Social Return on Investment (SROI) Analysis

A forecast of created social value

WRDA Women's Health Programmes

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Women's RESOURCE & DEVELOPMENT AGENCY
Supporting Women's Groups & Networks across Northern Ireland

Introduction

The Women's Resource and Development Agency (WRDA) commissioned Lodestar to undertake a Social Return on Investment (SROI) analysis of two distinct but closely related training and awareness raising programmes run for women, all of whom are from disadvantaged communities.

The two training programmes: ***Let's Talk - Parents Promoting Sexual Health*** and ***Breast and Cervical Screening Awareness****,* are delivered by women trained as Community Facilitators who have been through a facilitative leadership programme at the WRDA. The Community Facilitators programme has existed for eighteen years and has been designed to skill up women as leaders. Women who successfully complete the programme receive an NVQ Level 3 in Learning & Development, enabling them to act as a resource for their own communities.

While WRDA has extensive anecdotal evidence, collected over many years of delivering health programmes, that women's lives have been improved, sometimes quite dramatically, as a result of our work, we decided to initiate research that would go beyond evaluation and provide evidence for its value that could be expressed in monetary terms. WRDA health programmes directly address the strategic priorities of the Department of Health, Social Services and Public Safety. This research report demonstrates that the work we are engaged in has significant benefits for the economy. Empowering individuals to take control of their own lives and health reduces the incidence of costly medical intervention, thereby reducing public expenditure.

WRDA would like to thank Karl Leathem and Judy Seymour of Lodestar for the development of this research project and for their patience in explaining the intricacies of the SROI methodology. We hope that health professionals in particular will find it of help when considering future investment in community-based programmes.

The Lodestar full report is available on the WRDA website www.wrda.net. This summary version has been edited by WRDA staff.

Social Return On Investment (SROI)

SROI is a framework or methodology for capturing value that is created through an activity but may not be accounted for in normal project financial accounting. It tracks social value. Social value could be defined as the value of change that results from the activities of a project. One of the unique selling points of SROI is that it places a value on projected outcomes so that the value of return from an activity can be expressed in relation to the investment in it.

SROI enables stakeholders to map social value creation, and to communicate the 'story' of how our activities make an impact by monetising change, some of which we may not have accounted for before. SROI is a way of telling a story about what changes as a result of an activity and about the stakeholder contributions that made the changes possible.

Let's Talk - Parents Promoting Sexual Health

Northern Ireland has one of the highest rates of teenage motherhood in Europe, with 1,700 births a year. With teenage pregnancy continuing to rise here, especially in areas of social deprivation, and with sexually transmitted infections at an all time high, it is clear to see why parents are becoming increasingly concerned.

WRDA developed the ***Let's Talk – Parents Promoting Sexual Health Programme*** in 2003 to raise awareness and knowledge of sexual health amongst adults and increase their confidence to talk to children and young people about relationships, sexuality and sexual health. The programme won a National Training Award in 2007. It covers communication, attitudes to sexuality, relationships, pregnancy and contraception, and sexually transmitted infections.

Breast and Cervical Screening Awareness

The WRDA ***Breast and Cervical Screening Programme*** is a two session programme offered to community groups to raise awareness of the importance of breast and cervical screening, providing information that will encourage them to avail of the screening services on offer and help address any fears surrounding attending screening. The sessions are fully interactive and fun yet still deliver a high impact message.

With the exception of a dramatic rise in 2009, following Big Brother star Jade Goody's battle with cervical cancer, screening uptake figures have declined year on year since 2002. Overall uptake among eligible UK women now stands at 78.6%. WRDA's work is directed at women in disadvantaged communities and in particular at women who are the least likely to attend for screening. The programme has been delivered to groups since 2004.

Involving stakeholders

Over the summer period of 2011 a number of women across eleven sample groups were interviewed about their experiences as participants in either the ***Let's Talk: Parents Promoting Sexual Health Programme*** or the ***Breast and Cervical Screening Programme***. As well as course participants, other stakeholders considered likely to experience material outcomes were considered. The main engagement was with participants to determine their main outcomes, but also with members of their family. The table below shows the extent of stakeholder engagement.

Stakeholder	Number	Engaged
Women participants - Promoting Sexual Health	300	56 women engaged in 6 different focus group sessions
Women Participants - Breast & Cervical Screening	650	37 women engaged in 5 different focus group sessions
Family members influenced by programmes (sexual health)	300	Direct engagement not possible – outcomes derived through engagement with women and experience of WRDA staff
Family members influenced by programmes (Breast & cervical screening)	650	Direct engagement not possible – outcomes derived through engagement with women and experience of WRDA staff
Department of Health representing Health Trusts and including Public Health Agency	1	WRDA staff engagement with commissioners
Community Facilitators	10	4 facilitators engaged in meeting with SROI Practitioner

During the discussions with the various groups the following areas were covered:

- What they did they expect to get out of the programmes?
- What did individual group members bring to the programme?
- What changed as a result of the programme?
- Did they feel anyone or anything else had contributed to the changes they specified?
- Was the change all positive?
- How long was the change likely to last?

Let's Talk: Parents Promoting Sexual Health

Participants said they had wanted to talk to their children about sexual health but the course actually gave them the confidence to do it. Things that previously inhibited them included not feeling sufficiently informed or up to date, embarrassment, and not being able to find the way into opening up discussions, especially with teenage children. The outcome was that they had a much better understanding and awareness of the connection between self-esteem, emotional and sexual health leading to increased wellbeing.

The course enables women to explore the links between self-esteem and sex among young people and how low self-esteem impacts on their choices relating to sex. As a result parents had more confidence in their knowledge and were able to pass this on to friends and family. Their increased skill in talking to their children about sex in an age appropriate manner made behavioural change more likely.

Better communication with children

Women feel empowered through having up to date information and gain the confidence to choose when and how to talk to young people.

- *'I realised it's important to have conversation with younger kids; if you start early it's more natural and less embarrassing'*

- *'It has helped to open up lines of communication with my 13 year old son that I can build on in the future'*

- *'I spoke to my daughter about relationships and why she should wait until she was emotionally ready to have sex, and not just about contraception'*

Better communication with health professionals

The programme enables women to have better conversations with GP's about their own sexual health and to make decisions they are comfortable with. Older women appreciated the information on STI's and how this related to their own sexual health, as well as enabling them to pass information to daughters and grandchildren. Having up to date information about contraception and STI's improved their ability to discuss personal matters with health professionals, in this way increasing their confidence to approach GPs about their own sexual health issues. Overall this has led to improved sexual health.

- *'I feel I could now approach my GP and make informed choices about contraception'*

- *'I'm more confident to ask the doctor about sexual health and contraception'*
- *'I thought I knew about STI's but realised I didn't really know anything'*
- *'The only contraceptive I was aware of was the pill'*

Better sexual health

Women's fears for their teenage children include the impact of peer pressure, the prevalence of STI's and the possibility of unwanted pregnancies. Many spoke of now being able to speak to male teenage relatives about sexual health as a result of their participation in the programme. Knowing that their children had the correct information was an important factor in reducing parental stress. After having participated in the programme women were more open-minded and confident, leading to more imaginative solutions to sexual health issues experienced by young people and increased confidence in parenting skills.

- *'…she felt confident enough to speak to her son openly about STI's and sexual health. She felt she was able to protect him which made her feel good and gave her peace of mind'*
- *'I felt relieved that I've now talked to my son about sexual health'*
- *'Now I understand more on STI's I've been able to tell my daughter that most contraceptives only reduce the risk of pregnancy and not STI's'*

Sharing experiences

Locating the programme within women's community networks enables the sharing of diverse experiences, while being exposed to diverse opinions helps to broaden minds, shift stereotypes and enables participants to access a wider range of experience and expertise.

- *'It was good to have women from other cultures, we could learn about how sexual attitudes differ from culture to culture'*
- *'…she states she is more open-minded and although she would hate any of her children to be gay she could now support them'*
- *' women from the minority ethnic community particularly enjoyed working together on words associated with sexuality'*

Reducing the risk of unplanned pregnancies

The programme includes a workshop on pregnancy and contraception. This covers myths and superstitions about pregnancy, the realities of teenage parenthood and methods of contraception and emergency contraception. Factual information about abortion as well as contact lists for counselling and advice are provided. As a result participants had a better awareness of choices regarding contraception, reducing the risk of unplanned or unwanted pregnancies.

- *'…she wasn't able to talk to her own mother about sexual health so the group member was able to sit down with her and have a good chat about different contraceptive choice'*

- *'A grandmother stated that as a result of the course she had the confidence to speak to her two teenage grandsons about the consequences of not taking precautions' (i.e. using condoms)*

- *'The mother stressed that she spoke to her daughter about relationships and why she should wait until she was emotionally ready to have sex and not just about contraception. The mother reassured her daughter that when she was ready she would go with her to get contraception'*

Breast and Cervical Screening

The Breast and Cervical Screening Awareness programme takes as its starting point the reality that women tend not to prioritise their own health. Participants are invited to consider if and why this is true for them and what the consequences can be. This lays the ground for both sessions, which incorporate factual information, discussion and practical activities. Knowing how to examine breasts, understanding what happens when attending for a mammogram and understanding smear test results brings confidence and peace of mind, making behaviour change – regular breast self-examination and attendance at screening - more likely. The outcome is that women are empowered to collaborate with health professionals in the maintenance of good health through gaining skills to properly check breasts

Effective Breast Self-Examination

Some women reported that they regularly checked their breasts but through the course realised they weren't doing it properly. Others began self-examination for the first time. Many of the women did not check their breasts before as they were afraid of what they might find, but did afterwards.

Three women in the group reported that as they had started to regularly self examine as result of attending the course, they found breast lumps. Because the facilitator had continually reinforced the message they should go to their GPs as soon as possible if they found any lumps or changes in their breasts they went straight away. Two of the women were referred to the breast clinic for further investigation. Fortunately neither lump was cancerous. The third woman was on medication and the doctor changed her medication and the problem was resolved.

Improved Attendance at Screening

Women were now more informed and aware about what happens when going for breast or cervical screening, leading them to be more pro-active about attending breast and cervical screening sessions, thereby avoiding fear and stress resulting from misinterpretation of negative results.

All of the women said that the programme made them realise that if they found a lump it did not necessarily mean cancer, which is what they would have thought before taking part in the programme. They now understood that it could be a number of different things and that it was best to go to their GP immediately if they found anything different about their breasts, not just lumps:

- *'One woman in the group went for her first mammogram after the programme and said that if she had not participated in the group she probably would have binned the letter and not gone'*

- *'…one of the key learning points from the course was the information on smear test results and that abnormal cells didn't mean cancer'*

Prioritising self and reducing anxiety about tests

After taking part in the programme women were more likely to make their own health a priority, as a result, they responded to calls for screening. Early screening is a strong factor in contributing to improved prognosis and health:

- *'One woman in the group said after completing the programme she was encouraged to prioritise her own health and went to her doctor as she had been fighting depression for years. This was her first step in receiving treatment and she credited the programme with encouraging her to do so'*

- *'They agreed it can be scary checking your breasts and attending screening due to the fear of finding something wrong, but agreed that the benefits of self-examination and attending for screening far outweighed the fears'*

Reliable Information and Family Members

The ability to pass on reliable information to family members resulted in reduced worry and stress for the whole family. Participants cited peace of mind as one of the main outcomes. Peace of mind incorporated knowing how to self-examine, knowing what results meant and increased knowledge of the subject. The group felt that when they received letters inviting them for screening they then chatted about it amongst themselves and would regularly check whether their daughters were attending*:*

- *'Two participants talked about how participating in the programme had given them the information they needed on smear test results to be able to talk and reassure their daughters'*

- *'One women told her sister about the course, who then went for her first smear'*

- *…the grand daughter was diagnosed with abnormal cells. Both she and her mother thought this was an indication of cancer and the mother was ready to fly over to England to be with her. The grandmother (who had attended the programme) was able to reassure her daughter that the result meant pre-cancerous cells which re-assured both'*

Consideration of over-treatment for breast cancer

Women who are over-treated for breast cancers have increased stress and long term side effects of unnecessary treatment. It is no longer contested that screening leads to over-diagnosis[1]. Reporting in November 2011, the *British Medical Journal* refers to recent research:

> Mammography is one of medicine's 'close calls' – a delicate balance between benefit and harm – where different people in the same situation might reasonably make different choices. Mammography undoubtedly helps some women but hurts others. No right answer exists, instead it is a personal choice.

The analysis shows that inclusion of the harms from false positive results and unnecessary surgery reduced the benefits of screening by about half with negative net QALYs in the early years after the introduction of screening. We have therefore included a negative value in this forecast study for over-treatment for breast cancer, which for women concerned will reflect the possibility of negative outcomes as well as the often-implied positive outcomes of treatment.

Family members influenced by programmes (breast and cervical screening)

Many of the women in stakeholder groups said they passed on the information and spoke to their family / friends after attending the course. They said that if it had not been for the course they would not have talked about it as they would have thought it was too personal, but attending the course made them realise how important it was to be breast aware and attend for regular smear tests.

There was a great deal of information coming from the women themselves about how family members had benefitted. Family member here tends to refer to younger family members but there is also evidence from stakeholder engagement that some partners of the women were also involved, for example in talking to other male family members.

According to WRDA staff the average size of family they have worked with in these programmes consists of three children. Our projections will not claim influence over three children (in some cases grand-children), friends of children or members of the more extended family. To avoid over-claiming it will be assumed that one family member may be influenced. Using one family member influenced as a conservative estimate would result in a potential 300 close family members influenced by knowledge of parent/aunt/mother of friend attending the Promoting Sexual Health Programme and a potential 650 close family members influenced by knowledge of a parent/aunt/mother of a friend attending the Breast and Cervical Screening Programme.

It is worth noting that the outcomes mirror the outcomes of the women stakeholder groups as the outputs of this programme are around accurate information, knowledge and skills that are transferred to family members.

Enhanced collaboration with public services

The WRDA programme is an example of how an approach based on collaboration between health care professionals, community organisations and networks can deliver public health outcomes through mobilising women in the maintenance of their own health and that of their families. Women have information that is both medically correct and accessible to different age groups, people with literacy problems, learning difficulties and people from diverse cultures, building the women's capacity to promote good sexual health within their own communities.

The WRDA programme capitalises on long standing relationships with community support networks and is delivered through a peer learning programme that mobilises the leadership capacity of local women (community facilitators). A strength of the peer learning model is that it draws on and develops a community of knowledge and peer support that facilitates behaviour change. The model conforms closely to advice given by the National Institute for Health and Clinical Excellence in their guidance notes to support attitude and behaviour change[2]:

> …build on the skills and knowledge that already exists in the community, for example, by encouraging networks of people who can support each other; prioritise interventions and programmes that…are developed in collaboration with the target population, community or group and take account of lay wisdom about barriers and change (where possible).

Lasting Change

The evidence from this study is that as a result of participating in the programme, women now initiate conversations with their children and relatives about sexual health. Furthermore the change appears to be lasting. Respondents to this study were asked: 'if you feel a change has occurred, how long do you think this change will last?' Numerous examples were provided that, one year on from the programme, its impact endures:

- *'Once you've opened your mind to this type of information you can't close it'*
- *'They all said the learning would last forever and felt that now they had the information they would continue to talk with younger children and pass it on'*

As with the sexual health programme, the change in relation to screening appears to be lasting. Respondents to this study were asked: 'if you feel a change has occurred, how

long do you think this change will last?' Numerous examples were provided to support evidence that one year on from the programme, its impact endures:

- *'As the group had completed the course over a year ago and were still checking their breasts routinely, they believed this would continue as they had now incorporated this into their daily lives'*

N.I. Investing for Health: Addressing the Sexual Health Strategy

The sexual health awareness programme directly addresses the Sexual Health Strategy within the NI Investing for Health Framework[3]:

> It is important that parents and carers have the skills and knowledge to talk to their children as good parent/child communication about sexual health issues can help delay first sexual experience and limit poor sexual health outcomes.

Health research[4] broadly recognises that health outcomes are closely correlated with networks and communities. By using existing community infrastructure the WRDA programme empowers the women from those communities to become information givers. The women are connected to others in their community through family, voluntary work, cultural affiliations, friendships, their children and their children's friends, partners and families. By motivating and supporting women, information is dispersed across the community; the programme supports health providers to get their message to otherwise hard to reach groups. Information was provided to people with literacy problems, learning difficulties, and to people from diverse cultures:

- *'The five women from the ethnic minority group had difficulty reading English but because of the participative learning activities were able to participate fully'*

Addressing the needs of women from disadvantaged areas

The Northern Ireland Regional Cancer Framework states:

> Uptake of breast cancer screening is lower in areas of high deprivation. It is essential that we target these areas raising awareness of the value and importance of screening and utilising approaches which have been shown to influence attendance. Across Northern Ireland the uptake rate for cervical smear tests is 72%; this is a much poorer rate of uptake than for most parts of the UK.[5]

The report recommends:

> Commissioners and providers, working with local women and the voluntary sector, should target areas of poor uptake, find out why women are not coming forward, and

use an approach likely to best increase the number of women presenting for breast and cervical screening.

Information should be disseminated to people with a disability and to black and minority ethnic groups through more interactive methods (e.g. via road-shows, through outpatient clinics, or through peers and lay workers).

100% of the women contributing their feedback came from disadvantaged areas and 37% reported literacy problems.

- *'One woman in the group had not been for 15 years and attended for a smear test after completing the programme. Another woman had not been for 30 years and also attended for screening as a result of the programme. The rest of the group all said they attended for cervical screening when invited'*

- *'The five participants in this age range (65-74) felt the information on breast self-examination and mammograms was of particular relevance to them and talked about the peace of mind they had knowing that they could take some control over their own health by regularly self-examining'*

Community Facilitators

A stakeholder meeting with the Community Facilitators showed that the above outcomes were extremely important to them. The main experience was again of women being able to share stories but over and above this for the facilitators was the satisfaction they derived from delivering information that would not otherwise be delivered and the resulting growth for the course participants:

- '*The fact that learning is actually taking place…stuff that didn't happen in schools….stuff that can save someone from going through serious illness'.*

Being paid was important to these women, as was the flexibility of the programme; it enabled them to develop skills that could be important later in the Labour Market and fit in skills development and earning in a context that made their own child-care manageable. In one case the programme earnings gave the individual some security for her own self-employment ambitions.

Valuing Material Outcomes

SROI goes beyond other outcomes reporting systems by placing a financial value on outcomes. This may seem easier when there is a clearly available market value that can be attached to change. For example, the improvement in the health of a stakeholder group can be valued by the savings made through those stakeholders using less health

services from the viewpoint of the state. This valuation would be known as the application of a financial proxy to the outcome in question, in this case where the cost of less use of GP services, medicines or hospital services can be found.

SROI uses financial proxies to value all material outcomes - also in the case that a market value for the outcome is not known. For example this sometimes involves asking stakeholders how they value an outcome or what they might be prepared to pay to achieve an outcome or to avoid a negative outcome. The outcomes included in this study have all had financial proxies attached. First of all though, the outcomes have been subjected to a "materiality test" to ensure that they are both relevant to stakeholders and significant in terms of their proportion or in relation to the mission of the WRDA.

A materiality test for continued inclusion was applied testing for aspects of both relevance and significance. At the outset of the study all of the above stakeholders were included as potentially those with material outcomes resulting from the analysis.

The following table shows materiality decisions post- stakeholder engagement and at the conclusion of social account analysis

Stakeholder	Number	Materiality relevance test	Significance
Women participants - Promoting Sexual Health Prog.	300	Outcomes fit with stakeholder priorities as tested during engagement and with public policy on promoting skills and accurate information to disadvantaged communities	23% of the social value return after impact adjustments is to this group - **INCLUDED**
Women Participants - Breast & Cervical Screening Prog.	650	Outcomes from this activity also considered priority for stakeholders and fit with public policy aspirations for women in disadvantaged communities	The majority of the return after impact adjustments is to this group (44%) - **INCLUDED**
Family members influenced by programmes (sexual health)	300	Strong synergy with local community social norms, public policy and values of stakeholders to provide these outcomes for benefit of family members	10% of the return after impact adjustment is to this group - **INCLUDED**
Family members influenced by	650	Strong synergy with local community social norms, public policy and values of	As above – 14% - **INCLUDED**

programmes (Breast & cervical screening)		stakeholders to provide these outcomes for benefit of family members	
Department of Health representing Health Trusts and including Public Health Agency	1	Fit with stakeholder policy	5% of return after impact adjustments but this % is net of increases in budget spending as well as savings in spending. Not all increased spending is viewed as negative by stakeholder – in areas of health promotion for example - **INCLUDED**
Community Facilitators	10	Outcomes fit closely with stakeholder priority and desires	4% of overall social account returned to this group after impact adjustments but highest average individual return per stakeholder at £1,416 compared to nearest individual return which is £240 - **INCLUDED**

The values attached to the outcomes for stakeholders included in the table above are drawn from a number of sources. Some are what the stakeholder would need to pay in terms of open market values in order to achieve the outcome they have received from the WRDA courses. Others are based on available research – for example the cost of raising a child in its first year of life (£8853 - Liverpool Victoria study) is cited as the value to a women who has avoided an unplanned pregnancy.

The value to the state of increased regular testing for women is the expenditure potentially saved in cases of cervical abnormalities that later on would lead to treatment of a much more advanced cervical cancer. These are just a few illustrative examples. The wider study document contains the full information on how outcomes were given a value.

Impact

The outcome values have been subjected to further adjustments in order to arrive at impact that is attributable to the WRDA and not other sources. SROI recognises that these adjustments are necessary to take account of outcomes that would have happened anyway or for parts of outcomes that have been contributed by others. The following adjustments have been made to the social account:

- Deadweight – outcomes that would have happened without the WRDA courses
- Attribution – outcomes achieved through the WRDA courses but have been contributed to by others or by other factors
- Displacement: Have these outcomes displaced outcomes for others?
- Duration of outcomes: how long do they last?
- Drop-off: Do outcomes values reduce over time?

The original wider report contains information on how each of these adjustments were treated for the predictive stage of the study

SROI Calculations and results

The SROI ratio: the return value from the activities expressed as a ratio of the investment is set out below. Calculations include discounting to take account of reduced value of money over time (discounted at 3.5% as advised in Government Green Book for grant-aided investments).

Total Investment	£104,514
Impact Total Value (present value)	£448,523
SROI Ratio	**£1 : £4.29**

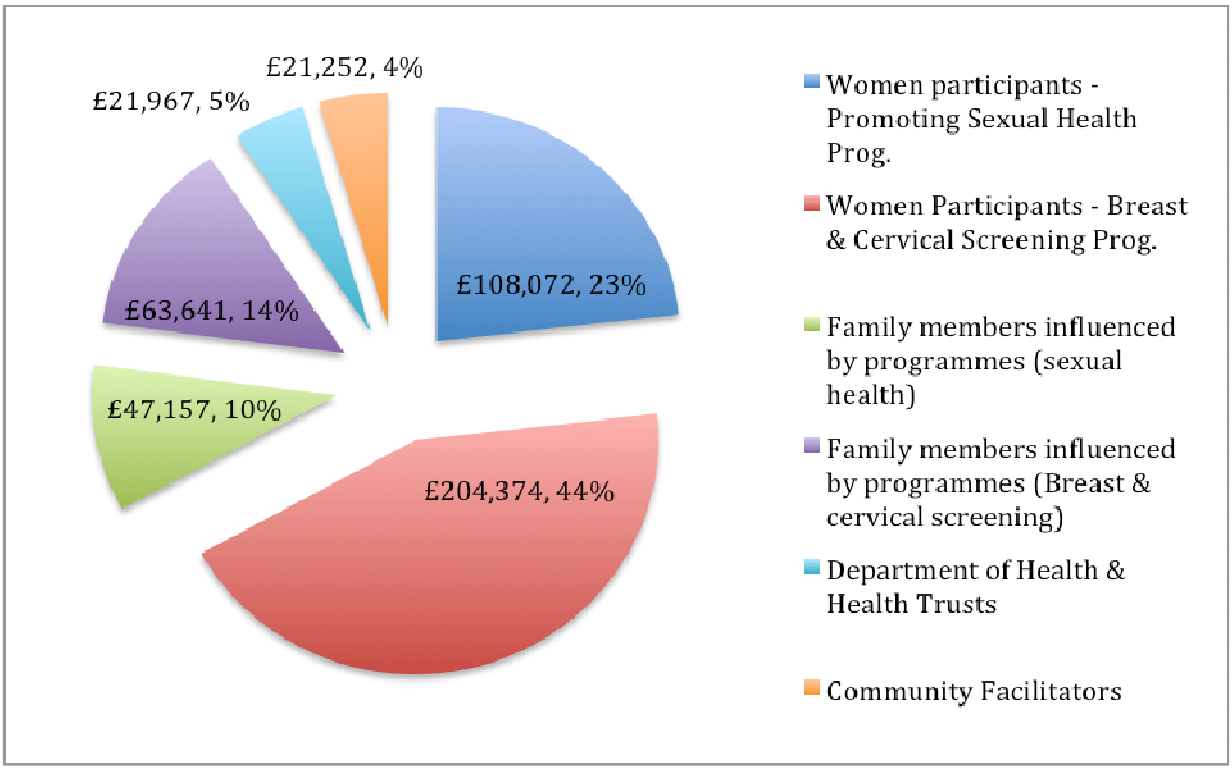
WRDA therefore returns social value of £4.29 for every £1 invested in these two courses.

The total impact value is derived over five years. Although the vast majority of outcomes last for only one year, a few last for two and five years.

Year 1	Year 2	Year 3	Year 4	Year 5
£419,864	£36,184	£3471	£3471	£3471

The accumulated total of all 5 years is £466,462 but reduces to £448,523 after discounting for Present Value.

The total value returned per stakeholder group is as follows:



Sensitivity analysis

There are some reporting conditions and assumptions that are inherent in the development of the social account and these are subjected to sensitivity analysis in order to judge the robustness of the result. The items included are:

- The estimation that one close or extended family member or friend will be influenced by the knowledge and information passed on by the women reduced by 50%
- Outcomes lasting for one year increased to two years.
- Although there is rationale in this report based on feedback from women the percentage assigned to attribution (25%) is a projection. Sensitivity tests a variance in this up to 50%.
- By far the largest proportion of the impact value in the study is returned to Women Participants – Breast & Cervical Screening Programme. Sensitivity tests a variance in the numbers of outcomes claimed for this group by a reduction of 50%

Sensitivity table

Variance	Base result	New result
Influence reduced from 1 to 0.5 people per family	4.29	3.78
Outcomes lasting 1 year increase to 2 years		7.69
Attribution increased from 25% to 50%		2.86
Largest impact value for stakeholder reduced by 50%		3.34

The fluctuations produced by the sensitivity analysis are small except for the scenario in which outcomes duration increases from one year to two years in which case the return ratio would rise to £7.69. This is not likely as the course duration is short and so most of the resulting outcomes are considered to last for one year only. Another fluctuation relates to attribution increasing from 25% to 50%, which would reduce the ratio to £2.86. All the evidence from women suggests that there were not significant other factors that contributed to the outcomes so attribution set at 25% is considered a conservative and prudent level.

WRDA and the future of health services

The Reform of Public Services, whilst at an early stage, has clearly set out that its aim is to re-shape the relationship between providers and users of services. Briefly the top-down approach is seen to be disempowering, leading to dependence and increased costs to the State. The desire is to make the relationship more collaborative (the terms most often used are 'co-produced' or 'co-created') so that users are empowered to work with professionals to find and follow through on decisions and solutions. It is assumed this can be done at less cost to the State.

The WRDA's programmes that are the focus of this SROI study have many characteristics of a co-created programme – health service input for example, in the production of the hand-outs and other literature; professional expertise in the design and facilitation of the programme itself; the participatory learning style that incorporates women's own expertise (their intellectual and experiential assets) to make the programme relevant.

From the stakeholder conversations, the benefits of the WRDA programmes to the women participants and the health sector are clear to see. They describe the processes and outcomes value of a more collaborative approach. They are an example of how an approach based on collaboration between health care professionals, community organisations and networks can deliver public health outcomes for promoting sexual health and breast and cervical screening awareness through mobilising women in the maintenance of their own health and that of their families.

In the future, WRDA will consider further development based on the findings of this SROI study:

- **Diversifying assets and markets**.

WRDA programmes targeted specifically at young people and older women. Partnership working with other infrastructural organizations, particularly those supporting young people, older women and minority ethnic groups.

- **Making a positive asset of different skills and knowledge.**

Using the programme to further enhance women's role as information givers, in line with WRDA's mission, while also adding value from the health service perspective.

- **Even more added value**

Being able to successfully recruit a substantial cohort of women from disadvantaged areas is one of WRDA's Unique Selling Points. Re-convening a representative sample from the group twelve months later raises the possibility of being able to conduct longitudinal studies of the programmes' impact. This has great value from a public policy perspective.

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[1]BMJ, November 2011 - http://www.bmj.com/content/343/bmj.d7627

[2]"The most appropriate means of generic and specific interventions to support attitude and behaviour change at population and community levels" http://www.nice.org.uk/PH6

[3]http://www.dhsspsni.gov.uk/public_health_sexualhealth

[4]For example: Improving health outcomes in deprived communities - Evidence from the New Deal for Communities Programme

[5] Regional Cancer Framework for Northern Ireland 2006