



# **SOCIAL RETURN ON INVESTMENT: CHAHA PROGRAMME**

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Cover image: Children's group run by Vasavya Mahila Mandali in Andhra Pradesh, India. © The Alliance  
Above: CHAHA nutritional programme. © Gideon Mendel for the Alliance

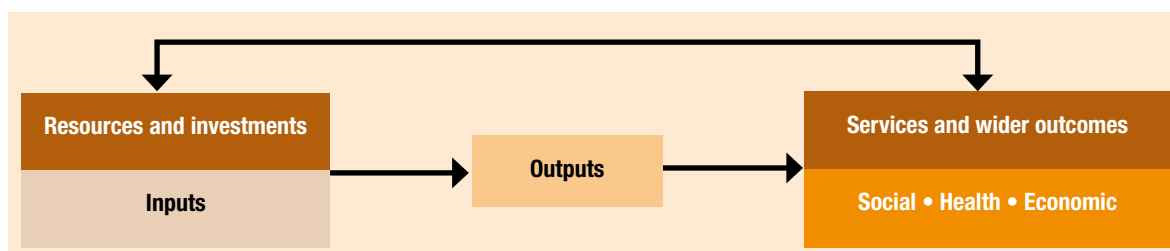
## Acronyms

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
CBO	Community-based organisation
CMIS	Computerised management information system
CSO	Civil society organisation
CTX	Co-trimoxazole
HIV	Human immunodeficiency virus
IR	Indian rupees
M&E	Monitoring and evaluation
NGO	Non-governmental organisations
NVP	Net value percentage
PMTCT	Prevention of mother-to-child transmission
PPP	Purchasing power parity
SSR	Sub-sub Recipient
SR	Sub-Recipient
SROI	Social return on investment
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development

# Introduction and background

In response to the growing urgency to effectively demonstrate aid accountability, through value for money and attention to cost efficiency and effectiveness, for the latter the Alliance is adapting and piloting a methodology based on measuring and valuing social and health outcomes against investment. The social return on investment (SROI) is one of a number of methods that has been proposed as suitable for simplification and adaptation and to be applied within a Linking Organisation to test the value for money of specific programmes or programme components.

**DIAGRAM 1:**  
SROI compares  
'monetised'  
outcomes with  
investments



SROI 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. It is of particular relevance to the Alliance as our programming results in social, health and economic outcomes, for which the Alliance has systems to describe and track, yet, so far, there is no satisfactory way of valuing or allocating a monetary value to. This method is a participatory, beneficiary-led approach which uses financial values defined by programme beneficiaries to represent social, health and economic outcomes, thus enabling a ratio of benefits to costs to be calculated. For example, a ratio of 1:4 indicates that an investment of \$1 delivers \$4 of social value.

In addition to testing the appropriateness of the method, the study assessed to what extent SROI could be used as a management tool to decide which programme components/activities and inputs are more effective at delivering which outcome, and conversely which derive little 'outcome value', thereby enabling a re-planning of programme strategy or activities in order to maximise the outcomes for end beneficiaries.

SROI is not without its challenges, in the absence of standards and a robust method of auditing an organisation's 'claims' to the value it creates, ratios of return can be easily dismissed. We have attempted to detail the assumptions, the processes, the measurement of outcomes in order to fully document how figures were calculated so that independent readers can make a judgement on the credibility of the assumptions and by extension study conclusions.

This pilot study assessed the SROI of the CHAHA programme – a child-centred home- and community-based case and support initiative and a 3½ year Global Fund programme – implemented by Alliance India and her partners.

More than 70 beneficiaries were consulted and a range of outputs and outcomes were identified from their perspective. Based on this work in Maharashtra State it appears that every \$1 invested in CHAHA from 2008 to 2010 generated \$4 of social, health and financial value. More than half (52%) of this value accrued to parents and caregivers with just under half (45%) benefitting children directly. Most value was created through improvement in livelihood status, improved health status of the child, other children having better income prospects and improved educational attendance and status. Less value was created through avoidance of family crisis, improved health status of the family and improved family care. It is anticipated that this information may be useful to CHAHA and the Alliance in making management decisions, e.g. on where to focus support.

# SECTION 1: Alliance India and the CHAHA Programme

Established in 1999 Alliance India comprises of a secretariat in New Delhi, five lead partner organisations and their networks of over 100 community-based organisations (CBOs) and non-governmental organisations (NGOs) across Andhra Pradesh, Tamil Nadu, Maharashtra and Manipur. CHAHA (meaning ‘wish’ or ‘hope’) is Alliance India’s response to the needs of children living with and affected by HIV. It receives funding from Round 6 of the Global Fund and was designed as a five-year expanded child-centered, home-based care and support programme, with a target of 64,000 children. The three main approaches for providing direct and indirect services to children living with or affected by HIV were to:

1. create a supportive environment through community mobilisation in all settings (health, social and legal) for HIV-related stigma reduction
2. strengthen and build the capacity of NGOs and CBOs
3. strengthen information systems and conduct operations research.

CHAHA works through its outreach workers to provide improved access to healthcare and improve health seeking behaviour of affected children and families. Referrals and linkages are created between families and healthcare systems, such as HIV testing, opportunistic infections (OI) prophylaxis and management, antiretroviral treatment (ART) and sexual and reproductive health (see Diagram 2).

An illustration of the areas of work CHAHA has been involved with that form part of this SROI are described briefly below.

## Nutritional support

CHAHA provides referrals and linkages to families of children living with and affected by HIV to government schemes, such as the Integrated Child Development Scheme. Direct nutritional support is also provided, as well as nutritional counselling and food demonstrations.

## Educational support and vocational skills development for youth

CHAHA facilitates the support of children living with HIV to return to school to complete their education, by creating a positive learning environment for them through sensitisation work with district and school authorities, advocacy with schools and community around the right of children living with HIV to access education, and direct support in the provision of books, uniforms and other educational material, counselling individual children and their families. Older children living with and affected by HIV are supported in vocational training.

## Psychosocial support

CHAHA provides counselling for children living with and affected by HIV and their families through one-to-one interaction and home visits.

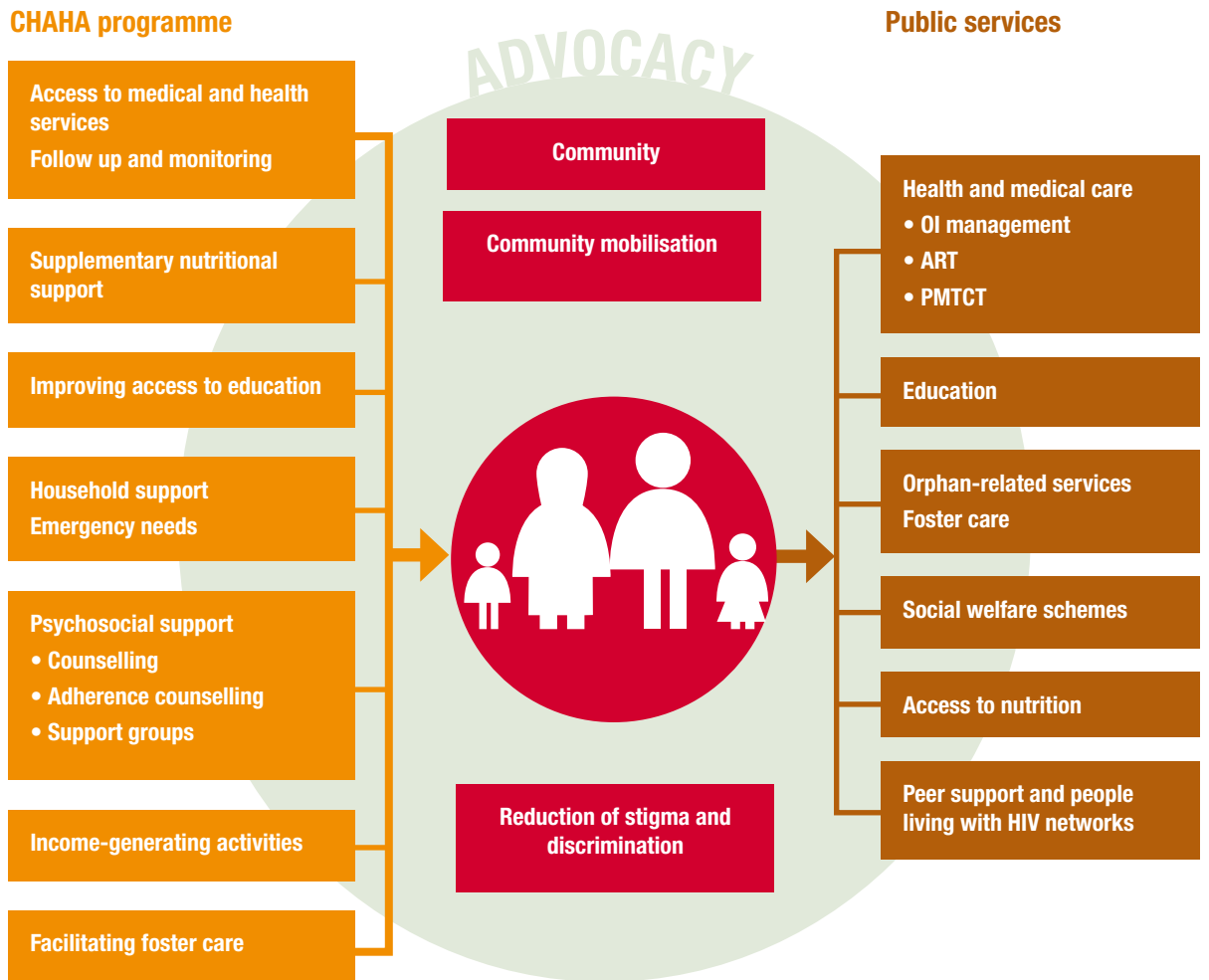
## Household support

In times of crisis CHAHA provides emergency support to families of children living with and affected by HIV in the form of funds for hospitalisation, travel for medical emergencies, treatment, diagnosis, water filters, bed nets and emergency housing material.

## Income-generation

This support targets families of children living with and affected by HIV and older children living with HIV that are able to run an income-generating scheme. Grants and skills building support are provided. Typical businesses would be tea selling, vegetable vending, petty shops, tailoring, etc.

DIAGRAM 2: Comprehensive framework of CHAHA services



Outreach worker with CHAHA mothers and children. © The Alliance

## SECTION 2: SROI methodology

The Alliance India and Alliance secretariat planned and conducted a SROI study in October 2010. The purpose of the study was to develop and test a simplified methodology to value and quantify social and health returns of a typical Alliance care and support programme in order to determine a ratio for return on investment for a) understanding cost effectiveness b) application in programme decision making.

As this was the first study of this nature to be conducted by the Alliance (and to our knowledge in India), it was considered useful to document the process as a step-by-step approach.

- Phase 1: Setting the boundaries of the study
- Phase 2: The stakeholder consultation and outcomes map
- Phase 3: Data collection (for outcomes)
- Phase 4: Developing the economic model
- Phase 5: The SROI ratio and benefits breakdown
- Phase 6: Programme recommendations

### Phase 1: Setting the boundaries of the study

Alliance India is the civil society Principle Recipient for CHAHA. It has 10 Sub-Recipient implementing partners in the states of Andhra Pradesh, Tamil Nadu, Maharashtra and Manipur.

The period over which the SROI was calculated is from 2007 to October 2010. This includes inputs over the three-year period.

The SROI covered two states, Maharashtra and Andhra Pradesh. It was considered that given the study's limitations with time and resources, two of the four CHAHA states would give a good indication of the range of return that could be expected of the programme for our purposes. (Note: it is acknowledged that the state variances in cultural context, costs and governance may result in a broader range of SROI and in the interests of a full SROI study for the whole of the CHAHA programme it would be preferable to conduct the study in all four states.)

Organisations taking part included the International HIV/AIDS Alliance, Alliance India, LEPR, NMP+, Gram, WORD, RIDES and PEACE.

Background documents included:

- CHAHA programme annual reports
- CHAHA end of year financial reports
- CHAHA baseline and midline study, quantitative findings
- Learning from change MSC report of CHAHA
- CHAHA midline assessment
- CHAHA computerised management information system (CMIS)

## Limitations of the study

The following describes the constraints and how the study team attempted to address them where possible:

1. **Limited timeframe to execute the stakeholder consultation.** Ideally the study would have been conducted over a longer period of time, a field consultation lasting one week was shortened due to public holidays occurring at the same time, however it was possible to combine stakeholder groups thereby shortening the actual time required to repeat the exercise with numerous groups.
2. **With SROI being a new concept in India, it was difficult to identify the secondary data sources.** This is the only example of a SROI study of this type being conducted in India (at least to our knowledge and attempts to refer to other studies), hence there was no precedent to base our experience on, other than UK-based examples. Alliance India has very good, robust monitoring systems and had conducted a midline survey which covered a number of the outcome indicators of interest.
3. **Difficulty in facilitating the primary stakeholders, who tended to relate themselves to the situations they came across or were familiar with** (which at times made it difficult for them to express their experiences as ‘outcomes’ per se). This was even more difficult with children. Given the nature of the CHAHA programme – and keeping to the fundamental principles of SROI – consultation with ultimate beneficiaries, conducting the discussions with children was challenging, however a simplified workshop approach was developed and refined as the team gained more experience.
4. The attribution value range (i.e. of the programme to outcomes experienced) has been collated from the primary stakeholders, as well as knowledge of other initiatives, projects and stakeholders operating in the area. **There was high variation in these values.** Thus the issue of subjectivity arose. The study team took the approach to use the average of values discussed for the calculation.
5. **Not all value created for the state has been reflected** – for example, the additional tax revenue created from people in employment, (in India the 10% tax rate starts when earnings are over \$300 a month).
6. **The outcome incidence value was determined through a mixture of beneficiary and NGO consultation.** Midline survey values against indicators ‘similar’ but not exactly the same as those expressed by participants were referred to. It is acknowledged that assumptions had to be made to determine approximate values here. See the later section on the economic model.
7. **The deadweight** or counterfactual – the measurement of the amount of outcome that would have happened in the absence of CHAHA activity – **was difficult to estimate as a percentage.** Reference to published secondary country statistics was difficult to find and we had to rely on programmatic staff estimates, and consultation with stakeholders. As an estimate we have used a 10% deadweight factor across all of the outcome areas.
8. Due to the lack of a timeframe, **some stakeholders could not be the part of stakeholder consultation**, e.g. Government, State AIDS Control Societies, other public health departments. These stakeholders, whilst important were not considered essential for the study as they were not ultimate beneficiaries.
9. This tests the potential sustainability of aspects of the programme, or otherwise. Again the study team took a conservative approach to drop off<sup>1</sup> in consultation with technical staff of the programme.

1. Drop off determines benefit period looks at how long the outcomes last for and is a measure of sustainability of the programme's investment. The drop off is a robust measure that takes into account the fact that outcomes may revert over time and that the CHAHA programme cannot take credit for them lasting for the full benefit period True benefit period and drop off values are only available through longitudinal surveys.



## Phase 2: Stakeholder consultation and outcomes map

Beneficiaries of the programme from two states were consulted over a period of three days. During this time two parents' and caregivers' groups and two children's groups took part in a four-hour facilitated discussion on the programme. A total of 72 ultimate beneficiaries were consulted and 20 to 25 NGO staff.

A fairly structured approach was followed: (See Annex 1 for a full description of the process as a workshop.)

1. Building a map of project stakeholders
2. Identifying activities, outputs and outcomes and creating an outcome map
3. Talking about other projects/activities in the area (attribution, deadweight)
4. Talking about outcome incidence
5. Indicators for measuring outcomes
6. Putting a value on project outcomes

The following stakeholders were identified before and during the community consultation. Some have been identified as significant for inclusion into the analysis, i.e. costs/resources/investment provided by them, or as ultimate beneficiaries, others we have listed as discussed at the consultations. Table 1 highlights the rationale for their inclusion or exclusion in the analysis.

**TABLE 1: Project stakeholders**

Stakeholder	Involvement in CHAHA	Rationale	Method of engagement	Number engaged
Children over 10 years old	Ultimate beneficiaries of the programme	Included	Survey	1,630
			Community consultation	36
Parents and caregivers	Very direct beneficiaries of the programme	Included	Survey	1,323
			Community consultation	36
NGO staff	Vocational training, income-generating programme support, legal, counselling, educational support	Not included (they implement the programme)	Community consultation	
Children under 10 years old	Very direct beneficiaries of the programme	Included	Survey through a questionnaire applied to caregivers on their behalf	
Women-headed households	Very direct beneficiaries of the programme	Included	Survey	
			Community consultation	
Teachers		Not included, did not consider that they could be categorised as ultimate beneficiaries (they are in effect an education service provider)		

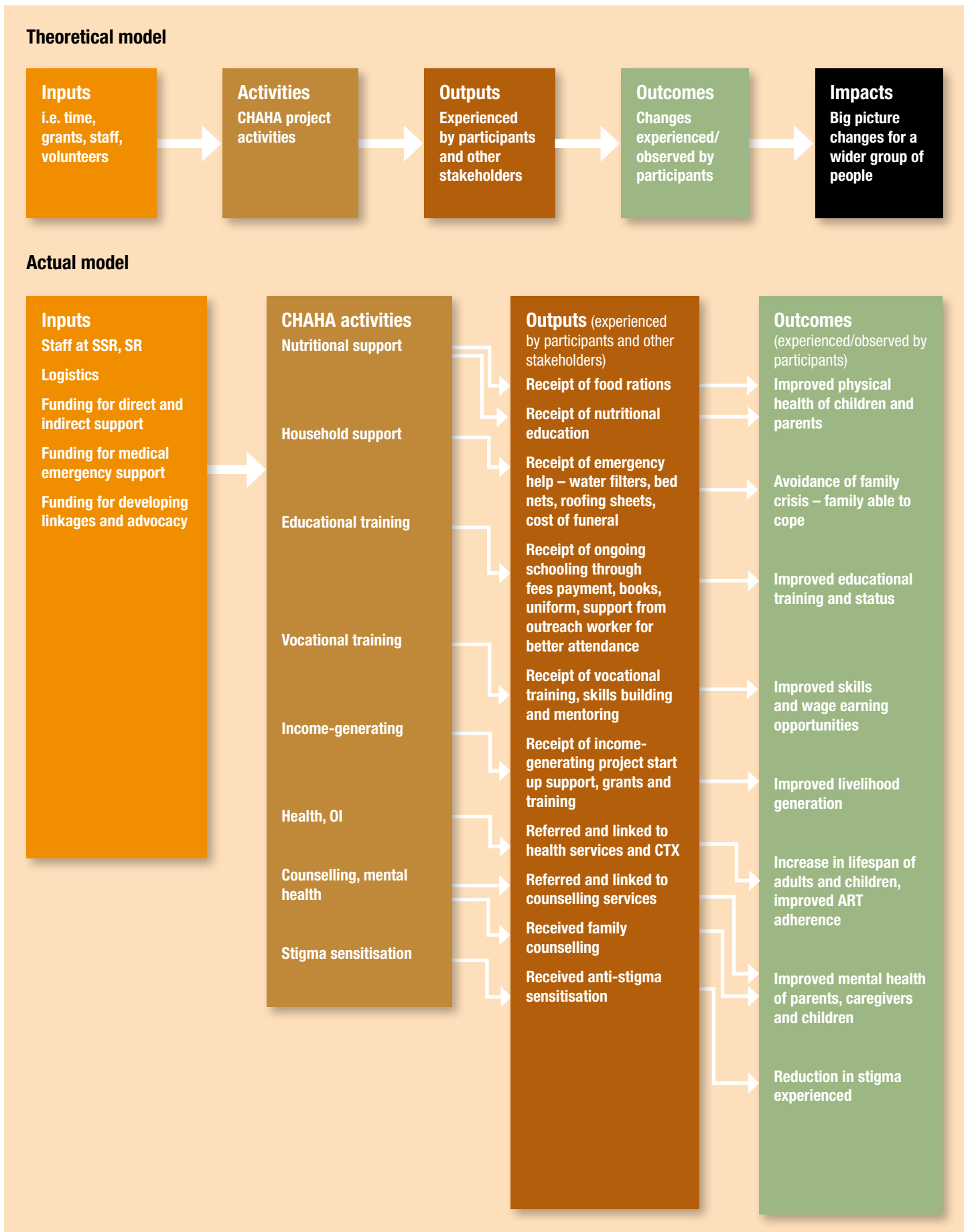
TABLE 1: Project stakeholders (continued)

Stakeholder	Involvement in CHAHA	Rationale	Method of engagement	Number engaged
Households		Included as a family unit	Survey	1,330
Relatives/friends of households affected		Not included (immediate relatives living in a beneficiary household were included, however more distant relatives were not considered to experience such a direct benefit)		
Government services: Grmapanchayat (legal services), Angawadi (nutritional schemes), ANM (health information), Government hospital, ICTC (counselling and testing)	Legal documents, nutritional and health support, free treatment for OI	State included as a beneficiary for the co-trimoxazole (CTX) prophylaxis component, as we wanted to explore the impact to the state of CTX on child health outcomes		
ART centre	Free ART, CD4 test, CTX, counselling	Not included (a service provider as opposed to receiving benefits directly – however there would be some cost saving, i.e. staff time, counsellors similar to the above)		
Local leader	Support for reducing stigma and discrimination	Not included (not considered to experience a direct benefit)		

### The outcomes map

The theory of change, used to base the analysis on, is that through the provision of multiple areas of direct and indirect support for children living with HIV and their families numerous outcomes are generated under the themes of physical and mental health, economic status and income-generating/earning potential and lifespan and ability of families to cope in crisis. This map was developed by the ultimate beneficiaries, during the consultation, and a separate qualitative CHAHA study *Stories of Significance: Understanding Change Through Community Voices* (March 2010) termed the outcome map (see Diagram 3).

DIAGRAM 3: The outcomes map



## Change from the perspective of the CHAHA parents and caregivers

The following is a series of short case studies or perspectives captured from community consultations.

**Nutritional support:** “Because of nutritional support we see improved children’s health and reduced OI episodes and ultimately reduced visits for treatment and now we are saving the expenditure of travelling and treatment, simultaneously child is attending school regularly.”

### Nutritional support

G.K. is a 15 year old boy living with HIV, studying in Standard 8. He was identified by a CHAHA outreach worker and registered in September 2007. Both his parents had died of AIDS. He is cared for by an elder sister who is married to his maternal uncle. Since registering on the CHAHA programme G.K. is now on ART. He has also been receiving nutritional support every quarter and is included in the nutritional monitoring. He gets educational and OI support. He is now able to attend school regularly and is achieving really good grades. The counselling has made him feel really positive about himself and his future, and has also helped him to take the medicine regularly.

**Household support:** “Household support has helped us a lot because in an emergency this support has helped us fulfil our basic needs and helped us to survive.”

**Educational support:** “My children are now attending school regularly and have the vision of being someone like a teacher or in the police in the future. This educational support will help them to sustain their lives.”

**Income-generating and vocational training:** “This has helped sustain our family and increased income, before that we were going to work on daily wages and could earn only 30 to 40 IRs, now we are earning 100 to 150 IRs a day.”

**Referral and linkages – OI support and improved health seeking behaviour:** “We have cured opportunistic infections on time because we are now going to get health treatment, we know where to get it”  
“Because of the referrals we got from CHAHA we are attending Government hospitals and getting free treatment and Co-trimoxazole medicine for children.”

**Referral and linkages – ART:** “Before contacting CHAHA we were not aware about free ART from the Government ART Centre. After registration in CHAHA, the outreach worker took us to the ART Centre, initiated free ART medicine and counselled us on the importance of adherence. Before that we took very expensive treatment around 4000 to 5000 IRs per month from a private doctor (some clients stated they have paid 35,000 to 100,000 IRs yearly for taking treatment). Now my CD4 has increased, my work efficiency has increased and I have reduced OI episodes and visits to the ART Centre.”

### Referral

Residing in Pune, Maharashtra, P.W. was identified by an outreach worker as suitable for registration onto the CHAHA programme. She is 17 years old and studying in the Standard 12. Both her parents were diagnosed as HIV-positive and her father died four months ago. Her mother burnt her face when a stove exploded which makes it difficult for her to get employment. P.W. has a younger brother and sister. Since registration for the CHAHA emergency household support, educational support and income-generating project loan the family have started a small tea stall. P.W. handles this and gains some income which she gives to her mother. P.W. is also associated with a dancing group which gives her some earnings and she has also had training in the hospitality business.

**Stigma and discrimination:** “We get confidence and a positive attitude towards life and this is an important change for us.”

### Stigma and discrimination

M.S.D., a 12 year old from rural Maharashtra, recollected her experience. “My father had HIV, we started ARV treatment for him at Satara. We were concerned about him, mother provided him food and medicines on time. He developed stress and started taking alcohol. He drank continuously for four days and injured his face and was not able to take food. People from the village started abusing him since he had HIV, they said he had an illness in his mouth and that he must go away from the village. They said other people would also contract this dreaded disease because of him ... One day he told my mother to look after the children. Without informing anybody, when there was no one in the house, he added poison to alcohol and drank it ... My grandmother started blaming my mother for losing her son. We came into contact with CHAHA and got psychological support. It has helped us in finding a new direction in our life. We are now able to live with pride in society due to help extended by the organisation. Girls in school do not trouble me, they do not discriminate against me and they talk with me nicely.”

*Stories of Significance, CHAHA, 2010*

### Summary of improvement in access in care and treatment

- Improvement of physical health, increase in livelihood, hope for life
- Able to provide educational support to children for life
- Treatment expenses reduced and the money saved is used for children’s education and fulfilling basic needs
- Increased hope of education for children
- Self dependence due to income-generating projects
- A sensitisation meeting reduced HIV-related stigma and discrimination at a community level
- Family sustainability



CHAHA treatment referral. © The Alliance

## Phase 3 and 4: Data collection and the economic model

At the end of 2009 Alliance India conducted a comprehensive mid-term assessment of CHAHA in each of the four provinces. The survey covered 1,500 children living with and affected by HIV and their parents/caregivers. Where possible common outcome indicators from the community consultation above and the midline survey were identified and cross-checked.

### Outcome incidences

**Step 1:** The outcome incidences were estimated during the community consultation and discussions with NGO support workers for parents/caregivers and for the children. We cross-checked this with information from the midline survey where possible.

The outcome incidence was calculated for both identified stakeholders against each outcome, using target and actual populations reached<sup>2</sup>, and for cases where no data existed stakeholders in the community consultation (both parent/caregivers and NGO support staff independently) were asked to provide an estimate of percentage of stakeholder population who experienced this outcome. Where there was an estimated range the study team always adopted the lowest percentage. The SROI spreadsheet details the incidence of each outcome per child/parent/caregiver.

### Monetising outcomes

**Step 2:** Each outcome was monetised using a financial proxy or direct cost. The financial proxies were developed during the community and NGO consultations. It must be noted that several different financial proxies were listed for each outcome area, the study team took the conservative view of valuing only a maximum of three key financial proxies. In effect the total stakeholder value has not been fully reflected.

TABLE 2: Monetising outcomes

Stakeholder	Outcome	Indicator description	Financial proxy description
Younger children (affected by HIV)	Improved health status (children, nutrition)	Changes in weight and health status of children receiving nutrition support through CHAHA and/or Government	Avoided costs of travel for health support and medicine
Older children (affected by HIV)	Older children have better income prospects	Number of children created income opportunities through vocational training	Increase in earning potential through income-generating projects
Younger children (affected by HIV)	Improved educational attendance and status	Number of children benefiting from educational support	Increase in earning potential through employment
Parents/caregivers	Improvement in livelihood status	Number of people employed. Additional income through income-generating projects	Increase in earning potential through income-generating projects (over 1 year)

2. The Alliance India CMIS contained this data.

TABLE 2: Monetising outcomes (continued)

Stakeholder	Outcome	Indicator description	Financial proxy description
Parents/caregivers	Improved health status (family)	Number of people accessing ART, number with increased drug adherence, reduction in OI and health expenditure, number receiving support for childcare	Savings in cost of ART, travel cost, medicine
Parents/caregivers	Increased confidence and positive living	Number of people disclosing status and accessing services	Monetary cost of referred services they access i.e. transport pass, medical insurance
Parents/caregivers	Reduction in community, societal stigma	Number of people going back to work with increased confidence	Number of working days and average salary
Family members	Avoidance of family crisis	Number of people with access to clean water, medicine and reduction of waterborne and OI disease	Savings in work days lost resulting from ill health caused by poor environmental conditions
Family members	Improved family care	Number of families receiving family counselling and started taking care of the family member by themselves	Avoided cost of hiring paramedical support and/or hospitalisation
State – Health Ministry	Healthier children (18 months–5 years)	Number of children receiving CTX	Avoidance of hospital admissions for specific HIV-related OI

## Impact

**Step 3:** Impact was determined by accounting for how much of the achievement of the outcomes is due to CHAHA. We have done this by taking account what would have happened anyway (deadweight), the extent to which we have created a net change (displacement) and the role of others in creating change (attribution).

Deadweight was assumed to be 5–10% (this varies per outcome area depending on what else is happening in the area). The populations that CHAHA targets are hard-to-reach groups, i.e. children living with HIV and their families. Traditionally these stakeholders fall outside of the safety nets provided by formal health systems due to lack of knowledge or barriers to accessing these services (notably stigma and discriminatory actions of the community and health service staff).

If we consider each outcome and ask the question, “*How much of this would have happened anyway?*” in discussion with beneficiaries, NGO and CHAHA programme staff, we have made the following estimates for deadweight (see Table 3).

TABLE 3: Deadweight estimates

Stakeholder	Outcome achieved	What would have happened anyway?	% deadweight estimate
Younger children (affected by HIV)	Improved health status (children – nutrition)	Nutritional (calorific) intake is lower than average across all states <sup>3</sup> , likelihood of children living with and affected by HIV accessing adequate nutrition and achieving health gains experienced is considered fairly low	10%
Older children (affected by HIV)	Older children have better income prospects	Since the catchment is children living with HIV, access to income-generating or vocation training opportunities is very limited given health-related issues, as well as lack of knowledge and confidence (self-stigma, lack of motivation and hope to plan for the future) regarding vocational opportunities as well as opportunity to access vocational training schemes in the area	5%
Younger children (affected by HIV)	Improved educational attendance and status	School drop out is high <sup>4</sup> for children living with and affected by HIV. It is highly likely the following factors compound the situation: Inability of families to afford fees for books, and uniform; stigma and discrimination by schools and peers discourages school attendance	10% (maybe this is slightly low. More of these children may have continued in school without CHAHA?)
Parents/caregivers	Improvement in livelihood status	The rural and urban-based population is subject to high degree of instability in incomes and levels of living. Opportunities for income generation are rare but do exist <sup>5</sup> , albeit on a very small scale. Some beneficiaries could point to other schemes, such as the Government Women and Child Welfare Department, as well as local leadership (provision of financial support for income-generating projects, equipment for business etc.) that existed	10%
Parents/caregivers	Improved health status (family)	Public investment and health expenditure is not only inadequate but has declined since the 1990s, lowering Maharashtra's position vis-à-vis the other states of India. Qualitatively and quantitatively there is a wide gap in healthcare infrastructure available in rural and urban areas. It is therefore unlikely that positive health gains would have happened to any significant degree	5%

3. 'UNDP Maharashtra Human Development Report 2002'. About 57% of rural and 54% of urban households consume less than the required standard calorie intake of 2,700 per day.

4. 'UNDP Maharashtra Human Development Report 2002'. High dropout levels are disturbing. By Standard 10 only 47% of boys and 40% of girls remain in school ... Except in Gadchiroli district, there is no village in the State having a population of 200 without a primary school within a radius of 1.5 km.

5. 'Maharashtra national family health survey 2006'. More than one-third (36%) of women have heard of any micro-credit programme in the area and about 2% have ever used one.



TABLE 3: Deadweight estimates (continued)

Stakeholder	Outcome achieved	What would have happened anyway?	% deadweight estimate
Parents/caregivers	Increased confidence and positive living	Beneficiaries consulted were all of the opinion that without the intervention of counselling, support and motivation from CHAHA outreach workers families would be in a state of physical and mental breaking point. We could not identify any other or similar sources of support of this kind	5%
Parents/caregivers	Reduction in community, societal stigma	Beneficiaries consulted, as well as NGO implementers and programme staff were clear that little or no initiatives exist at community level to reduce stigma and discrimination towards families and children affected by HIV. There is a slight possibility that exposure to positive media and the visible positive effects of ART may influence a reduction in the absence of a targeted anti stigma and discrimination programme	5%
Family members	Avoidance of family crisis	Families may be able to access some support through their local networks and village leaders, but this is likely to be limited given the high levels of stigma faced by HIV affected families	5%
Family members	Improved family care	Similar to above comment	5%

### Attribution

The issue of how much of the achieved outcome can be attributable to CHAHA is a difficult issue to determine with any level of objectivity, in the absence of a counterfactual, which is the norm for NGO implemented programmes of this nature. Beneficiary consultations through focus group discussion provide some means of debate around likely contribution of the programme to achieving identified outcomes, and it is from these discussions, triangulated with discussions with NGO implementing partners and Alliance India staff that estimates of percentage attribution were provided for the model. Percentages presented are an average of higher and lower range estimates.

In order to aid thinking around CHAHA attribution a lot of the discussion focused on determining what other activities/actions of others in the vicinity could have contributed to the achievement of the outcomes, and sought opinion about CHAHA attribution. Beneficiaries were overwhelmingly of the opinion that without CHAHA none of the positive outcomes would have happened for their family or themselves. However we challenged this assertion by discussing the issue of apportioning credit to others giving the example of referral – whereby CHAHA would not be providing direct services but referred beneficiaries on to government services, therefore some of the attribution would be down to government action. (See Table 4.)

TABLE 4: Attribution

Outcome	Attribution apportioned: Initiatives occurring in area that may influence this outcome, who/what else contributed to the change?
Improved health status (nutrition) children	50% attributable to CHAHA, as CHAHA provides direct nutritional support to children, but links families and children to Government nutritional schemes (which contribute to the remaining 50%) of achieving this outcome
Older children with better income prospects	40% attributable to CHAHA which provided vocational skills training, support, counselling and building self-esteem amongst youth to find employment opportunities. Clearly the ability of youth to find employment is in the main influenced by an individual's initiative as well as the supporting workers and adults (including relatives, parents and teachers)
Improved educational attendance and status	25% attributable to CHAHA. Outreach workers supported children and families to attend and then continue in their education. Absence of any other educational support external initiative. Significant credit apportioned to teacher parent/caregiver encouragement to individual children
Improvement in livelihood status	70% attributable to CHAHA – absence of other income-generating support in area. Very small scale government micro credit schemes may have a marginal significance in livelihood generation amongst this group, as well as individuals ability to secure credit from relatives or neighbours (in rare cases)
Improved health status (adults)	20% attributable to CHAHA as outreach workers provided referrals for ART, OI to health services, rather than providing services directly. Beneficiaries argue that without CHAHA they would not have received any health service support for their condition.
Avoidance of family crisis	70% attributable to CHAHA – short-term support to help in an immediate crisis. No other scheme in existence. Few families may be able to mobilise limited support from relatives/neighbours. Few families have savings for use in these circumstances.
Increased confidence and positive living	50% attributable to CHAHA as outreach workers providing individual parent/caregiver, child counselling and psychosocial support is unique in the area. Beneficiaries claim the CHAHA support has been fundamental to their positive outlook on life and ability to 'carry on'. This is therefore considered a very significant attribute of CHAHA.
Improved family care	70% attributable to CHAHA, this relates directly to family targeted counselling and support for families to cope and care for HIV-positive family members at home during times of illness. There are no other supported (similar) schemes in the area.
Reduction in community, societal stigma	40% attributable to CHAHA as outreach workers provided anti-stigma and discrimination awareness raising amongst communities, health service staff. No other stigma and discrimination activity is occurring in the area.

The study team, in discussion with programme staff, concluded that it was not necessary to consider displacement, as this community mobility was not going to be relevant, and issues relevant to our programmatic area of coverage would not be displaced to different areas.

## Sustained value, benefit and drop off periods

**Step 4:** When calculating the sustained value, the benefit period and drop off is the period considered to determine how long outcomes last beyond the timeframe of a programme. Historical data to determine the benefit period and to what extent year on year the influence of the programme diminishes over time (the drop off rate as a percentage) was not available and had to be estimated. This was done in consultation with the programme beneficiaries and implementing NGOs of CHAHA. The discussion around benefit period is of course highly relevant when considering the potential sustainability – and ongoing creation of value – of a particular outcome following programme closure.

The benefit period for each of the outcomes was considered separately and the following estimated benefit period (years following the end of programme) and drop off rate (percentage wise, used to account for the decrease in influence the programme has on the outcome value in subsequent years).

TABLE 5:

Outcome	Comment
Improved health status (nutrition)	10% drop off in health gains due to improved nutrition in the first year. Drop off rapidly increases year on year (20%, 30%, 40% in subsequent years due to the activity of other services – children above 14 no longer accessing mid-day meals, village structures panchays, continued CSG activities, referrals to the government run nutritional schemes, and the long lasting changes in policy, resulting from CHAHA advocacy around 'double nutrition' have ensured that nutritional benefits have a long lasting effect. The estimated duration of benefit is five years for child beneficiaries.
Older children have better income prospects	10% first year drop off was used here as CHAHA influence from vocational training and access to employment related activities still has a significant effect up to year three where drop off increases to 20% then 30% for year four. We estimate training, capacity support has a residual value for a five-year period.
Improved educational attendance and status	Since government attribution for this outcome is high as schooling is government provided, yet CHAHA has created the conditions for children to access and continue accessing educational services, so even after CHAHA has ended support from the government will continue, so a benefit period (the duration following school completion where Grade 10 leavers will have greater opportunity to find employment and earn a higher average monthly salary) has been estimated at five years. The initial drop off is low (high influence from CHAHA and pegged at 10% in the first two years, this drops off to 20% and 30% in the latter two years.
Improvement in livelihood status	The initial drop off for the first two years is considered to be around 10%, as following the establishment of a new income-generating project residual CHAHA influence training, business set-up and mentoring, and the award of initial grant funding, is high. The effects of this capacity building and start-up support after an estimated four-year period will fall to 20% and 40% in years three and four.

Outcome	Comment
Improved health status	CHAHA links and refers hard to reach families to the ART services provided by government, who are responsible for providing the actual ART service therefore government attribution is high once CHAHA has provided access. When CHAHA support ends this government support will still remain, a five-year benefit period is reasonable (the benefit period in this case would be for the life of those affected families), however drop off whilst low initially 10% will increase rapidly in subsequent years as government systems influence these health gains (20%, 20% and 30% yearly increase).
Avoidance of family crisis	CHAHA is the only source of emergency support, attribution is therefore high, however drop off is considered high (30% and 60%) in subsequent years as the nature of the support is to help families out of a crisis situation – it is clear by year five there will be very little residual value in the benefit, the benefit period is therefore assumed to be two years.
Increased confidence and positive living	Sensitisation activities and counselling services are also provided by the Government facilities for the families thus once beneficiaries are linked into these systems the sustained benefits are expected to be experienced over a long term period, in this case we have used five years. Drop off however will be significant following the first two years as a result of other services and improved family environment overriding CHAHA influence (initially 10% increasing to 20%, 40% and 60% in following years).
Improved family care	Family counselling services provided through CHAHA and also referrals to government facilities are established to create a better family environment for affected families, such that the family is enabled to take care of its own members without having to rely as much on external support. It is expected that this is a lasting change, therefore the residual benefit lasts over the period of five years, drop off was considered to be initially 10% in the first two years increasing to 20% and 30% as other influences beyond CHAHA impact on the family environment in the following years.
Reduction in community, societal stigma	CHAHA initiatives around anti stigma and discrimination are considered to have a significant contribution towards positively changing the environment. Benefits of this change are likely to be experienced for a significant number of years to come – because here we are referring to lasting attitude and practice changes. The effects of CHAHA family and individual counselling and community/institutional sensitisation activities will drop off fairly rapidly, from an initial 10% to 50% by year four.

## Phase 5: SROI ratio and benefits breakdown

The SROI ratio for CHAHA in the Maharashtra State, once a purchasing power parity (PPP) conversion factor to the dollar has been applied (2.5 source World Bank), is 1:4. This means every \$1 invested in the programme between 2007 and 2010 generated \$4 of social, health and financial value.

DIAGRAM 4: CHAHA value created per beneficiary group

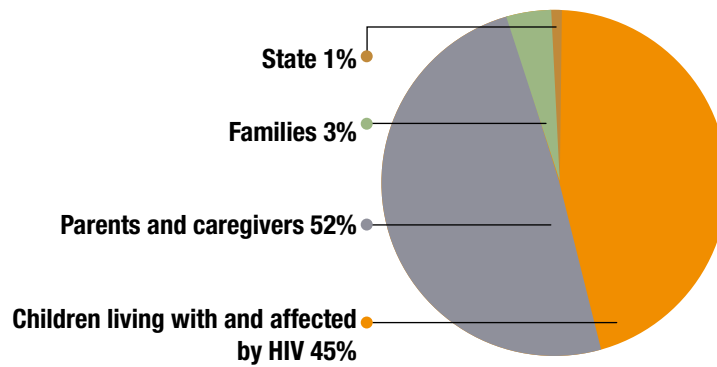
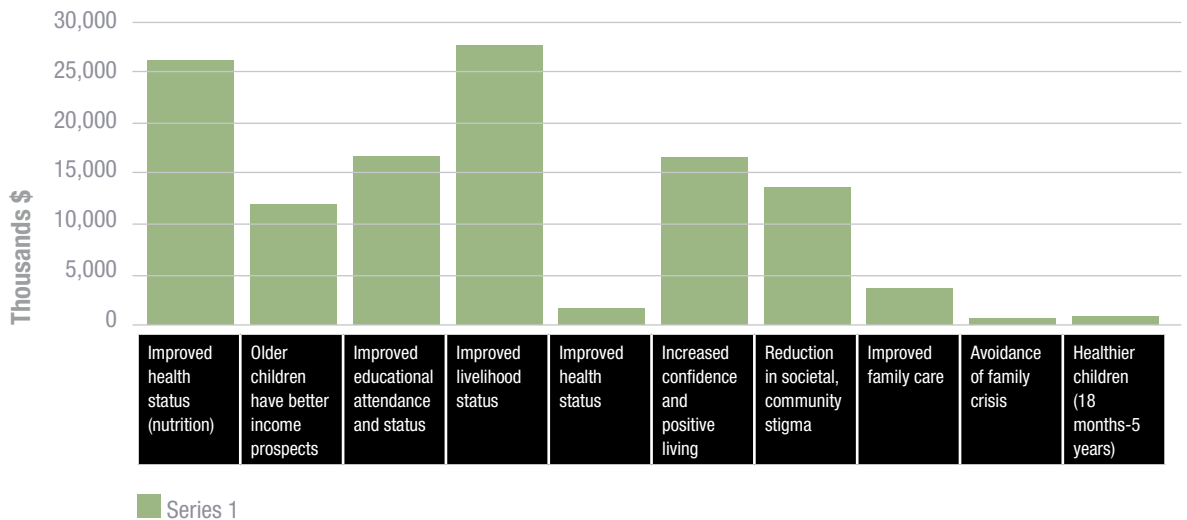
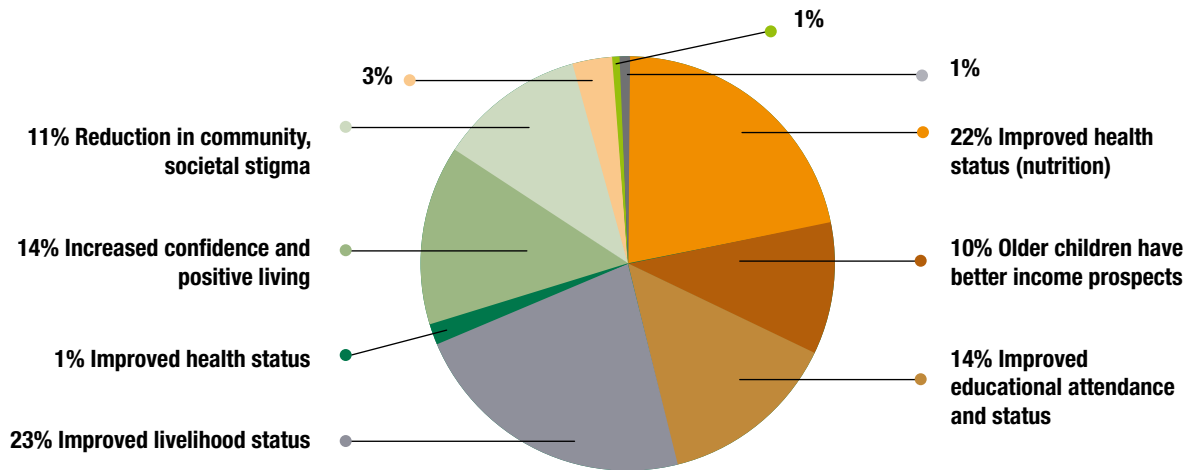


DIAGRAM 5: Total value created per outcome area in dollars, adjusting for NVP (net value percentage?) and purchasing power parity



**DIAGRAM 6:**  
Value created per  
outcome area



It is interesting to note that 52% of the value created is obtained by the parents/caregivers. Whilst this would appear to be an unexpected result, it would have been expected that the children affected or infected by HIV would receive most of the direct programme value, this is due to the high financial value generated by tangible improvements in livelihood status – financially through income-generating or increased wage earning opportunity. The benefits of improved parent/caregiver income will clearly positively impact children.

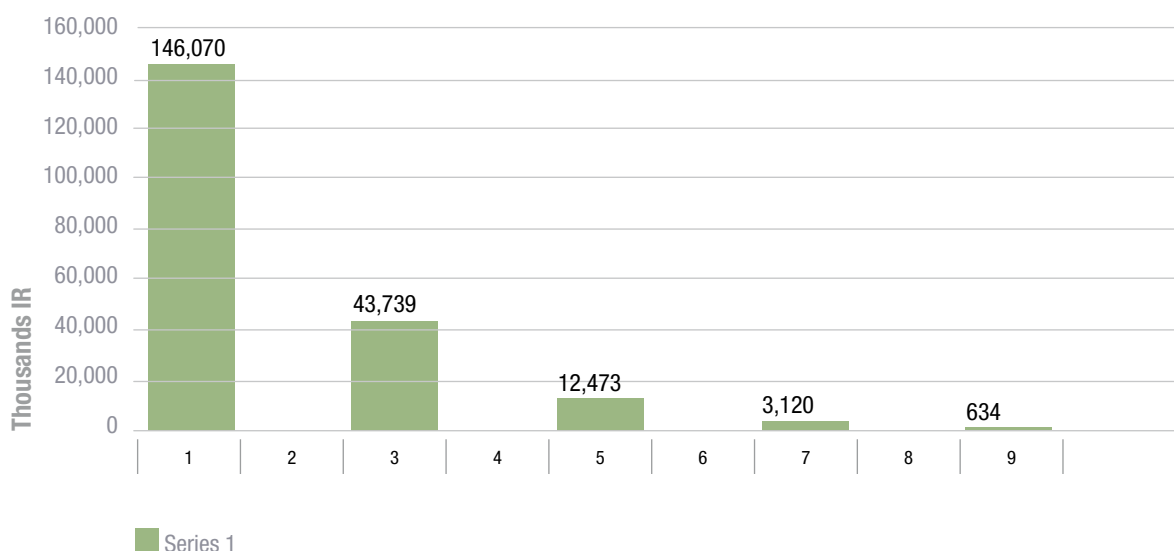
Value created for children living with and affected by HIV is high in all three key outcome areas. It is expected that the health, nutritional outcomes would generate most savings, (translated to beneficiary value) as a result of better health, and less need for treatment of OI and other illness, which was a significant cost/burden to families.

For parents and caregivers an interesting result was around the generation of tangible financial value associated with the ability to earn a living – resulting from the decrease in self-community and institutional stigma experienced by HIV-positive parents or caregivers. Anti-stigma actions coupled with focused counselling with families provided the motivation to seek paid work as they had previously been involved with.

The improved health value generated for parents and caregivers was relatively low in comparison to other value created, this was due to a low attribution percentage being assigned to this outcome.

As expected – and due to the nature of this type of support – there was the least value created by the emergency household support – the outcome of which was to help a family out of an immediate crisis.

**DIAGRAM 7: Year on year drop off value in IR**



Looking at the estimated drop off and decrease in value created over the next five years it is likely that by year six or seven there will be almost no residual value left – attributable to CHAHA.

### Financial assumptions for the model

The net present value was calculated for each outcome valued, using a discount rate of 6% – applicable to all future benefits.

The net present value in IR was converted to its dollar equivalent using the GDP-based PPP<sup>6</sup> rate of 2.5 (2008).

The total budget spent (investment for Maharashtra) over the period was 75,048,039 IR. Again, this was converted using the same PPP rate as above to convert to the dollar equivalent.

### Sensitivity analysis of the model

A number of factors were varied to test the sensitivity of the model.

**Financial proxies:** Halving the financial proxy for avoided costs of travel for health support and medicine resulting from improved health decreases the SROI ratio to 1:3.57. Similarly halving the expected income generated from increase in earning potential through income-generating projects decreases the SROI ratio to 1:3.55.

Halving the income generated by people who are able to earn as a result of increased confidence, reduced stigma results in a SROI ratio of 1:3.78. This indicates that the model is not very sensitive to changes in the financial proxies of the higher value outcomes.

**Attribution to CHAHA:** Halving the attribution (50% from 25%) against health outcomes from nutritional gain results in a drop in SROI ratio to 1:3.57. CHAHA provided direct nutritional support to some beneficiaries, in addition beneficiaries were clear that without CHAHA they would simply not have accessed the nutritional support and health services, or been referred/linked to any Government support, hence the estimate of 50% attribution.

**Drop off:** Taking the highest value generating outcomes to test the sensitivity of the model to drop off: by increasing the annual drop off for the outcome improved educational attendance and status to 10% in year 1, 30%, 60% and 80% in subsequent years, this decreases the SROI very marginally to below 1:4 indicating that the model is not very sensitive to drop off for this indicator. Similarly doubling the drop off each year for improvement in livelihood status to 40%, 60% and 80% corresponds to a decrease in SROI to 1:3.98.

6. <http://tradingeconomics.com/india/gdp-per-capita-ppp-us-dollar-wb-data.html>

This ratio underestimates the value created for a number of the following reasons:

- We have not fully costed the value created for the State, in terms of cost savings to the State as a result of decreased payments in ration cards, for families involved in income-generating projects or with higher earning capacity (ration cards are available for people below the poverty line), and health service cost savings (due to decrease in illness amongst adults and children) additional costs for government outreach workers covering referrals for high risk groups. We have not valued tax revenues created for state for beneficiaries with earnings over 16,000 IR per year.
- Savings to the health service due to avoided costs of health treatment for OI in HIV-positive children.
- The value of positive mental attitude or 'motivation for living' has been highly underestimated (in consultations parents and caregivers stated simply that they may not have had the will to continue living without the support they had received, particularly through counselling and support from their outreach worker).
- The impact of the double nutrition policy enacted by the State, for which CHAHA was a leading advocate has not been entirely valued – both in terms of coverage of populations this affects and the lasting change this has created. This policy resulted in disbursement of an additional nutritional package for malnourished children living with and affected by HIV.



SROI consultation with children living with HIV and their caregivers, Pune Maharashtra. © Liza Tong for the Alliance



TABLE 6: SROI ratio calculation

Stakeholder	No. stakeholders	Outcome	Indicator description	Indicator	Outcome incidence	Deadweight	Incidence (after 3 year programme) after deadweight	Attribution proportion	Incidence after attribution and deadweight	Financial proxy description	Proxy in IR	Total value produced in IR	Value year 1	Drop off year 1	Value year 2	Drop off year 2	Value year 3	Drop off year 3	Value year 4	Drop off year 4	Value year 5	Total value in IR	NPV	PPP conversion \$ equivalent
Children living with and affected by HIV	18,531	Improved health status (nutrition)	No. of children with improved health (and weight gain) who have received nutrition support through CHAHA and/or Government	0.3	5,559.3	0.10	5003.4	0.50	2,501.7	Avoided costs of travel, health support and medicine	20,500	51,284,543	51,284,543	0.10	15,385,363	0.20	4,102,763	0.30	957,311	0.40	191,462	71,921,443	66,420,67	26,568,269
	1,132	Older children have better income prospects	No. of children created income opportunities through vocational training	0.30	339.7	0.05	322.7	0.40	129.1	Increase in earning potential through income-generating projects	18,000	23,237,874	23,237,874	0.10	6,971,362	0.10	2,091,409	0.20	557,709	0.30	130,132	32,988,487	30,421,99	12,168,799
	15,854	Improved educational attendance and status	No. of children benefitted from educational support	0.40	6,341.7	0.10	5707.5	0.25	1,426.9	Increase in earning potential through employment	22,500	32,104,958	32,104,958	0.10	9,631,487	0.10	2,889,446	0.20	770,519	0.30	179,788	45,576,198	42,030,391	16,812,156
Parents/ Caregivers	1,547	Improvement in livelihood status	No. of people employed/ with additional income through income-generating	0.30	464.1	0.10	417.7	0.7	292.4	Increase in earning potential through income-generating projects	18,000	52,628,940	52,628,940	0.10	15,788,682	0.10	4,736,605	0.20	1,263,095	0.40	252,619	74,669,941	68,868,019	27,547,208
	778	Improved health status	No. of people accessing ART, with increased drug adherence, reduction in OI and health expenditure, receiving support for childcare	1	778.1	0.05	739.1	0.20	147.8	Savings in cost of ART, travel, medicine	20,500	3,030,505	3,030,505	0.10	909,151	0.20	242,440	0.20	64,651	0.30	15,085	4,261,833	3,934,148	1,573,659
	19,480	Increased confidence and positive living	No. of people disclosing status and accessing services	0.42	8,181.6	0.05	7,772.5	0.50	3,886.3	Monetary cost of referred services accessed – transport pass, medical insurance	8,400	32,644,584	32,644,584	0.10	9,793,375	0.20	2,611,567	0.40	522,313	0.60	69,642	45,641,482	42,171,330	16,868,532
	15,561	Reduction in community, societal stigma	No. of people able to earn some form of living as a result of increased confidence/ reduced stigma	0.25	3,890.3	0.05	3,695.7	0.40	1,478.3	No. of working days and average salary	18,000	26,609,310	26,609,310	0.10	7,982,793	0.20	2,128,745	0.30	496,707	0.50	82,785	37,300,341	34,450,415	13,780,166

TABLE 6: SROI ratio calculation (continued)

Stakeholder	No. stakeholders	Outcome	Indicator description	Indicator	Outcome incidence	Deadweight	Incidence (after 3 year programme) after deadweight	Attribution proportion	Incidence after attribution and deadweight	Financial proxy description	Proxy in IR	Total value produced in IR	Value year 1	Drop off year 1	Value year 2	Drop off year 2	Value year 3	Drop off year 3	Value year 4	Drop off year 4	Value year 5	Total value in IR	NPV	PPP conversion \$ equivalent
The family	10,295	Improved family care	No. of families through family counselling are better able to cope and started taking care of the family member by themselves	0.10	1,029.5	0.05	978.0	0.70	684.6	Avoided cost of hiring paramedical support and/or hospitalisation	10,000	6,846,175	6,846,175	0.10	2,053,853	0.10	616,156	0.20	164,308	0.30	38,339	9,718,831	8,962,710	3,585,084
	5,148	Avoidance of family crisis	No. of families who have avoided an emergency situation within the household	0.50	2,573.8	0.05	2,445.1	0.70	1,711.5	Savings in work days lost resulting from ill health caused by poor environmental conditions	720	1,232,312	1,232,312	0.30	287,539	0.60	38,339	NA	NA	NA	NA	1,558,190	1,450,657	580,263
The State	494	Healthier children (18 months-5 years)	No. of children receiving CTX	0.90	444.6	0.05	422.4	0.40	168.9	Avoidance of hospital admissions (children 18 months-5 years)	10,560	1,784,091	1,784,091	0.20	475,758	0.30	111,010	0.40	22,202	0.60	2,960	2,396,022	2,219,532	887,813
																						<b>Total value generated</b>	300,929,872	120,371,949
																						<b>Total investment</b>	75,048,039	30,019,216
																						<b>Return on investment</b>	4.01	4.01

## Phase 6: Recommendations

### 1. As a methodology for the Alliance

- The SROI approach is clearly a useful method and tool to quantify the value Alliance programmes, using a community consultative approach. SROI must be based on consultation, it is not sufficient to perform a desk-based study, stakeholders must provide their perspective and input to the exercise.
- SROI should be used as a forecastive as well as evaluative tool in mid point and end of the programme which will lead to increase in the ownership of the project amongst beneficiaries and implementing organisation level. It will help guiding the programme implementation if it is implemented at the beginning.
- More time should be allocated to do the stakeholder consultation at field level and also the scope should be increased to organise the consultation in the village setup where the programme is being implemented.
- All stakeholders should be consulted to come out with the actual outcome of the investment – for example in this exercise, Government, Panchayati Raj Institutions and existing health facilities could not be part of the stakeholder consultation.
- Whilst the resulting ratio is interesting it is important not to get too focused on this end result, for the Alliance, interest in this method should be based on an understanding of the differences in ‘relative outcome value’ created as a result of the programme. In this way it is possible to discuss and identify high performing (i.e. creation of high value) and lesser performing (creation of low value – relatively speaking) outcomes, and by association outputs and activities.
- Programme management and decision making should use SROI as one of a number of sources, for example SROI results should be discussed, disseminated, and presented to programme managers and implementers for validation, clear interpretation, and finally to make use of. They should be viewed alongside other qualitative reports of outcome and impact where these exist, as well as standard monitoring systems.
- The annex to this report outlines a step by step consultative approach used with the communities (or ultimate beneficiaries). It is recommended that this can be used as a starting point for these consultations.
- The method has its limitations and there are unavoidable areas of subjectivity and assumptions. These must be identified on a programme by programme basis, and clearly set-out in the report.
- Programmes planning to conduct a return on investment study (whether evaluative, or forecastive) should build into their M&E set-up good systems for monitoring outcomes, baselines and midline studies where possible should be conducted to determine change against a broad set of outcome indicators.
- There are not much secondary data sources available, so for measurement dependence was mostly on the consultation. This can be further triangulated with other data sources available internationally.

## 2. For the CHAHA programme management

- The income-generating component, and related activities to build skills and raise earning potential of families appears to be generating a significant amount of value, which it is assumed for those successful income-generating projects can be sustained for a period into the future (beyond CHAHA). It is necessary to test this assumption concerning the sustainability of these tiny enterprises, a recommendation would be to track a small sample of income-generating projects and individuals that have received grants for business set-up and skills development, to test the sustainability of their businesses and determine factors future income-generating programmes need to take into account. One issue to consider might be the size of the initial grant issued.
- Bearing in mind project sustainability, there should be a focus on longer term support for existing schemes, such as ongoing income-generating project mentoring and maximising the sustainability of micro enterprise.
- There should be a strategy addressing stigma and discrimination implemented from the beginning and this should be clearly articulated.
- Linkages with other organisations towards addressing the issues over and above HIV needs to be established from beginning.
- The strategy around household emergency support should be looked at closely for its impact and achievements. The SROI seems to indicate less value created in this area.
- Recommendation to roll out to other areas covered by the programme.

## 3. For implementing NGO partners

- CHAHA should disseminate and discuss findings of the study with Sub-Recipients (and Sub-sub Recipients) in Maharashtra and Andhra Pradesh.
- The methodology for community consultation should be promoted as a tool for consultation between Sub-Recipients and programme stakeholders.

## 4. For policy

- CHAHA's influence on the policy to provide double nutrition to children living with HIV, has generated value that will last for many years to come – that has a wide ranging impact well beyond the geographic location of the CHAHA programme. It would be useful to conduct a full separate SROI on the impact of this policy and CHAHA's contribution to this.
- In a concentrated epidemic situation like India, impact mitigation is often neglected. India should design impact mitigation strategy to ensure the protection, development and health of children affected by HIV.
- Care and support programme limit to peer support and adherence. There is a need to address the feminisation of HIV in India with holistic support for children and women, since HIV affects social, economic and health parameters.

# ANNEX 1: Stakeholder consultations

## Workshop

### Introductions and explain the purpose of the workshop

*“The Alliance are reviewing the CHAHA project and speaking with different stakeholders to ask them about their experiences. We are interested in trying to work out what sort of value and importance you place on the different aspects of this project so that we can improve what we are doing for you. It will take approximately 2-2½ hours.”*

Throughout the workshop we will be doing:

- Introductions (15 minutes)
- Building a map of project stakeholders (20 minutes)
- Creating an impact map (50 minutes)
- Drawing the map (15 minutes)
- Talking about other projects and activities in the area (15 minutes)
- Putting a value on project outcomes (30 minutes)

### Step 1: Introduction – 15 minutes

- Ask participants to introduce themselves and say where they are from.
- Ask how many people know about the CHAHA project and what it is trying to do. You can select one or two people who know about CHAHA to explain briefly what they know about it. If no-one wants to explain then ask a local NGO staff member to say a few words about CHAHA – such as, its activities, when it started and who it is working with.

### Step 2: Building the stakeholder map – 20 minutes

- On a flipchart draw the table below and ask participants to list the different stakeholder groups for CHAHA.
- Once you have a list ask what each stakeholder involvement is with the project, such as, are they providing services, help or support? Are they working on the project? Are they beneficiaries of the project?

<i>Stakeholder identity</i>	<i>Involvement with project</i>

### Step 3: Creating the impact map – 30 minutes

- Ask participants to speak with their neighbour for 15 minutes and ‘buzz’ about what each person knows about CHAHA’s activities, i.e. services, staff provided, what they do, meetings, training. They should also talk about how they have been involved in CHAHA’s activities, i.e. training and support, and what sort of inputs they provided to the project, i.e. volunteering.
- Ask each ‘buzz’ group to shout out the activities they have discussed and then write them on a flipchart. Then ask groups to talk about their experience and that of other people they know who have been involved.
- You should transcribe each activity and output onto post-it notes or card.

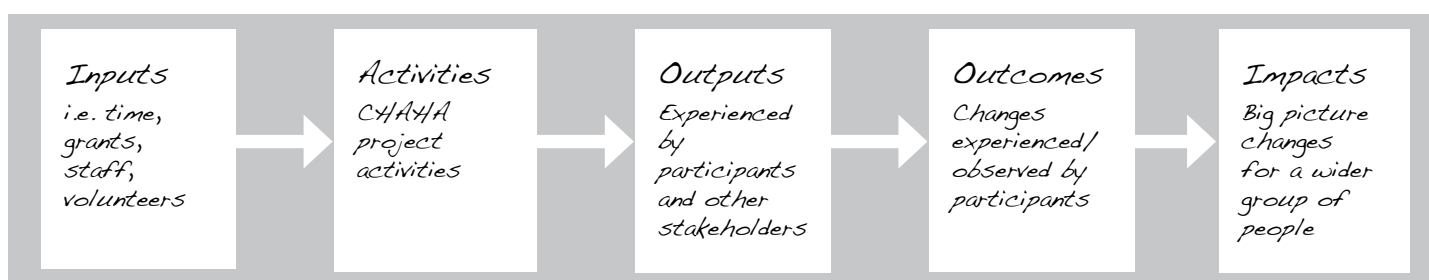
### Step 4: Impact map (continued) – 20 minutes

This step deals with project outcomes as experienced by the stakeholders.

- Explain to the group that: *“We have talked about the project activities and how you have been involved, now we are going to look at what these activities have resulted in. In other words, what changes are you – or others that you know – experiencing because of these activities?”*
- Ask participants to shout out in the plenary some key changes they, or other people they know have experienced – these can be positive or negative. Prompt any further answers about change in behaviour or attitude by asking: *“Who? What? Why? What are you doing differently? What are others doing differently? How are the project’s activities leading to these changes or ‘outcomes’.”*
- You should write down each point on a card or post-it note.
- You can ask: *“Can you see any problems or barriers preventing these project activities or changes happening?”* Note these separately.

### Step 5: Drawing the impact map – 15 minutes

- Put the following headings on the wall – you can then place the information you have gathered above on cards under each of these headings.
- Explain the logical link between activity – output – outcome.



### Step 6: Attribution and deadweight – 15 minutes

This is a plenary discussion with points captured on a flipchart.

- Ask: “What other activities or projects are going on in this area that might influence these outcomes? i.e. any other similar projects to CHAHA’s, even things done by the Government.”

If the participants identify other projects or activities then list them and ask: “How important is this project? High – do they contribute to more than 70% of this outcome? Do you know why this is? Medium – do they contribute to 20-70% of the outcome? Or low – do they contribute to less than 20% of the outcome.”

Ask: “What would have happened if the CHAHA project did not exist? Would any of these changes or outcomes have happened anyway? Why?”

### Step 7: Valuing the outcomes – 30 minutes

- Explain that we are going to look at these outcomes again.
- Take outcome cards down from wall and stick them on a flipchart that has the following headings:

<i>Outcome</i>	<i>Why is this change important? What does this change allow you to do that you couldn't before? (Try to specify this in terms of an activity.)</i>	<i>How can we measure this?</i>	<i>What value in rupees can we put to this activity?</i>

Finally, thank the participants for their time.



A global partnership:  
**International HIV/AIDS Alliance**  
Supporting community action on AIDS in developing countries

Established in 1993, the International HIV/AIDS Alliance (the Alliance) is a global alliance of nationally-based organisations working to support community action on AIDS in developing countries. To date we have provided support to organisations from more than 40 developing countries for over 3,000 projects, reaching some of the poorest and most vulnerable communities with HIV prevention, care and support, and improved access to HIV treatment.

The Alliance's national members help local community groups and other NGOs to take action on HIV, and are supported by technical expertise, policy work, knowledge sharing and fundraising carried out across the Alliance. In addition, the Alliance has extensive regional programmes, representative offices in the USA and Brussels, and works on a range of international activities such as support for South-South cooperation, operations research, training and good practice programme development, as well as policy analysis and advocacy.

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