social contracting of NGOs for prevention of HIV and other communicable diseases, some key population groups, including MSM, do not have regular and easy access to services procured using social contracting mechanisms.²⁴ Expert provided anecdotal evidence also points out to similar challenges in Kazakhstan. Furthermore, as evidenced by Table 2, in some of the countries of the region (e.g. Kyrgyzstan, Ukraine), there are legal restrictions requiring that HIV services only be provided in healthcare facilities, which makes the process of outsourcing and provision of services in community settings difficult.

Second, across the region, there are significant challenges regarding NGOs participation in the public procurement process. This is due to the fact that public procurement procedures discourage most NGOs from

18 SOS Project Consortium, *Budget Advocacy as a Key for Sustainability of Services for Key Populations in EECA and SEE*, presentation delivered at the Regional Dialogue on Sustainability, December, 2020.

19 Zhao et al., *Tackling the world's fastest growing HIV epidemic: more efficient HIV response in Eastern Europe and Central Asia*, Human Development Perspectives, Washington DC, World Bank, 2020, <https://openknowledge.worldbank.org/handle/10986/33959>.

20 Global Fund, *Update on sustainability, transition, and efficiency in the EECA region*, presentation, 2019.

21 Drug Policy Network SEE, *Budget advocacy and monitoring in South East Europe*, presentation delivered at the Regional Dialogue on Sustainability, December, 2020.

22 Open Society Foundations, *A global consultation on social contracting: working toward sustainable responses to HIV, TB, and malaria through government financing of programmes implemented by civil society*, 2017, http://shifhivfinancing.org/wp-content/uploads/2018/06/Social_Contracting_Report_English.pdf.

23 Global Fund, *Update on sustainability, transition, and efficiency in the EECA region*, presentation, 2019.

24 EHRA, *Ensuring sustainability of services for key populations in the EECA region: Taking stock of budget advocacy efforts to date*, Initial meeting of regional analysis and dialogue, December 2020. https://harmreductioneurasia.org/wp-content/uploads/2021/01/Budget-Advocacy-Partners-Dialogue-Dec-2020_REPORT_Eng.pdf.

applying because they are complex and require a bidding and registration fee, complex licensing process, and initial prepayment of services.²⁵ Moreover, while the procurement processes include special provisions for small and medium enterprises, such special provisions for NGOs do not exist.²⁶ Furthermore, despite the ongoing capacity building, very few NGOs in the region have sufficient financial and technical capacity to engage in public procurement processes.²⁷

Finally, in addition to having less priority compared to state institutions, there are challenges with timelines in provision of services. While there have been improvements in some Central Asian republics, where the funding available to NGOs is starting to be more closely aligned with the budget cycle, expert anecdotal evidence suggests inefficiencies in the annual social contracting cycle.²⁸

Table 2. Selected EECA countries: Regulatory barriers to community-led service delivery

	Restrictions requiring that HIV services only be provided in health-care facilities	Restrictions on providing services to key populations	Overly restrictive criteria for eligibility for community-based service delivery	No regulatory barriers	Other	Comment
Belarus				X		
Kyrgyzstan	X	X	X			
Moldova				X		
Montenegro		X			X	NGOs are not allowed to perform any kind of medical procedures, including doctor examination, testing, and even harm reduction programme is still illegal and can be prosecuted by Criminal Law
Serbia	X		X			
Tajikistan				X		
Ukraine	X				X	Providing some community based health care services (HIV testing, ART, PReP) requires a medical license. NGOs claim that getting the medical license and meeting requirements are complicated procedure for them. In addition, some health care services can be provided only by public/ municipal health care facilities.
Uzbekistan				X		

Source: UNAIDS National Commitments and Policy Instrument 2019, <http://lawsandpolicies.unaids.org/topicresult?i=619>, retrieved on 12th of October, 2020.

SROI methodology

Social contracting for HIV services can create significant social returns. In order to study the social returns arising from social contracting, we adapted and implemented the social return on investment (SROI) methodology to the context of HIV in the EECA region. Overall, the SROI methodology allows a deeper

25 UNAIDS, *Independent evaluation to the UN system response to AIDS in 2016–2019*, 2020, <https://www.unaids.org/en/resources/documents/2020/evaluation-of-the-UN-system-response-to-AIDS-2016-2019>.

26 AETS Consortium, *Social Economy in Eastern Neighbourhood and in the Western Balkans: Synthesis report*, March, 2018. https://ec.europa.eu/growth/news/social-economy-eastern-neighbourhood-and-western-balkans-2018-06-04_en

27 Gotsadze et al., *The Challenges of Transition from Donor-Funded Programs: Results From a Theory-Driven Multi-Country Comparative Case Study of Programs in Eastern Europe and Central Asia Supported by the Global Fund*. Global Health: Science and Practice, 2019, Volume 7, Number 2, <https://pubmed.ncbi.nlm.nih.gov/31249022/>.

28 SOS Project Consortium, *Budget Advocacy as a Key for Sustainability of Services for Key Populations in EECA and SEE*, presentation delivered at the Regional Dialogue on Sustainability, December, 2020; EHRA, *Ensuring sustainability of services for key populations in the EECA region: Taking stock of budget advocacy efforts to date*, Initial meeting of regional analysis and dialogue, December 2020. https://harmreductioneurasia.org/wp-content/uploads/2021/01/Budget-Advocacy-Partners-Dialogue-Dec-2020_REPORT_Eng.pdf.

understanding of the social, health, environmental and economic values created through the process of social contracting by a range of stakeholders identified as primary beneficiaries. It 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 cost 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 value²⁹ to the direct beneficiaries of the programme³⁰ (further details are provided in the appendix).

SROI methodology is slightly different compared to previous and ongoing studies of allocative efficiency across the region conducted with the Optima tool. As discussed elsewhere, methodologically, Optima's key feature is its ability to perform resource optimization to meet strategic HIV objectives, including HIV-related financial commitment projections and health economic assessments.³¹ Specifically, Optima allows users to choose a set of objectives (such as minimizing new infections, minimizing HIV-related deaths, and/or minimizing long-term financial commitments) and then determine the optimal resource allocation (and thus programme coverage levels) for meeting those objectives. As such, Optima falls within the narrower scope of cost-effectiveness analysis.

Case studies of applying HIV SROI methodology in EECA

Four case studies from three countries (Belarus (2 case studies), Bosnia and Herzegovina, and North Macedonia) were selected in order to pilot the SROI methodology in the area of HIV related activities. The selection of the case studies was conducted after an open call to NGOs working on HIV prevention, treatment and care programmes. Moreover, the selection allowed a balanced mix of type of activities (e.g. activities covering PLHIV and key populations) as well as a good mix of countries. By doing so, these case studies provide an illustration of this, very first, application of the SROI methodology in the HIV and AIDS context in the wider EECA region.

Against this background, inputs in this exercise were provided from the following four partners:

Partnership in Health (Bosnia and Herzegovina), **HERA** (North Macedonia), **Belarusian Red Cross** (Belarus) as well as **Pozitivnoe Dvizhenie** (Belarus). The inputs in terms of data and expertise received from the partners were instrumental in having enough substance to conduct this first ever HIV SROI exercises for the EECA region.

Brief description of the case studies

The objective of the activities in **Bosnia and Herzegovina** featured in this SROI work was the provision of HIV counselling to key populations at higher risk of HIV (MSM, PWID and prison population) as well as the support of PLHIV with various social support measures (e.g. provision of food and personal hygiene products). In that respect, the main beneficiaries encompassed the key populations (MSM, PWID and prisoners), and PLHIV. In 2018, almost 10,000 people from the key populations were counselled, while 69 PLHIV were targeted with social support. In **North Macedonia**, activities assessed encompassed mobile testing and counselling of key populations in the country (MSM, PWID and sex workers). In addition, the activities covered testing and counselling of young people. In 2019, about 2,500 people from the key communities were reached. The Belorussian Red Cross case study focused on provision of free testing and prevention activities for key populations and the provision of palliative care to PLHIV as well as additional services (e.g. distribution of free condoms and syringes). In 2020, over 5,000 people from key populations were reached with the various prevention activities, while 76 PLHIV received palliative care at home. The Belarus **Pozitivnoe Dvizhenie** case study activities encompassed helping PLHIV to access ART in two regions (Minsk and Gomel).

It is important to note that while the case studies illustrate the SROI application in two major types of activities (i.e. counselling and testing/prevention activities and palliative care/access to ART), the same methodological approach can be applied to a wider set of NGOs doing work in areas relevant to HIV and AIDS such as fighting stigma against key populations, providing livelihood support (help with training and employment) to selected key populations or advocacy/lobbying and activism.

29 In this instance, social value is a monetary equivalent of the social, health, environmental and economic outcomes achieved as a result of the social contracting activity.

30 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>.

31 Kerr CC et al., *Optima: A Model for HIV Epidemic Analysis, Program Prioritization, and Resource Optimization*, J Acquir Immune Defic Syndr. 2015 Jul 1;69(3):365-76. doi: 10.1097/QAI.0000000000000605. PMID: 25803164, <https://pubmed.ncbi.nlm.nih.gov/25803164/>.

Outcomes and assumptions

Given that the case studies focused on two main types of activities (prevention, testing and counselling; access to ART and support services for PLHIV, including palliative care), there are two outcomes related to these activities: (i) averted infections as a result of the counselling and testing provided to key populations; and (ii) improved health of PLHIV (due to improved palliative care, access to ART, subsistence needs covered). After assessing the activities' background information and consultations with the NGOs, no other outcomes were identified. One of the most important parts of the SROI involves monetizing of the outcomes. In this regard, when monetizing the outcomes and as per the SROI methodology we used: (a) average cost of ART for the averted infections; and (b) average minimum wage for PLHIV in good health to join the labour market.³²

When considering the counselling of key populations, an additional set of assumptions was made. First, not all people that were counselled immediately adopt safer practices; moreover, even if they continue with unsafe practices, not all of them will be infected. So, to refine the numbers, the transmission infection rate per type of unsafe practice first was applied (e.g. unsafe sex, sharing injecting equipment).³³ Furthermore, estimates from the literature on the reduction of HIV infections through counselling were relied upon.³⁴

There are three additional steps in the process of SROI methodology implementation. Firstly, an important part of the SROI is the **time horizon** of the effects of the stated activities mentioned above (so-called **drop-off**). In other words, while some of activities (e.g. counselling) last longer, others (e.g. help to PLHIV such as food or products for personal hygiene) have a limited duration and are expected to end as soon as the activity is completed. Hence, for the counselling, the assumption is that the effect will last for five years and that it will gradually reduce over time. In doing so, the following percentage reductions were applied to the original value in year 1, 50 percent in year 2, 70 percent in year 3, 90 percent in year 4, and 100 percent in year 5. Secondly, **the monetized outcomes** ought to be adjusted for the effect of others on the final outcomes (so-called **attribution**). Thirdly, the monetized outcomes should be adjusted for the share of the final outcomes that would have happened without the activities mentioned above (so-called **deadweight**). While the deadweight is 0, attribution is assumed to be 10 percent. In other words, there might be other channels through which messages about safer practices could be distributed (radio, TV, print) (this assumption is applied in cases covering prevention activities).

Finally, the monetized outcomes of the activities above (adjusted for attribution and deadweight) are expressed as a ratio to inputs/costs. The inputs/costs for the activities above were provided by the respective NGOs.

In order to ascertain the assumptions above as well as to collect additional information on the crucial elements of the exercise (i.e. attribution, deadweight, inputs/costs), a questionnaire was prepared and administered to the participating NGOs. The information of the questionnaire was further triangulated with a subsequent conference call/discussion with representatives from the selected NGOs.

Results

When SROI methodology was applied in the cases above, the results indicate that there are significant social returns associated with the implemented activities. More specifically, in the case study of **Bosnia and Herzegovina**, the results suggest a total return of 630,000 Bosnia and Herzegovina convertible marks (BAM) (approximately 400,000 United States dollars (USD)). These benefits, as mentioned above capture things such as: avoided number of infections, improved quality of life among PLHIV, improved quality of life among the key population groups and other. The case study activities in **North Macedonia** result with a total social return of 5 million Macedonian denars (MKD) (approximately 100,000 USD), which is significant, given the project cost of 3 million MKD. Finally, the cases in **Belarus** resulted with a social return on investment of 622,000 Belarussian rubles (BYN) (approximately 240,000 USD) (Belarussian Red Cross) and 84,000 BYN (approximately 32,412 USD) (Pozitivnoe dvizhenie).³⁵

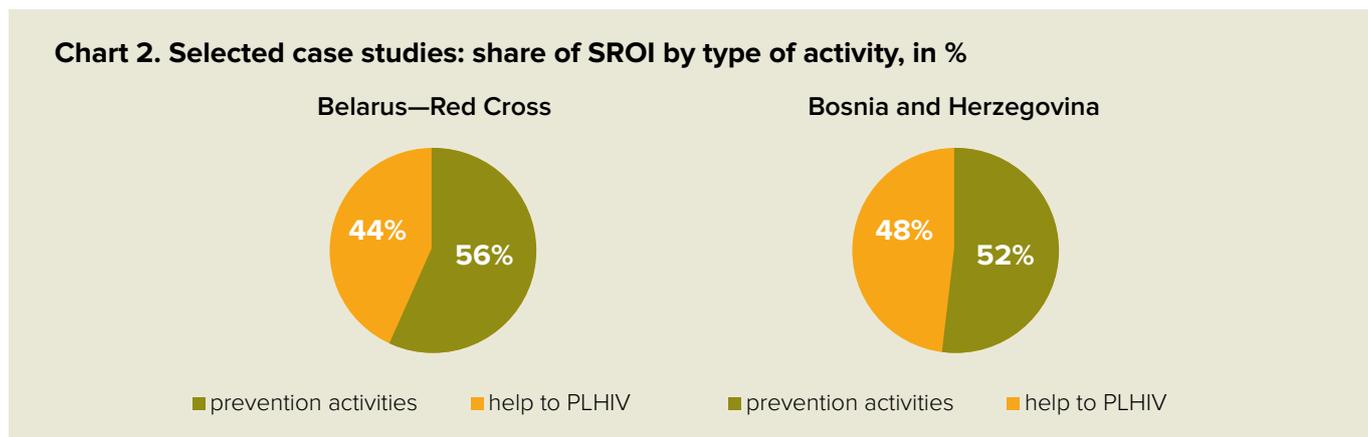
32 Tong, L., H. Sopheab, Tuot S., *Social Return on Investment "Doing more with less": Evidence based operational research on the KHANA integrated care and prevention project in Cambodia*, Phnom Penh, KHANA, <https://khana.org.kh/km/project/social-return-on-investment-doing-more-with-less-evidence-based-operational-research-on-the-khana-integrated-care-and-prevention-project-in-cambodia/>.

33 Public Health Agency of Canada, *HIV transmission risk: a summary of the evidence*, 2012, <https://www.catie.ca/sites/default/files/HIV-TRANSMISSION-RISK-EN.pdf>.

34 Hallett et al., *The role of testing and counselling for HIV prevention and care in the era of scaling-up antiretroviral therapy*, *Epidemics*, Volume 1, Issue 2, 2009, <https://pubmed.ncbi.nlm.nih.gov/21352753/>.

35 The following exchange rates were used: 1 USD=1.7 BAM (Bosnia and Herzegovina); 1 USD=2.4 BYN (Belarus); 1 USD= 54 MKD (North Macedonia). The data pertains for 2020 and it is taken from the World Development Indicators (WDI, 2021)—<https://databank.worldbank.org/source/world-development-indicators>

Chart 2 below depicts the share of total social returns by the type of activities (testing and counselling/HIV prevention among key populations as well as access to ART and psycho-social support for PLHIV). In both case studies, there is roughly an equal share of social return to investment created by the two types of activities.



For the activities that involve testing and counselling/prevention activities to different key populations a further disaggregated analysis was conducted and Chart 3 captures the share of SROI realized through testing and counseling/prevention activities by different key populations in two of the selected countries (Bosnia and Herzegovina and North Macedonia). While the shares are slightly different in the two countries, they are a reflection of the nature of the epidemic as well as the focus of the prevention activities. In other words, the counselling/prevention activities are mainly focused on MSM, a sub-group of the population where the HIV epidemic is spreading fastest. The share is also high among the other groups bearing the heaviest burden of the epidemic (e.g. sex workers and PWID in the case of North Macedonia as well as PWID and prisoners in the case of Bosnia and Herzegovina).



Photo: Momira Marković / UNDP Serbia

THERE ARE SIGNIFICANT SOCIAL RETURNS
ASSOCIATED WITH THE IMPLEMENTED ACTIVITIES

In Bosnia and Herzegovina



Input: **179,259** BAM (approximately **113,815** USD)



Total social return on investment of **630,000** BAM
(approximately **400,000** USD)

In North Macedonia



Input: **3.1 million** MKD (approximately **62,000** USD)



Total social return on investment of **5 million** MKD
(approximately **100,000** USD)

In Belarus

Belarusian Red Cross



Input: **392,085** BYN (approximately **151,287** USD)



Total social return on investment of **622,000** BYN
(approximately **240,000** USD)

Pozitivnoe dvizhnenie

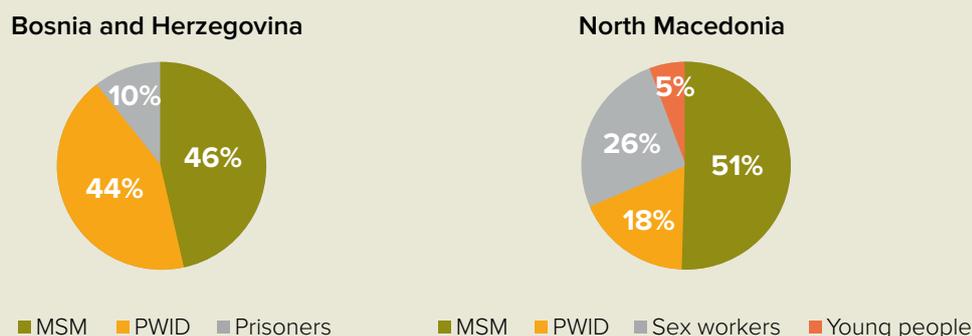


Input: **31,594** BYN (approximately **12,191** USD)



Total social return on investment of **84,000** BYN
(approximately **32,412** USD)

Chart 3. Selected case studies: share of SROI realized through HIV counselling/prevention, by beneficiary, in %



As discussed above, the final SROI is expressed as a ratio of costs required to implement certain activities and the social returns of the undertaken activities. Table 3 below captures the results of the SROI methodology for HIV-related activities in the case studies. In addition to the main findings of the analysis, the table also captures the upper and lower bounds of the SROI based on the additional sensitivity analysis (details of the sensitivity analysis are provided in the appendix of the brief and they cover variations in the drop-off rate, attribution as well as the deadweight). There are a few broad findings that emerge as illustrated in Table 3.

First, in all of the selected activities, there are significant social returns as a result of project implemen-

tation. The SROI ratio ranges from 1:1.5 in the case of North Macedonia to 1:3.5 in the case of Bosnia and Herzegovina. This is mostly due to the type of activities that are implemented. The case of Bosnia and Herzegovina encompasses both psycho-social support to PLHIV as well as testing and counselling/prevention activities among key populations.

Second, the sensitivity analysis indicates that the results are robust to changes in assumptions such as modification of the drop-off or attribution rate.

Finally, and given the similarity of the activities which are implemented (as well as similarities in assumptions), the social return on investment across the case studies is similar.

Table 3. Results of the SROI analysis in the four case studies

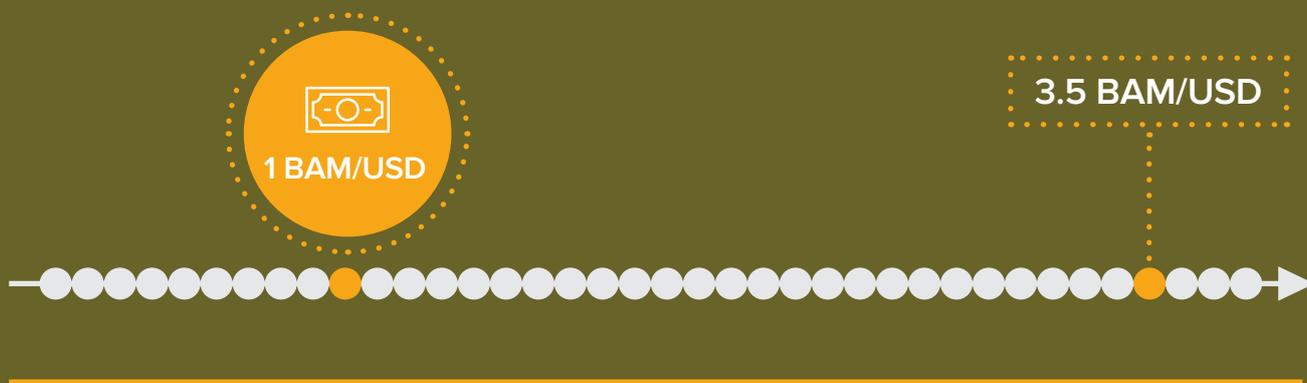
Country/Case study	SROI: main findings	Sensitivity analysis	
		Lower bound	Upper bound
Bosnia and Herzegovina	1:3.5	1:3.1	1:4.1
North Macedonia	1:1.5	1:1.4	1:2.0
Belarus: Red Cross activities	1:1.6	1:1.4	1:1.9
Belarus: Pozitivnoe Dvizhenie	1:2.6	1:1.3	1:2.3

Limitations

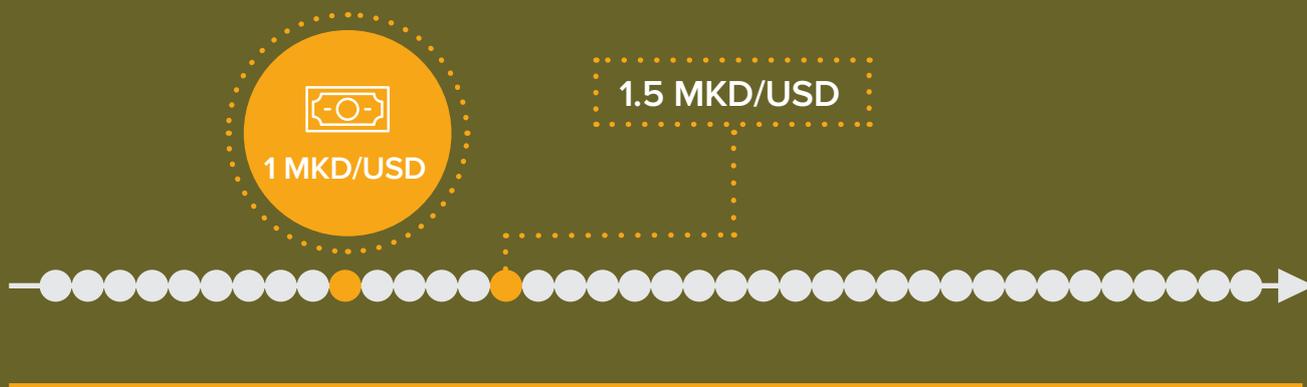
The SROI approach is not without limitations, and in the absence of SROI standards and a robust method of auditing an organisation's 'claims' to the value it creates, ratios of return could be challenged. An attempt was made to detail the assumptions, processes, and measurement of outcomes in order to fully document how figures were calculated or estimated. Given the ongoing situation with the COVID-19 pandemic, all of the consultations were conducted virtually over the phone or email, which is another limitation to this research. Ideally, the method should involve a face to face interaction with respondents and other stakeholders. With that said, some of the stakeholders (e.g. national authorities, healthcare professionals) were not involved in the SROI estimation exercises.

Furthermore, given the methodology, we cannot make distinction between 'need' and 'ability to pay'. Moreover, data constraints prevented further assessment of the probability of paying out of pocket (including informal payments) for some healthcare services. Finally, the exercise above was mainly focused on two types of activities (testing and counselling/prevention and care services provided to PLHIV) which somewhat limits the generalizability of the results.

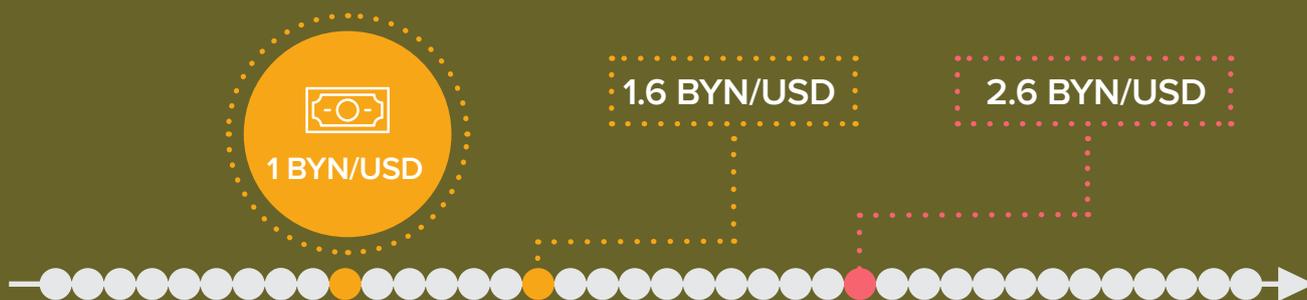
For every BAM/USD invested in HIV-related prevention activities (including psycho-social support and testing and counselling), the country will receive a social return on investment of 3.5 BAM/USD.³⁸



In North Macedonia, every MKD/USD covering mobile testing and counselling of marginalized and key populations (men who have sex with men, people who inject drugs and sex workers) generated a social return on investment of 1.5 MKD/USD.



In the case of Belarus, investing 1 BYN/USD in the context of 2 assessed HIV-related projects translated into a total social return on investment of 1.6 and 2.6 respectively.



38 The ratios are obtained by dividing the social returns and inputs presented in both local currencies and USD on page 8.

Conclusions and recommendations

Countries in EECA region have made significant progress in setting the foundation for effective social contracting mechanisms. All of the countries have legal structures that allow them to contract NGOs for the provision of various HIV-related activities as well as provide care and support to PLHIV. Moreover, as the literature review at the beginning of this brief suggests, countries in the region have also made progress on other key aspects of effective social contracting (e.g. political leadership, earmarking funding for HIV-related activities, increasing capacity among NGOs to participate in the social contracting process). Some challenges remain, including legal obstacles, complex bidding processes as well as lack of technical capacity (by NGOs) to participate in the bidding processes.

Nevertheless, for the NGOs that are engaged in social contracting and obtain funding, as the case studies featured in this brief have shown, **activities that are conducted under the auspices of social contracting can result in significant returns on investment.** As the case studies show, **for each USD invested, there is a social return on investment of between 2 to 3 USD.** These social returns, as indicated in the analysis include, inter alia, improved quality of life among PLHIV, numerous averted infections among key population groups, through testing and counselling and distribution of needles and condoms, ultimately resulting in improved self-esteem and better quality of life among the key populations.

A set of recommendations that stem from this first HIV SROI exercise in the EECA region are as follows:

- 1 While the case studies featured in this brief provide a flavour of the numerous economic and social benefits of NGO social contracting in the area of HIV (going beyond the simple financial value), the next stage of the SROI analysis should include a broader set of NGOs to provide additional activities (e.g. livelihood support to PLHIV, support to people with co-infections (e.g. HIV and TB), fighting stigma and discrimination) which may further increase the overall SROI;
- 2 SROI analysis should be used in the management of programmes and for decision making, alongside other qualitative reports of outcome and impact, as well as standard monitoring systems. In particular, a well-executed SROI methodology can go a long way in capturing the benefits of various social contracting activities in a simple and unambiguous way;
- 3 Building on recommendation 2 above, the SROI methodology can be used in future advocacy activities by NGOs to emphasize the benefits brought about by NGO social contracting. Moreover, using the results of future SROI assessments in the area of HIV could further reduce existing obstacles to social contracting in HIV (for example, results of SROI assessments can be used to show that some activities, like harm reduction can be effectively and efficiently delivered by NGOs in a non-clinical setting);
- 4 The easy quantification of the SROI assessment results could also be used in bidding for funding, particularly when the funding is performance-based;
- 5 The results of the SROI analysis can also be used to emphasize the sustainability and medium-term effect of some activities implemented through social contracting. In the current case studies, we assume a drop-off period of 5 years, although in some other cases (e.g. providing livelihood support to key populations or fighting stigma and discrimination), the effects could be longer;
- 6 When using the SROI assessment results to advocate for further expansion/scale up of social contracting, emphasis should be given to proposed attribution and deadweight factors. In other words, given the concentrated epidemic and marginalization of key populations, the high returns on investment, as demonstrated in these case studies, would have not happened without the activities implemented through social contracting;
- 7 While this is an initial, pilot application of the SROI methodology, future endeavours should be based on consultation with all stakeholders and beneficiaries (including some which were not featured in our analysis, e.g. national or local authorities or healthcare workers);
- 8 The methodology for community/stakeholder consultation should be promoted/piloted in other areas where social contracting becomes an important vehicle for NGO financing (e.g. TB, HIV-TB co-morbidity, harmful use of alcohol, ART, co-morbidity with diseases of ageing such as cardiovascular disease).

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