



THINK PIECE:

Social Return on Investment (SROI): SROI Analysis of Health Services delivered on the Streets of Moshi, Tanzania

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Background: M&E at Mkombozi...

The aim of Mkombozi's Monitoring and Evaluation (M&E) system is manifold, including: to support us in identifying and learning from both expected and unexpected results **1** of our work, and hence enabling us to celebrate and build upon our successes; to transform Mkombozi by bringing about new solutions and creativity throughout the organisation; to offer a meaningful opportunity to capture the perspectives of our stakeholders in determining the impact of our work; to explore and pilot putting a fiscal value on Mkombozi's impact; to ensure that we remain sensitive and relevant to our environment; to support the board of trustees, director and management to make strategic and operational decisions and finally; to ensure that we remain accountable and true to our mission and vision, to our stakeholders, to our donors and to ourselves.

Mkombozi's M&E system consists of three main approaches; namely Result Based Management (RBM), the Most Significant Change (MSC) Technique and the Social Return on Investment (SROI) approach. The aim is for these approaches to complement each other in enabling Mkombozi to assess its progress and impact on a regular basis and in enhancing organisational learning, as we acknowledge that one approach by itself will not give us the full range of data we require to achieve this goal. Unlike RBM and the MSC technique, which have become standard practice in the organisation, our use of SROI is still very much in a pilot stage.

SROI has its roots within social enterprises and is a relatively new approach in assessing impact in the sector of international development. Since 2006, steps have been taken to explore the applicability of SROI in this sector (Context international cooperation (Context) 2010). Inspired by our partner International Child Support (ICS), Mkombozi started exploring SROI and its potential for application in the organisation in 2007. In 2008 a pilot SROI analysis was conducted, focusing on assessing the impact of an apprenticeship programme offered to vulnerable youth by Affordable Computers and Technology for Tanzania (ACTT), a section of Mkombozi. At this stage, the analysis was based solely on inputs from Mkombozi staff members. The pilot was taken further in 2009, when the apprentices themselves contributed to and took part in the SROI process. **2** Following this, the organisation decided that it was time trying to assess also other interventions using SROI. The choice fell on our health services. Before elaborating the SROI process, we provide a short rationale for choosing to pilot this approach as part of our M&E system.

"I feel good when I am healthy"



Medical counseling is everyday work at Mkombozi

...and the added value of SROI

SROI is designed in such a way that it includes different data types, such as narrative, qualitative, quantitative, monetisable and financial information (Context 2010). This holistic design is part of what attracts Mkombzi to the approach. Equally important for us, is the strong focus on stakeholder participation in SROI process; it provides a good opportunity for capturing the perspectives of those who are meant to benefit from our work. These aspects are on the other hand not very groundbreaking as such, most of the present M&E approaches do aim at including different types of information and at being participatory. The feature of SROI that gives it a particular added value in Mkombzi's view, is that it provides us with tools to put a fiscal value on our impact.

Although it is recognised that not all results or changes can be monetised, the aim is to use monetary value as the way of expressing the higher level changes, outcomes or impacts, resulting from an intervention or project:

The process of an SROI analysis leads to the so-called SROI ratio. This is the ratio between the value of the benefits and the value of the investment. For example, a ratio of 3:1 indicates that for every € 1 invested in an activity, project or programme, € 3 of value (economic, social and/or environmental) is generated for society (Context 2010:9).

Mkombzi's thinking and experience so far is that in combination with other types of data collected either through the SROI process itself or through our other M&E approaches, an SROI process resulting in a SROI ratio can provide both our stakeholders, the organisation and our donors with a meaningful way of capturing and understanding the actual results of our work because it is so tangible.

Again, not all changes can or even ought to be assessed in these terms. It is moreover quite challenging to find indicators that both reflect changes resulting from our work well and can be monetised. When Mkombzi chose which interventions to start with when piloting the SROI approach, the main rationale for choosing ACTT's apprenticeship programme and our health services was the assumption that the changes in children and young peoples lives that these interventions have resulted in, lend themselves more easily to being captured in monetary terms than do some of the other changes we contribute to.

As already mentioned, Mkombzi's use of SROI is in a pilot stage. A main reason for this is the fact that the approach is new in our field of work, also internationally speaking, and hence, the process of developing standards for it is still ongoing. In November 2009, a member of Mkombzi's SROI team **3** participated in an SROI workshop, designed as a 'writeshop', in Anantapur, India. The workshop was arranged by Context, international cooperation, an organisation that has taken the lead in exploring the possibility of applying SROI in the development sector, and the participants were 15 development practitioners with different experiences in SROI and one journalist. The purpose of the workshop was for the participants to exchange experiences and reflect on the SROI approach, and to create a draft practical guide on SROI (Context 2010). The goal is for this practical guide to be finalised and made generally available during the course of 2010, but a second draft is at present accessible for those who participated in the writeshop.

When making preparations for Mkombzi's SROI process with regards to our health interventions, the SROI team decided to make use of this guide, by working our way through the nine stages it outlines. **4** The remaining part of this paper will be dedicated to describing and discussing this process, and hence creating an SROI report (Context 2010) regarding the changes resulting from Mkombzi's health interventions.

EndNOTES 1-4:

1. The term result is here used in line with internationally acknowledged terminology; it refers to the effects of an intervention, programme or project. There are however different levels of results; normally captured by the terms 'output', 'outcome' and 'impact'. Although Mkombzi also monitors its outputs, the short term products of completed activities, being able to assess the outcomes and impact of our work is what we ultimately aim for. These two terms refer to the longer term changes, the impact being the highest level of change, that the organisation hope to contribute to (cf. e.g. NORAD 2008, Nthuku 2008). In this document 'change' and 'result' will be used interchangeably, as we find it useful to think of the results of our work in terms of changes.

2. As the SROI analysis regarding the training and apprenticeship programme was conducted in a piecemeal manner, it has yet to be documented in one comprehensive report. Shorter reports from different stages of the process is however available.

3. Mkombzi practices a team based way of working, with the aim of distributing leadership throughout the organisation and reducing fragmentation between projects, programming and staffing levels. The M&E team consists of members from all Mkombzi's and is divided in three sub teams; the RBM team, the MSC team and the SROI team. It is in the sub teams that most of the practical work is carried out.

4. At the time this report was written the guide existed only as a draft so not all steps were elaborately explained as we would like. It will become clear which steps we found most difficult to understand and hence work on. The finalised practical guide is now available through the website of "Context, international cooperation":

[WWW.DEVELOPMENTTRAINING.ORG](http://www.developmenttraining.org) as well as the following URL:

[HTTP://CONTEXTINTERNATIONAL-COOPERATION.FILES.WORDPRESS.COM/2010/11/SROI-PRACTICAL-GUIDE_CONTEXT-INTERNATIONAL-COOPERATION.PDF](http://contextinternational-cooperation.files.wordpress.com/2010/11/sroi-practical-guide_context-international-cooperation.pdf)

THE ACTUAL SROI ANALYSIS: What changes are resulting from Mkombozi's provision of health services to youth on Moshi streets? 5

STEP 1: Defining the Boundaries: Objective & Scoping

This mainly refers to the process of clarifying exactly what one wants to assess in terms of type of project, geographical area and time period, as well as who we believe the analysis will be relevant for. This step also includes a description of the rationale and intended result of the project, programme or intervention. The SROI team, which for this particular analysis was supplemented by the Mkombozi nurse, decided that it at this stage would be too big a task to aim at assessing the impact of the whole range of health services provided by the organisation. It was therefore decided to narrow it down to services related to physical health, provided to children and young people on the streets of Moshi. This includes basic medical care and health education provided directly on the streets as well as hospital referrals. The reason for this demarcation was basically our own curiosity about the results of this particular work, as the information we were able to get through other sources so far had been limited. For practical reasons, such as the fact that we have reliable statistical, budget and expenditure information for this period, we initially decided to look at these health interventions in a one year perspective; the year of 2009. Since this is a rather short period, we anticipated not being able to get information regarding changes at an impact level, but probably more at the level of shorter term outcomes. Following the workshop with the stakeholders, the time period was adjusted some as will be described below.

With regards to Mkombozi's rationale for providing health services, and the intended result of these interventions, we aimed at extracting this information from relevant organisational documents such as our Planning Structure Tree, M&E framework and Children's Programmes Manual. Through this process, we became aware of that the rationale for and expected results of our health interventions have not been as extensively documented as those related to other areas of the organisation's work. This might be because the need for provision of health services to the children and young people that we work with seem rather obvious. Based on the review of documents and discussions within the team, the intended results of and rationale behind health provision to children and young people on the Moshi streets was formulated in the following way:

Intended results:

- Children and young people are increasingly able to prevent and protect themselves from disease and sickness;
- Children and young people's health status is improving;
- Street involved children and young people demonstrate increased mental and physical resilience and ability to function in the community, in their education and in the workplace. 6

Rationale:

Street involved children and young people spend their time in an environment that can be characterised as a risk zone as regards physical health: Their income generating activities, such as collecting scrap metal or carrying heavy loads, expose them to health risks such as getting wounds; it is hard to keep a good hygiene and to protect oneself from diseases such as malaria; the food they get hold of is not nutritious and at times even unhealthy; and they are exposed to temptations related to risky sexual behaviour and drug abuse. As per today, no other organisation provides services to address this situation and the need for provision of health services on the streets of Moshi and there is in general a gap in Tanzania's health service provision to the group of children and young people that we work with. It may also seem as the community that surrounds these children and young people in general do not care very much about their health status. Furthermore, these children and young people do not have the money required to get treatment at the existing health institutions. Hence, since Mkombozi knows that having a good health is vital for children and young people's positive growth and development we do provide health services as part of our holistic approach.

STEP 2: Identification and selection of key stakeholders

This relates to identifying and involving the people or organisations that experience change as a result of ones interventions, or who themselves contribute to that change, in the SROI analysis. As a first step, the following potential stakeholders were listed: Street involved children and young people; Mkombozi staff, specifically street workers which also includes the nurse; a doctor from Mawenzi regional hospital which is the hospital we mainly refer street involved children and young people to; the social welfare officer at Mawenzi regional hospital who is the one giving exemptions from payment for those without means; a counsellor from ANGAZA or KIWAKKUKI which are the organisations we refer children and young people to for voluntary testing and counselling; a guard who works in an area where many of the children and young people spend their time; a woman in the Mbuyuni market area who in the past used to let street involved children and young people stay with her and who still has contact with many; and one of the women making and selling food (Mama Lishe) in the areas where many of the children and young people spend their time.

Next, we discussed which of the above to involve in doing the actual SROI analysis; the criteria being that they are either 'the primary beneficiaries' or 'the ones that can make a difference' in the sense that their contributions are important for achieving the changes Mkombozi aims for as a result of providing health services on the streets of Moshi.

The following primary stakeholders were hence identified: Children and young people from the streets of Moshi; Mkombozi street workers; a doctor from Mawenzi regional hospital; the social welfare officer at Mawenzi regional hospital; and a counsellor from ANGAZA since this is the one of the two mentioned organisations we work most with.

A decision was reached to aim at inviting 12 children and young people, so as to keep the number of people involved in the process manageable, and to aim at making this group representative for the whole group of direct beneficiaries. Factors to consider here was the different age groups we work with, gender, which area on the street they spend time, full time versus part time street involvement and how they earn their money; through collecting scrap metal, carrying luggage or illegal means.

From the next step (step 3) onwards the stakeholders are to take part in the process, and to achieve this we decided to invite the primary stakeholders to a half day workshop at Mkombozi. Street workers were given the task of inviting children and young people, and being the one who cooperates closest with the other stakeholders our nurse personally gave them letters of invitation so as to at the same time being able to provide additional information.

Sessions notes were next prepared, allowing also for short introductions to M&E, SROI and the services Mkombozi provides on the street. It was originally planned for some group work, so as to allow the different groups stakeholder to separately identify changes they had experienced. Another reason for this was that we were worried that the children and young people might not speak up in from of the other invited stakeholders. Due to time constraints, but also because we realised the benefit of the different stakeholders listening to each others perspectives and not just getting short résumés through later presentations, we ended up doing all the work in plenary. This did however have some disadvantages that will become clear when the next steps are described.

In total, 22 participants took part in the SROI workshop: 12 children and young people from the streets of Moshi of whom three were girls; Romana Olomi, social welfare officer Mawenzi regional hospital; Dr. Kireja Mlay, doctor at Mawenzi regional; Joyce Lyimo, counsellor ANGAZA; and seven Mkombozi staff including street workers, the nurse and members of the SROI team. **7**

STEP 3: Developing a theory of change

This was one of the steps the SROI team found challenging to understand the content of, and address, when looking at the draft guide. It is first stated that developing a theory of change '[...] tells the story of how stakeholders involved in the project believe their lives have changed or will change' (Context 2010:13). On the other hand, it is said that '[f]or a theory of change you will have to clarify the final goals of the project (impact), identify the strategies to achieve the overall goal and create "so that" chains in order to make the assumptions about how change occurs explicit' (Context 2010:14).

To us it was not clear how these two aspects of developing a theory of change fit together, and bearing in mind the group of stakeholders we were going to work with during the workshop, we decided to address this step by focussing mainly on how the different stakeholders believe their lives have changed or will change. This was done through a plenary session where the following question was asked and discussed:

EndNOTES 5-9:

5. The preparation for and main SROI analysis took place during March to May 2010. The first two steps were done by Mkombozi's SROI team, while stakeholders were involved from step 3 through a workshop that took place on May, 19. Due to other work commitments, the final verification of data and fine-tuning of the calculation and ratio did not take place until late August.

6. This was one of Mkombozi's then strategic objectives, which provision of health services relate to. During 2010, the organisation has gone through a process of making a new strategic plan for the coming five years (2011-2015).

7. The workshop was conducted in Swahili; the translations of inputs from the stakeholders have been translated by Mkombozi staff for the purpose of this report.

8. What follows was said by the youth themselves. However, in line with the disadvantages of doing all sessions in plenary, it was clear that some of the points being made by the youth were prompted by leading comments and questions from the three other external stakeholders. Another observation was that it was mainly the boys who talked.

9. This was also a very positive, albeit unintended result of the workshop: youth and other stakeholders, realised that the children themselves also contribute something to make the interventions possible, and are not only receivers. This made the children and young people more confident.

Which changes have happened /are happening as a result of Mkombozi's health services on the streets of Moshi?

The following points came up from the 12 children and young people: **8**

- To focus on and follow advice
- To get health education and protect myself from different diseases
- To learn about and change regarding hygiene
- To go for voluntary testing for HIV/Aids
- To understand who I am/my identity
- To protect myself
- To know and understand the effect of using drugs
- To stop using drugs; e.g. very few children in Moshi sniff glue lately
- Improved health status
- To use condoms
- To not have sex, or at least until you have a condom
- To be able to educate others
- To get well after having being treated and having followed the conditions of and advice about using medicine
- To not go to the hospital frequently

Further, Romana Olomi said that she had seen a marked decrease in the number of children and young people that Mkombozi works with coming to get treatment at Mawenzi during the last couple of years, and that she believes that this is because they are less ill. Joyce Lyimo on her part, said that the biggest change for her is that ANGAZA gets new clients from a group that they would not have reached otherwise.

And so what?

With the aim of capturing changes at an even higher level, or the outcomes of this part of Mkombozi's work, the children and young people were next asked: 'And so what? – What other kind of changes have or could the kind of changes you have already mentioned lead to?' This is what the children and young people mentioned:

- To be active, to commit more;
- To change behavior wise;
- To work hard so as to get money, to increase the income, to keep looking for money and in the end become self reliant.

A further question asked was: 'What would you have done if the service was not there?' These were the answers the children and young people gave: "We would not have gotten education and been able to protect ourselves from diseases"; "Wounds and diseases would get worse and we would have had to go to the hospital more often".

STEP 4: Identifying INputs for each OUTcome

This step is about identifying the resources that have been contributed in order to make the project or intervention possible. According to the guide, the resources can be money, material or labour, and, the resources contributed can be divided into individual, community and organisational contributions. During the discussion at the workshop, it did however seem most meaningful to distinguish between inputs from the children and young people; inputs from other stakeholders; and input from Mkombozi.

Inputs from the youth... **9**

Inputs from other stakeholders...

Others contributing to making the intervention possible...

Inputs from Mkombozi...

>>> each input is depicted in SideBAR on right side of this page >>>

SideBAR:

Inputs from the youth:

The children and young people did at first not see that they had contributed anything to make the intervention possible, however, after some leading questions related to whether they thought Mkombozi could claim any results from our work if they themselves did not show up for example for health education sessions, the following aspects came up:

/ To respond, to show up and to listen
/ Time / Commitment / Readiness and understanding / Paying attention and being patient / Focus and concentration / Cooperation / Taking time to teach one another / Strength and energy /

Inputs from other stakeholders:

Angaza

/ Counselling / Time / Money to buy and analyse tests / Office space / Staff / Expertise /

Mawenzi regional hospital **10**

/ To give Mkombozi its mandate and to recognise its work / Medicine / Expertise / To make laws such as the one about giving exemption from payment at government hospitals for those without means /

Others contributing to making the intervention possible:

The participants further stressed that also others made significant contributions with regards to making the intervention possible or even successful. They did however find it challenging to specify in exactly which way, but said that the following contributed in one way or the other:

/ The police and others working with security / Local leaders / Parents / Women making and selling food on the streets or in market areas (Mama Lishe) /

Inputs from Mkombozi:

The contributions listed here was mentioned different participants, not only Mkombozi staff:

/ Time of all the staff involved, meaning also salary / Medicines, condoms, toiletries and clothing / Office and office equipment / Petrol for the mobile unit going to the streets / Cooperation, love, preparations and patience / Expertise and the vision of helping children /

STEP 5: Identifying Results

We had originally planned to do this part of the workshop in groups. This since we anticipated that the different groups of stakeholders might have different views on the changes that the provision of health services on the streets of Moshi had resulted in and that these could be easier to discuss in smaller groups. However, due to the reasons listed earlier, also this step was addressed in plenary.

In line with the difficulties we had with addressing step 3, step 5 was also a challenge when planning the workshop. This was however not because it was unclear, but because if following the draft guide, the two steps (3 and 5) seem very similar. Step 5 relates to asking the stakeholders about the results of the project:

These results can be on both outcome or impact level. In order to get an overview of what came out of the project, ask stakeholders to sum of the results of the project or have them tell how it has affected their lives and their environment. These effects can be both positive and negative. Make a list of all results mentioned by the stakeholders. Once you have established what results have come out of the project, ask the stakeholders to prioritise the impact. Which do they feel have had the most important effect? (Context 2010:15)

The SROI team did in the end choose to address this step by taking the list made by the participants as part of step 3, as the starting point for a discussion around which of these changes that were thought to be of most importance. After some discussion, the result chosen was:

Improved health status for children and young people on the streets

Next, and again following the guide, the stakeholders were asked to think of something that could be an indicator of this change, that is, a simple and reliable means to measure whether and to which extent this change is actually taking place. At this stage, the workshop participants were reminded of the purpose of SROI and hence that the indicator should be possible to monetise. These indicators were suggested:

- Work performance and self reliance;
- Cheerfulness;
- Reduction of diseases leading to fewer hospital visits for children and young people on the streets.

The latter was chosen; specifically 'fewer hospital visits for children and young people on the streets' as everyone agreed that it was the indicator that would lend itself most easily to being monetised.

STEP 6: Valuation

This is where one assigns a value to the inputs and the social outcomes and impact of a project or intervention, which will form the basis for calculating the SROI ratio. Both because of time constraints and because it was evident that especially the children and young people lost motivation and interest if explanations became too technical, we decided to do this in a simple and quick way just for the participants to get the main principles. We focussed on getting the views of the stakeholders, in particular on the value of the results, so that we would have all the relevant data for making a more thorough valuation as well as calculation at a later stage.

For the sake of simplicity, it was agreed to use the costs of a one day health education workshop as the worth of the total inputs. By adding up the costs of stationeries, fuel and salaries for staff this totalled to 112,900 Tanzanian shillings. **11**

As for valuating the indicator 'fewer hospital visits for children and young people on the streets', it was agreed to compare the income of a child or young person who receive basic medical care and health education on the streets and thus is healthy and goes to the hospital rather seldom with one who does not receive these services and hence is more often ill and assumingly go to the hospital more often. **12** The main point here was that a healthy child or young person would have more time to look for income as well as being more effective in his or her work as compared to one who is not. The children and young people calculated that a healthy child or youth working or begging on the streets would get an average income of 1400 shillings per day, while one that is often ill could expect to earn an average of 700 shillings per day.

The calculation was made for a period of three months (90 days); where the income for a healthy child or young person would total to 126,000 shillings while that of one whom often falls ill would total to 63,000 shillings. The difference, and hence value of the outcome of the health services provided by Mkombozi on the streets of Moshi, is then 63,000 shillings per child or youth. This was next multiplied by 15, which is the number of children and young people there is room for in the mobile unit where the health education workshop would have taken place. The total value of the outcome was thus calculated to be 945,000 shillings.

STEP 7: Calculation of the SROI ratio

As already mentioned, calculating the SROI ratio means calculating the ratio between the value of the benefits and the value of the investment. In its simplest manner, which for the reasons described above is what we opted for during the workshop with the stakeholders, this means dividing the total value of results with the total value of inputs. The calculation then looked like this:

945,000/112,900 = 8.37, meaning that the SROI ratio is 8:1; indicating that for every 1 shilling Mkombozi invests in the provision of health services for children and young people on the streets of Moshi, 8 shillings of value is generated for society, or in this case, for the children and young people themselves.

The discussions around valuation and the calculations, especially given the end result, seemed to be very meaningful and generate interest on the part of all the participants. We ended the workshop with a short feedback session, which we will return to in the conclusion of this report.

STEP 8: Verification

According to Context's draft guide, once back at the office, it is advisable to validate the data obtained during the process with the stakeholders, and if necessary, to also recalculate the ratio. Mkombozi's SROI team did just that, with a particular focus on the total value of inputs. The main reason for this is that the way this valuation was done during the workshop was too simplistic, as it was primarily for the purpose of allowing the stakeholders to grasp the principles of the methodology and see how a calculation could be carried out without getting too technical.

We do not believe that a one day workshop could give the described results, and decided to rather look at the total costs of the inputs contributed from Mkombozi to make the intervention possible over a period of six months. Further, as this verification process and fine tuning of the calculation did not take place until late August 2010, we were able to use data from the first six months of 2010 both regarding costs and number of children and young people reached by this intervention. These had not been available when we did the workshop with the stakeholders but do in our view give the most accurate picture.

The final valuation of the inputs thus looked like this...

TIME OF STAFF: 2 hours / week for health education on the streets (one hour preparation and one hour delivering the session); 3 hours / week planned provision of basic medical care on the streets; 3 hours per week of unplanned provision of basic medical care on the streets; Total: 8 hours per week. By dividing the basic monthly salary of those providing this services, including what Mkombozi has to pay to the National Social Security fund, by the total hours worked each month, the cost for Mkombozi per hour was calculated. This was multiplied by 8 hours, next 4 weeks and finally six months which totalled to 739,200 shillings.

MEDICINE COSTS: The total amount spent on buying medicines over the six months period described above was 1,135,560 shillings. During the same period a total of 299 children and young people were provide with health services from Mkombozi. Roughly one third of these (108) received these services on the streets of Moshi. We hence found it reasonable to calculate the cost of medicine to be one third of the total amount, totaling to 378,520 shillings

OTHER COSTS: A total of 240,000 shillings was used for fuel per month for the mobile unit that goes to the street twice per week, for a total of eight hours. The health education sessions are usually conducted from the mobile unit, but the unit serves many other purposes as well such

EndNOTES 11-14:

10. Romana Olomi stressed that she spoke as a representative of the government, in particular the social welfare department.

11. The valuation of inputs was altered drastically after step 8: Verification, see below. Moreover, only the input provided by Mkombozi was valued, which is a weakness of this SROI process.

12. We also discussed using Mawenzi's budget or records related to numbers / costs of children who get exemption from paying their hospital bills, but this was discarded as there was no clarity on whether such records exist or would be available. This might be worth looking into if we were to do processes like these at a later stage.

13. Asking the stakeholders about their views might have made this part easier, but we did as previously mentioned try not to make the workshop more technical than it had to be.

14. It would however be fair to acknowledge that Mkombozi works to encourage that such things happen.

REFERENCES:

Context, international cooperation 2010, Applying SROI in development cooperation: A practical guide, Draft version 2, Context, international cooperation. Work in progress.

Norwegian agency for development cooperation (NORAD) 2008, Result management in Norwegian development: A practical guide, NORAD.

Nthuku, F. 2008, Manual: Participatory planning, monitoring and evaluation, International Child Support.

as delivering non formal education lessons, sports sessions and being the general meeting point between street workers and children and young people. We decided to calculate the cost related to delivering health services to be one eighth of the total fuel costs, equalling the one hour spent on delivering health education. This means 30,000 shillings per month totalling to 180,000 shillings over the six months period.

Stationeries such as flip charts and marker pens are used during the health education sessions. The total expense of these items totals to roughly 30,000 shillings over the six months period.

Adding all these costs together, the total value of inputs from Mkombozi equals: 1,327,720 shillings.

The final valuation of the results...

Next, the SROI team redid the valuation of the results. First, we decided to increase the number of children and young people who were provided with and hence got value from Mkombozi's health services on the streets of Moshi to 108. This was as previously mentioned the total number of children and young people benefitting from this intervention during the first six months of 2010.

Now, it might not be realistic to assume that the health status improved for all these 108 during this period, as we know that it may take some time before one sees actual results of this kind of work. On the other hand, during the previous 6 months period, the total number of CYP who received health services on the streets of Moshi was 166. This does in our view makes it realistic that the health status of 108 children and young people did improve during January to June 2010. When using the value of this outcome which was suggested and calculated by the children and young people themselves; 108 multiplied by 63, 000 shillings equals a total value of the outcome of 6,804,000 shillings.

However, to make what in the draft guide is called 'a methodological justified SROI calculation' (Context 2010:17) some other adjustments must be made. This relates to what in the guide is termed 'dead weight', 'attribution' and 'inflation adjustment' (Context 2010:17). This was another area the SROI found rather challenging to address, especially because data related to it in general was not easily available **13**, but also because what is meant by these terms is not completely clear. We did nonetheless do our best.

There are influences outside the control of a project or an intervention that may affect the beneficiaries of the intervention in a positive or a negative way. This is what is referred to as 'dead weight', or in other words; 'what would have happened anyway'. In this case factors such as children and young people managing to rent their own room or going to stay with friends or relatives for a while, or that the hygiene in the areas where they sleep get better, could be factors that Mkombozi is not in control of **14** but which probably would impact positively on their health status. The SROI team estimates that the dead weight could be approximately 20 percent.

Next, one must consider 'who else helped' or so called 'attribution'; '[...] not all results can be claimed by this particular project, as other actors are intervening in the same sector' (Context 2010:17). Now, to our knowledge no other nongovernmental organisation or government actor provides health services directly on the streets in Moshi. However, the children and young people we work with do interact with other service providers in different ways. We would calculate for this to account for approximately 30 percent of the total result obtained.

Lastly, as the value for money change over time, the SROI team included a three percent inflation adjustment based on the inflation rate over the last years. These adjustments equal 53 percent of the total value of the results; meaning that the total adjusted value of the results equals 47 percent or 3,197,880 shillings.

The final calculation of the SROI ratio in conclusion looks like this...

$3,197,880 / 1,327,720 = 2.4$, meaning that the SROI ratio is 2.4:1; indicating that for every 1 shilling Mkombozi invests in the provision of health services for children and young people on the streets of Moshi, 2.4 shillings of value is generated for society, or in this case, for the children and young people themselves.

STEP 9: Narrative

This step is basically about doing what this entire report has been about:

An SROI ratio as such provides interesting information, but it should be embedded within the larger context in order to fully understand its meaning. Therefore, by writing up a narrative, you will be able to explain the process leading towards the calculation of the ratio and how the was established. Furthermore, the narrative allows you to clarify on assumption and/or description of areas which have not been measured or could not be valued (Context 2010:18).



Feedback from stakeholders, unintended results and summing up...

At the end of the workshop with the stakeholders, we encouraged the participants to give their feedback on how they had experienced the process. We also told the children and young people that they could give it to the street workers the following day if they did not feel comfortable doing it there and then. Most of the children and young people hence chose not to say anything, but one youth contributed that he was very happy to get the chance to meet people like the three other external stakeholders, which he otherwise would not have met. In a similar vein, Joyce Lyimo said she was happy to meet the children and young people in a different setting from what she is used to. Romana Olomi on her side said that she really had enjoyed learning the SROI methodology and would like to try it in a project she is working on.

On the streets the following day, feedback from the children and young people included: It was nice to learn and talk more about sexually transmitted infections, the life of children on the streets and the problems we get and to live in a good way and protect oneself from issues that are not good. They further said that all of the children and young people on the streets should have been invited.

In sum, this feedback indicates that the stakeholders in general found the workshop meaningful. An unintended but positive result of the workshop itself, seems also to have been that the different groups of stakeholders appreciated and learned from the chance to meet and listen to each other in such a setting. This does again suggest that it would be fruitful to arrange similar kind of forums for our different stakeholders.

As for the process of calculating the SROI ratio itself; our impression was that this was an evaluation tool that at least in its simple form was rather easy to grasp and which made sense to the stakeholders involved. Furthermore, and as already touched upon, the exercise of discussing the inputs of the children and young people themselves and the importance of these, seemed to be a rather empowering experience for them. Again, this was a positive outcome of the workshop which was not planned for or expected.

Lastly, there are still aspects of the SROI approach which is unclear and in the making, and we do feel that it needs to be further piloted to properly ascertain the value of it as an additional M&E approach.

However, this particular process did teach Mkombozi a lot and the SROI ratio itself seems to indicate clearly that to invest in the health of children and young people on the streets is a good investment!

