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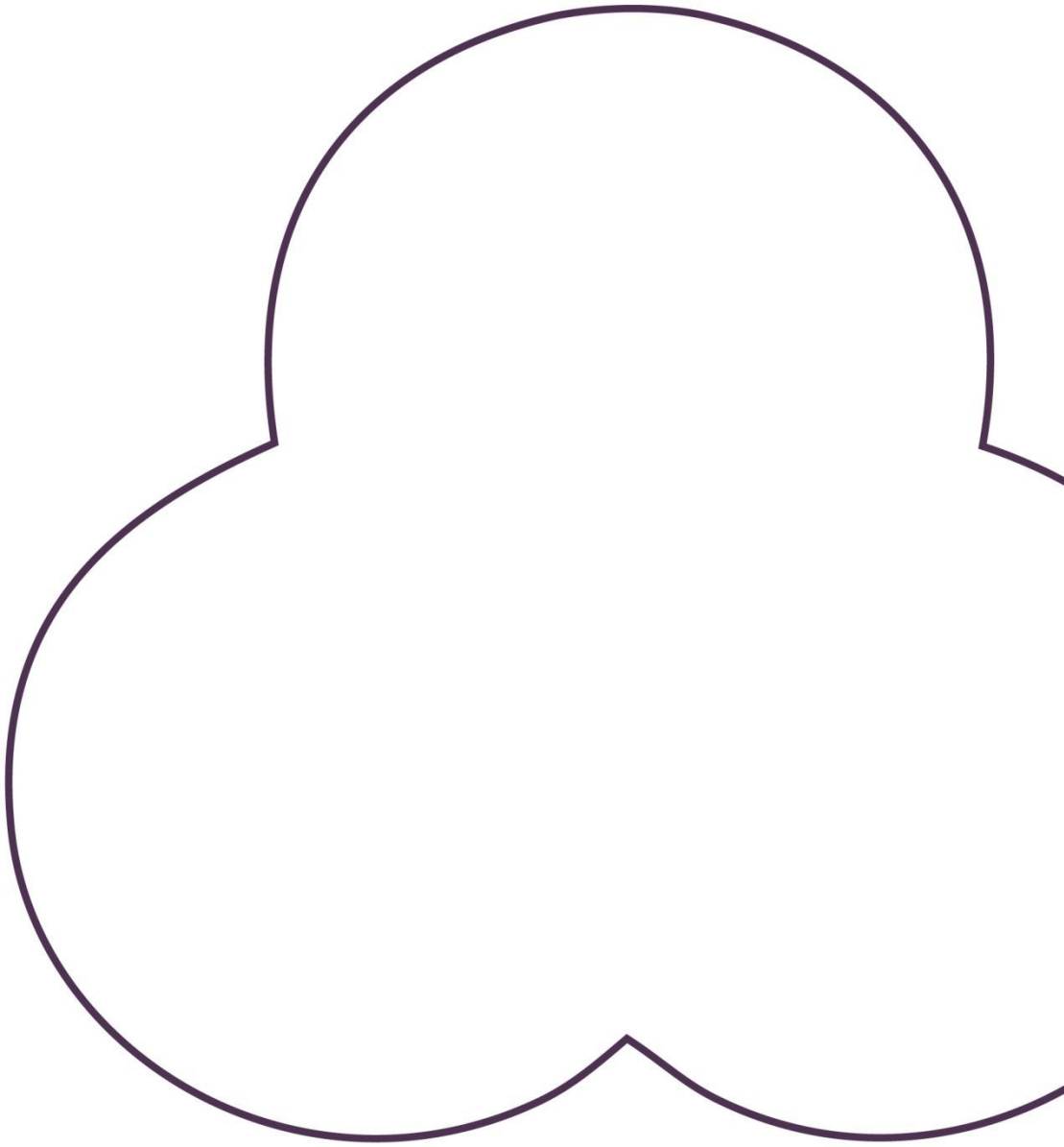

Filling the Gaps
A social return on investment analysis
May 2013

Title	Filling the Gaps: A social return on investment analysis
Commissioned by	Christian Aid
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Contents

Abbreviations

ADS	Anglican Development Services
ART	Anti-retroviral therapy
CA	Christian Aid
CBHF	Community-based health financing
FGD	Focus group discussion
FtG	Filling the Gaps
HBCG	Home-based care giver
KENERELA	Kenya network of religious leaders living with AIDS
KENWA	Kenya network for women living with HIV
IGA	Income-generating activity
INGO	International non-governmental organisation
nef	new economics foundation
PPP	Purchasing power parity
PWHIV	People living with HIV
QALY	Quality adjusted life year
RL	Religious leader
SDD	Stigma, discrimination, and denial
SLAs	Savings and loans associations
SROI	Social return on investment
ToC	Theory of change
VfM	Value for money
WTA	Willingness to accept compensation
WTP	Willingness to pay

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Executive summary

The aim of the analysis is to bring a more holistic (understanding the impact for all material stakeholders) and quantitative (social return on investment; SROI) approach to understanding value for money. The focus of the analysis was the Filling the Gaps (FtG) project, a project designed to improve the demand-side factors necessary to achieve the successful adherence of PWHIV (people living with HIV) to their ARTs (anti-retroviral therapies) thus improving their quality of life.

Theory of Change

The direct and immediate need addressed by the project was that effective uptake and use of ARTs in target communities was sub-optimal. While the Kenyan government has made the availability of ARTs more widespread in recent years, the efforts are predominantly of a supply-side nature. Research conducted by Christian Aid (CA) and its partners suggested the poor uptake/use was principally on account of poor nutrition among PWHIV. Supplementary evidence also indicated ART uptake was sub-optimal as a result of stigma, discrimination, and denial (SDD), as well as the costs involved in accessing the treatments (transportation costs).

At its centre, the SROI methodology requires the development of a theory of change (ToC). The ToC explores the modalities and mechanisms of social and economic value generated for different beneficiaries of the Filling the Gaps (FtG) project. SROI analysis goes beyond enumerated activities to focus on outcomes, which are defined from the recipients' perspective as valued change. In essence, this is an account of *how* FtG activities have changed stakeholders' health and well-being in a way they identify as significant. These identified changes are then tested empirically. Stakeholders identified as being impacted materially by the project included:

- PWHIV
- Households (with one or more PWHIV)
- Home-based care givers (HBCGs)
- Religions leaders (RLs)
- Local community

Central to the FtG's ToC is the recognition that meaningful involvement of PWHIV is a critical success factor in the execution of any HIV-related project. As such, the formation of support groups of PWHIV to counter SDD is a central tenant of the project.

Complementary to the support groups is the provision HBCGs who provided both psycho-social care as well as positive prevention education. By locating the care in the PWHIV's households, assistance was provided not only in a safe environment but also mitigated potential barriers to

accessing care such as SDD and financial costs. Use of RLs to counter discrimination in local communities was the third key part of the approach employed. The theory suggested that the reach and standing of RLs within the community would make them an effective vehicle to break down SDD. For those RLs who had HIV to share their status would also send out a powerful message to the community.

Specific efforts to address barriers to effective access and use of ARTs were developed in direct response to the identified need for better nutrition and higher disposable income. These included a range of income-generating activities (IGAs) such as:

- Business training
- Establishment of savings and loans associations (SLAs)
- Kitchen gardens
- Nutritious food rations

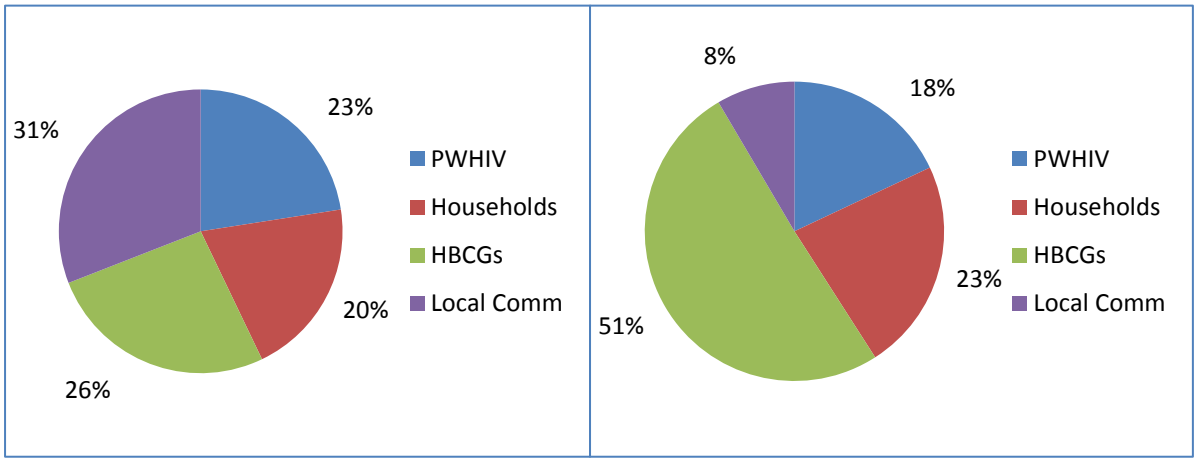
Because of the community-based approach to the intervention, the types of outcomes the stakeholders experienced fell into three categories:

1. Physical and mental health (greater life expectancy and lower rates of depression/anxiety)
2. Psycho-social well-being: greater agency, supportive relationships, community acceptance.
3. Economic: higher disposable income, avoided expenditures

Findings

In value for money terms, the analysis produced SROI ratios well in excess of 1:1 – the level at which interventions are considered cost effective. Figure EX1 presents the distribution of value created by stakeholder for the two partners (ADS (Anglican Development Services) and KENWA (Kenya network for women living with HIV):

Figure EX1: Distribution of value by stakeholder: ADS and KENWA, respectively



The noticeable difference between the two partners' impacts is the greater value created for the local community by ADS and the higher value produced for HBCGs by KENWA. The former is as a result of the provision of SLAs and CBHF by ADS. The latter is a product of greater earning potential on the part of HBCGs (resulting from their engagement with the project) in the areas in which KENWA operates. In both cases, the value to the target population (PWHIV) and the secondary group (households) accounts for less than 50% of the total value created through the FtG project.

Disaggregation of the values by outcome for each of the stakeholders indicates that in general the greatest value created is principally in terms of improvements in economic outcomes. This improvement took different forms for different stakeholders. For example, PWHIV and households experienced an improvement in disposable income plus reduced probability of the costs involved with disinheritance (driven by community stigma and discrimination). For members of the local community, it meant avoided costs of caring for families where the head of the household had died from AIDS. For HBCGs, it meant greater employment opportunities resulting from the skills and experience gained for working with the project.

While PWHIV and households experienced improvements in all outcomes, the net impact (over and above the change witnessed in the control sites) for certain well-being outcomes was not statistically significant. That these outcomes were unintended positive changes and therefore no activity was directed to their achievement in the original project work plan may account for this finding.

Recommendations

1. Consider all material stakeholders at the design stage of a project, and map out their potential impacts (ToC). Understanding the change that may occur for a range of stakeholders provides the type of information which can facilitate the conversations with different actors that can precipitate more effective resource use.
2. In line with current moves in the international development arena, identify a select number of projects where control groups are engaged at the beginning of the project and tracked alongside the project's recipients in order to provide a more accurate understanding of net change.
3. Interrogate this analysis alongside partners to identify what findings are new and what simply confirms the findings and conclusions of other studies. Reach consensus on which parts of the process/analysis were most useful and instigate a process to include these in future impact analyses.

Background and introduction

This piece of analysis was commissioned to help Christian Aid gain a better understanding of its ability to deliver results and contribute to development outcomes given invested resources. It was envisaged that the SROI analysis on the Filling the Gaps health programme in Kenya would demonstrate the value for money of Christian Aid's work to external stakeholders and also act as a first step towards a broader and more in-depth discussion within Christian Aid on the usefulness and applicability of demonstrating value for money (VfM) in the international development context.

The terms of reference included the following set of research questions. These questions were considered during the execution of the work and the analysis of the findings. Responses to these questions are highlighted in the 'findings and analysis' section as well as the 'challenges of retrospective analysis' and 'recommendations' sections of the report.

Research questions

a. Main questions:

   i. To what extent can Christian Aid Kenya demonstrate that the intervention has delivered added benefit and value to PWHIV , participating groups, communities and partners and others if applicable?

   ii. To what extent can this be considered an effective use of invested resources?

   iii. To what extent has the programme overall delivered value for money?

   iv. To what extent has the programme incorporated learning to improve subsequent/current programming?

b. Sub-questions:

   i. To what extent can the SROI methodology feasibly be applied given available documentation and information, as well as the context and various strategies employed by the CA Kenya Health programme? What are the challenges in this regard?

   ii. How could CA's monitoring and evaluation system be adjusted to better facilitate socio-economic cost benefit analysis in future?

DFID (Department for International Development) – a principal funder of Christian Aid's work in Kenya – has of late become increasingly interested that its funded projects consider different approaches to value for money. The SROI methodology is one such approach that attempts to capture the wider impact of an intervention, considering both primary and secondary stakeholders and the intrinsic value of social

outcomes (alongside economic and environmental outcomes) beyond just their economic use value.

Approach and methodology

The SROI methodology as detailed in the SROI guide[1] is the approach and methodology used for this piece of analysis. Greater detail of how elements of the SROI methodology were executed for this analysis is included in Appendix 1. A summary of the different stages of the methodology is presented.

SROI stages

Stage 1: Setting parameters and Theory of Change (Impact map)

Boundaries

- At the outset of the analysis, it was agreed that the work of two (of the six) partner organisations responsible for the delivery of the FtG project would form the basis of the analysis. ADS and KENWA were the partners selected on the grounds of their contrasting geographical and urban/rural settings. ADS operates in the predominantly rural province of Nyanza in the west of Kenya while KENWA is located principally in the slums of Nairobi and central Kenya. Both partners deliver the core activities of the FtG project while ADS also provided community-based health financing (CBHF) and SLAs. One location/community was selected for each partner to act as a sample for evidencing the impact of the project.
- The timeframe for the analysis was the full duration of the project, 2009–2012 inclusive.

Stakeholders

- Stakeholder engagement focused on discussions with FtG staff from both CA and its partners. These stakeholders identified the following persons/groups as those who had experienced an impact as a result of the FtG project:
    - PWHIV, Households (with one or more PWHIV), HBCGs, RLs, Local community
- These groups were deemed material to the analysis – the accountancy term for ensuring that all the areas of performance needed to judge an organisation's overall performance are captured by the analysis. They were deemed material due either to their close relationship with the target population or because they were significant in terms of numbers.

'Those people or groups who are either affected by or who can affect policy.'"

Stakeholders

Theory of Change (Impact map)

- Background research[2] and a workshop with FtG delivery partners and CA staff identified the outcomes, activities, and approach as well as the external factors that together constituted the FtG project ToC. Refinement of the ToC was subsequently conducted between the consultant and CHRISTIAN AID core staff.

Stage 2: Data collection

Indicators

- Indicators (to evidence outcomes) were identified between the consultant, Christian Aid staff, and partner representatives. Where possible, indicators (and data) from existing surveys were employed. Where gaps existed, new questionnaires were created (Appendix 2). Questionnaires were cognitively tested with the enumerators and delivered in the local language.
- Two intervention sites (Moro sub-location in Nyanza province and Olembo sub-location in central province) and two non-intervention sites were selected. The questionnaires for intervention and non-intervention sites were identical and a range of demographic data also collected to measure the similarities between the intervention and non-intervention sample populations.

Valuation

- Adjusted QALYs (quality adjusted life years) were employed as the principal valuation approach for physical and mental health changes. In the case of the well-being outcomes, a range of techniques was employed (detailed in Appendix 1). Principal among these was WTP (willingness to pay), WTA (willingness to accept compensation) and value game approaches. Valuation exercises were conducted in both locations and results compared. The same value was used for each outcome for both sites to ensure relative performance (of the two partners) for any one outcome was based purely on changes in outcome incidence.

Data collection

- Questionnaires were administered to both intervention and non-intervention sites in the selected locations. This approach produced both outcome and counterfactual data.
- Additional impact data, such as attribution, benefit period, and drop-off, were generated through stakeholder focus groups and secondary research.

Stage 3: Model and calculate

- All the data (indicator, impact, and investment) and projections (benefit period and drop-off) were modelled using an Excel cost-benefit model. The model produced:
    - SROI ratios for the two intervention sites
    - Distribution of value across stakeholders
    - Distribution of value across outcomes by stakeholder
    - Comparisons of gross and net change for indicator data

Stage 4: Report

- Key elements of the report include:
  - The ToC
  - The evidence to support the ToC The distribution of value by outcomes and stakeholders
  - The cost effectiveness of the initiative

Theory of Change

Introduction

'Theory of Change is a rigorous and a participatory process whereby stakeholders identify the conditions that have to unfold for their long-term goals to be met.'

ActKnowledge

The ToC explores the modalities and mechanisms of social and economic value generated for different beneficiaries of the FtG project. SROI analysis goes beyond enumerated activities to focus on outcomes, which are defined from the recipients' perspective as valued change. In essence, this is an account of *how* FtG activities have changed stakeholders' health and well-being in a way they identify as significant.

A ToC is at the heart of any SROI analyses. It attempts to present the (often complex) pathways through which an intervention is (un)successful. The ToC provides a crucial tool to re-examine the selection of various activities and their delivery model when outcomes are evidenced, i.e. the ToC allows you track back from final outcomes to interim outcomes and ultimately activities to understand how project effectiveness is achieved.

Need

The direct and immediate need addressed by the project was that effective uptake and use of ARTs in target communities was sub-optimal. While the Kenyan government has made the availability of ARTs more widespread in recent years, the efforts are predominantly of a supply-side nature. Research conducted by CA and its partners in November 2006 suggested the poor uptake/use was principally on account of poor nutrition among PWHIV. Supplementary research (verified by the London School of Hygiene and Tropical Medicine (LSHTM)) also indicated ART uptake was sub-optimal as a result of stigma, discrimination, and denial (SDD), as well as the costs involved to access the drugs (transportation costs).

Approach

This research influenced the design of the project and the range of activities co-developed by Christian Aid, partners, and PWHIV. Christian Aid's research and experience of HIV assistance projects across a range of African countries coupled with the extensive first-hand experience (of the partner organisations) of the lives of PWHIV recognised that

meaningful involvement of PWHIV was a critical success factor in the execution of any HIV related project. As such, the formation of support groups of PWHIV to counter SDD was a central tenant of the approach taken by FtG.

Complementary to the support groups were provision of HBCGs who provided both psycho-social care as well as positive prevention education. By locating the care in the PWHIV households, assistance was provided not only in a safe environment but also mitigated potential barriers to accessing care such as SDD and financial costs. Use of RLs to counter discrimination in local communities was the third key part of the approach employed. The theory suggested that the reach and standing of RLs within the community would make them an effective vehicle to break down SDD. For those RLs who had HIV to share their status would also send out a powerful message to the community.

Specific efforts to address barriers to effective access and use of ARTs were developed in direct response to the identified need for better nutrition and higher disposable income. These included a range of IGAs such as:

- Business training
- Establishment of SLAs
- Kitchen gardens
- Nutritious food rations

Intended outcomes

The original log frame for the FtG project identified seven key outcomes for the FtG project.

1. Increased numbers of PWHIV receiving quality care and support
2. Increased safe and effective access and adherence to ART
3. Increased economic and nutritional status of PWHIV and their families
4. Reduced SDD associated with HIV and improved knowledge, attitudes and practices (KAP) around HIV among the general community
5. Increased uptake of positive prevention messages by PWHIV (such as couples using condoms to prevent re-infection)
6. Increased capacity of community-based organisations and PWHIV to advocate for the rights of PWHIV
7. Increased capacity of communities to deliver and monitor best practise models of care and support

The approach taken in identifying outcomes in an SROI analysis is to identify the change that is valued by the person/group impacted, measure the extent to which it has been achieved, and then value it. For example, in an SROI, outcomes 1 and 2 identified above would be combined in the outcome 'improved physical health'. Outcome 4 actually results not only in improved physical health but also in improved mental health as well as certain components of well-being.

By asking the question 'so what?' in the ToC workshop, Christian Aid and partner staff were able to use their knowledge and experience of the project to go beyond the stated outcomes to a set of outcomes that represented the change valued by the beneficiaries and which encompassed health (both physical and mental), well-being, and economic outcomes. To help to arrive at the final list of well-being outcomes, two models of well-being were used as aids.[3,4] These models helped avoid the potential issue of double counting.

As mentioned earlier, SROI goes beyond traditional forms of cost-benefit analysis through its full exploration of both intended and unintended (externalities) changes of an intervention. The latter may be positive or negative and affect either the target beneficiary group or a different stakeholder group. To bring all changes resulting from the FtG project 'onto the balance sheet', the following section articulates the changes experienced by the full range of material stakeholders.

The importance of mapping out the theories of change for all impacts to all stakeholders is that it is then possible, by measuring the direct outcomes, to make a stronger case for the indirect outcomes occurring, even when some of them are too difficult (or too far into the future) to measure. This distinction between direct and indirect outcomes is crucial, as the main body of evidence collected through other FtG evaluations has been concerned with the analysis of direct outcomes for only the target population: PWHIV.

To demonstrate the relationships between the activities and approach of the FtG project and the impacts on each of the material stakeholders, impact maps present the changes for:

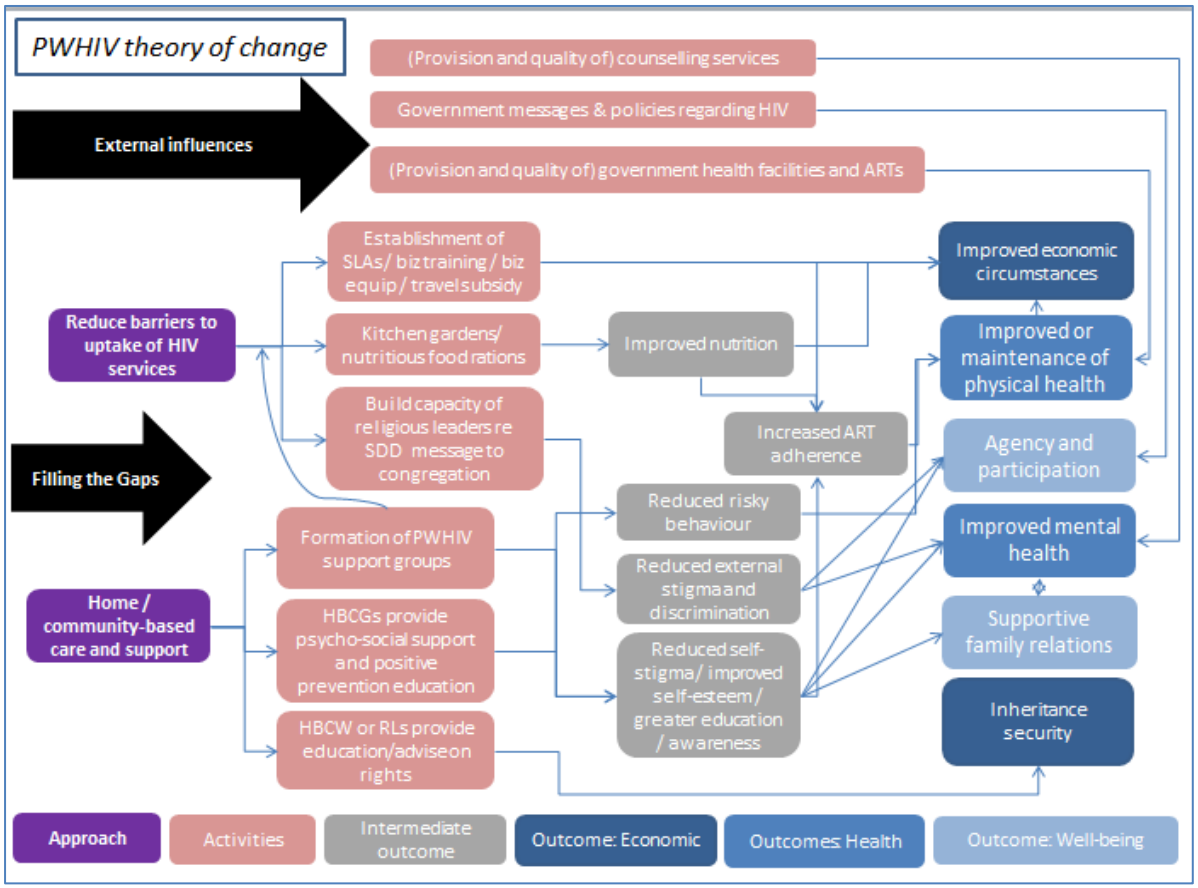
1. PWIV
2. Households
3. HBCGs/RLs
4. Local community

Theory of change by stakeholder

PWHIV

PWHIV are the target population for the FtG project. They are the group that benefits either directly or indirectly from all the intended outcomes listed earlier. However, as already mentioned, the intended outcomes, as formulated in the project's original logic model, were adjusted and in fact enhanced with a wider range of outcomes. These outcomes plus the theoretical linkages between activities, interim outcomes and external factors are presented in Figure 1.

Figure1: PWHIV theory of change



As presented in Figure 1, the ToC suggests that the FtG activities stemming from the two approaches to focusing support in the community (both in the home and between PWHIV) and reducing barriers to uptake of HIV services result in a range of intermediate changes (outcomes). These in turn support a range of final outcomes, the outcomes valued by the beneficiary group.

In the analysis, we recognise the intermediate outcomes as part of the journey the PWHIV experiences en route to the achievement of the identified range of health, well-being, and economic outcomes. The figure attempts to demonstrate

some of the complexity of the interrelationships between multiple activities and multiple outcomes as well as highlighting the reinforcing nature of certain outcomes, for example, supportive family relationships (a key social well-being outcome) and improved mental health. It is likely that in fact the final outcomes (as indicated to the right of the figure) are not just ends in and of themselves but have feedback loops that reinforce other outcomes, i.e. they also act to sustain other outcomes, acting as means to other ends. While this level of complexity is recognised, it is not included in the figure.

Households

Figure 2 presents the theory of change for the households of the PWHIV.

Figure 2: Households' theory of change

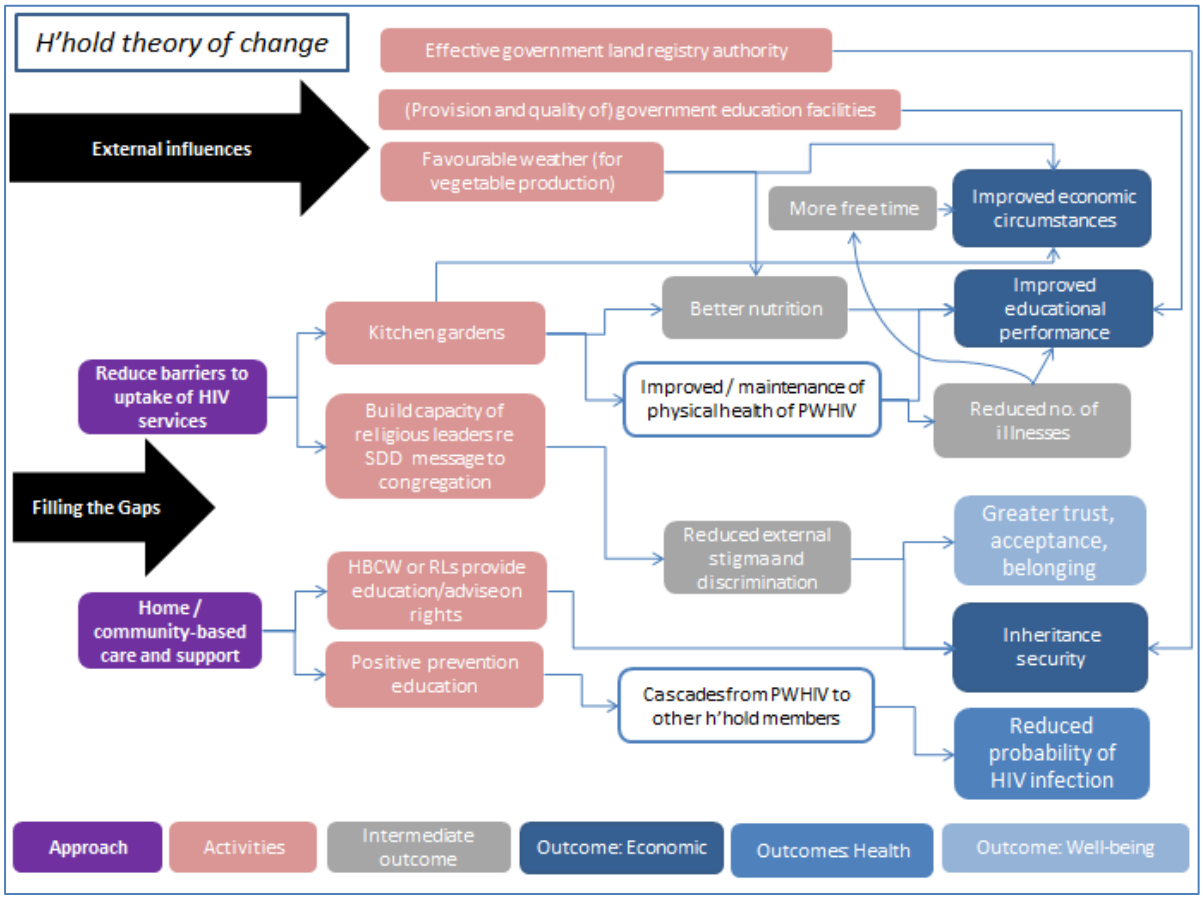


Figure 2 suggests that a number of changes (outcomes) beneficial to household members come about as a result of the change in the health of the PWHIV. For example, the theory suggests the improved health of the PWHIV (as indicated by a reduction in opportunistic diseases) can benefit household members indirectly through a reduction in the numbers of communicable illnesses passed on by the PWHIV, for example, diarrhea. This allows the other household members to spend more time in school or

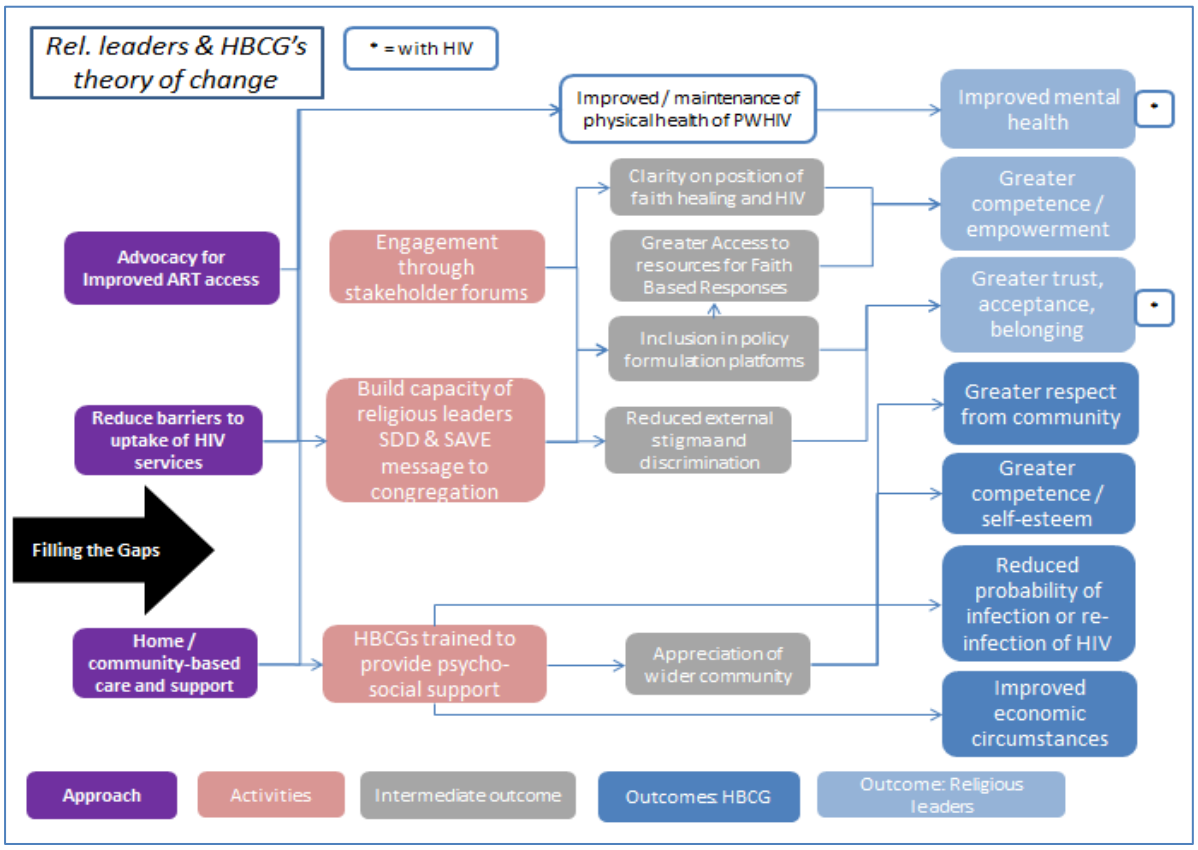
working. Other outcomes, however, such as 'greater trust/ acceptance/belonging' (a key social well-being component) are captured directly by the household as a result of the changed attitudes of the local community, driven in part by the messages communicated by RLs (in those areas where the religious are engaged).

Of course, a number of the activities designed to benefit PWHIV also extend to the householders of which they are a part. While kitchen gardens are designed to improve the ability of PWHIV to absorb their ARTs more effectively and ultimately improve their physical health, surplus produce can be sold on the market for the benefit of the whole household.

HBCGs

In many cost-benefit analyses, volunteer time is often captured as an investment but the benefits of volunteering are not always fully explored or recognised. Figure 3 presents the theory of change for the principal external provider of FtG activities, the HBCG.

Figure3: HBCGs' theory of change



The theory suggests that HBCGs receive additional income as a result of the skills/training received through the FtG project, but also social and personal well-being through greater levels of respect as well as greater competence and self-esteem from the position they hold within the community and the service they deliver.

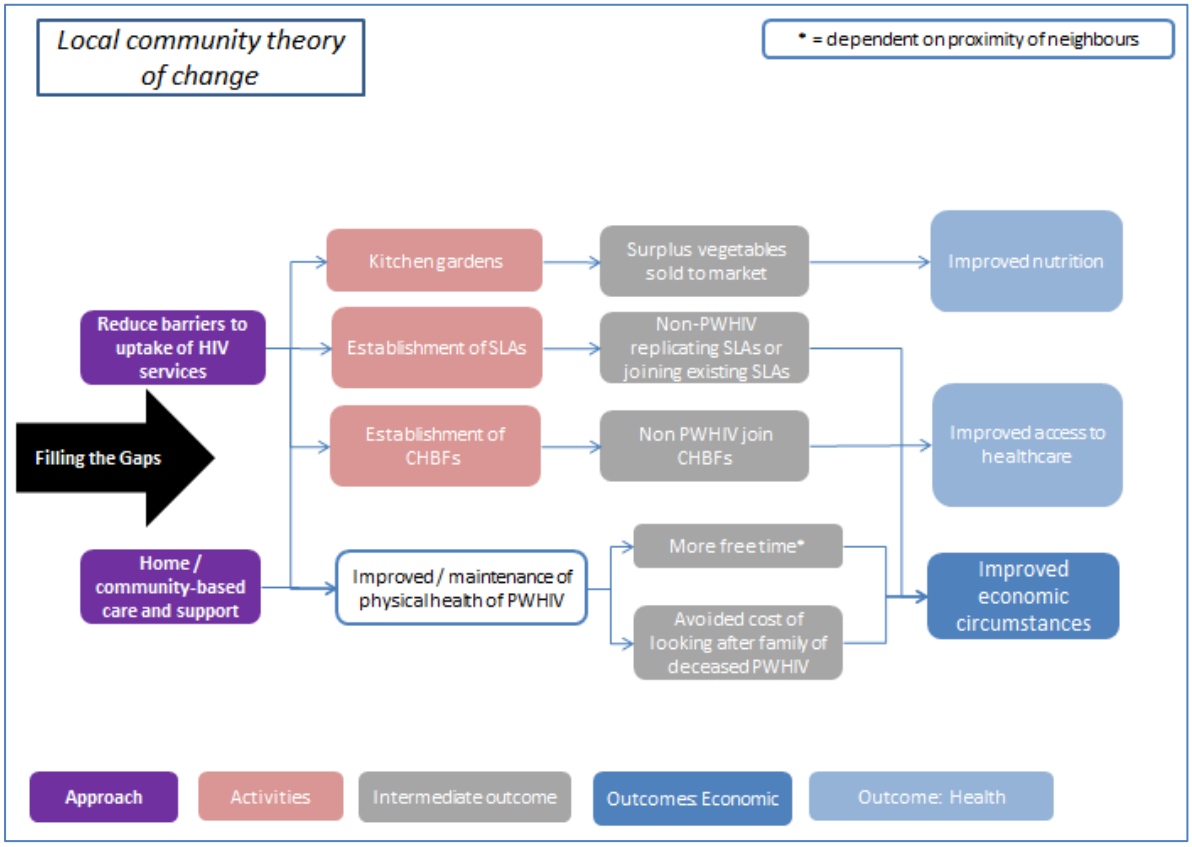
Religious leaders

Religious leaders are considered a material stakeholder for only one of the partner organisations – KENERELA (Kenya network of religious leaders living with AIDS). Only this partner actively engages RLs to undertake the activities as presented in Figure 1. For the purposes of the analysis, RLs are split into two categories: those with HIV and those without. All RLs theoretically receive well-being in the form of greater empowerment (from being able to do their job more effectively on account of their training and additional resources). The theory suggests only those who live with HIV benefit in terms of their mental health (living with HIV but previously unable to share their status) and social acceptance from the community.

Local communities

Finally, the activities of the FtG project are also deemed to impact the local community (Figure 4). The provision of CBHF and SLAs to non-PWHIV is not a feature of the work of KENWA and therefore not available to its local communities. The other benefits resulting from inheritance rights are however a benefit for all local communities in which FtG operates.

Figure 4: Local communities' theory of change



Findings and analysis

The findings and analysis section reviews key findings from the SROI model and are divided into four sections.[5]

1. An overview of the total value created
2. Distribution of value created for PWHIV
3. Distribution of value created for households
4. Distribution of value created for other stakeholders

Overview

The results for the two partners included in this analysis are presented in Table 1. Based purely on a review of the SROI ratios of both partners, the ratios suggest both produce positive returns on the investments made (both financial and social).

Table 1: SROI ratios

Partner	SROI ratio
KENWA	1 : 8.5
ADS	1 : 8.4

To test the robustness of the ratios, a sensitivity analysis was conducted on a number of the assumptions and variables used in the model. The assumptions varied included the source for the counterfactual figures,[6] the drop-off rate,[7] and an increase in the 'overestimation' rate – a result of people's recall bias.[8] The lowest the ratios fell to under a higher overestimation bias and a higher annual drop off rate was 4.0 and 4.2 for ADS and KENWA, respectively. Thus both ratios demonstrated a degree of robustness in the finding that FtG is a cost effective project.

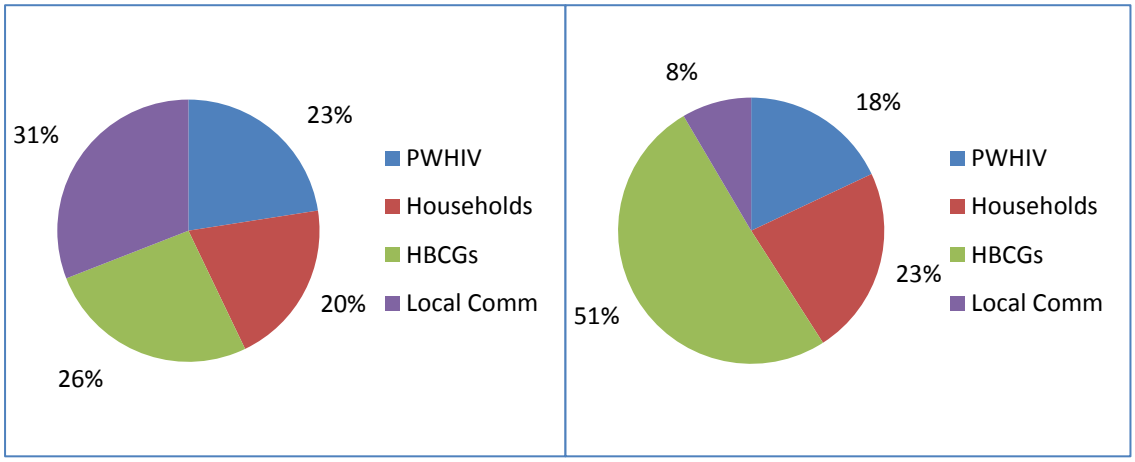
The difference between the two ratios in the base case scenario is insignificant. While ADS produces slightly greater value, it does so at a marginally higher cost (Table 2).

Table 2: Value and investment by partner

Partner/Site	Value	Investment[9]
ADS / Moro	£862,847	£102,162
KENWA / Olembo	£794,995	£93,272

The similarity in ratios is not, however, mirrored in the distribution of net value between stakeholders for the two partners. Figure 5 presents the distribution of value by stakeholder for the two partners.

Figure5: Distribution of value by stakeholder: ADS and KENWA, respectively



The noticeable difference between the two partners' impacts is the greater value created for the local community by ADS and the higher value produced for HBCGs by KENWA. The former is as a result of the provision of SLAs and CBHF by ADS. The latter is a product of greater earning potential on the part of HBCGs (resulting from their engagement with the project) in the areas in which KENWA operates. In both cases, the value to the target population (PWHIV) and secondary group (households) accounts for less than 50% of the total value created by the project.

Research question A1 asked whether the analysis demonstrates added value to the various material stakeholders. Figure 5 suggests that there is a net positive impact (added value) for all material stakeholders – PWHIV, households, HBCGs, RLs, and local communities.

Research question A2 asked whether the project can be considered an effective use of invested resources. An SROI ratio cannot provide a full answer to this question. It can only tell us whether the value generated by an intervention exceeds the investment made. It does not tell us whether an alternative project would have created greater value for a similar level of investment.

Table 3 presents the values created for each stakeholder alongside the investments made by each partner (and supporting organisations[10]).

Table 3: Value and investment by stakeholder and partner

Stakeholder	ADS (Moro)	KENWA (Olembo)
PWHIV	£194,503	£143,094
Household	£175,509	£182,286
HBCG	£226,008	£402,282
Local community	£266,826	£67,332
Investment	£102,162	£93,272

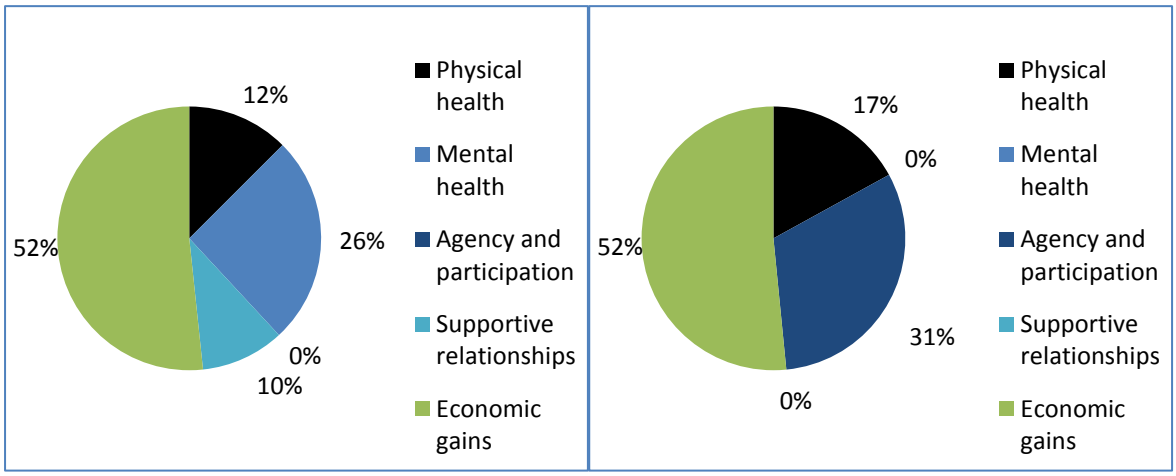
If we were to consider the value created only for the target population (PWHIV) in an attempt to estimate whether the project has been value for money, then the ratios for ADS and KENWA would amount to 1:1.9 and 1:1.5, respectively. This would suggest the project is cost effective, and produces value for money. With, on average, around 20% of the total value captured by PWHIV, the question as to whether ADS and KENWA could have delivered the FtG project in a different way that increased that percentage is not straightforward to answer. However, as most activities were focused on PWHIV and a number of the impacts experienced by other stakeholders were unintended, it would seem that a significant increase in the proportion of value captured by PWHIV would be unlikely. The suggestion of real value (both financial as well as social) created for other stakeholder groups indicate the limits (risks) associated with measuring only the impact of a project on its target population.

Research question A3 asks whether the programme has delivered value for money overall. In terms of cost effectiveness, the SROI ratios suggest the response is yes. However, SROI considers only the cost effectiveness of an intervention, not the cost economy and cost efficiency. Only a review of the procedures Christian Aid and partners employ for the procurement of goods and services necessary for the delivery of FtG can estimate the cost economy of the project. As for the cost efficiency of the project, the achievement of one key output of the project, for example, the number of people using ARTs would need to be compared with other projects with the same desired output to know whether the project is cost efficient.

PWHIV

The ToC suggested PWHIV experienced six outcomes, two of which were psycho-social well-being focused (greater agency in community matters and more supportive family relationships), two were economic (IGAs and avoided costs of dis-inheritance), and two were related to health (physical and mental). Figure 6 presents the breakdown by value across the seven outcomes for both intervention sites.

Figure 6: Distribution of value by outcome: ADS and KENWA, respectively



There are both similarities and differences in the distribution of value by outcome between the two partners. PWHIV in both locations experience an approximately similar proportion of their total benefit as economic as well physical health. However, while around one-quarter of the net value created in ADS is in the form of improvements in mental health, there is no such apparent net change for PWHIV in KENWA. Conversely, a large net change in agency and participant for PWHIV served by KENWA is absent for ADS. The difference in agency and participation between the two delivery partners may have been on account of differences in their target populations. During the ToC stage of the work, there was the suggestion that improvements to agency and participation was likely to be experienced more by women than men. The sample for ADS contained both men and women. However, the sample for KENWA (as a women's focused organization) was exclusively women.

For both the above examples where one or other partner did not appear to create a net positive change, it is not to say that a positive change was not experienced. It was, as Figures 7 and 8 show. It is that the difference between the sizes of the changes in the intervention sites versus the control sites was not statistically significant, i.e. PWHIV in

the intervention site would have experienced the same change in the absence of the FtG project.

Figure 7: Outcome incidence (number of full change person equivalence) for PWHIV served by ADS

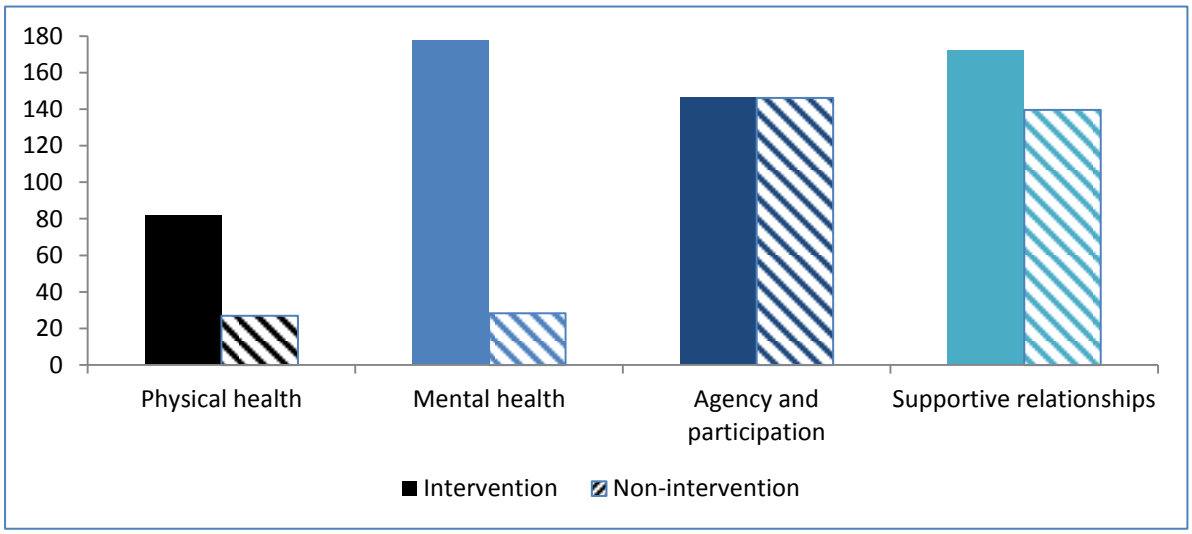
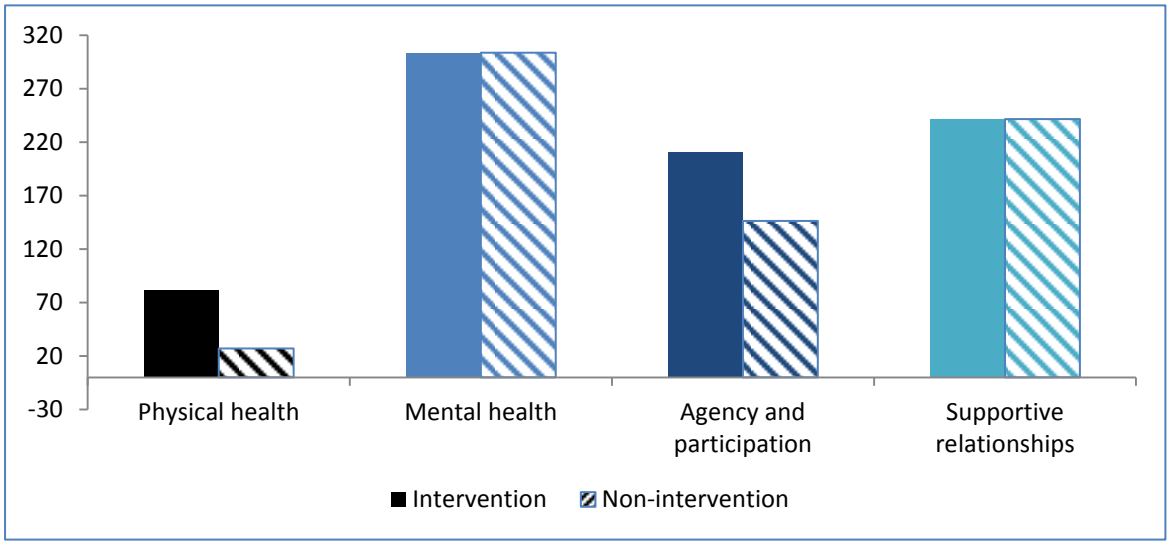


Figure 8: Outcome incidence (number of full change person equivalence) for PWHIV served by KENWA



Figures 7 and 8 suggest that the activities identified in the ToC as driving an increase in the well-being outcomes of PWHIV are not especially effective. In one regard, this may not be unexpected. These outcomes were not identified in the original needs analysis and are in effect unintended consequences of the project. As such, they are an 'added benefit' of the project.

The data appear to support the link between 'supportive relationships' and mental health as suggested in the ToC. A positive net change was experienced in both these outcomes

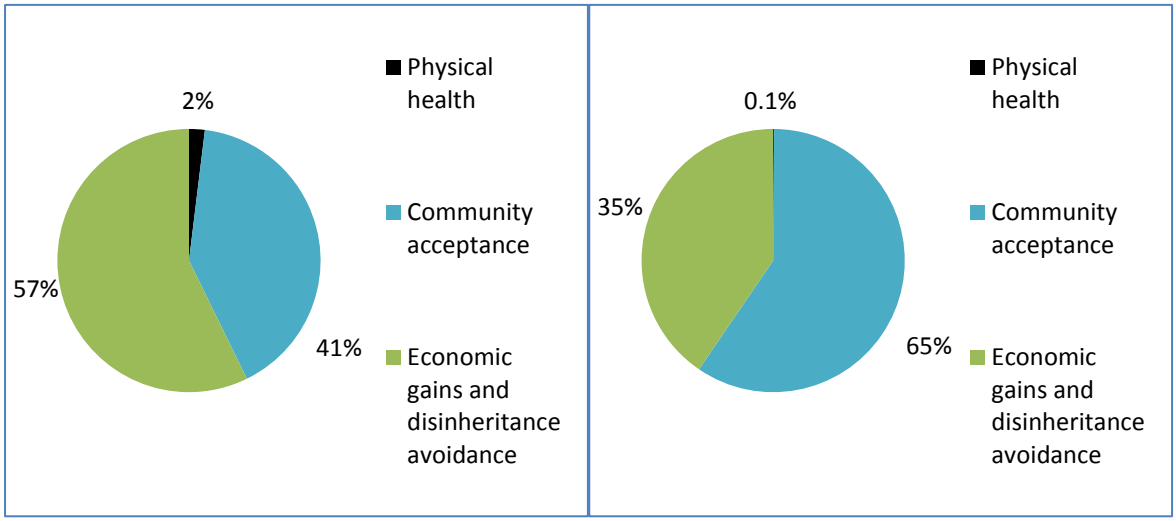
by PWHIV served by ADS where a net improvement was not in evidence for either in KENWA.

Improved physical health (as indicated by the extent of people regularly using ARTs and adhering to their schedules), one of the original outcomes identified at the design stage of the project, showed a net rise in both locations, as did economic outcomes (via rises in disposable income).

Households

Figure 9 presents the distribution of value created across the three key outcome groupings identified in the theory of change for households.

Figure 9: Distribution of value by outcome: ADS and KENWA, respectively



Physical health improvements constitute a small percentage of the total value as they relate solely to changes in attitudes to risk, itself related to the probability of becoming infected with HIV. There is also very little difference (in the case of KENWA) between the intervention and control groups (Table 4).

Unlike PWHIV, the net change in the well-being outcome for households constitutes a signficant proportion of the total value created for households. Whereas the well-being outcomes for PWHIV could be categorised as positive unintended consequences, an improvement in levels of community acceptance directly corresponds with the fourth outcome identified at the beginning of the project. Thus activities were specifically targeted toward the attainment of that goal.

Table 4 presents the intervention and control site results for each of the outcomes experienced by the household.

Table 4: Average full change person equivalence scores by outcome by partner[11]

	ADS	KENWA
Outcome: Physical health		
Indicator: Reduced probability of HIV infection		
Av. outcome FCPE score	97	70
Av. counterfactual FCPE score	67	68
Outcome: Community acceptance		
Indicator: Levels of community acceptance		
Av. outcome FCPE score	73	81
Av. counterfactual FCPE score	50	46
Outcome: Economic gains and disinheritance avoided		
Indicator: Share of new business income, Kitchen garden savings (+ income), avoided disinheritance		
Av. outcome FCPE score	£633	£824
Av. counterfactual FCPE score	£11	£345

The ToC suggests that prevention education cascades down to other household members from the PWHIV in the household. This reduces their probability of becoming infected with HIV. Certainly the data suggests behaviour does change, potentially reducing the probability of HIV infection. However, similar levels of behaviour change is apparent in those households in the control groups for both locations. The small net change (particularly in the case of KENWA) may be explained by the presence of messages about prevention from other sources, for example, the government.

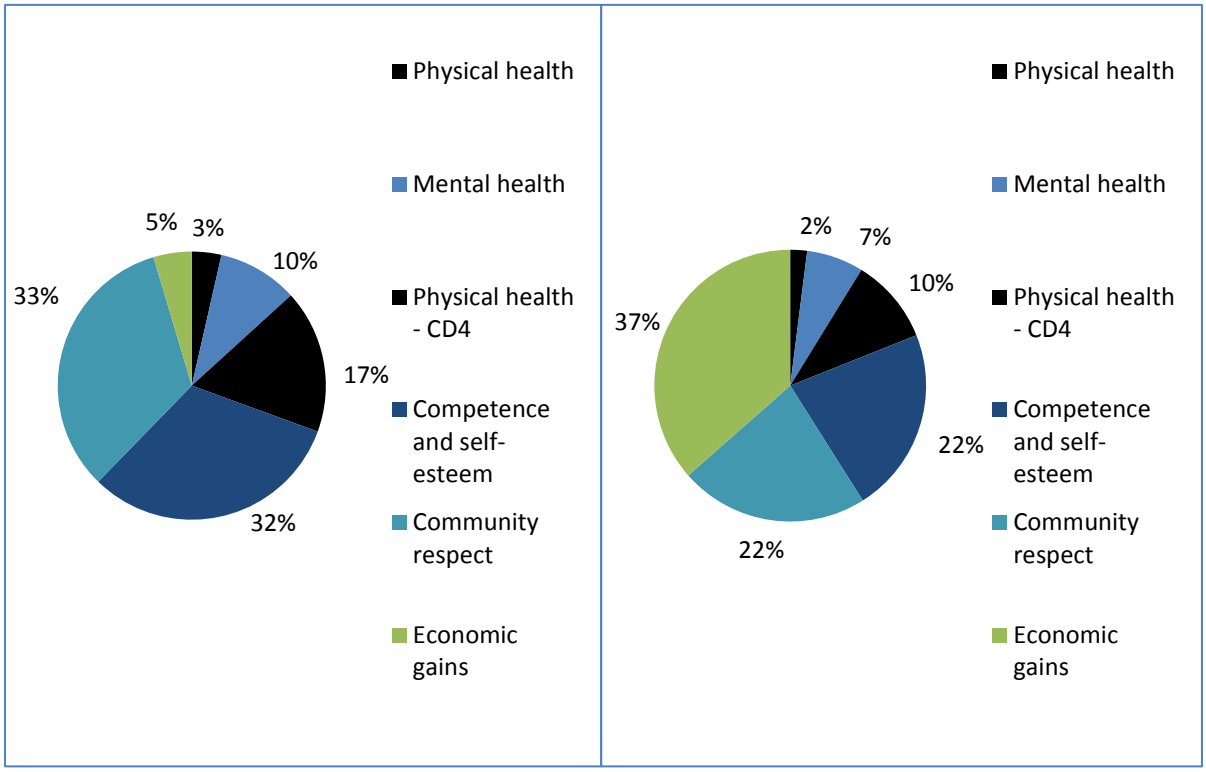
Of all the components that make up the change in economic circumstances (sick days avoided, improved earnings from improved educational performance, higher earnings from new IGAs), only additional income from new IGAs proved statistically signficant for the intervention site when

compared with the control site. This income rise was driven in large part by the presence of SLAs and the provision of business training/equipment.

HBCGs

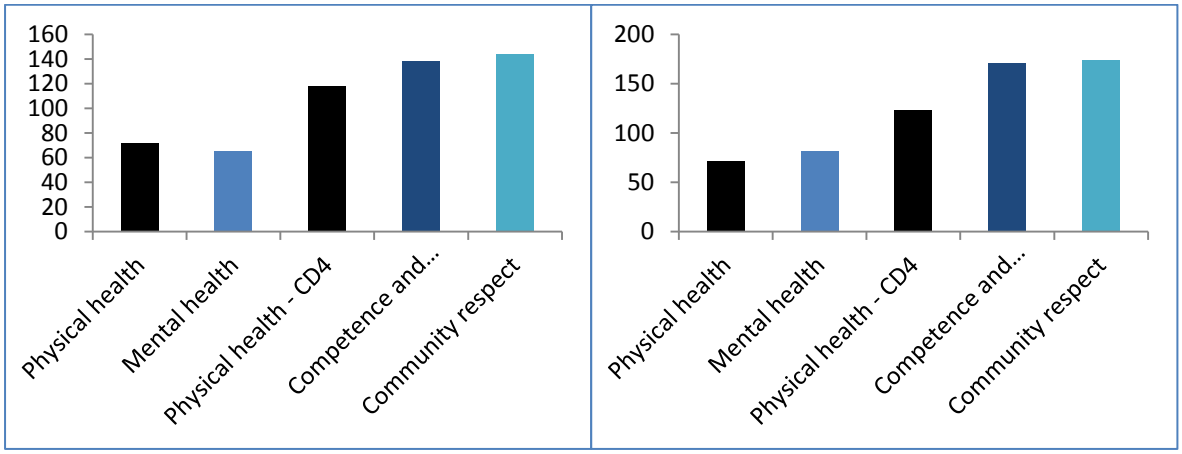
Figure 10 presents the distribution of value created across the outcomes (identified in the theory of change) for HBCGs.

Figure 10: Distribution of value by outcome: ADS and KENWA, respectively



As a deliverer of a number of the key activities for the FtG project, HBCGs experience a range of outcomes. Those that live with HIV experience the same physical and mental health outcomes as those they assist. All HBCGs, however, benefit from increased levels of community respect and feeling more competent/self-assured in the execution of their work. Physical health is represented twice in Figure 10. The smaller segment of physical health relates to the reduced risk of infection (for those HBCGs without HIV) and reduced risk of re-infection for those with HIV versus the physical health benefits (indicated by improved CD4 counts) for those with HIV from better adherence to ARTs. Information to provide a counterfactual for HBCGs was taken from focus groups discussions. The likelihood of these outcomes occurring in the absence of FtG was taken from questionnaire data and ranged from between 10% and 30%, depending on the outcome.

Figure 11: Outcome incidence (number of full change person equivalence) for HBCGs working with ADS and KENWA respectively

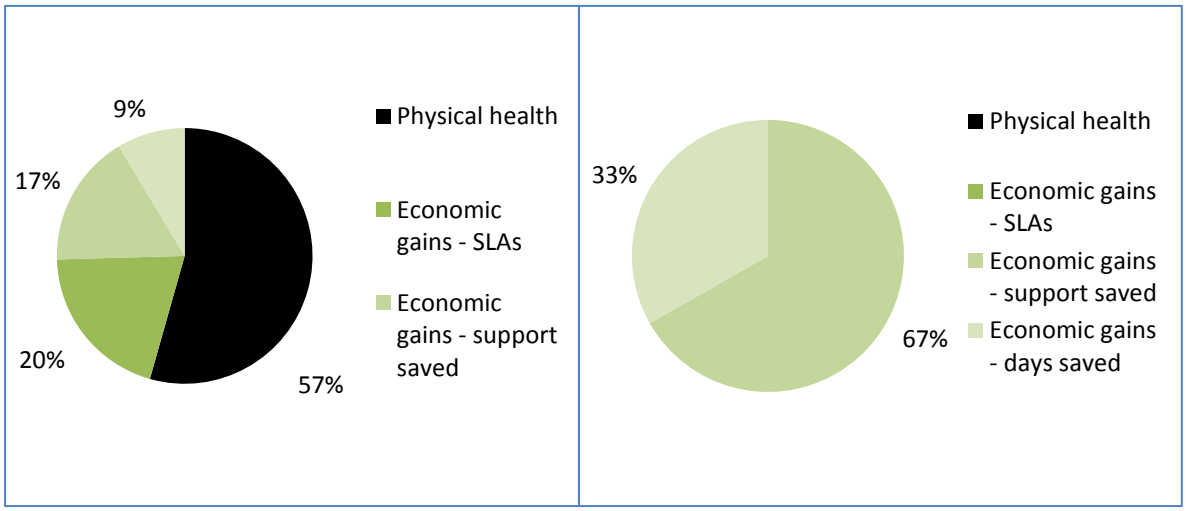


The greatest impact (net change) for HBCGs in terms of both the number seeing an improvement and the size of that improvement are the well-being outcomes 'competence and self-esteem' and 'community respect' (Figure 11). Prior to becoming HBCGs on the FtG project, many were community health volunteers, providing services for the local government. It is likely they would have received preventative education and ART assistance from that time. The model employed by FtG, however, places a greater emphasis on individual relationship building with PWHIV. This focus on building an on-going relationship is likely to account for the greater well-being changes witnessed.

Local community

Figure 12 presents the distribution of value created across the three outcomes identified in the theory of change for the local community.

Figure12: Distribution of value by outcome: ADS and KENWA, respectively



The notable difference between the two sites is the absence of health benefits for members of the local community served by KENWA. As previously mentioned, this is because KENWA does not operate a CBHF scheme. The value ADS local community members receive from access to such a scheme is the ability to access healthcare without fearing that the costs associated with such access will be ruinous. As such, they are less likely to base their healthcare decisions on costs and thus more likely to be healthier. The community value for non-PWHIV local community members is partly on account of the high value they assign to this outcome, but also the relatively high numbers of households signed up the scheme – 25% of the total membership, or 16% of the total Moro sub-location population.

The economic gains experienced by both communities include:

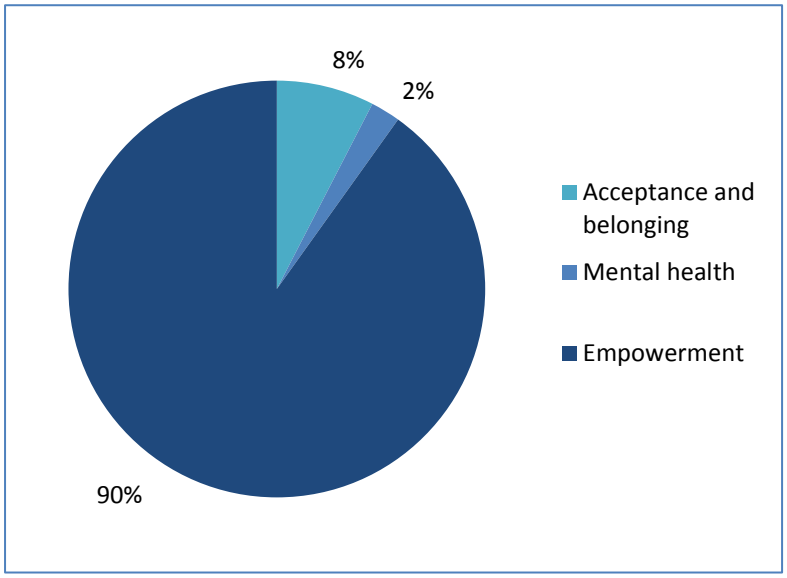
- The avoided cost of having to look after members of families where the head of the household died prematurely on account of AIDS.
- The opportunity cost of time spent caring for neighbours who are PWHIV.

Such expenses, ranging from the short-term such as funeral costs to the long-term, such as supporting children's education, can amount to a considerable sum. Thus, an extension in the life expectancy of PWHIV can have significant cost savings for the local community. In addition, those communities with SLAs have 'opened' their doors to allow non-PWHIV to join. New businesses have been developed from commercial farming to trading, livestock rearing, and beekeeping, as well as tailoring and provision of tree seedlings.

Religious leaders

While not an explicit contributor to the work of the ADS and KENWA, religious leaders are proactively engaged by another of the FtG partners, KENERELA. Figure 13 presents the distribution of value created across the three outcomes identified in the theory of change for religious leaders.

Figure13: Distribution of value by outcome: KENERELA



The feeling of empowerment, the ability to affect change, to feel free to achieve the goals of one's work constitutes the overwhelming value created for RLs. This is partly on account of this outcome being applicable to all RLs engaged by KENERELA whereas improvements in mental health and greater feelings of belonging are confined to those RLs living with HIV, who constitute only a percentage of all RLs engaged.

Partners

Focus group discussions (FGDs) with partners (KENWA and ADS) suggested these organisations also realise a certain net benefit as a result of their engagement with Christian Aid and the FtG project. These changes have not been monetised in this analysis but (in qualitative terms) include the following:

- Capacity building. Both partners highlighted the investment in training provided by Christian Aid over and above what they have received when working with other international non-governmental organisations (INGOs). In recent years, capacity building in HIV management and home-based care, gender awareness training, SROI training, was provided by Christian Aid. The net effect of this has been to help them mature as organisations, broaden their offer, and make them a more highly skilled more attractive proposition for INGOs to work with in the future. While neither could assume a direct causality between the training received and, for example, the growth in the size of their organisations, there was a feeling that they could serve

their constituents better as a result of their connection to Christian Aid and FtG.

- The use of challenging targets by Christian Aid was mentioned as helping KENWA to have to think creatively about how they would achieve those targets, resulting in it reaching beyond its core constituents to work in other counties.

Challenges of retrospective analysis

The key challenge for this analysis was the lack of existing data demonstrating the magnitude of change for the outcomes identified in the ToCs. In a way it is understandable that no data were collected at the beginning of the project for the outcomes identified in the ToC as unintended. That is not to say it would have been impossible to predict their materialisation at the start of the project, just that it would have been more difficult. Their absence and the subsequent recording of baseline indicator data presents the problem of recall. For certain outcomes the most appropriate indicators are subjective (perceptive). Asking an interviewee to recall the emotion they experienced upwards of four years ago is problematic. Research[12] suggests that an individual's powers of recall are not perfect and that in instances of retrospective data collection, there is the risk that the magnitude of the change experienced is overestimated. It is particularly problematic to ask control groups subjective questions when there is no 'anchor point' for them to refer to in the past such as 'at the time of your first involvement with the project'.

Research question A4 asks to what extent the programme has incorporated learning to improve subsequent/current programming. The SROI analysis does not answer this question directly. To do so would have required the collection of data at three points in time: the start of the project (baseline), mid-term, and at the project's end along with detailed investment data as to when funds were spent during the four-year life of the project. It is highly unlikely that interviewees could have accurately responded about their status (retrospectively) for two different points in time.

If we focus simply on the data utilised in this SROI analysis collected from existing surveys at the base line, mid-term, and end of the project, i.e. the extent of use of ARTs and ART adherence in the target populations, then the rates of growth suggest no significant difference between the first half of the project compared with the second half. This is not to say that early lessons weren't learned and implemented later and rates of increase would not have declined in the absence of those lessons being incorporated into the service delivery model. It is, however, impossible to answer this question in the absence of control data measured at multiple points in time.

Research sub-question B1 asks to what extent the SROI methodology can be feasibly applied given available documentation and information. The completion of the analysis based on primary data from the full range of material stakeholders (and control groups) demonstrates the feasibility and applicability of the SROI methodology to this type of project, regardless of the existence of data. In the final analysis, only data on the extent of ART usage plus the

frequency of usage collected by the mid-term review and end-term evaluation were incorporated into the SROI model.

Many of the other indicators used in these surveys/reviews were deemed output (or process) indicators, evidence that an activity had taken place or how well it had taken place, but not how, and by how much, the stakeholder had experienced the change they valued.

Recommendations

Christian Aid

That only certain parts of the existing project data were appropriate to the SROI analysis talks to **research sub-question B2**: How could Christian Aid's M&E system be adjusted to better facilitate socio-economic cost-benefit analysis in the future? This is not a surprise as traditional M&E formats tend to focus on collecting data for the intended consequences of a project. The SROI methodology deliberately explores the unintended consequences, both for intended and unintended beneficiaries.

The SROI methodology is an outcomes-based methodology. As such, it does not explicitly measure progress indicators. Through a focus on the creation of a clear ToC combined with the collection of outcomes data, it permits an analysis of the performance of the activities of a project.

A collection of three short (relative to the mid-term review and end evaluation) questionnaires provided all the required outcomes data for the SROI analysis. Coupled with investment data routinely recorded by Christian Aid and its partners and valuation data collected through one-off FGDs, all required impact data could be collected by Christian Aid and its partners in the future in a relatively time efficient manner.

The key advantage of developing a ToC at the design stage of a project and basing the project's outcomes on what recipients value most is that unnecessary data is not collected.

A key recommendation for Christian Aid is the ***consideration of all material stakeholders*** at the design stage of a project ***and mapping out their potential impacts*** (ToC). Understanding the change that may occur for a range of stakeholders not only provides the potential (unintended consequences can be negative as well as positive) for a more convincing narrative on VfM, but also provides the type of information which can facilitate the conversations with different actors that can precipitate more effective resource use. For example, if your project is health focused, but your ToC suggests the benefits extend to the education field, a conversation with education project providers could provide for a more optimal use of shared resources and thus greater VfM.

Engaging control groups can increase the costs of an evaluation or impact analysis considerably. However, they are becoming more popular in the development arena. It may be worth Christian Aid ***identifying a select few projects where control groups are engaged*** at the beginning of a project and tracked alongside the project's recipients. To ensure accuracy of comparative findings between intervention and non-intervention sites, the

selected projects should be those which have a 'flagship' outcome, one outcome that is expected to capture the majority of the value created. The reason for selection of such projects is that with multiple outcomes it is more difficult to be confident that the net impact measured across multiple outcomes is only on account of the project/intervention being analysed.

Resist the urge to measure only output data. Output indicators (evidence that activities have taken place) are attractive because they are often observable and relatively easy to measure. However, the majority of output indicators will not tell you about the quality (and hence effectiveness) of a project.

Interrogate this analysis alongside partners to identify what findings are new and what simply confirm the findings and conclusions of other studies. Reach consensus on which parts of the process/analysis were most useful and instigate a process to include these in future impact analyses. Use the analysis to understand best practise and share these across other HIV response programmes.

Partners: general

This SROI analysis ultimately considers the impact on the lives of a range of stakeholders as a result of the investment made by Christian Aid. Whether that investment is value for money largely rests on the delivery by the partners. The results of the analysis suggest that the partners are doing a good job in the execution of the project, delivering VfM. To maintain and to possibly improve performance in the future it is recommended that ***partners utilise outcomes-based impact methodologies to regularly review the achievement of their project goals*** at timed intervals during the lifetime of a project. It is not always necessary/possible to complete a full SROI. The identification (ToC) and measurement of (evidence of the ToC) the outcomes (without valuation) may provide sufficient data to permit learning and improved future performance.

Recognise your successes. It is often easier to focus on the negatives. It is important is to understand how the gains made can be protected.

Partners: specific

For KENWA, the principal recommendation is to ***consider adoption of SLAs and CBHF*** in any future relevant projects, both of which provided great value for the wider community supported by ADS.

Investigate with your stakeholders the results of the analysis. In particular, why (as the data suggests) there was no statistically significant difference in the improvement in mental health and supportive relationships between the intervention and control sites.

For ADS, ***investigate with your stakeholders the results of the analysis.*** In particular, why (as the data suggests) there was no statistically significant difference in the improvement in agency and participation between the intervention and control sites.

Interrogate the workings and findings of this analysis to understand what data is useful and ***consider which other projects might benefit*** (both in terms of internal improvement and/or external validation) ***from an SROI analysis.***

Appendices

Appendix 1: SROI methodological details

Indicators, sampling and testing

Primary data collection was employed for all indicators used to evidence the outcomes except for the extent of ART usage plus adherence to ART programmes. These indicators plus the data they yielded were drawn from the FtG mid-term review and end term evaluation. Table A1 details the sources for the indicators employed in the SROI questionnaires (appendix 2).

Table A1 – Sources of indicators for questionnaires

Stakeholder	Outcome	Indicator	Source
PWHIV	Physical health	Nos. adhering to ART	FtG end-term evaluation
		Nos. of non-scheduled visits to health facility	New
		Self-reported CD4 count	New
	Supportive relationships	Levels of supportive relationships	National accounts of well-being (NAWB)
	Mental health	Levels of optimism	SWEMWBS (short Warwick Edinburgh well-being scale)
		Level of anxiety/depression	PHQ-2 – World Health organisation
	Agency and participation	Degree of participation in community groups/committees	New
	Improved economic circumstances	Net consumption plus net savings	New
Household	Greater acceptance / belonging	Extent to which feel community accepts you	Adapted NAWB
	Physical health	Use of preventative measures	CA
		Nos. of non-scheduled visits to health facility	New

	Improved economic circumstances	Value of excess produce from kitchen garden	New
		Nos. of non-scheduled visits to health facility	New
		Number of people who feel fully aware of their rights	New
HBCG	Physical health	Use of preventative measures	CA
	Improved economic circumstances	Whether gained work opportunities as a result of involvement with project	New
	Greater self-esteem	Amount people in the local community ask for your help	New
	Greater community respect	Perceived level of respect from community	NAWB

The data collection (questionnaires plus FGDs) took place during the week of 25th March. Table A2 provides the sample size of the target sites. Around one hour was taken to complete each PWHIV and household questionnaire. A half hour was taken for the HBCG questionnaire. The only stipulation for the sample selection was that the proportion of the PWHIV sample that was male or female approximately matched the wider PWHIV population. Otherwise, interviewees were selected at random. In order to increase the sample size, representatives of household needed to be from different households to the PWHIV interviewed.

Table A2 – Sample sizes

Stakeholder	Intervention site	Control site
Questionnaires		
PWHIV	45	30
Household	45	30
HBCG	20	n/a
Total (for ADS and KENWA)	**220**	**120**

FGDs		
PWHIV/H'hold/Local comm/RLs	10-15	n/a
Total (for ADS and KENWA)	**Approx. 90**	

A number of statistical tests were employed to test the data. The first test compared the demographic data from the intervention and non-intervention sites. For the ADS sample, only the difference in education level was statistically significant, in favour of the analysis i.e. the intervention site had a lower level of education than the control site. For the KENWA sample, the only statistically significant difference was for marital status, not deemed a hugely influential variable on the analysis.

For the vast majority of the data, a chi-squared test was performed, being the most appropriate for testing statistical significance for ordinal data. Where there is no statistically significant difference between the changes (for a specific piece of indicator data) for the intervention site versus the control site, they are considered to be equal. And as highlighted in the findings section of the report, the net change is treated as equal to zero. For testing the health question 'CD4 count' which did not produce ordinal data, a man-whitney test was employed.

Impact considerations and changes over time

The control survey data accounted for the counterfactual…the key impact consideration in any analysis. In the case of HBCGs, an attribution question was used in the questionnaire to ascertain how much of the change experienced was on account of the role played by government, the only other actor in a counterfactual scenario. In fact, the absence of any actors other than FtG and the government when the attribution question was asked more generally in the FGDs suggested that to include a consideration of attribution (as is normal in an SROI analysis) here, would in effect be double counting. This is so because the government's actions had already been accounted for in the counterfactual. Care was taken in selection of the control sites that only the government was providing similar type services. This was the 'business as usual' scenario.

As regards how long the changes created by the project might last in to the future, in the absence of any longitudinal studies for similar interventions, a conservative figure of five years was employed across the board. As for drop off, ADS staff contacted participants that had been involved in a

project with a not dissimilar community owned focus to it that they had been involved with previously. That project had concluded three years ago. The staff performed an attribution exercise to understand by how much the benefit attributable to ADS had dropped off over time. The figure came to approximately 10% per year. This figure was used as the annual drop off amount for all outcomes other than for economic outcomes related to new business startup for which we assumed a drop off rate of 30%. The rationale for this higher figure was the assumption that after 3 years the entrepreneur will be sustaining the business through their own efforts.

Valuation and proxies

A range of proxies and valuation techniques were employed in the analysis to place a monetary value on non-market traded outcomes i.e. non-economic outcomes. Table A3 presents the proxy figure plus the valuation technique. The description of how the valuation techniques were employed can be found in the relevant FGD guide in appendix 3. Across the majority of outcomes, different forms of stated preference approach were employed e.g. Willingness to pay (WTP) and willingness to accept compensation (WTA).

Stated preference approaches (as opposed to revealed preference approaches e.g. observed spending or the value game) tend to generate higher values than revealed preference approaches as they attempt to capture the full (instead of the 'use') value of a change to an individual. As such, care was taken to ensure the values relative to each other were consistent with the views of the beneficiaries.

Table A3 – Proxy values and valuation techniques

Stakeholder	Outcome	Annual proxy value	Valuation technique
PWHIV	Physical health	£153	WTP to derive an adjusted QALY
	Mental health	£153	" "
	Supportive family relationships	£281	Value game
	Agency and participation	£320	WTA compensation
Household	Community acceptance	£281	Value game

	Physical health (avoided HIV infection)	£52	As per WTP above but multiplied by probability of infection (estimated at 50% for high risk behaviour)
HBCG	Physical health (avoided HIV infection)	£52	" "
	Physical health	£153	WTP to derive an adjusted QALY (See above)
	Competence and self-esteem	£239	50% of opportunity cost of time spent working as HBCG
	Community acceptance	£239	50% of opportunity cost of time spent working as HBCG
Local community	Physical health	£668	WTP
Religious leaders	Community acceptance	£281	Value game (see above)
	Empowerment	£320	WTA compensation (see above)
	Mental health	£153	WTP to derive an adjusted QALY (See above)

Modelling

For many of the outcomes identified in the theory of change, multiple indicators were developed to evidence each outcome. When modelling the outcomes, two approaches were taken dependent on the types of indicators employed.

1. When the indicators were of the same type e.g. subjective with ordinal response codes, then the movement of all were averaged.
2. When the indicators were different e.g. subjective and objective with in response codes, then the data from one indicator was selected for modelling purposes. This was conditional on all the indicators suggesting the same direction of travel for the outcome.

Full change equivalence (FCE) was used to calculate the extent of the change that had taken place for each outcome for each stakeholder population. For explanatory purposes we provide the following example of FCE: If 50% of the population experienced an improvement of 50% in a particular outcome, then that is equivalent to 25% of the population experiencing a 100% (or full) change. This was a necessary step to take in the calculations as the proxies often used in the model represented the value of a full change in an outcome.

Appendix 2: Questionnaires

SROI PWHIV Questionnaire Survey – Filling the Gaps (FtG)

PARTNERS…….Partners' Code

(Partners Code: ADS=1, KENWA =4, KENERELA=5)

COUNTY OF EVALUATION NAME ……County Code

CONSTITUENCY NAME……

VILLAGE ……

QUESTIONNAIRE NUMBER

ENUMERATOR CODE

DATE OF INTERVIEW -------- March, 2013

ORAL CONSENT TO PARTICPATE IN SROI EVALUATION FOR FILLING THE GAPS (FtG) PROJECT: "maximizing the effectiveness of existing ART, care and support programmes for people with HIV"

"Good morning/afternoon, my name is ……and my colleague is……..We are from ..... (Mention the Partner) .The purpose of this evaluation is to establish the degree to which the outcomes of the FTG project were, or were not achieved. We would like to ask you to spare us some time. The information you provide will assist us to get feedback on whether/how the interventions have impacted on your life. The information collected will be kept confidential and your name will not be written on the SROI report.

Do you agree to participate in the assessment? (Circle.) 1=YES 2=NO. I hereby witness that the participant agrees to consent in the survey on this date _____.

_____

(Signature of enumerator)

Supervisor check box

All cover sheet codes completed	
All required questions answered	
Supervisor signature	

1.0 DEMOGRAPHIC & SOCIAL INFORMATION

***Read**: I would like to ask some simple questions about you.*

1.1 Age of the respondent

1. <20
2. 21-30
3. 31-40
4. 41-50
5. >50

1.2 Sex of respondent

1. Male
2. Female

1.3 Marital status of respondent

1. Married (monogamy)
2. Married, polygamy
3. Widow(er)
4. Separated
5. Single
6. Living with a partner

1.4 What is your relationship with the head of the household?

1. I am the head
2. Spouse
3. Child by Birth
4. Grand child
5. Other children by relation
6. House help
7. Other (specify)……..

1.5 What is your highest level of education?

1. None
2. Primary
3. Secondary
4. Vocational
5. Tertiary
6. Madrasa

1.6 When did you first engage with the FtG project?

1. 2008
2. 2009
3. 2010
4. 2011

SECTION 2: PHYSICAL HEALTH OF (People with HIV and AIDS) PWHIA

***Read**: I would like to ask you questions related to your general physical health. Please answer the questions as accurately as you can.*

[You may need to provide clarity on non-schedule visits. Examples are opportunistic illnesses]

2.1 How many **scheduled** visits to a health facility have you made in **the past month**?

1. None
2. 1-3
3. 4-6
4. More than 6

2.2 How many **non-scheduled** visits to a health facility have you made **in the past month**?

1. None
2. 1-3
3. 4-6
4. More than 6

2.3 How many **scheduled** visits to a health facility did you make **per month around the time of your first involvement** with the project?

1. None
2. 1-3
3. 4-6
4. More than 6

2.4 How many **non-scheduled** visits to a health facility did you make **per month around the time of your first involvement** with the project?

1. None
2. 1-3
3. 4-6
4. More than 6

2.5 What is the average total cost (transport, drugs, consultation etc.) to you of a non-scheduled visit to a health facility?

…… (KES)

2.6 What was your **last known** CD4 count and weight?

CD4……KGs…….

2.7 What was your CD4 count and weight **around the time of your first involvement** with the project?

CD4…… KGs……

SECTION 3: MENTAL HEALTH AND WELL-BEING OF (People with HIV and AIDS) PWHIA

Read: *I would like to ask you question related to your general mental and emotional health. Please answer the questions as honestly as you can.*

[The following question relates to agency and participation.]

3.1 What is your **current** level of involvement in community groups other than the Support groups?

1. Engaged as an elected/appointed representative.
2. Actively participate (e.g. ask questions) in community meetings.
3. Invited to attend community meetings.
4. Not involved in community groups.

3.2 What was your level of involvement in community groups **at the time of your first involvemen**t with the project?

1. Engaged as an elected/appointed representative.
2. Actively participate (e.g. ask questions) in community meetings.
3. Invited to attend community meetings.
4. Not involved in community groups.

[The following questions relates to supportive family relationships.]

3.3 Has your relationship changed with other member(s) of your **immediate** family since they learned of your HIV status?

1. Yes
2. No
3. Don't know
4. Never disclosed

[If interviewee answers yes (in a positive way - if not clear, check), continue with question 3.4. If they answer yes (in a negative way), no, don't know or never disclosed, go to question 3.5.]

3.4 By how much has your relationship changed with other members of your **immediate** family since they learned of your HIV status?

1. A little
2. Moderately
3. Significantly

Please describe the change in one sentence

……

3.5 Has your relationship changed with other member(s) of your **extended** family since they learned of your HIV status?

1. Yes
2. No
3. Don't know
4. Never disclosed

[If interviewee answers yes (in a positive way - if not clear, check), continue with question 3.6. If they answer no or don't know, go to question 3.7.]

3.6 By how much has your relationship changed with other members of your **extended** family since they learned of your HIV status?

1. A little
2. Moderately
3. Significantly

3.7 How much of the time you spend **now** with your immediate family is enjoyable?

0. None
1. A little
2. Moderately
3. Significantly

3.8 How much of the time you spent with your immediate family **at the time they learned of your status** was enjoyable?

0 None
1. A little
2. Moderately
3. Significantly

[The following questions relates to mental health].

3.9 Thinking about your life **currently**, in general would you say you've been feeling optimistic about the future?

0 = Strongly disagree

1 = Disagree

2 = Neither agree nor disagree
3= Agree
4= Strongly agree

3.10 Thinking about your life **at the time of your first involvement** with the project, in general would you say you were feeling optimistic about the future?

0 = Strongly disagree

1 = Disagree
2= Neither agree nor disagree
3= Agree
4 = Strongly agree

3.11 Over the **past two weeks**, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things (daily activities, work).

0 = Not at all
1 = A few days
2 = More than half the days
3 = Nearly every day

Feeling down, depressed, or hopeless.

0 = Not at all
1 = A few days
2 = More than half the days
3 = Nearly every day

Total point score: _____

3.12 **Around the time of your first involvement** with the project, how often were you bothered by any of the following problems?

Little interest or pleasure in doing things(daily activities, work)..
0 = Not at all
1 = A few days
2 = More than half the days
3 = Nearly every day

Feeling down, depressed, or hopeless.
0 = Not at all
1 = A few days
2 = More than half the days
3 = Nearly every day

Total point score: _____

SECTION 4: LIVELIHOOD AND ECONOMIC EMPOWERMENT (People with HIV and AIDS) PWHIA

***Read**: Now I'd like finally to ask you about the spending and earning of you and your household. Please respond fully and completely, as your answers will not affect any kind of benefits at all.*

[The following questions will require you to have a conversation with the interviewee to obtain the answers.]

4.1 Are there items you can now afford to purchase that you could not afford **around the time of your first involvement** with the project?

1. Yes
2. No
3. Don't know

[If interviewee answers yes, continue with question 4.2. If they answer no or don't know, finish interview.]

4.2 Please estimate how many KES each item has cost you and over what time period this spending will last.

1. Items related to your child's education
   a. Books KES……Time……..
   b. Uniforms KES……Time……..
   c. Fees KES……Time……..
   d. Other…… KES……Time……..
2. Transport KES……Time……
3. Drugs and medication KES……Time……..……
4. Other (please describe)……..KES……Time……..……

4.3 What items do you no longer need to purchase because of changes to your life since your first involvement with the project? Please estimate how many KES each item has saved you and over what time period.

1. Food items KES…….Time……..……..
2. Transport KES…….Time……..…….
3. Other (please describe)……..KES……Time…….……

4.4 Have the level of your household savings changed since your first engagement with the project? If yes, please estimate by how much.

KES……..

SROI HOUSEHOLD Questionnaire Survey – Filling the Gaps (FtG)

PARTNERS…….Partners' Code

(Partners Code: ADS=1, KENWA =4, KENERELA=5)

COUNTY OF EVALUATION NAME ……County Code

CONSTITUENCY NAME……

VILLAGE ……

QUESTIONNAIRE NUMBER

ENUMERATOR CODE

DATE OF INTERVIEW -------- March, 2013

ORAL CONSENT TO PARTICPATE IN SROI EVALUATION FOR FILLING THE GAPS (FtG) PROJECT: "maximizing the effectiveness of existing ART, care and support programmes for people with HIV"

"Good morning/afternoon, my name is ……and my colleague is……..We are from ..... (Mention the Partner) .The purpose of this evaluation is to establish the degree to which the outcomes of the FTG project were, or were not achieved. We would like to ask you to spare us some time. The information you provide will assist us to get feedback on whether/how the interventions have impacted on your life. The information collected will be kept confidential and your name will not be written on the SROI report.

Do you agree to participate in the assessment? (Circle.) 1=YES 2=NO. I hereby witness that the participant agrees to consent in the survey on this date _____.

_____

(Signature of enumerator)

Supervisor check box

All cover sheet codes completed	
All required questions answered	
Supervisor signature	

1.0 DEMOGRAPHIC & SOCIAL INFORMATION

***Read**: I would like to ask some simple questions about your household.*

[A household is defined as the group of people who share resources for food and usually eat together under one leadership for the last three months.]

1.1 Age of the respondent

1. <20
2. 21-30
3. 31-40
4. 41-50
5. >50

1.2 Sex of respondent

1. Male
2. Female

1.3 Marital status of respondent

1. Married (monogamy)
2. Married, polygamy
3. Widow(er)
4. Separated
5. Single
6. Living with a partner

1.4 What is your relationship with the head of the household?

1. I am the head
2. Spouse
3. Child by Birth
4. Grand child
5. Other children by relation
6. House help
7. Other (specify)……

1.5 Other than yourself, how many adults (18 years old and above) make up the household?

0

1.

2.

3.

4.

5.

More than five

1.6 How many children of school age (6-18) are there in the household?

0

1.

2.

3.

4.

5.

More than five

1.7 When did you first engage with the project?

1. 2008
2. 2009
3. 2010
4. 2011

SECTION 2: PHYSICAL HEALTH OF (H'holds of PWHIV) HOUSEHOLDS

***Read**: I would like to ask you questions related to your (and other members of your household's) general physical health. Please answer the questions as accurately as you can.*

2.1 How many **non-scheduled** visits to the local health facility have household members (other than members with HIV) made in total **in the past month**?

1. None
2. 1-3
3. 4-6
4. More than 6

2.2 How many **non-scheduled** visits to the local health facility did household members (other than members with HIV) make in total **per month around the time of your first involvement** with the project?

1. None
2. 1-3
3. 4-6
4. More than 6

2.3 Approximately how many days in total **in the last month** have adult household members (other than members with HIV) been ill?

1. None
2. 1-3
3. 4-6
4. 7-10
5. 11-15
6. More than 15

2.4 How might those days have otherwise been spent?

1. On the farm……..
2. Casual labour…….
3. Running business……
4. Other (please specify)……..

2.5 Approximately how many days in total **in a typical month around the time of your first involvement** with the project were household members (other than members with HIV) ill?

1. None
2. 1-3
3. 4-6
4. 7-10
5. 11-15
6. More than 15

[Introduction to next section required: Non-threatening introduction, mention dealing with sensitive issues, mention you appreciate their views]

2.6 Are you **currently** in a sexual relationship with someone?

1. Yes
2. No
3. I don't wish to say

[If interviewee answers yes, continue with question 2.7. If interviewee answers no or I don't wish to say, go to section 3]

2.7 Have you had sexual relationships with more than two people in the last month?

1. Yes
2. No
3. I don't wish to say

2.8 Do you **currently** take precautionary measures (such as using a condom) when having sexual intercourse?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

2.9 Around the **time of your first involvement** with the project, did you take precautionary measures (such as using a condom) when having sexual intercourse?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

[*If there is a difference in the responses to questions 2.8 and 2.9, ask the following attribution question]*

Attribution question:

A1 If you had 10 points to distribute between the following parties, how much of the change in your use of precautionary measures would you attribute to each?

- *The FtG project……*
- *Government facilities……..*
- *Media……*
- *Other (please specify)……*

SECTION 3: WELL-BEING OF (H'holds of PWHIV) HOUSEHOLDS

Read: *I would like to ask you questions related to your general emotional health. Please answer the questions as honestly as you can.*

3.1 Do you feel that the level of acceptance you receive from your community has changed **since the time of your first involvement** with the project?

1. Yes
2. No
3. Don't know

[If interviewee answers yes (in a positive way), continue with question 3.2. If they answer yes (in a negative way), no or don't know, go to next section.]

3.2 By how much do you feel that the level of acceptance you receive from your community has changed **since the time of your first involvement** with the project?

1. A little
2. Moderately
3. Significantly

SECTION 4: LIVELIHOOD AND ECONOMIC EMPOWERMENT OF (H'holds of PWHIV) HOUSEHOLDS

Read*: Now I'd like to ask you about the spending and earning of you and your household. Please respond fully and completely, as your answers will not affect any kind of benefits at all.*

4.1 As a result of your household's engagement with the project, are you able to articulate your rights for (inheritance, own property, moveable assets and other resources)?

1. Yes
2. No
3. Don't know

[If interviewee answers yes (in a positive way), continue with question 4.2. If they answer no or don't know, go to question 4.3.]

4.2 Have you used this knowledge to demand for your right to inheritance?

1. Yes
2. No

4.3 Does your household have a kitchen garden created as part of the project?

1. Yes
2. No

[If interviewee answers yes, continue with question 4.4. If they answer no, go to question 4.5.]

4.4 If you have surplus produce, how much do you earn from selling it at the market in an average month?

KES……..

*[The next question need **only be asked** if the interviewee responded there was a child/children of school age in the household (question 1.6). If there are no children in the household, please go to Q.4.9.]*

4.5 Has there been a change in the school attendance record(s) of the children in the household **since the time of your first involvement** with the project?

1. Yes
2. No
3. Don't know

[If interviewee answers yes, continue with question 4.6. If they answer no or don't know, go to question 4.7.]

4.6 By how much has school attendance improved?

1. A little
2. Moderately
3. Significantly

4.7 Has there been a change in the school performance record(s) of the children in the household **since the time of your first involvement** with the project?

1. Yes
2. No
3. Don't know

[If interviewee answers yes, continue with question 4.8. If they answer no or don't know, go to question 4.9.]

4.8 How would you describe the improvement in school performance (exam scores, test results etc.)?

1. Poor
2. Fair/Satisfactory
3. Good
4. Excellent

Attribution question:

A2. If you had 10 points to distribute between the following parties, how much of the change in school performance would you attribute to each?

- *The FtG project……*
- *Government……*
- *School……*
- *Other (please specify)……..*

4.9 Do any members of the local community (other than the HBCG) provide help to the household because you have a PWHIV living in the house (this could be either help offered directly to the PWHIV or to other members of the household)?

1. Yes
2. No
3. Don't know

[If interviewee answers yes, continue with question 4.10. If they answer no or don't know, finish the interview.]

4.10 In total, approximately how long do they (the member(s) of the local community) spend helping you in an average week?

1. An hour
2. Half a day
3. 1 day
4. 2 days
5. More than 2 days

SROI HBCG Questionnaire Survey – Filling the Gaps (FtG)

PARTNERS…….Partners' Code

(Partners Code: ADS=1, KENWA =4, KENERELA=5)

COUNTY OF EVALUATION NAME ……County Code

CONSTITUENCY NAME……

VILLAGE ……

QUESTIONNAIRE NUMBER

ENUMERATOR CODE

DATE OF INTERVIEW -------- March, 2013

ORAL CONSENT TO PARTICPATE IN SROI EVALUATION FOR FILLING THE GAPS (FtG) PROJECT: "maximizing the effectiveness of existing ART, care and support programmes for people with HIV"

"Good morning/afternoon, my name is ……and my colleague is……..We are from ..... (Mention the Partner) .The purpose of this evaluation is to establish the degree to which the outcomes of the FTG project were, or were not achieved. We would like to ask you to spare us some time. The information you provide will assist us to get feedback on whether/how the interventions have impacted on your life. The information collected will be kept confidential and your name will not be written on the SROI report.

Do you agree to participate in the assessment? (Circle.) 1=YES 2=NO. I hereby witness that the participant agrees to consent in the survey on this date _____.

_____

(Signature of enumerator)

Supervisor check box

All cover sheet codes completed	
All required questions answered	
Supervisor signature	

1.0 DEMOGRAPHIC & SOCIAL INFORMATION

***Read**: I would like to ask some simple questions about you.*

1.1 Sex of respondent

1. Male
2. Female

1.2 What is the highest level of education you have completed?

1. None
2. Primary
3. Secondary
4. Vocational
5. Tertiary
6. Madrasa

1.3 Are you comfortable to share information on your HIV status?

1. Yes
2. No

[*If yes*] Are you HIV positive?

1. Yes
2. No

1.4 When did you first engage with the project?

1. 2008
2. 2009
3. 2010
4. 2011

SECTION 2: PHYSICAL HEALTH OF (home-based care giver) HBCG

***Read**: I would like to ask you questions related to your general physical health. Please answer the questions as accurately as you can.*

2.1 Are you **currently** in a sexual relationship with someone?
1. Yes
2. No
3. I don't wish to say

[If interviewee answers yes, continue with question 2.2. If response is no, or I don't wish to say, go to 2.5 (if they are HIV positive) or section 3 (if they are HIV negative).]

2.2 Have you had sexual relationships with more than two people in the last month?
1. Yes
2. No
3. I don't wish to say

2.3 Do you **currently** take precautionary measures (such as using a condom) when having sexual intercourse?
1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

2.4 **Around the time of your first involvement** with the project, did you take precautionary measures (such as using a condom) when having sexual intercourse?
1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

[*If there was a difference between the responses to 2.3 and 2.4, ask the following attribution question]*.

Attribution question:

A1. If you had 10 points to allocate between the following parties, how much of the change in your use of precautionary measures would you attribute to each?

- *The FtG project……*
- *Local Government……..*
- *Other (please specify)……..*

[The remaining questions in this section should only be asked if the interviewee responded that they are HIV positive in question 1.3.]

2.5 What was your **last known** CD4 count and weight?

CD4……KGs……..

2.6 What was your CD4 count and weight **around the time of your first involvement** with the project?

CD4……KGs……..

SECTION 3: WELL-BEING AND MENTAL HEALTH OF (home-based care giver) HBCG

Read: *I would like to ask you question related to your general emotional health. Please answer the questions as honestly as you can.*

3.1 Do you feel that the level of respect you receive from your community has changed **since the time of your first involvement** with the project?

1. Yes
2. No
3. Don't know

[If interviewee answers yes (in a positive way - if not clear, check), continue with question 3.2. If they answer yes (in a negative way), no, don't know or never disclosed, go to question 3.3.]

3.2 By how much do you feel that the level of respect you receive from your community has changed **since the time of your first involvement** with the project?

1. A little/Negligible
2. Moderately
3. Significantly

3.3 Has the frequency of people seeking your help changed **since the time of your first involvement** with the project?

1. Yes
2. No
3. Don't know

[If interviewee answers yes (in a positive way), continue with question 3.4. If they answer no or don't know, go to question 3.5 (if they are HIV positive) or section 4 (if they are HIV negative).]

3.4 By how much, has the frequency of people seeking your help changed **since the time of your first involvement** with the project?

1. A little/Negligible
2. Moderately
3. Significantly

[The remaining questions in this section should only be asked if the interviewee responded that they are HIV positive in question 1.3.]

3.5 Over the **past two weeks**, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things.

0 = Not at all

1 = A few days

2 = More than half the days

3 = Nearly every day

Feeling down, depressed, or hopeless.

0 = Not at all

1 = A few days

2 = More than half the days

3 = Nearly every day

Total point score: _____

3.6 **Around the time of your first involvement** with the project, how often were you bothered by any of the following problems?

Little interest or pleasure in doing things.

0 = Not at all

1 = A few days

2 = More than half the days

3 = Nearly every day

Feeling down, depressed, or hopeless.

0 = Not at all

1 = A few days

2 = More than half the days

3 = Nearly every day

Total point score: _____

SECTION 4: LIVELIHOOD AND ECONOMIC EMPOWERMENT (People with HIV and AIDS) PWHIA

***Read**: Now I'd like to ask you about any changes to your income that have occurred since your participation with the intervention. Please respond fully and completely, as your answers will not affect any kind of benefits at all.*

[The following questions will require you to have a conversation with the interviewee to obtain the answers.]

4.1 Since your involvement with the intervention, have you had the opportunity to find additional forms of employment e.g. with other agencies e.g. mobilizations, speaking engagements in public forums, health committees, surveys etc?

1. Yes
2. No
3. Don't know

[If interviewee answers yes, continue with question 4.2. If they answer no or don't know, go to question 4.3.]

[For the following question, you may need to help the interviewee categorize the different income sources]

4.2 Please estimate how much extra money you have received from that additional work over the last 12 months.

(KES)……

Attribution question:

A2. If you had 10 points to allocate to the following parties, how much of the change in earnings would you attribute to each?

- *The FtG project……*
- *Other NGOs……*
- *Government……..*
- *Other (please specify)……*

4.3 Approximately how much time (hours) do you spend in an average week delivering HBCG services?

……

SROI RLs Questionnaire Survey – Filling the Gaps (FtG)

PARTNERS…….Partners' Code

(Partners Code: ADS=1, KENWA =4, KENERELA=5)

COUNTY OF EVALUATION NAME ……County Code

CONSTITUENCY NAME……

VILLAGE ……

QUESTIONNAIRE NUMBER

DATE OF INTERVIEW -------- March, 2013

Supervisor check box

All cover sheet codes completed	
Supervisor signature	

[Give questionnaire to interviewee to fill out themselves.]

ORAL CONSENT TO PARTICPATE IN SROI EVALUATION FOR FILLING THE GAPS (FtG) PROJECT: "maximizing the effectiveness of existing ART, care and support programmes for people with HIV"

"Good morning/afternoon. We are from Christian Aid .The purpose of this evaluation is to establish the degree to which the outcomes of the FtG project were, or were not achieved. We would like to ask you to spare us some time. The information you provide will assist us to get feedback on whether/how the interventions have impacted on your life. The information collected will be kept confidential and your name will not be written on the SROI report.

Do you agree to participate in the assessment? (Circle.) 1=YES 2=NO.

EX1. Are you comfortable to share information on your HIV status?

1. Yes
2. No

[If you answered yes, please continue to question EX2. If you answered no, please go to section 1.]

EX2. Are you HIV positive?

1. Yes
2. No

SECTION 1: MENTAL HEALTH AND WELL-BEING OF (Religious leaders) RLs

[Question 1.1 - 1.6 are only for RLs with HIV]

1.1 Do you feel that the level of trust you receive from your community has changed since the beginning of the intervention?

1. Yes
2. No
3. Don't know

[If you answered yes (in a positive way), continue with question 1.2. If you answered yes (in a negative way), no or don't know, go to question 1.3.]

1.2 By how much do you feel that the level of trust you receive from your community has changed since the beginning of the intervention?

1. A little
2. A moderate amount
3. A significant amount

1.3 Do you feel that the level of acceptance you receive from your community has changed since the beginning of the intervention?

1. Yes
2. No
3. Don't know

[If you answered yes (in a positive way), continue with question 1.4. If you answered yes (in a negative way), no or don't know, go to question 1.5.]

1.4 By how much do you feel that the level of acceptance you receive from your community has changed since the beginning of the intervention?

1. A little
2. A moderate amount
3. A significant amount

1.5 Thinking about your life **currently**, in general would you say you've been feeling optimistic about the future?

0 = Strongly disagree

1 = Disagree

2 = Neither agree nor disagree

3 = Agree

4 = Strongly agree

1.6 Thinking about your life **at the time of your first involvement** with the project, in general would you say you were feeling optimistic about the future?

0 = Strongly disagree

1 = Disagree

2 = Neither agree nor disagree

3 = Agree

4 = Strongly agree

[Qs 1.7 and 1.8 are for all RLs.]

1.7 Please state whether you agree or disagree with the following statement: **Currently**, I feel able to deliver those aspects of my work related to HIV SDD (stigma, discrimination, denial) effectively.

1. Strongly disagree
2. Disagree
3. Neither agree nor disagree
4. Agree
5. Strongly agree

1.8 Please state whether you agree or disagree with the following statement: **At the beginning of my involvement** with the project, I felt able to deliver those aspects of my work related to HIV SDD (stigma, discrimination, denial) effectively.

1. Strongly disagree
2. Disagree
3. Neither agree nor disagree
4. Agree
5. Strongly agree

KES……..

Appendix 3: Focus Group Discussion Guides

SROI Focus Group Discussion: PWHIV – Filling the Gaps (FtG)

Good morning/afternoon, my name is ……and my colleague is……...We are from Christian Aid (CA) and (Mention the Partner in that area). The purpose of this focus group discussion is to understand the value created by certain outcomes of the Filling the Gaps project and attribution of that value. We would like to ask you to spare us some time to talk about the project in your county (Mention the Partner). The information you provide will assist CA to know more about Filling the Gaps (FTG) project in the county and to analyse its value for money. The information collected will be kept confidential and your name will not be written on the SROI report. The discussion may take approximately one hour.

Do you agree to participate in the assessment? (Circle.) 1=YES 2=NO.

I hereby witness that participants agrees to consent in the survey on this date _____.

Moderator: _____
Partner: _____
County: _____
Site of Activity _____

INTRODUCTION

[Provide explanation about how we are trying to identify a KES figure for different outcomes to be able to compare that with the costs of the project.]

1. IMPROVED ECONOMIC CIRCUMSTANCES

1. Please describe the type of items [*create a list on a flip chart*] that would be included in a typical inheritance (own property, moveable assets and other resources etc.)

2. Please place a KES value against each of those items.

Attribution question:

A1. Thinking about the improvement in economic circumstances, if you had 10 points to distribute between the following parties, how much of the value created would you attribute to each?

- *The FtG project……..*
- *Government……*
- *Other (please specify……*

2. PHYSICAL AND MENTAL HEALTH (People with HIV and AIDS) PWHIA

PART 1

[Prepare flipchart with thermometer scale between 0.0 and 1.0]

***Read**: We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale*

indicates how good or bad your health state is today."

PART 2

[Prepare flipchart with three options below written up]

***Read**: we would like to conduct a willingness to pay exercise now. I am going to give you a background of the exercise.*

1. **Background information:** there are approximately 10 million Kenyans who have reported Malaria infection. Malaria can lead to death, with children under 5 years old and pregnant women being at particularly high risk (higher than average). For those who do not die of Malaria, this disease lead to serious health disruptions such as anaemia, chronic brain damages – particularly for young children. Whereas not all regions of Kenya pose the same threat, the eradication of Malaria transmissions requires taking action at a national level in order to reduce transmission rates. The UN[13] has calculated that Malaria can be **completely eradicated in Kenya by 2022 if 16.8 billion schillings were spent each** year in prevention (in order to reduce transmissions) and treatment activities to 2022. This would mean for each individual (particularly children) of this country a highly reduced risk of getting Malaria and thus of dying from Malaria. But in order to do so, the State is investigating whether households would be willing to pay a special tax in order to eradicate Malaria for all. This tax would be spread equally among poorer citizens while richer citizens would be asked to pay a higher tax.

2. **The question**: ***Are you willing to pay an extra (special) tax to reduce the likelihood of you, your children or family members getting transmitted with Malaria? And if yes, how much?***

Because of State corruption issues in Kenya tell participants that this fund will be directly managed, say, by the UN (it will resonate them more than WHO) with no interference from the Kenyan State.

[If they say yes, then instead of leaving the question open (in terms of money) ***give them three options*** *(here expressed in Kenyan Schillings)]*

- Option 1: an (additional) annual tax of **1010 Ksh per household** for the duration of 9 years. This will progressively eradicate Malaria incidence by 2022 while providing funds for Malaria diagnosis and appropriate treatment.

- Option 2: an (additional) annual tax of **5057 Ksh per household** for the duration of 5 years. This will progressively eradicate Malaria transmission incidence by 2018 while providing funds for Malaria diagnosis and appropriate treatment.

- Option 3: a one off (additional) tax of **9100 Ksh for just this year** (2013). This will allow virtually minimizing Malaria transmission to zero by 2014 – and completely by 2015 - while providing funds for Malaria diagnosis and appropriate treatment.

Get participants to put a marker against the one they would go for, or ask them to put their hand up

Attribution question:

Thinking about the achievement of an improvement in physical and mental health, if you had 10 points to distribute between the following parties, how much of the value created would you attribute to each?

- *The FtG project……*
- *Local Government……..*
- *Other (please specify……..*

3. WELL-BEING(People with HIV and AIDS) PWHIA

1. *[Provide information about the outcome [Supportive relationships] we are looking to value. Explain how it has been described using the indicator questions used in the survey. The survey questions were related to how much of the time with your family was enjoyable (in the past and now) and by how much as your relationship changed with your family.]*

"We are going to undertake an exercise called the 'value game'. I would like for you to describe for me a number of material things/items that underpin a sound home life i.e. good family relations. E.g. a washing machine, a house extension for a new bedroom etc.." – (USE APPROPRIATE EXAMPLES)

"Please shout out the different things/items you feel contribute to a harmonious family environment."

[Facilitator scribes]

"Now, we are going to prioritize them."

[After prioritization, ask the group], "Now please add in supportive relationships. Where does this social (as opposed to economic) item sit in your list of priorities?"

"Finally, I want us to estimate the cost of these things/items immediately above and below 'supportive relationships'"

[Facilitator to add prices for different activities on the list in order to produce an approx. value for supportive relationships.]

[Go back to the group to ask them to validate that the figure you have selected reflects their value]

Attribution:

Thinking about the achievement of more supportive relationships from your family, if you had 10 points to distribute between the following parties, how much of the value created would you attribute to each?

- *The FtG project……*
- *Government……....*
- *Other (please specify……*

2. *[Provide information about the outcome [greater agency and participation] we are looking to value. Explain how it has been described using the indicator questions used in the survey. The survey questions were related to how much of the time with your family was enjoyable (in the past and now) and by how much as your relationship changed with your family.]*

"We are going to undertake an exercise called 'Willingness to accept compensation'. It is basically finding from you how much I need to pay you for taking something away from you. I would like you to share with me how much time you are spending participating in community events which give you agency i.e. a feeling that you have a voice.

"Please shout out the amount of time per month you spend in such gatherings".

[Facilitator scribes]

"Okay, now imagine that I am proposing to take away the feeling you get from spending these hours in these gatherings because for example I [CREDIBLE EXAMPLE REQUIRED FOR WHY TO TAKE THOSE HOURS AWAY]. I am going to offer you [APPROPRIATE COMPENSATION REQUIRED EG. CASH, ANIMAL, OTHER ITEM] X amount per month

[Start the bidding low and go up, recording each person's acceptance level. Then find a median figure.]

Attribution:

Thinking about the achievement of greater agency and participation from your family, if you had 10 points to distribute between the following parties, how much of the value created would you attribute to each?

- *The FtG project……*
- *Government……....*
- *Other (please specify……*

SROI Focus Group Discussion: Households - Filling the Gaps (FtG)

Good morning/afternoon, my name is ……and my colleague is……..We are from Christian Aid (CA) and (Mention the Partner in that area). The purpose of this focus group discussion is to understand the value created by certain outcomes of the Filling the Gaps project and attribution of that value. We would like to ask you to spare us some time to talk about the project in your county (Mention the Partner). The information you provide will assist CA to know more about Filling the Gaps (FTG) project in the county and to analyse its value for money. The information collected will be kept confidential and your name will not be written on the SROI report. The discussion may take approximately forty five minutes.

Do you agree to participate in the assessment? (Circle.) 1=YES 2=NO.

I hereby witness that participants agrees to consent in the survey on this date _____.

Moderator: _____
Partner: _____
County: _____
Site of Activity _____

INTRODUCTION

[Provide explanation about how we are trying to identify a KES figure for different outcomes to be able to compare that with the costs of the project.]

1. IMPROVED ECONOMIC CIRCUMSTANCES OF (H'holds of PWHIV) HOUSEHOLDS

1. We have asked respondents in the household questionnaire how they spend the time they gain because they are no longer ill as frequently. Please describe what a typical day might look like if you were [*Facilitator to scribe*].

a. Spending time on the farm
b. Doing casual labour
c. Running business

2. Please place a value on the extra income/revenue you could generate from an extra day doing each of the above activities or how much it would cost you if you lost a day.

Attribution question:

A1. Thinking about the improvement in economic circumstances, if you had 10 points to distribute between the following parties, how much of the value created would you attribute to each? [*Facilitator to scribe*].

- *The FtG project……*
- *Local Government……..*
- *Other (please specify……*

2. WELL-BEING OF (H'holds of PWHIV) HOUSEHOLDS

*[Provide information about the outcome (**community acceptance**) we are looking to value. Explain how it has been described using the indicator questions used in the survey. The survey questions were related to how much they felt the community trusted and accepted them.]*

"We are going to undertake an exercise called the 'value game'. I want you to imagine we are in a meeting where we are voting for the different priorities of a local NGO's spending i.e. the community get to decide directly the priority activities for NGO spending. These priorities could be economic, social or environmental, or a combination of both. For example, spending on community health facilities, education programmes, waterpoint, waste management etc."

"Please shout out the different activities you feel are important."

[Facilitator scribes]

"Now, we are going to prioritize them."

[After prioritization, ask the group], "Now please add in government activities to reduce stigma and discrimination. Where should such programmes sit in your list of priorities?"

"Finally, I want us to estimate the cost of delivering such programmes."

[Facilitator to add prices for different activities on the list immediately above and below community acceptance in order to produce an approx. value for a stigma reduction programme]

[Go back to the group to ask them to validate that the figure you have selected reflects their value]

Attribution:

Thinking about the achievement of reduced stigma and discrimination in the community, if you had 10 points to distribute between the following parties, how much of the value created would you attribute to each?

- *The FtG project……*
- *Local Government……..*
- *Other (please specify……..*

SROI Focus Group Discussion: Local community – Filling the Gaps

Good morning/afternoon, my name is ……and my colleague is……..We are from Christian Aid (CA) and (Mention the Partner in that area). The purpose of this focus group discussion is to understand the value created by certain outcomes of the Filling the Gaps project and attribution of that value. We would like to ask you to spare us some time to talk about the project in your county (Mention the Partner). The information you provide will assist CA to know more about Filling the Gaps (FTG) project in the county and to analyse its value for money. The information collected will be kept confidential and your name will not be written on the SROI report. The discussion may take approximately one hour.

Do you agree to participate in the assessment? (Circle.) 1=YES 2=NO.

I hereby witness that participants agrees to consent in the survey on this date _____.

Moderator: _____
Partner: _____
County: _____
Site of Activity _____

INTRODUCTION

[Provide explanation about how we are trying to identify a KES figure for different outcomes to be able to compare that with the costs of the project.]

1. IMPROVED ECONOMIC CIRCUMSTANCES OF LOCAL COMMUNITY

4. How many businesses have been established as a result of non-PWHIV members joining SLAs?

5. Please describe the types of businesses that have been created?

6. What is the typical value (turnover, no. of employees etc.) of such a business?

7. We would like to better understand the amount of resources it costs the community to look after the family of a person who has died from HIV/AIDS. Can you please describe the types of costs incurred by the community *(please obtain a monetary figure for each of the cost items)*

8. What are the factors behind those costs *(if the costs tend to be a factor of the size of the household, please obtain an average figure for the number of people per household)?*

Attribution question:

A1. Thinking about the improvement in economic circumstances, if you had 10 points to distribute between the following parties, how much of the value created would you attribute to each?

- *The FtG project……*
- *Government……....*
- *Other (please specify)……..*

2. PHYSICAL HEALTH OF LOCAL COMMUNITY

1. We would like to understand the value you gain from being a member of a community based health financing (CBHF) scheme. Could you please describe the benefits you receive?

2. How does the situation now contrast with your health payments in the past?

3. You are paying X KES for membership of the CBHF scheme. If I were to take away membership of the CBHF, how much would you be willing to pay to become a member again? *[Please obtain the time period for which the amount is for e.g. 1 month, 1 year etc.]*

Attribution:

A2 Thinking about the achievement of an improvement in physical and mental health, if you had 10 points to distribute between the following parties, how much of the value created would you attribute to each?

- *The FtG project……*
- *Local Government……..*
- *Other (please specify)……..*

SROI Focus Group Discussion: Religious leaders – Filling the Gaps

The purpose of this focus group discussion is twofold. 1) to review the results of the Filling the Gaps project against project objectives and expected outcomes. 2) To consider the value of these outcomes (changes). We would like to ask you to spare us some time to talk about the project in your county (Mention the Partner). The information you provide will assist CA to know more about Filling the Gaps (FTG) project in the county and evaluate its impact and value. The information collected will be kept confidential and your name will not be written in the SROI report. The discussion may take about one hour.

Do you agree to participate in the assessment? (Circle.) 1=YES 2=NO.

I hereby witness that participants agrees to consent in the survey on this date _____.

Moderator: _____
Partner: _____
County: _____
Site of Activity _____

INTRODUCTION

[Provide explanation about how we are trying to identify a KES figure for different outcomes to be able to compare that with the costs of the project. Explain that this is a continuation of the questionnaire they have just completed]

[Section 1 was the questionnaire]

SECTION 2: MENTAL HEALTH OF (Religious leaders) RLs

[The following questions should be used to encourage a group conversation.]

2.1 Your work includes providing comfort and support to households that have been affected by HIV, including those who have lost loved ones to HIV/AIDS. Please describe how the intervention has changed that aspect of your work.

[If the responses include that the intervention has meant less time required for providing comfort and support, ask how much time has been saved and what that time is now used for.]

2.2 Has that change to your work impacted your mental health and if so, in what way?

3. WELL-BEING VALUATION CONVERSATION

"The questionnaire considered the magnitude of the change that had occurred for different outcomes. I'd like us to now think about value that change is."

PART 1

*[Provide information about the outcome (**community acceptance**) we are looking to value. Explain how it has been described using the indicator questions used in the survey. The survey questions were related to how much they felt the community accepted them.]*

"We are going to undertake an exercise called the 'value game'. I want you to imagine we are in a meeting where we are voting for the different priorities of local government spending. These priorities could be economic, social or environmental, or a combination of both. For example, spending on community health facilities, education programmes, waste management etc."

"Please shout out the different activities you feel are important."

[Facilitator scribes]

"Now, we are going to prioritize them."

[After prioritization, ask the group], "Now please add in government activities to reduce stigma and discrimination. Where should such programmes sit in your list of priorities?"

"Finally, I want us to estimate the cost of delivering such programmes."

[Facilitator to add prices for different activities on the list in order to produce an approx. value for a stigma reduction programme]

[Go back to the group to ask them to validate that the figure you have selected reflects their value]

Attribution question:

A1 Thinking about the achievement of reduced stigma and discrimination in the community, if you had 10 points to distribute between the following parties, how much of the value created would you attribute to each?

- *The FtG project……*
- *Government……..*
- *Other (please specify……..*

PART 2

*[Provide information about the outcome [**greater competence - empowerment**] we are looking to value. Explain how it has been described using the indicator questions used in the survey. The survey questions were related to how capable they feel of delivering their SDD message.]*

"We are going to repeat the exercise called the 'value game'. I would like for you to describe for me a number of material things/items that underpin being successful in life e.g. a good education, a good salary etc." –(USE APPROPRIATE EXAMPLES)

"Please shout out the different things/items you feel contribute to a successful life."

[Facilitator scribes]

"Now, we are going to prioritize them."

[After prioritization, ask the group], "Now please add in comptenence-empowerment. Where does this social (as opposed to economic) item sit in your list of priorities?"

"Finally, I want us to estimate the cost of these things/items immediately above and below 'competence-empowerment"

[Facilitator to add prices for different activities on the list in order to produce an approx. value for supportive relationships.]

[Go back to the group to ask them to validate that the figure you have selected reflects their value]

Attribution question:

A2 Thinking about feeling more competent-empowered, if you had 10 points to distribute between the following parties, how much of the value created would you attribute to each?

- *The FtG project……*
- *Government……..*
- *Other (please specify……..*

Endnotes

[1] SROI Network (no date) The SROI Guide. Available at: http://www.thesroinetwork.org/sroi-analysis/the-sroi-guide

[2] Project reference documents included:
- Herald Consultants (2010) FtG, Mid-term review
- Herald Consultants (2012) FtG, End-term evaluation report
- Christian Aid internal document (2012), General PPA programmes: East Africa Health, 6-month report for period 1st April – 30th September 2012
- Christian Aid internal document (2012), Baseline Report review tool: Kenya Health baseline review
- Christian Aid internal document (2012), Annual programme report East Africa Part 2: Strategic Focus Area Report – Community Health and HIV
- Christian Aid (2012), How Christian Aid assesses value for money in its programmes
- Christian Aid internal document, FtG log frame

[3] **nef** (no date) National accouts of well-being. Available at www.nationalaccountsofwellbeing.org

[4] Well-being and Poverty Pathways (no date) Our model of well-being. Available at: http://www.wellbeingpathways.org/what-we-do/our-model-of-wellbeing

[5] The models contain more details of the change experienced by the different stakeholders.

[6] Control group data provided the counterfactual data for the base case. Attribution FGDs also provided an estimate of the value creation in the absence of FtG by assigning a figure to how much of the change (in the target sites) was on account of the government's efforts.

[7] The rate at which the benefits sustained beyond the lifetime of the project can be attributable to FtG. The rate was increased from 15% (and 30% for economic outcomes) to 50%. A base case of 15% (for non-economic outcomes) was generated through research undertaken by ADS. An attribution exercise was conducted for two projects whose investment had finished three years previous. The project beneficiaries were asked how much of the sustained change could still be attributable to the project. This data was then trended up to 5 years – the benefit period used for the FtG outcomes. 30% was used as a base case drop off rate for economic outcomes. The rationale for this was that for economic outcomes to remain sustainable would require more rapid introduction of other factors beyond the completion of FtG's inputs.

[8] It is a recognised phenomenon that when people are asked to describe how they felt at two points in time (with one of those points being in the past), their recall function often sees them overstate the difference between those two points. The sensitivity analysis adjusted the magnitude of change by 25% from a base case overestimation rate of 25% to 50%.

[9] Precise figures for investments made for the respective sites were not available. A percentage based on the total number of sites where FtG was delivered was used as a proxy.

[10] These include CA, KENERELA, and COPTIC

[11] The figurese in Table 4 are presented before an overestimation figure is applied.

[12] Colosi L and Dunifon R (no date) *What's the difference? Post then pre and pre then post*. Available at : http://www.human.cornell.edu/pam/outreach/parenting/research/upload/What-s-20the-20Difference-20Post-20then-20Pre-20and-20Pre-20then-20Post.pdf

[13] Exercise drawn from data available at the following websites:
http://www.rbm.who.int/gmap/gmap.pdf
http://www.who.int/malaria/publications/country-profiles/2009/mal2009_ken_en.pdf
http://www.nationmaster.com/country/ke-kenya/lab-labor