KHANA
UNITED FOR A STRONGER COMMUNITY

International HIV/AIDS Alliance

"Doing more with less"

SOCIAL RETURN ON INVESTMENT

Evidence Based Operational Research on KHANA Integrated Care and Prevention Program in Cambodia

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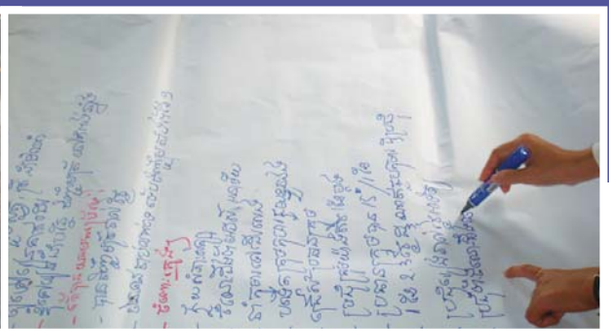
INTRODUCTION AND RATIONALE

KHANA is the largest national, non-governmental organization (NGO) providing HIV prevention, care and support services in Cambodia. KHANA works in 20 provinces and municipality through a network of 38 implementing partners. These partners are community-based organizations, local NGO working with communities, and networks that are committed on HIV, health and development issues.

From 2007 to 2011, KHANA implemented an European Commission (EC) supported program including two main program components: Focused Prevention for most at risk populations (MARP), and Integrated Care and Prevention (ICP) for people living with HIV (PLHIV) and orphans and vulnerable children (OVC). The program operated in three provinces: Kampong Chhnang, Kampong Speu and Prey Veng. Through the ICP component KHANA and our implementing partners provide community based care and support taking a holistic approach to the varied needs of individuals and communities. The program include addressing psycho-social needs, reducing stigma and discrimination, improving economic sustainability, food support, and financial support to reduce barriers impeding access to basic services such as health care and schooling.

Recently there has been increased debate about value for money related to development and health programs. In response to this, International HIV/AIDS Alliance adapted and simplified a Social Return on Investment (SROI) methodology for use at the community level. SROI is a form of social cost benefit analysis which aims to monetise program outputs and outcomes. The methodology incorporates social, health, environmental and economic costs and benefits, enabling the calculation of cost to benefit ratio to indicate the return on investment of a particular program.

KHANA integrated a SROI study into the end-line evaluation of EC supported program. This SROI study was the first of its kind conducted in Cambodia, focused on community based care and support for people affected by HIV. It is a timely study and interesting approach in line with donors' current emphasis on cost efficiency and effectiveness, value for money, and "doing more with less". Our objective was to assess the return on community based responses to HIV, care, support and treatment, using primary research in communities reached by the EC supported program.



METHODOLOGY

The SROI methodology is a framework to measure and account for the value created by a program or series of initiatives. It looks beyond financial value, **to quantify hard to measure outcomes of community mobilization work** around HIV. The methodology uses a common outcomes framework, which is a theory of change defining the link between program inputs, activities, outputs, outcomes, and impact. It is a participatory, beneficiary-led approach and uses financial values defined by program beneficiaries to monetise social, health and economic outcomes, thus enabling a ratio of social benefits to costs to be calculated. For example, a ratio of 1:1.54 would indicate that an investment of $1 delivers $1.54 of social value - a 54% return on investment.

Six stages of SROI analysis

1	Establish study scope and identify stakeholders	4	Establish program impact
2	Map program outcomes	5	Calculate the SROI
3	Itemise outcomes and giving them a value	6	Report and disseminate findings

PROCESS

Over a two-week period during November 2011, a consultative workshop with KHANA staff from the Research Department, Monitoring and Reporting Unit, and Finance Department was organised to establish the cost of living and reasonable financial proxies for Cambodia. At the community level, focus group discussions and key informant interviews were conducted with over 140 PLHIV, OVC, caregivers, and community support volunteers (CSV) to explore how the activities of the program and the implementing partners impacted on them as key beneficiaries.

STAKEHOLDER GROUPS CONSULTATION AND IDENTIFICATION OF COMMON OUTCOMES AND PROXIES

Key stakeholders in the ICP community based care and support component were identified, and a decision made over whether to include them in the analysis (i.e. PLHIV, OVC, care giver). Once program outcomes were identified through the consultation and focus group discussion, we mapped these beneficiary defined outcomes against relevant indicators collected in the program end-line evaluation. The evaluation had a sample size over 1,600.

More than 20 outcomes were identified for PLHIV, OVC, family members and households, caregivers, health centers and the wider community in the geographical vicinity of the program. These were used as units of analysis in the study.

FINANCIAL PROXY ESTIMATES

The monetisation of social value in SROI is considered controversial by some, who argue it is not possible to quantify outcomes related to quality of life. Whilst by no means a perfect science, it is important to note that all monetary values, or financial proxies used to represent a program outcome should be informed by program beneficiaries. Establishing financial proxies was a major part of the consultation process with beneficiary groups and key informants. Where it was difficult to find a financial proxy through consultation we referred to secondary sources of data (i.e. the cost of a bicycle).

INPUTS – INVESTMENTS TO THE INTEGRATED CARE AND PREVENTION PROGRAM 2007-2011

The resources that were invested in the ICP include the direct program budget from EC, complimentary food support from the World Food Programme (WFP) and economic costs captured within the community (i.e. self help groups, caregivers, volunteers, opportunity costs). Traditionally, return on investment may overlook the financial costs borne by community members in participating in the program.

The World Food Programme monthly food support for vulnerable PLHIV and OVC households covered 30 kg rice, 1 kg cooking oil, and 0.5 kg iodine salt. The ICP budget accounted for 73% of the total EC program budget of US$ 3,295,741 and covered staff costs, equipment and supplies, administrative costs, travel, training and sub-grants to implementing partners.

ASSUMPTIONS IN BUILDING AN ECONOMIC MODEL FOR SROI

After the specific program outcomes were identified, each outcome was monetised using a financial proxy or direct cost. The financial proxies were developed during community and KHANA staff consultations. Three main assumptions (attribution, deadweight, and drop-off) were taken into account when establishing the program impact and developing the SROI economic model.

Attribution, deadweight and drop-off

Attribution refers to how much the achieved outcomes for beneficiaries may result from the contributions of other organisations or people. Deadweight is the percentage of outcomes that is likely to have happened anyway for beneficiaries, without any intervention. This is possible to estimate with some level of accuracy if there is a reliable control group. In the absence of a control, we have referred to beneficiary discussions and secondary information to provide an estimated range. Following the end of a program, benefit is still created for some time into the future. However the amount of outcome value gained is likely to be less or will be more influenced by other factors, so a drop off percentage on a year on year basis needs to be determined. In our context, we calculated outcome value for the next 4 years following the end of the program. There is likelihood of strong ICP remnant influence in the first few years following the program end. Drop off values have been estimated to be 10% in the first year, 20% in the second year, 30% in the third year and 50% in the fourth year.

RESULTS

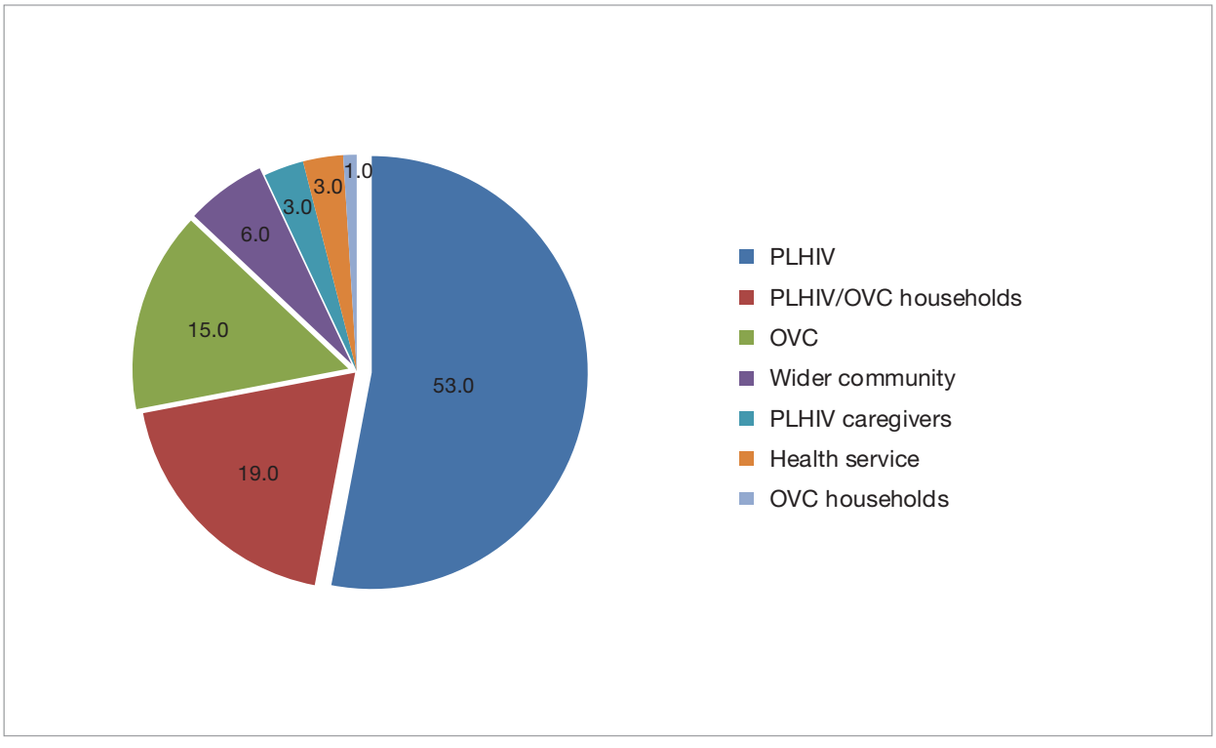
SROI RATIO AND BREAKDOWN OF VALUE

The Social Return on Investment for the ICP program was 73%. For every US$1 invested in the program between, 2007-2011, US$1.73 was generated in social, health and economic related values. In other words, a combined investment of approximate US$ 2,406,000 from the EC plus US$ 624,000 from WFP and community inputs generated total benefits worth US$ 5,228,321.

Though significant, 73% is not an unexpected return if one takes into account the level of investment plus the period of investment. KHANA's financial commitment to a long term (5 years) investment strategy or life of program has built an enabling environment to a certain degree, which is critical when working towards increasing the sustainability of the program.

Further analysis shows that the proportion of value created varied considerably according to beneficiary type. The top four categories of beneficiary were: PLHIV (53%), PLHIV/OVC households (19%), OVC (15%), and the wider community (6%).

Figure 1: Distribution of value created per beneficiary type (%)



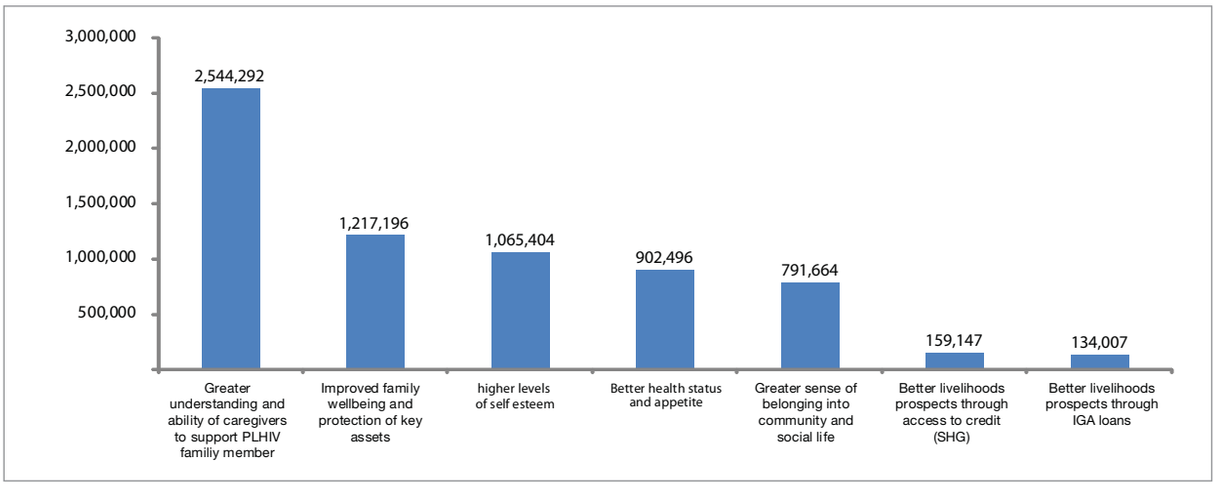
Outcome values are discussed below using 'international dollars', which are adjusted to consider the amount of goods one dollar can purchase in Cambodia.

OUTCOME VALUE FOR PLHIV

The three highest outcome values created for PLHIV of the total value created were: 1) Greater understanding and ability of caregivers to support PLHIV family member; 2) Improved family wellbeing, or feeling of greater economic security resulting from decreased level of debt and the need to sell off key family assets (rice fields, farm land); and 3) Higher levels of self esteem.

Figure 2 shows that the two livelihoods outcomes represent about 4% of the total value created. While we may have expected these outcomes to generate a higher proportion of the value, the result is likely to the small scale of the income generation activities (IGA) conducted and the late introduction of self help group (SHG) financing schemes in the program.

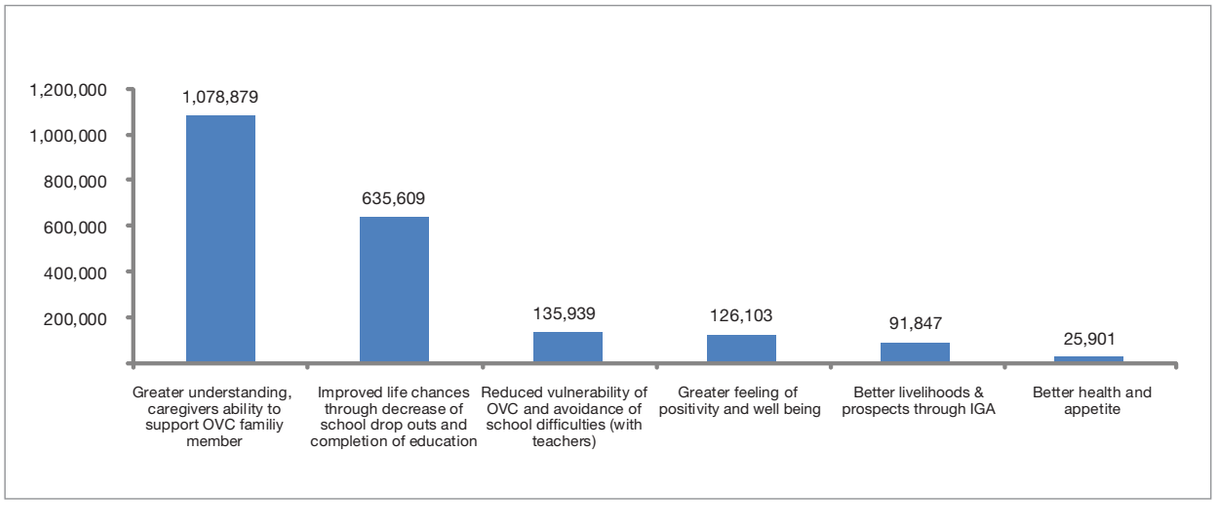
Figure 2: Outcome value created for PLHIV (Int'l $)



OUTCOME VALUE FOR OVC AND FAMILIES

The highest outcome value for OVC was greater understanding and ability of caregivers to support their OVC family member, which signals important positive changes for OVC within their household. As indicated in a previous KHANA survey on children affected by AIDS in 2009, 40% of OVC at that time were going without sufficient food, clothes and basic necessities. ICP program targeting of caregivers for OVC, sensitization, family counseling and support has promoted and resulted in a better quality of life for OVC within their family environment. The OVC outcome around greater feeling of positivity is linked, and has also generated high value. Certainly self help groups and peer support have had a large effect on this outcome.

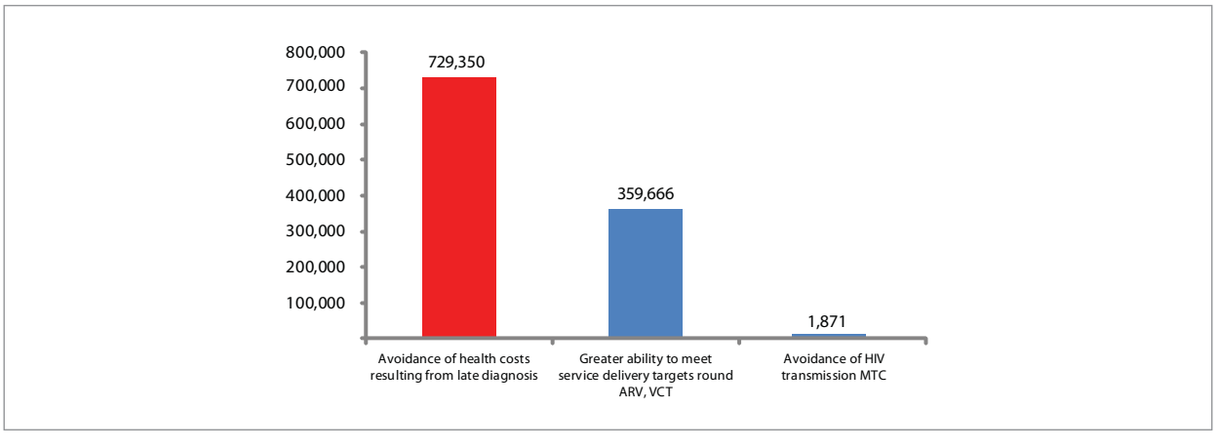
Figure 3: Outcome value created for OVC and families (Int'l $)



OUTCOME VALUE FOR THE WIDER COMMUNITY AND HEALTH SERVICE

A key outcome value created for the wider community relates to avoiding the potentially devastating impact of late diagnosis, and associated tremendous health related expenses incurred. The study was an opportunity to quantify how much these avoided costs might be, for the people reached by the ICP, through enabling them to access VCT and then treatment.

Figure 4: Outcome value created for community and health service (Int'l $)



CONCLUSIONS AND RECOMMENDATIONS

- The SROI study found the ICP program delivered a cost to benefit ratio of 1:1.73 or a 73% social return on investment. This indicates a positive return for a community based response to HIV and shows the program works.
- The highest outcome value created for PLHIV and OVC was greater understanding and ability of care givers to support PLHIV and OVC. This contributed to increased quality of life for PLHIV/OVC and indicates the significant contribution of caregivers to the community based approach used in the ICP program.
- A high outcome value was also noted from avoidance of health costs resulting from late diagnosis. This outcome contributes to preventing households affected by HIV slipping into health related debt and poverty.
- The SROI approach is clearly a useful method and tool to quantify the value of programs, using a community consultative approach. SROI should be used as a forecasting as well as an evaluative tool at the mid-point and end of programs to lead to increased ownership of the program amongst beneficiaries and implementing partner organisations.
- Whilst a ratio of 1:1.73 or 73% return is a significant and positive result, KHANA and partners should not be complacent about ensuring there is maximum opportunity to identify and effect cost saving measures.
- A comprehensive costing of community input is necessary to give a true reflection of how much the community invests through its involvement with the ICP. The true costs of this have not been completely captured in the SROI study.
- The livelihoods component of the ICP to build skills and increase incomes for PLHIV/OVC households appears to be generating some value; however the scale of reach was limited due to small budget allocation which resulted in small size for initial grants that were issued. The potential for sustained benefit to be created beyond the life of the ICP is high; further research to test this assumption should be conducted.
- Focus group discussions highlighted the issue of continuation of emergency household food support after the end of the WFP project in 2012. The SROI indicated the high outcome value of decreased burden related to food security. KHANA and implementing partners need to gather further evidence to advocate with donors and the Cambodian government.

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