

SOCIAL RETURN ON INVESTMENT

“Doing more with less”



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

MAY 2012

Liza Tong (Alliance)
Heng Sopheab (KHANA), Tuot Sovannary (KHANA)

This project is funded by:



EUROPEAN UNION

Suggested citation: Tong, L., H. Sopheab, Tuot S. (2012). Social Return on Investment “Doing more with less”: Evidence based operational research on the KHANA intergrated care and prevention project in Cambodia. Phnom Penh, KHANA.

DISCLAIMER:

The contents of this publication are the sole responsibility of KHANA and in no way reflect the view of the European Union

TABLE OF CONTENTS

LIST OF TABLES	2
LIST OF FIGURES	2
LIST OF ACRONYMS	3
ACKNOWLEDGEMENTS.....	4
EXECUTIVE SUMMARY	5
BACKGROUND AND CONTEXT	8
METHODOLOGY.....	11
IDENTIFICATION OF STAKEHOLDER GROUPS.....	11
RESEARCH APPROACH	14
MAPPING PROJECT OUTCOMES USING THE THEORY OF CHANGE	15
IDENTIFICATION OF COMMON OUTCOMES AND PROXIES	17
STORIES OF CHANGE FROM THE PERSPECTIVE OF ICP PROJECT BENEFICIARIES	18
ESTABLISHING IMPACT	20
CALCULATING INPUTS – INVESTMENT INTO THE ICP PROJECT 2007-2011	22
FINANCIAL PROXY ESTIMATES.....	23
IMPORTANT FINANCIAL ASSUMPTIONS AND VARIABLES USED FOR THE MODEL	25
LIMITATIONS AND ASSUMPTIONS OF THE METHODOLOGY	25
RESULTS.....	27
THE SROI RATIO AND BREAKDOWN OF VALUE	27
PERCENTAGE OF OUTCOME VALUE CREATED BY BENEFICIARY TYPE	27
OUTCOME VALUES BROKEN DOWN PER BENEFICIARY.....	28
OUTCOME VALUE CREATED FOR PLHIV.....	30
OUTCOME VALUE FOR PLHIV/OVC HOUSEHOLDS IN TERMS OF FOOD SECURITY	30
OUTCOME FOR THE WIDER COMMUNITY AND HEALTH SERVICE.....	31
SENSITIVITY ANALYSIS OF THE MODEL	32
RECOMMENDATIONS	34
FOR THE USE OF THIS METHODOLOGY.....	34
FOR THE ICP PROJECT MANAGEMENT.....	35
FOR IMPLEMENTING NGO PARTNERS.....	35
FOR POLICY-MAKERS	36
REFERENCES	37
ANNEX 1: STAKEHOLDER IMPACT MAPS.....	38
ANNEX 2: DESCRIBING OUTCOMES, INDICATORS AND FINANCIAL PROXIES	42
ANNEX 3: CASE STUDIES	46
ANNEX 4: ATTRIBUTION TABLE.....	50
ANNEX 5: DEADWEIGHT ASSUMPTIONS BY BENEFICIARY.....	54
ANNEX 6: SROI FULL ECONOMIC MODEL	58

LIST OF TABLES

Table 1: Stakeholders included in the SROI analysis 12

Table 2: Stakeholders considered but not included in the analysis 13

Table 3: Summary of participants in SROI study..... 14

Table 4: Selected outcomes by beneficiary..... 17

Table 5: Actual costs for the action: January 2007- December 2011 23

Table 6: Common outcomes and their financial proxies 24

Table 7: Value created for beneficiaries per outcome area 29

LIST OF FIGURES

Figure 1: Theory of change maps for the ICP project 16

Figure 2: Percentage value created per beneficiary type..... 28

Figure 3: Outcome value created for PLHIV (Int' \$)..... 30

Figure 4: Outcome value created for OVC (Int'\$) 31

Figure 5: Outcome value created for wider community & Health Service (Int'l \$)..... 32

LIST OF ACRONYMS

FAPD	Finance Administration and Procurement Department
ARV/ART	Antiretroviral Therapy
CSV	Community Service Volunteer
DfID	Department for International Development
EC	European Commission
FGD	Focus Group Discussion
HBC	Home Based Care
HCBC	Home and Community Based Care
ICP	Integrated Care and Prevention
IGA	Income Generating Activity
Int' \$	International Dollars
IP	Implementing Partners
KII	Key Informant Interview
NAPA	National Prosperity Association,
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
MTC	Mother to Child
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
SAHACOM	Sustainable Action against HIV and AIDS in Communities
SHG	Self-Help Group
SROI	Social Return on Investment
VCCT	Voluntary Confidential Counselling and Testing
VSL	Village Savings and Loans
WFP	World Food Programme



ACKNOWLEDGEMENTS

The Social Return on Investment study introduces an innovative way of assessing the impact of community-based HIV programmes, and was made possible by the contributions of many people. First, we gratefully acknowledge the support of the International HIV/AIDS Alliance and KHANA Management team who have provided guidance throughout the project.

Our thanks also go to Ms. Sin Sovanna, Team Leader for Corporate Finance, Mr. Moeun Soksan, Database Management Officer, the M&R team, Programme Management Officers, and Ms. Touch Sokunthea, volunteer to Research Department, for their active collaboration and support during data collection.

We would also like to express our appreciation to all the project supervisors, interviewers, and field facilitators from the implementing partners, whose dedicated efforts ensured we kept to the timeline of the study whilst maintaining high quality standards. Our thanks also go to all the respondents and beneficiaries for contributing their time and sharing their stories.



EXECUTIVE SUMMARY

Methodology: The SROI method is a form of cost benefit analysis to monetize project outcomes. It has been adapted and simplified for the community level with the incorporation of social, health, environmental and economic costs and benefits enabling the calculation of a ratio of cost to benefit [1]. This is an appropriate approach, in line with the current donors' growing emphasis on cost efficiency and effectiveness and the Paris declaration on aid effectiveness – demonstrating value for money, “doing more with less”.

Results: A combined investment of approximate US\$2,406,000 from the EU plus US\$1,957,934 (WFP and community input) generated total benefits worth US\$10,894,835. For every \$1 invested in the ICP generated a return of approximately \$2 worth of social, health and economic value, adjusted for Purchase Power Parity (PPP). The Return on Investment (ROI) is therefore 1: 2.

Monetised outcome values ranged from \$30 (the avoided cost of informal school fees paid by OVC) to \$1,200 the avoided burden of debt and asset loss caused by health costs prior to diagnosis. Sensitivity analysis was performed against: financial proxies, attribution and deadweight. Beneficiaries gaining the most outcome value were PLHIV and OVC and their families (food security outcome 51% of total value), PLHIV (32%) and OVC (9%).

Conclusions and recommendations: The ICP yielded significant impacts, notably in the area of food security, wellbeing, improved health and improved productive capacity which enabled greater economic returns for the household.

- ❑ The SROI approach is clearly a useful method and tool to quantify the value of programmes, using a community consultative approach. SROI must be based on consultation, stakeholders must provide their perspective and input to the exercise.
- ❑ Additional time would allow for a broader range of stakeholders, in particular health and facility based staff, to be consulted to develop government related outcomes of the investment.
- ❑ Whilst the resulting ratio is interesting it is important not to get too focused on this end result. The interest in this method should be based on an understanding of the differences in “relative outcome value” created as a result of the programme. In this way it is possible to discuss and identify high performing (i.e. creation of high value) and lesser performing (creation of low value – relatively speaking) outcomes, and by association outputs and activities.
- ❑ The method has its limitations and there are unavoidable areas of subjectivity and assumption. These must be identified on a programme by programme basis, and are clearly set-out in the report.

- ❑ There is a need to find a systematic way of measuring outcomes e.g distance-travelled for a sample, but alternatives include setting up a panel survey of representative stakeholders and regularly engaging with them to measure outcomes.
- ❑ There are limited secondary data sources available, information from consultations must be further triangulated with other data sources available internationally where possible.

FOR THE ICP PROGRAMME MANAGEMENT

- ❑ Whilst a ratio of 1:1.96 or 96% return is a significant and positive result KHANA and partners should not be complacent about ensuring there is maximum opportunity to identify and affect cost saving measures – that will have no negative impact on outcome achieved.
- ❑ A comprehensive costing of the **community input** is necessary to give a true reflection of how much the community invests itself, in its involvement with the ICP. This is particularly relevant because rightly **community mobilisation** is the mechanism through which KHANA programmes are implemented. However, the true costs of this are not captured. This cost should be reflected in new programme budgeting to avoid burdening the community with hidden costs of the programme.
- ❑ The **livelihoods component**, and related activities to build skills and raise earning potential of families, appears to be generating some value, however, the scale of reach is limited. The **potential for sustained benefit to be created beyond the life of the ICP is high**; however, this is an assumption which should be tested
- ❑ Bearing project sustainability in mind there should be a focus on longer term support for existing schemes, such as the IGA ongoing mentoring and maximising the sustainability of micro-enterprise.
- ❑ There were some **negative experiences** (outcomes) mentioned in consultations – such as inability to access poverty cards, beneficiaries having failed IGA schemes. Due to insufficient time we were unable to quantify this as a negative value (and did not feel this was of sufficient scale to change the ratio), however, it is important that in future SROI exercises more attention is given to these negative areas.

FOR IMPLEMENTING NGO PARTNERS

- ❑ KHANA should disseminate and discuss findings of the study with IPs, in particular within the EU-ICP programme catchment, but also more widely across the broader USAID funded programme.
- ❑ The methodology for community consultation should be promoted as a tool for consultation between IPs and programme stakeholders.

FOR POLICY

- ❑ Of critical importance was the issue of the **WFP emergency household food support**, which was leveraged by KHANA as an additional input for the poorest affected communities. This support terminates at the end of 2012. It is necessary for KHANA and IPs to gather evidence on the need to sustain this support for the very vulnerable households as an advocacy issue. At the very minimum this issue should be raised as a critical concern to government from now onwards. This study needs to be used to support this case.
- ❑ The issue of true costing for community investments to programme is another area of interest for policy. This is the only way to provide a complete picture of socio economic impact and change a programme has on its intended beneficiaries. KHANA should develop a position about costing community mobilisation, bringing this to the attention of donors and government. This position can draw from a parallel, but usefully linked piece of work *“Costing Community Mobilisation within the UNAIDS Investment Framework KHANA – Focused Prevention Programme”*
- ❑ Linked to the point above is the need for the Alliance (and also KHANA) to develop a position around stipends and incentives for beneficiary involvement.



BACKGROUND AND CONTEXT

Cambodia has been praised for its success in slowing its HIV epidemic: by 2010 HIV prevalence had fallen to 0.8% from a peak of over 2% a decade before [1]. Outstanding national leadership and commitment was recognised through a Millennium Development Goal Award in 2010, when Cambodia reached its universal access target for antiretroviral treatment. The focus now needs to be on ensuring the most effective use of resources whilst maintaining a strong impact at the national level.

KHANA is the largest national non-governmental organisation (NGO) providing HIV prevention, care and support services in Cambodia. Initially established in 1996 as a project of the International HIV/AIDS Alliance, KHANA became an NGO in its own right in 1997. In 2008 it went through the International HIV/AIDS Alliance accreditation process, and was the first Alliance partner to receive full endorsement as an accredited member.

Today, KHANA works in 19 provinces and municipalities through a network of 38 implementing partners (IPs). These partners are community-based organisations, local NGOs working directly with communities, and networks focusing on HIV and AIDS, health, and development issues. KHANA has provided funding to scale up their programmes, as well as training to build their skills and strengthen their organisational and financial management capacity. These partners are KHANA's essential connection to the communities that they serve, and they ensure that our programme priorities are grounded in the real needs of Cambodian people. KHANA's programmes focus on:

- ❑ HIV prevention among most at risk populations (MARPs) such as men who have sex with men (MSM), drug users (DUs), and entertainment sector workers (ESW);
- ❑ Integrated care and prevention for people living with HIV (PLHIV) and orphans and vulnerable children (OVC) through home and community based care (HCBC);
- ❑ Impact mitigation through livelihood support and food security interventions for PLHIV, OVC and their families;
- ❑ Policy dialogue, advocacy and networking, bringing the voice of affected communities to national and international policy fora.

With funding support from the EC, KHANA's Integrated Care and Prevention (ICP) project has been providing focused prevention and comprehensive care and support to MARPs, PLHIV, and OVC through home and community based care teams since 2007. The project covers three provinces in Cambodia: Kampong Chhnang, Kampong Speu and Prey Veng. Since October 2010, KHANA has been implementing a new HCBC approach adapted from the SAHACOM (Sustainable Action against HIV and AIDS for Communities) model, which provides "a more sustainable and improved management and coordination of services by redistributing tasks" [3]. KHANA has been working with six partners to implement the ICP

activities in the three provinces listed above. Beneficiaries receive primary health care, counselling, social welfare and emotional support, and have access to income generating activities. KHANA and its partners have focused on taking a holistic approach to the varied needs of individuals and communities, which includes addressing psycho-social needs, reducing stigma and discrimination, improving economic sustainability, ensuring appropriate nutrition, and reducing barriers impeding access to basic services such as health care and schooling [4].

The Social Return on Investment (SROI) study uses an innovative form of cost-benefit analysis which can be used to monetize project outcomes that may otherwise be difficult to quantify. It has been applied to the ICP project to assess the impact of its community-based responses to HIV prevention, care and treatment. It has been adapted and simplified for use at the community level, and incorporates analysis of the social, health, environmental and economic costs and benefits of the project, enabling the calculation of a ratio of cost to benefit for the community in terms of HIV care, support, and treatment.

The SROI study includes primary research from communities across Kampong Speu, a province in south-western Cambodia, as well as additional support data from Kampong Chhnang and Prey Veng provinces. SROI methodology was applied in an effort to determine the value generated by KHANA's ICP project through the social, health, environmental and economic support it provides. Values were allocated to common outcomes of the project which were defined by key beneficiaries during a community consultation exercise.

During the SROI research period KHANA were also conducting their end line survey for the ICP project, capturing outcome changes across a range of indicators. The timing of the survey was purposely designed to coincide with the SROI primary data collection and field work, as outcome incidence for use in the SROI study was informed by the results of the end-line.

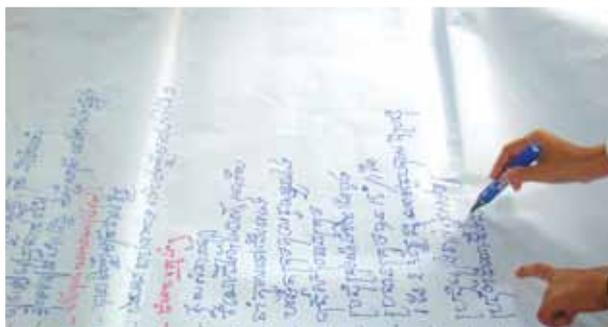
The outcomes or results of the project that were of particular interest for the SROI study were:

- ❑ Increased number of PLHIV and OVC receiving integrated HIV/AIDS community based care, treatment and support;
- ❑ Increased numbers of people from target groups involved in impact alleviation activities and accessing services;
- ❑ Increased capacity of civil society to implement and contribute to policy development on HIV/AIDS prevention, care, treatment and impact alleviation;
- ❑ Supportive environment for HIV/AIDS interventions established at community, province and national level.



The SROI research focused mainly on the first three results, as the consultation period available was limited and we prioritised discussions with direct beneficiaries such as PLHIV, OVC, family members, caregivers, and community service volunteers (CSVs). Time constraints meant that there was less discussion with health service staff (see section on methodology limitations).

The results of the SROI study will be of wider interest than solely to HIV/AIDS programme implementers. At the time of writing there are several international initiatives that have helped shape, but would also benefit from, the results of this study. The UNAIDS Investment Framework [2] emphasizes community mobilisation as a critical enabler in the HIV/AIDS response, yet the definitions of what this means in relation to a range of different programmatic interventions such as behaviour change communication, prevention with key populations, and treatment and care, are not clear. The SROI approach would help to quantify the importance of community mobilisation in different interventions.



METHODOLOGY

The SROI study attempts to assess the benefits of KHANA's Integrated Care and Prevention project in three provinces in Cambodia. The SROI methodology allows a deeper understanding of the social, health, environmental and economic values created by the project for a range of stakeholders identified as primary beneficiaries. It is a framework to measure and account for the value created by a programme or series of initiatives, beyond financial value. It incorporates social, health, environmental and economic costs and benefits.

SROI is a participatory, beneficiary-led approach which uses financial values defined by programme beneficiaries themselves to represent social, health, environmental and economic outcomes, thus enabling a ratio of benefits to costs to be calculated. For example, a project ratio of 1:4 indicates that a donor investment of \$1 delivers \$4 of social value to the direct beneficiaries of the programme.

THE STAGES OF SROI ANALYSIS IN CAMBODIA INCLUDED:

1. Establishing scope and identifying key stakeholders
2. Mapping project outcomes with the stakeholders using the theory of change
3. Assigning a financial value to the project outcomes
4. Establishing project impact from the project end line evaluation
5. Calculating inputs to the project
6. Calculating the SROI
7. Reporting and disseminating findings

We have broadly followed this stage by stage process, and this is reflected in the structure of the overall report.

IDENTIFICATION OF STAKEHOLDER GROUPS

The key groups of stakeholders in the ICP project were identified and a decision made over whether to include them in the analysis. The table below comprises the list of stakeholders, the rationale for their inclusion or not as a beneficiary, and the manner in which the study engaged with them.

Table 1: Stakeholders included in the SROI analysis

Stakeholder	Involvement with ICP project	Rationale for inclusion	Method of engagement
PLHIV	Main target beneficiary, supported by CSVs	Included as main target beneficiary	End line evaluation survey Community consultation
OVC	Main target beneficiary supported by CSVs, supported to continue in schooling both materially and through counselling and self-help groups sessions. Food support. Skills development.	Included as main target beneficiary	End line evaluation survey Community consultation
Caregivers	Provide significant time and support to PLHIV as family members. Support OVC.	Included – time inputs captured	Community consultation National social economic impact report
Community Service Volunteers (CSV)	Focal points for delivery of community services providing basic health care, psychosocial support, referral services for PLHIV, OVC and families.	Included with PLHIV as key service providers	End line evaluation survey Community consultation
Wider community	Receive IEC prevention activities from partner organisations and anti-stigma awareness. Some have access to the revolving loan scheme. Referred for VCCT.	Included in analysis to test the potential value generated through VCCT early referral and PMTCT	N/A
Health service - health center level	Accept referred individuals from CSVs for care and treatment, VCCT	Benefit from greater outreach by CSVs to affected communities (not included here is the actual cost to the health center of this additional staff time)	N/A Key Informant Interviews to inform re. issues
Health facility – operational district (referral hospital)	Administer ARVs, conducts regular testing of CD4 and viral load, VCCT	Included - we have estimated one CSV is equivalent to 0.33 of a junior health service staff member. The project helps the center meet its ARV and VCCT targets through referrals, benefits captured at the health center level.	N/A

Table 2: Stakeholders considered but not included in the analysis

Stakeholder	Involvement with ICP project	Rationale for inclusion	Method of engagement
Village chief	Supports and attends monthly regular SHG meetings	Not included as beneficiary, but time inputs captured	N/A KII to inform re. issues
Pagoda – monks	Source of spiritual and mental health support for PLHIV and families through blessings and meditation, and at times home visits. Also a role in reducing stigma amongst community members.	Not included as a beneficiary, but time inputs captured	N/A
Non-governmental organisations - implementing partners	Build capacity of the CSVs, some community based activities. Has own capacity built by KHANA.	Not included [- their inputs would be captured under the programme budget / costs.	N/A KII to inform re. issues
Ministry of Health	KHANA works with government to mobilise resources, influence policy and engage with technical working groups to develop guidance in policy and advocacy tools.	Not included at the National level as this is beyond the scope and timeframe available for this analysis.	N/A
School (teachers)	Support the schooling and attendance of OVC	Not included – do not benefit themselves and it is not possible to quantify if how much their input is in terms of time spent with OVC over and above their normal working pattern.	N/A

RESEARCH APPROACH

The aim of the SROI study was to try to quantify the hard-to-measure outcomes of community mobilisation work around HIV/AIDS. A common outcomes framework based on reconstructing the theory of change behind the project (Figure 1) was a difficult but necessary step in the study. This framework allowed us to analyse the link between project activities, outputs, outcomes, and impact, from the point of view of the primary beneficiaries,

One of the first steps in the study was to organise consultative workshops and key informant interviews (KIIs) with over 130 PLHIV, OVC, caregivers, and community service volunteers (CSVs), using a guided focus group discussion (FGD) approach to explore the impact the project activities have had on them as the key beneficiaries. These FGDs also allowed the project team to identify the most common and important outcomes of the project. Stories of change (i.e. in participants' living and health conditions) were also captured during the discussions.

The questions and guidance for the FGDs were discussed at an initial briefing meeting between research, monitoring, and finance staff at KHANA. The majority of the staff was new to SROI methodology, and because of this some of the concepts were a little difficult to understand at first, for example the idea of monetisation and financial proxies. These ideas became much clearer once fieldwork had started, and the discussions regarding financial equivalents and cost of living were invaluable in constructing reasonable financial proxies.

Following the identification of the common outcomes for the project beneficiaries, the research team examined the extent to which these outcomes had been achieved, by mapping the beneficiary-defined outcomes against relevant indicators collected in the end line evaluation. The data collection for the end line evaluation took place in November and December 2011, based on more than 1600 interviews. This data was then used to determine the outcome incidence to be used in the SROI model.

For ease of logistical planning, the research team conducted the beneficiary consultations in areas that were already being covered by the end line evaluation. Ideally, beneficiaries would have been selected at random, but due to time constraints this was not possible.

Table 3: Summary of participants in SROI study

Participant	Kampong Speu	Kampong Chhnang	Prey Veng	Total
FGD-PLHIV	29 (2 FGDs)	22 (2 FGDs)	11 (1 FGD)	62 (5 FGDs)
FGD-OVC caregivers	39 (2 FGDs)	10 (1 FGD)	13 (1 FGD)	62 (4 FGDs)
Village chief		1	1	2
Community support volunteers	2	1	1	4
Project staff	1	1	1	3
Health center staff	1			1
Total	72	35	27	134

MAPPING PROJECT OUTCOMES USING THE THEORY OF CHANGE

Mapping the outcomes of a project allows us to understand how increasing community action on HIV/AIDS prevention, care and impact mitigation can lead to tangible changes in the lives of beneficiaries. SROI analysis enables us to measure the value of the impact of activities on beneficiaries' lives, and to see how a series of programmatic activities led by community or implementing programme partners have led to certain measurable outputs, which in turn have led to measurable changes in beneficiaries' lives, both positive and negative. The relationship between the project activities, outputs, outcomes, and impact can be assessed using the theory of change, and represented through impact maps.

For example, in PMTCT, community mobilisation increases the supply of PMTCT services, the uptake of services, and improves the enabling environment; Building partnerships between the health system, community organisations, social welfare and PLHIV groups leads to an extension of the workforce (through community service volunteers, better linkages and referrals e.g. for PMTCT, ARV, child welfare). Highlighting a few of the causal pathways identified through this work allows linkages to be made between project activities, outcomes, and impact, and allows us to demonstrate that community mobilization through the ICP project resonates with these theoretical concepts.

The following series of impact maps were reconstructed from beneficiary consultations. Beneficiaries were consulted in groups of 15 or so respondents, the majority (not exclusively) were from the same beneficiary group: PLHIV, OVC, caregiver, etc. KHANA's secondary qualitative research from baseline and mid-term reviews has also been instrumental in informing and framing outcomes from the perspective of beneficiaries, allowing a better understanding of outcome level change in their lives[3].

Figure 1: Theory of change maps for the ICP project



(See annex 1 for the complete set of stakeholder impact maps)

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES
Community stakeholder time inputs	Village savings and loans (VSL) meetings VSL training and support Running and managing emergency fund	No. of people trained No. of people saving regularly No. of people accessing emergency fund support No. of VSL established	Improvement in family wellbeing and protection
Self-help group financial inputs through loan schemes	Emotional support and counseling for PLHIV and families Visits to PLHIV and households from IPs CSV support Self-help group activities	No. of PLHIV households and members receiving psycho-social support No. of visits to PLHIV households from IPs No. of PLHIV support groups established	Higher levels of self esteem
WFP food support	Training on self-care, health, and exercise Hygiene awareness and safe water storage Referrals for ART, OIs Care and support (HCBC team) Training of CSVs in HCBC	No. of PLHIV received care and support from HCBC team PLHIV (adults and children) received ART through facilitation and support of home care teams No. trained in ART adherence No. of referrals to OI services (adult) No. CSVs trained in HCBC No. of referrals for VCT No. of families receiving WFP support	Better health and nutritional status
ICP project budget	ART adherence support Training on identification of OIs and VCT referral WFP monthly food support PLHIV and OVC households 3 bags rice, 1 kg oil, 0.5 kg salt		

IDENTIFICATION OF COMMON OUTCOMES AND PROXIES

Following the theory of change, common outcomes as a result of the ICP project were identified. It is important to note here that we want to understand the outcome benefits/value created for each stakeholder group, as each group will experience a different impact from the project. There is overlap between some of the beneficiary groups, as one outcome may be relevant for more than one beneficiary type.

We identified a list of 21 emerging outcomes for the following beneficiaries as our unit of analysis:

- | | |
|----------------------------------|--|
| 1. PLHIV | 6. OVC households |
| 2. PLHIV family members | 7. Wider community in the geographical vicinity of the project |
| 3. Caregivers for PLHIV | 8. Health center staff |
| 4. PLHIV/OVC households combined | |
| 5. OVC | |

Table 4: Selected outcomes by beneficiary - PLHIV

(See annex 2 for full table of outcomes and financial proxies for all stakeholder groups)

Beneficiary	Outcome description	Indicator	Financial proxy	Comments
PLHIV	Improvement in family wellbeing and protection of key assets	% reporting the need to sell key assets in the past year	Sale of key asset: rice field	Severe family and personal stress was reportedly are being caused by the need to sell key assets such as rice fields, farms and vehicles.
	Higher level of self esteem	% reporting higher levels of confidence/ self esteem	Cost of sessions with a health service counsellor	The average salary of a health service staff member of a grade that would provide counselling is \$800 per month, an hourly rate of \$5. We used an estimate of 2 one-hour sessions per month, which works out at \$120 per year.
	Better health status and appetite	% receiving ARV, OI, TB treatment through HCBC team reporting improved health	Average rate for day labour for farming, construction and factory work and number of days of work/ year	Through access to a referral system and ultimately ARV, OI treatment, and TB treatment support, health is improved and therefore there is an increased ability to work. However, the health status of some PLHIV remains unpredictable, making it difficult for them to seek permanent, regular, paid employment, establishing a threshold limit to their earning potential. We estimated the proxy to be \$439 per year, which represents an average harvesting/construction salary and factory work at \$3.75/day x 30 days x 3 months per year (harvest season only).

STORIES OF CHANGE FROM THE PERSPECTIVE OF ICP PROJECT BENEFICIARIES

In order to get a better understanding of the context and actual change experienced by individuals in the target populations, a selection of stories of change were captured during the guided focus group discussions with communities, PLHIV, OVC, caregivers and community service volunteers. These give more depth to the outcomes outlined in the mapping exercise above, and give an excellent account of the challenges faced by community members in the three target provinces.

Late diagnosis leading to debt and overwhelming poverty

Prior to diagnosis, many families seek treatment from a variety of different sources, including the private sector. Time and time again our focus group discussions (FGDs) and secondary research [4] revealed the devastating loss of assets experienced by undiagnosed PLHIV, when they are sold to pay for treatment and medical appointments. Many private practices do not encourage or even carry out HIV testing. In some cases these asset losses push families that are already typically in the bottom quartile in terms of income, so deep into poverty that it is difficult for them to ever recover the ability to sustain themselves through income generation.

Information from the FGDs revealed the extent of debt incurred by PLHIV and their families. Individual stories included:

- ❑ Selling land, cow and motor car for treatment;
- ❑ Someone with HIV spending approximately US\$4,000 on medical care, but without his HIV status ever being diagnosed;
- ❑ Selling gold jewellery worth 700,000 Riel (US\$175) to pay for treatment;
- ❑ A PLHIV borrowing 10,000 Riel (\$2.50) from a neighbour, and paying interest of 4,000 Riel.
- ❑ Borrowing US\$500 from ACLEDA Bank, and selling his rice field and all the equipment in his house to pay it back;
- ❑ Borrowing 750,000 Riel (\$188) from Village Credit, and paying interest of 3%.

These stories, and the others recorded during the FGDs, show the dire situations many families find themselves in before and during HIV diagnosis. The strongest impression we were left with following these discussions was the consensus from all of those we consulted that the ICP project had given them hope, and a reason for wanting to live. Positive mental health and hope are among the most important factors in turning lives around.

Community and self-stigma

“Before (the project), PLHIV families stopped attending community functions in the village, including weddings. Now it is not an issue at all, they are invited to weddings. Usually people will pay up to \$10 as a contribution to the newlyweds, a gift... but it is understood that PLHIV families should not be expected to contribute anything”.

“Before I came to know NAPA (National Prosperity Association) I had to sell everything. I used to be quite well off but our ill health meant we needed to sell our rice field to pay for medical treatment. My family disowned me; I was very disappointed, they just abandoned us. I did not have the mental strength to go on, every day I would think ‘I am dying, I am dying’... if ever I would go out of the house, I would let other people pass first, so they wouldn’t see me. People would treat me so bad, even if I went to the market to buy food... if I went to a food stall and touched the vegetables, no one would then buy from that seller. Now I feel NAPA has changed my life. They have supported me, made me stronger, some days I don’t even think I am positive, I believe I am normal like everyone else. I can even eat with other people. We don’t even think about it anymore...if anything it is me that is self-discriminating - I went to my relatives’ house recently and we were having a big meal together. I wanted to have my own plate, but they insisted I shouldn’t mind about that and we should all eat together.”

CSV, Ang Popel Commune

These gradual changes in attitude were said to have come about for a number of reasons, including a better understanding of how HIV is transmitted as a result of the community sensitisation meetings run by NAPA, as well as better communication and information about HIV from the media. However, in the FGDs, people mentioned that stigma and discrimination, whilst improving, is still an issue, and importantly that this included feelings of self-stigma – individuals isolating themselves from their communities.

“I was diagnosed in 2004. Back in 2005 my neighbour had a wedding party. They wanted to use the water from my pond. Then when it came to the wedding there were hardly any people that went. We didn’t know why until someone said it was because the people were afraid because they had used my pond.”

PLHIV self-help group members, FGD

Peace of mind and greater financial security

The ICP project supports groups of PLHIV and OVC families to establish savings groups, using a village saving scheme model similar to those introduced by CARE International and others [5]. Respondents clearly felt that one of the greatest benefits of these schemes was the financial peace of mind they gave families, knowing that in an emergency some form of financial support was available, and without having to pay extortionate rates of interest.

“Every month we put aside 5000 Riel (US\$1.25) for savings and 1000 Riel (US\$0.25) for emergency issues. Our group leader keeps the money safely. The groups learn a lot from one another, about different experiences, how to save your money, how to manage yourself financially. The NGO taught us how to pool our money and they explained that if we put our money together we would be able to do more, buy morehave a better business, and each person would benefit as we would take turns”

FGD with PLHIV self help group

ESTABLISHING IMPACT

Another important aspect of an SROI approach is that it allows researchers to isolate the impact of a particular activity on the project outcomes. To look at this in more depth, the research team analysed the outcomes by measuring a) attribution, b) deadweight, and c) drop-off.

- a) Attribution** – an assessment of how much of the outcome was caused by the contribution of others (organisations or people): “who else contributed and what is their claim in achieving the outcome?”

Attribution estimate

Understanding attribution is an important step in the estimation of the impact of a project, and failing to do so would result in an overestimation of the benefits attributable to our project, as we would effectively be claiming 100% of the credit for any changes that have taken place. This is a key difference between an SROI approach and many other evaluation techniques.

We estimated the percentage attribution of the ICP project per outcome in three steps. Firstly, by consulting with the beneficiaries about who else was carrying out similar activities in the target areas (government agencies, other NGOs, individuals, community groups etc.), and who may have influenced or contributed to the outcomes or changes experienced. Secondly, we discussed it with project staff and implementing partners. Lastly, we referred to secondary information, research, and reports from other organisations about programmes of a similar nature and coverage area.

The attribution rate per outcome has been estimated as a range, as it is difficult to allocate an exact percentage that will be applicable to all the project areas. The following table shows the attribution percentage estimate per beneficiary type and outcome, and groups the estimates into low (0-30%), medium (30%-60%), and high (>60%) attribution rates. The percentage estimates reflect the percentage of the outcome that can be attributed to the ICP project, for example an 80% estimate indicates that 80% of the outcome is due to the work of the ICP project, and 20% of the outcome is due to some other factor (See annex 4 for the full attribution table).

- b) Deadweight** - a measure of the outcome that would have happened even if the project activity had not taken place. This determines the percentage of the outcome that would have happened without any intervention.

Deadweight estimate

This is possible to estimate with some level of accuracy, provided there is a reliable control group with which the intervention target group can be compared. In the absence of a control group, we have referred to beneficiary discussions and secondary information to provide an estimated range of low (0-30%), medium (30-60%) or high (>60%). Through the consultative meeting with community, a deadweight estimate of 80% was agreed to imply that most of the outcome would have happened even without the intervention taking place. The deadweight estimates are listed in the following table (See annex 5 for full tables of deadweight assumptions by beneficiary).

- c) **Drop-off** - this measures the effect of an outcome after the project has finished i.e. the value that is forecast to continue for a period of time into the future. For example, when the ICP project ends it is likely that some of the benefits realised through IGA will continue, meaning that the drop-off estimate would be low for this outcome.

Drop-off estimate

Key questions in estimating project drop-off are how can we measure benefits into the future? And how do these benefits drop-off over time? For some outcomes, the drop-off could be 100%, meaning that any beneficial outcome ends as soon as the project activity stops. A clear example of this is the WFP food support activity, which creates much of the positive food security outcome. As soon as this support finishes, there is virtually no further benefit experienced (unless beneficiaries are able to store food for the future, or possibly sell the food and use the proceeds for a longer term productive purpose. However, we cannot capture the extent of this, and the amount of food provided by the WFP means it is unlikely that this storage would be an important factor).

Even when the contribution of the project to a given outcome has dropped off completely, this does not necessarily mean that the beneficiaries are no longer benefiting from the project activity. It simply means that the relative importance or influence of the project activity on that outcome has diminished. For example, four years after the end of the ICP project a family of someone living with HIV might have a very successful poultry rearing micro-enterprise, and would be benefiting economically from this. However, other factors influencing the success of this business would now have come into play, and those would overshadow any remaining influence that the project might have had on the business four years previously (for example developing skills and experience in poultry rearing, the ability of the family to scale-up production from loans obtained elsewhere, additional training, marketing support etc.).

Drop-off values for this project have been estimated to be 10% in the first year, 20% in the second year, 30% in the third year, through to 50% in year 5. . This is because there is the likelihood of strong ICP project influence in the first few years following the project end, but drop-off will have become much steeper in years 3 and 4. We have assumed this to be true for most outcomes, with the exception of those below:

1. Greater food security: the level of drop-off in Y1 is 0% as this component continues one year after the end of the ICP project. However, drop-off from then on is 90% and then 100%, i.e. the project provides no more value for this outcome beyond year 4.
2. For income generation projects, specifically the IGA grants, we have considered drop-off to fall sharply from year 2 onwards, as other factors start to have more influence over the success of IGAs. This is also true of the loans received from self-help groups for small micro-enterprise development.

CALCULATING INPUTS – INVESTMENT INTO THE ICP PROJECT 2007-2011

Inputs to the ICP project

The resources invested in the ICP project include, but go well beyond, the project budget. In order to carry out a comprehensive cost-benefit analysis of the project, the study team also attempted to capture the inputs contributed by stakeholders at the community level.

Examples of inputs:

- ❑ **Village chief** –time spent supporting the self-help groups plus meetings; identification of suspected PLHIV in village and encouraging them to be tested; attendance and support of community-based meetings with implementing partner organisations. Average time spent: **3 days per month.**
- ❑ **Pagoda support and monks** - time spent by monks and head monk in supporting/visiting PLHIV, contributions of food.
- ❑ **Caregivers** – time spent in caring for PLHIV or OVC. This is usually significant, as 25% of PLHIV have a caregiver, 90% of whom are an unpaid household member [4]. The estimated time spent on care giving is 50% (based on the study findings, those caregivers able to retain their employment faced a 50% reduction in salary, which indicates that they worked 50% less, assuming previous full-time employment). Input of time of caregivers is therefore estimated at 25 hours/week, or **100 hours / month per caregiver.**
- ❑ **Self-help groups, PLHIV village savings and loan schemes:** - the SHGs have a regular monthly savings scheme that is used on a rotational basis by members of the group. In some villages this benefit is also extended to the wider community. The amount of money invested by members each month is 5,000 Riel (US\$1.25) for one share and 1000 Riel (US\$0.25) for the emergency fund. The savings fund works on a loan and payback basis – PLHIV can access loans from this fund and pay them back with 5% interest. The money is redistributed back to the investors every year.
- ❑ **World Food Programme monthly food support** – each month the WFP provides vulnerable PLHIV and OVC households with 30 kg rice, 1 kg cooking oil, 0.5 kg iodine salt. The total WFP budget from January 2007 to September 2011 was \$1,950,374.
- ❑ **ICP EU programme budget,** broken down against the following lines (ICP accounted for 73% of the total EU project budget):
 - a) Staff costs
 - b) Equipment and supplies
 - c) Administrative costs
 - d) Travel, training
 - e) Implementing partner budget allocation

Table 5: Actual costs for the action: January 2007- December 2011

Beneficiary	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Budget line	184,678	172,489	210,208	319,545	114,804	1,001,724
Human resources	18,343	19,085	14,768	31,936	36,424	120,556
Travel	7,512	23,416		17,455		48,383
Equipment and supplies	34,891	35,626	39,414	73,716	32,002	215,649
Local office and action costs	31,902	11,244	15,293		1,337	59,776
Other services	215,404	296,212	514,917	650,465	25,149	1,702,147
Partner implementing costs	24,734	28,014	39,887	54,871		147,506
Administrative costs	517,464	586,086	834,487	1,147,988	209,716	3,295,741

Source: Finance, Admin & Procurement Department, 2012

The EC SANTE fund provided 73% of the total ICP project costs, therefore the total input to the project from the EC was 73% x 3,295,741 = **US\$2,404,891**.

FINANCIAL PROXY ESTIMATES

The monetisation aspect of the SROI approach is by far the most controversial part of the project. Whilst by no means a perfect science, it is important to note that all monetary values/financial proxies assigned to represent an outcome indicator were informed by programme beneficiaries, to ensure that they were realistic and relevant in the project areas. This formed a major part of the consultation process with beneficiary groups and key informants. Where it was difficult to find a financial proxy, we referred to sources of secondary data. A list of common outcomes and their financial proxies with explanations is provided in table 6 below.

Table 6: Common outcomes and their financial proxies

Beneficiary	Outcome	Financial proxy description	Proxy Amount US\$ (not adjusted) over 1 year
PLHIV	Decreased need to sell major assets for day-to-day living	Cost of average rice-field	750
	Higher levels of self esteem	Cost of sessions with a health service counsellor in Government health service	120
	Better health status and appetite	Ability to work, rate for day labour for farming/factory work and number of days able to work	439
	Greater sense of belonging in community and social life	Cost of wedding, community function attendance per year	70
	Better livelihood prospects	Average amount of income gained through a typical IGA	420
	Better livelihood prospects II – microfinance	Average amount gained through a small informal business	50
	Decreased need to sell major assets for day to day coping	Equivalent cost of training in care	275
	Greater feeling of positivity and well-being (OVC)	Cost of a bicycle – according to our consultations with project beneficiaries, owning a bicycle gives OVC a sense of well-being, and allows them to visit friends and support their families. It saves time and encourages them to attend school	50
	Better health status and appetite	Reduced cost of medical attention required for HIV children on ART vs. those not on ART	138
	OVC	Improved life chances through decrease in level of school drop-outs and completion of education	Difference in earning power of someone with completed education vs. uncompleted (skills vs. non skills based employment in Cambodia)
Reduced vulnerability of OVC and avoidance of school difficulties (with teachers)		Avoidance of average informal fees paid by school children per year	30
Greater understanding and ability of caregivers to support OVC family member		Equivalent cost of care in residential orphanage	550

IMPORTANT FINANCIAL ASSUMPTIONS AND VARIABLES USED FOR THE MODEL

Following the allocation of financial proxies to the outcomes of the IPC project, the figures needed to be adjusted to take into account any changes (positive or negative) in the value of money over time.

The net present value (NPV) accounts for the value of money over time and includes inflation and a comparable return. When calculating the present value of an investment or input, the NPV uses a rate that discounts the cost of capital and deducts the sum from the investment level. A positive result would indicate a good investment in financial terms. A process called discounting is used to do this, and for this study a discount rate of 5.3%¹ was applied to all projected benefits. This reflects the ‘time value of money’, as a dollar today is worth more than a dollar tomorrow, because its value will have decreased by a certain percentage – this percentage is the **discount rate**.

The net present value was converted to its international dollar equivalent using a GDP-based Purchasing Power Parity (PPP) rate² of 2.58.

LIMITATIONS AND ASSUMPTIONS OF THE METHODOLOGY

The key limitation in this research was time. We conducted a rapid SROI study, completing consultation, field and office-based work with relevant teams in KHANA within a period of just two weeks. The period in the field enabled us to consult with a range of different beneficiaries from different localities, but only within one province. The ICP project covers three provinces, so a decision had to be made concerning the scope of the SROI, i.e. whether it should attempt to cover all three provinces and capture inputs and benefits across the whole geographic area, or whether we should confine the analysis to one province. After discussion with programme staff, it was decided that there would be no significant variation in results between provinces, as the ICP package provided to PLHIV and OVC is the same standard package across provinces and IPs. However, the research team was collecting end line survey data from other provinces, so they were also able to conduct additional FGDs and some KIIs with respondents in the other provinces. Although most data comes from Kampong Speu, additional data was gathered from the other two provinces so outcomes, financial proxies and value created was recorded across all three provinces.

The SROI approach is not without its challenges, and in the absence of SROI standards and a robust method of auditing an organisation’s ‘claims’ to the value it creates, ratios of return can be easily dismissed. We have attempted to detail the assumptions, processes, and measurement of outcomes in order to fully document how figures were calculated or estimated so that independent readers can make a judgment on the credibility of the assumptions and by extension on the study’s conclusions. In order to be able to do this, readers are asked to take into account the other limitations of the study listed below:

1 Cambodia Central bank discount rate 5.25%

2 2010 trading economics Cambodia PPP rate conversion factor

1. Lack of reliable secondary information to validate financial proxies.
2. Community-level consultation required simplification, as there were low levels of literacy within the discussion groups.
3. Consultation with government and local health service providers was limited due to time constraints.
4. Unable to quantify negative value – such as ‘inability to access Government poverty card’.
5. Unable to include costs incurred by government into the model.
6. Unable to value the benefit of the project in terms of a decrease in financial burden to health services (of untreated PLHIV).
7. Attribution percentages were estimated as a range, rather than an exact amount, making calculations more complicated
8. Some positive outcomes were valid for a number of different beneficiary types (i.e. families, broader social network surrounding PLHIV), but were captured under the main PLHIV/OVC target beneficiary group.
9. Lack of comparable data means it is difficult to benchmark this return on investment.
10. This is a pioneering experience in Cambodia, so there are no previous examples to draw from.



RESULTS

THE SROI RATIO AND BREAKDOWN OF VALUE

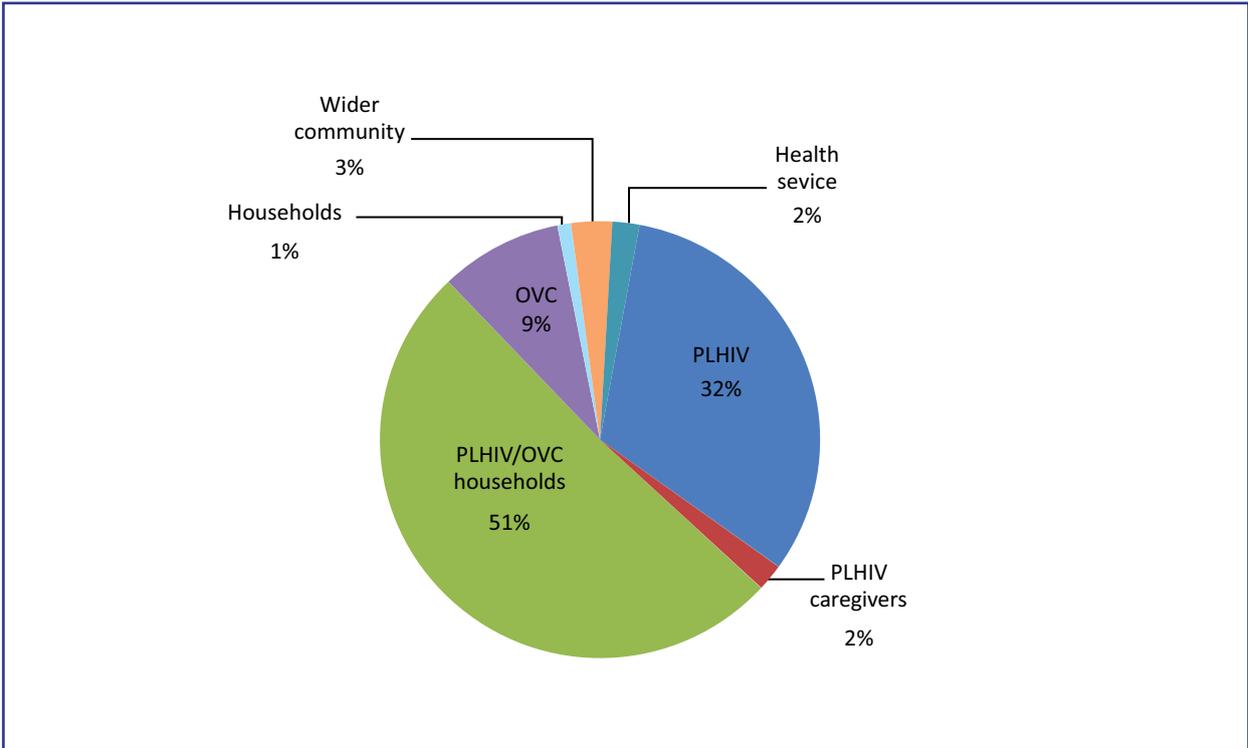
The **Social Return on Investment** for the ICP project when using the total inputs invested into the programme was **96%**; **for every \$1 invested, \$1.96 was generated in social, health and economic value.** In other words, a combined investment of approximate US\$2,406,000 from the EU plus US\$1,957,934 (WFP and community inputs) generated total benefits worth **US\$10,894,835.**

Though significant, a 1:2 SROI is not an unexpected return if one takes into account the level and the period of investment. Importantly, KHANA's financial commitment to a longer-term (5 year) programme strategy has created an enabling environment for working towards the sustainability of the project. Without such levels of commitment, it is unlikely that the project would have generated enough of an impact to sustain social, health, environmental, and economic benefits for an estimated 3-5 years after completion. Most importantly, the exercise has enabled the provision of an answer to the challenge "whose value counts?" The methodology of SROI clearly focuses on the outcomes identified by beneficiaries, and the value they have received from the project with each step of the process being led by beneficiary-inputs (See annex 6 for the full SROI model).

PERCENTAGE OF OUTCOME VALUE CREATED BY BENEFICIARY TYPE

Further analysis of the model shows that the proportion of value created varies considerably according to beneficiary type: PLHIV/OVC households (51%), PLHIV (32%), OVC (9%), and the wider community (3%), are the top four categories of beneficiary. One unexpected result was that significant value was generated for caregivers of PLHIV (2%). This came about in two ways: through the opportunity to return to productive work (as the burden of caring for a PLHIV in the household was reduced due to health gains), and through the opportunity to support and take better care of their family member, and the opportunity to be supported in their own right by the ICP project.

Figure 2: Percentage value created per beneficiary type



OUTCOME VALUES BROKEN DOWN PER BENEFICIARY

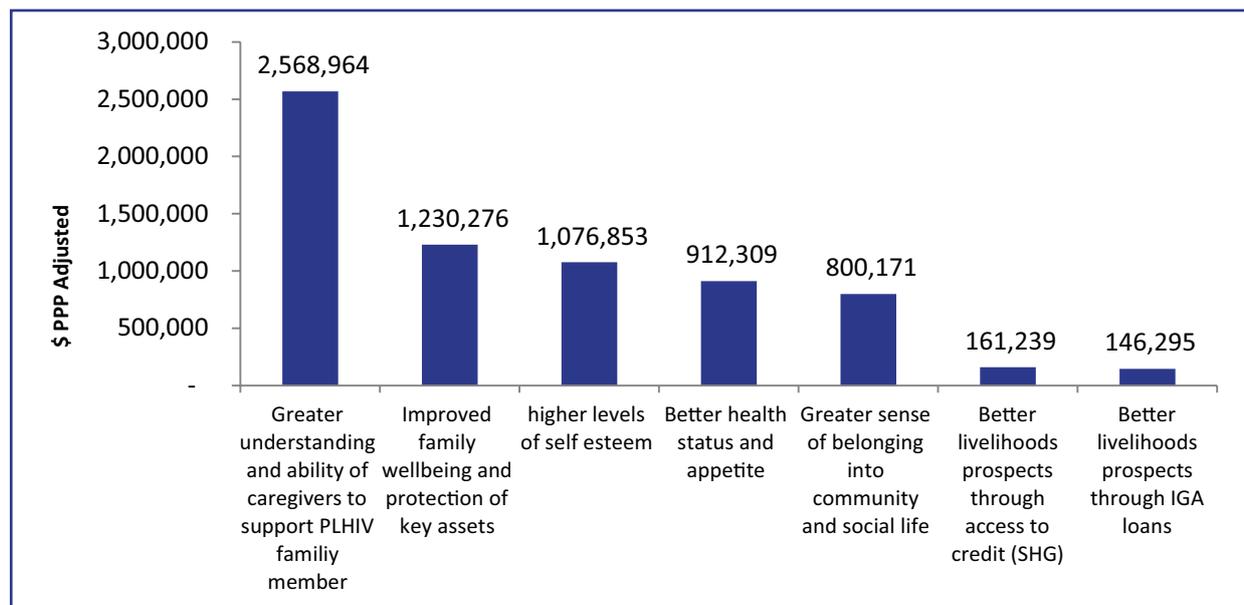
The details of value created for specific beneficiaries per outcome are presented in table 7. Outcomes related to i) PLHIV, ii) OVC, and iii) the wider community, are then described in more detail below.

Table 7: Value created for beneficiaries per outcome area

Beneficiary group	Outcome area	Value (Int'l \$)
PLHIV		6,896,107
	Improved family wellbeing and protection of key assets	1,230,276
	Higher levels of self esteem	1,076,853
	Better health status and appetite	912,309
	Greater sense of belonging in community and social life	800,171
	Better livelihood prospects through IGA loans	146,295
	Better livelihood prospects through access to credit (self-help groups)	161,239
	Greater understanding and ability of caregivers to support PLHIV family members	2,568,964
OVC		2,002,431
	Greater feeling of positivity and well-being	126,103
	Better health status and appetite	25,901
	Improved life chances through decreased level of school drop-outs	635,609
	Reduced vulnerability of OVC and avoidance of school difficulties	135,939
	Greater understanding and ability of caregivers to support OVC family members	1,078,879
Wider community and health service		1,090,887
	Avoidance of health costs resulting from late diagnosis	729,350
	Avoidance of HIV transmission MTC	1,871
	Greater ability to meet service delivery targets round ARV, VCT	359,666
PLHIV-OVC households	Less stress and greater peace of mind in relation to food security	10,822,771
PLHIV caregivers	Greater ability to earn a wage, resulting from reduced hours of care giving	442,994
OVC household	Better livelihood prospects through IGA	91,847

OUTCOME VALUE CREATED FOR PLHIV

Figure 3: Outcome value created for PLHIV (Int' \$)



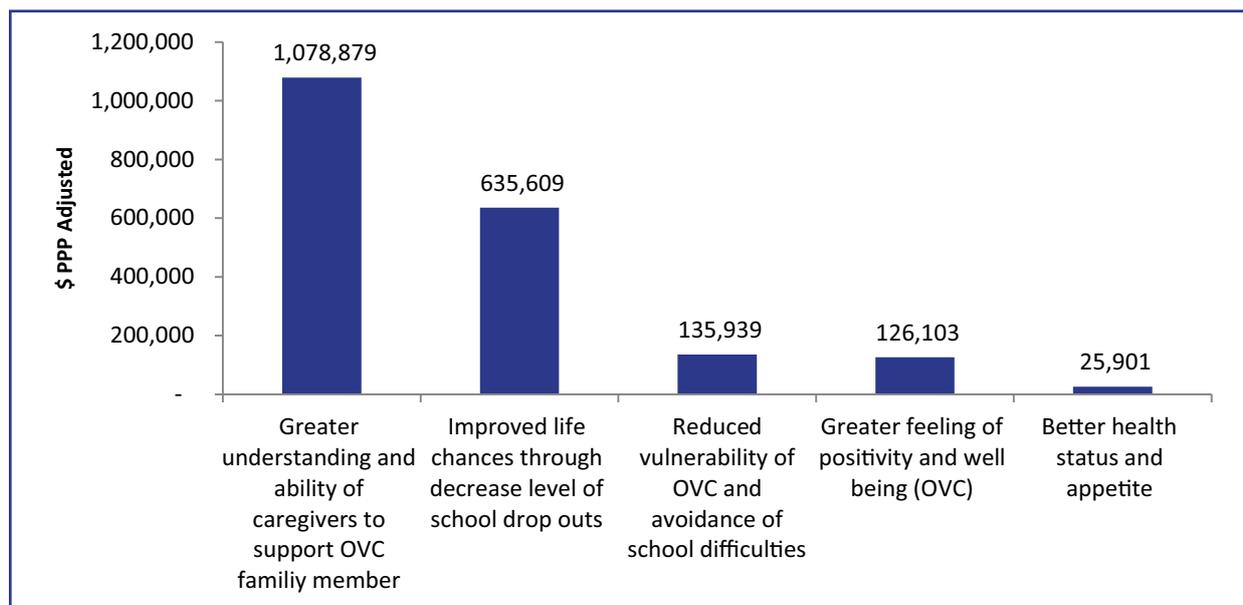
The three highest outcome values created for PLHIV through the ICP project, which constituted 71% of the total value created, were i) higher quality caregiver support to PLHIV at 37%; ii) improved family wellbeing, and a feeling of greater economic security resulting from a decreased level of debt and decreased need to sell-off key family assets at 18%; iii) higher levels of self esteem at 16%. As can be seen from the results above, the two livelihood (or economic productivity) outcomes represent just 2.1% and 2.3% of the total value created for PLHIV by the IPC project. Whilst we might have expected these outcomes to generate a higher proportion of the value created, the scale of the IGA programme (numbers reached and outcome incidence) and the recent introduction of the self-help group financing scheme has meant that these outcomes seem less significant relative to other outcomes.

An important consideration would be to assess the sustained value of the ICP project in more detail by determining what the longer term socioeconomic impact of the IGAs and self-help financing loans is on PLHIV and their families. **This would then allow KHANA to ensure that their livelihood generating activities are continuing to provide value after any project activities end.**

OUTCOME VALUE FOR PLHIV/OVC HOUSEHOLDS IN TERMS OF FOOD SECURITY

The food aid provided to PLHIV/OVC households generated huge value for the beneficiaries. The outcome was defined by beneficiaries in our focus-group discussions as “less stress and greater peace of mind in relation to food security”. The indicator ‘number reporting that food support is helping them with their family daily living’ was considered a valid representation of outcome change for families of PLHIV and OVC, and this can be directly linked to the provision of food support through WFP. The value created under this outcome was \$10,822,771 (see table 7 above). Outcome value for OVC and their families

Figure 4: Outcome value created for OVC (Int'\$)



The highest value outcome for OVC from the ICP project was the greater understanding and ability of caregivers to support their OVC family member, and this signals an important positive change for OVC within their households. As indicated in the USAID KHANA survey on children affected by AIDS, 40% of OVC at that time were going without sufficient food, clothes and basic necessities. The ICP projects targeting of caregivers for OVC, sensitisation, family counseling, and support has resulted in a better quality of life for OVC within their family environment. The OVC outcome of a greater feeling of positivity is linked to this, and has also generated high value. The self-help groups and peer support will have had a large effect on this outcome. We might have expected the outcome of a greater feeling of positivity to be even more significant, however the baseline for this indicator was conservatively estimated at 50% (based on data from World Vision Battambang and the ICP project midterm review 2010) i.e. half of OVC already felt some level of positivity about their lives at the baseline.

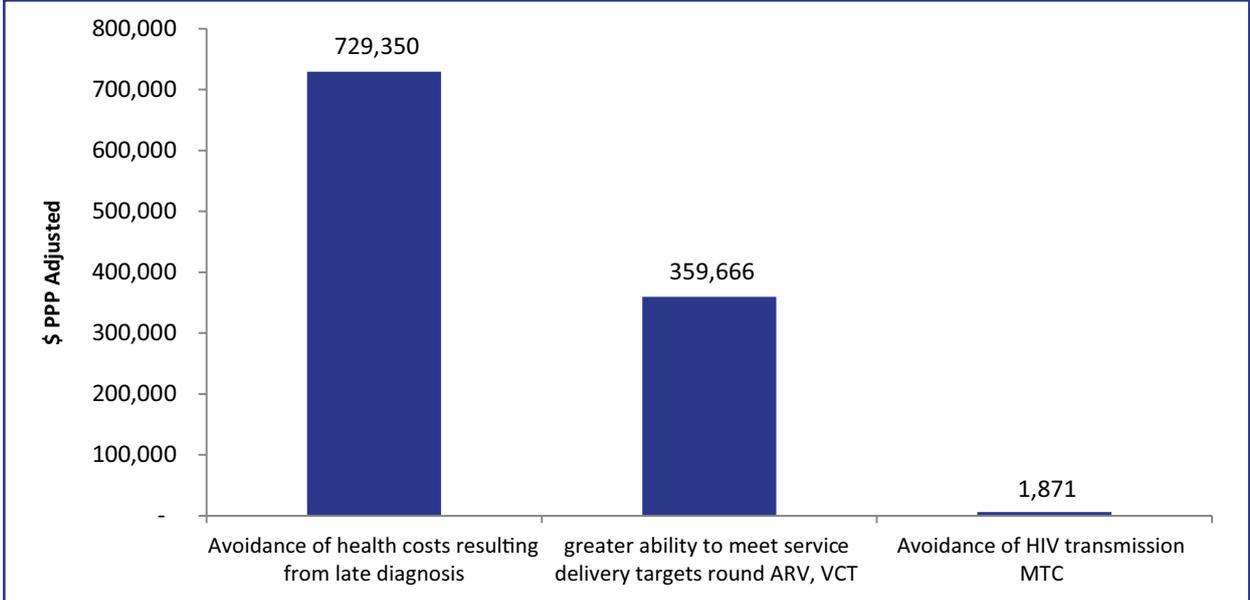
It should be noted that the IGA scheme targeting OVC households only reached a relatively small number of households, so this was not expected to result in a strong outcome for OVC.

OUTCOME FOR THE WIDER COMMUNITY AND HEALTH SERVICE

It was important to ensure that we captured the outcome value created for the wider community as well as for the direct beneficiaries (i.e. PLHIV and OVC), as feedback from beneficiaries, validated by our secondary research, consistently pointed towards the potentially devastating impact of late diagnosis, due to the tremendous health related expenses incurred. This exercise was an opportunity to quantify the avoided costs for people reached by the ICP project, through enabling them to access VCT and then treatment (Figure 6).

We also wanted to analyse the outcome value ‘avoidance of HIV transmission MTC’; we did not expect significant value to be created through this outcome, but it was important to test whether the SROI approach could be a mechanism by which these broader outcomes for societal good could be valued e.g. the cost benefit of the ICP project’s influence on MTC transmission.

Figure 5: Outcome value created for wider community & Health Service (Int'l \$)



The results show that the value for communities in terms of avoiding late diagnosis and related health costs is very high, which confirms the information that the research team gathered during the consultations with project beneficiaries. Whilst the model was able to quantify the impact created by the project in terms of MTC transmission of HIV, the value of this outcome was trivial.

SENSITIVITY ANALYSIS OF THE MODEL

There are uncertainties in all models where variables are not known with exact precision, and where the relationship between inputs and outcomes are not straightforward (for example when dealing with issues such as human behaviour and interaction, wellbeing, and support). Therefore, to test the robustness of our SROI model, we varied a number of factors to test the sensitivity of our economic model.

Financial proxies: halving the financial proxy for the outcome ‘avoided costs resulting from improved family wellbeing as a result of protection of key assets’ decreased the SROI ratio from 1:1.96 to 1:1.90, showing a low sensitivity to this change. Similarly, halving the expected income generated from an increase in earning potential through income generating projects decreases the SROI ratio to 1:1.95 (negligible sensitivity).

Halving the financial proxy for ‘equivalent cost in care training for caregivers of PLHIV’ reduced the SROI ratio to 1:1.84 indicating the model has some sensitivity to this indicator, as the scale of numbers reached was significant.

Attribution to the ICP Project: halving the attribution of the project (to 40% from 80%) for health outcomes through referrals, treatment literacy and adherence support results in a drop in the SROI ratio to 1:1.92.

For the outcome value created for food security, halving the attribution of the project from 90% to 45% results in a decrease in the SROI ratio to 1:1.46. For OVC, halving the attribution portion for the outcome 'greater understanding and ability of caregivers to support OVC family member' from 70% to 35% reduced the SROI to 1:1.91. **The model is therefore sensitive to the food security attribution percentage, but not significantly sensitive to the other key outcomes.**

Drop-off: We analysed the highest value-generating outcomes in order to test the sensitivity of the SROI model to drop-off. By increasing the annual drop-off for the outcome '*improved understanding and ability to support PLHIV family member*' to 70% in year 3 and 90% in year 4, the SROI was decreased very marginally to 1:1.95, indicating that the model is not very sensitive to drop-off for this indicator. Similarly, increasing the drop-off each year for *improvement in livelihood status* to 40%, 60% and 80% is insufficiently sensitive to change the ratio.



RECOMMENDATIONS

FOR THE USE OF THIS METHODOLOGY

- ❑ The SROI approach is clearly a useful way of quantifying the value of community-based health programmes, using a community consultative approach. However, it must be based on consultation with stakeholders and beneficiaries in order to get meaningful results - a desk-based study will not be sufficient. Stakeholders must provide their perspective and input to the exercise for it to be of any value.
- ❑ The SROI approach is not only of relevance as an evaluative tool at the end of a project; it also has value in guiding implementation if carried out at the start of the project, and as a forecasting tool at the mid-point of a project. Adequate time should be allocated to the stakeholder consultations at the field level. Consultations should also take place in the village setup where activities are being implemented.
- ❑ Adequate time should be allocated to allow for a broad range of stakeholders, in particular health and facility based staff, to be consulted. This would ensure that government-related outcomes of an investment are also included in the analysis.
- ❑ While the resulting SROI ratio is interesting it is important not to focus solely on this end result. The interest in this method should be based on an understanding of the differences in “relative outcome value” created as a result of the project. In this way it is possible to identify higher performing (i.e. creation of high value) and lesser performing (creation of low value – relatively speaking) outcomes, and by association the differential values of outputs and activities.
- ❑ SROI analysis should be used in the management of programmes and for decision making, alongside other qualitative reports of outcome and impact, as well as standard monitoring systems. SROI results should be discussed, disseminated, and presented to programme managers and implementers for validation, interpretation, and finally for use. The method has its limitations and there are unavoidable areas of subjectivity and assumption. These must be identified on a programme by programme basis, and clearly set-out in the report.
- ❑ Any project planning to conduct a return on investment study (whether evaluative or for use in forecasting) should build a strong system for monitoring outcomes. Where possible, baseline and mid-line surveys should be conducted to determine change against a broad set of outcome indicators.
- ❑ It is important to develop a systematic way to measure outcomes. One option would be to establish a panel survey of representative stakeholders and engage with them regularly to continuously measure outcomes. Information gathered through consultations with stakeholders and beneficiaries should be triangulated with secondary data sources where possible.

FOR THE ICP PROJECT MANAGEMENT

- Whilst a ratio of 1:1.96 or a 96% return on investment is a significant and positive result, KHANA and its implementing partners should not be complacent about ensuring that cost-saving measures are identified and implemented wherever possible, provided they have no negative impact on the outcomes achieved.
- A comprehensive costing of the **community's input** is essential to give a true reflection of how much the community invests in activities through its involvement with the project. This is particularly relevant because **community mobilisation** is the mechanism through which KHANA programmes are implemented. However, the true costs of this are often not captured. KHANA should attempt to reflect these costs in new programme budgeting to avoid over-burdening the community with hidden costs.
- The **livelihoods component** of the project and related activities to build skills and raise the earning potential of families appears to be generating some value, but the scale of its reach is limited. The **potential for a sustained benefit to be created beyond the life of the ICP project should be high**, but this is an assumption that needs to be tested. It would be useful to track a small cohort of PLHIV and their families who received IGA loans through the IPC project, and follow the sustainability of their businesses. This would help KHANA to determine factors and lessons that future IGA projects need to take into account. This recommendation is also valid for the self-help group loans scheme. KHANA should also consider the size of the initial grant issued through the IGAs, and analyse whether the size of the grant has an impact on the sustainability of the value given to PLHIV and their families.
- Project sustainability should be prioritised, with a focus on longer-term support for existing schemes, such as ongoing mentoring for IGAs and maximising the sustainability of micro-enterprises.
- There were some **negative outcomes** mentioned in consultations, for example inability to access Government poverty cards, and beneficiaries having been unsuccessful in implementing IGA schemes. Time constraints meant that we were unable to quantify these outcomes as negative values. In this case, the research team did not feel these were of sufficient scale to change the overall SROI ratio.). However, it is important that in future SROI exercises more attention is given to these negative outcomes, and a way to integrate them into the SROI model is found.

FOR IMPLEMENTING PARTNERS

- KHANA should disseminate and discuss the findings of this study with its implementing partners (IPs), particularly those within the EU-ICP programme catchment area, but also more widely across the broader USAID-funded SAHACOM programme.
- The methodology for community/stakeholder consultation should be promoted as a tool for implementing partners to use with programme stakeholders.

FOR POLICY-MAKERS

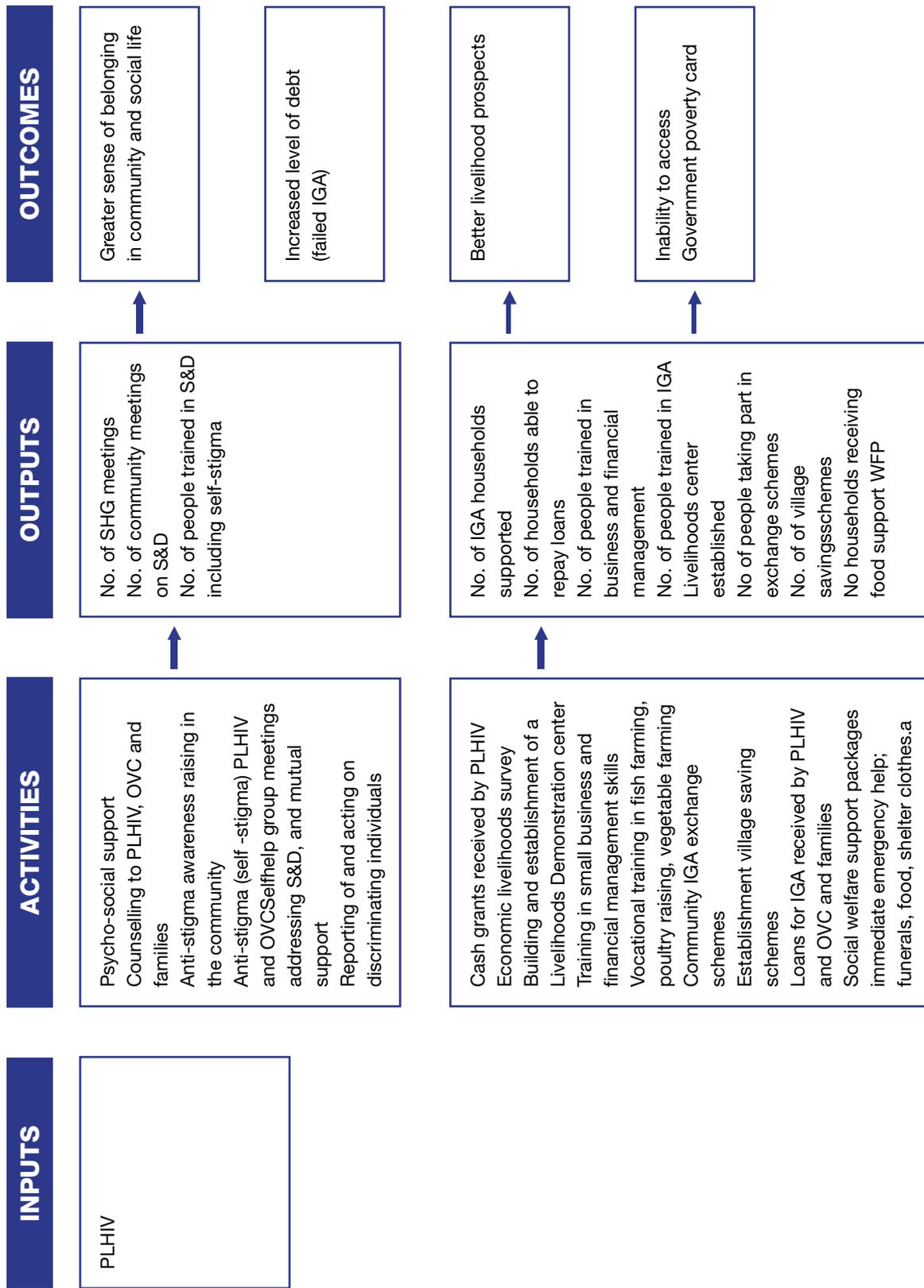
- ❑ The issue of the **WFP emergency household food support**, which was leveraged by KHANA as an additional input for the poorest households and communities, is of critical importance. This support terminates at the end of 2012. KHANA and its IPs need to gather evidence on the need to sustain this support for the most vulnerable households, and raise it as an advocacy issue. At the very minimum it should be raised as a critical concern to local government, and this study can be used to support the case.
- ❑ The issue of the true costing of community investments is another area of interest for policy-makers. This is the only way to provide a complete picture of the socio-economic impact a programme has on its intended beneficiaries. A position paper about costing of community mobilisation, has been conducted with joint effort with Alliance “*Costing Community Mobilisation within the UNAIDS Investment Framework KHANA – Focused Prevention Programme*”.



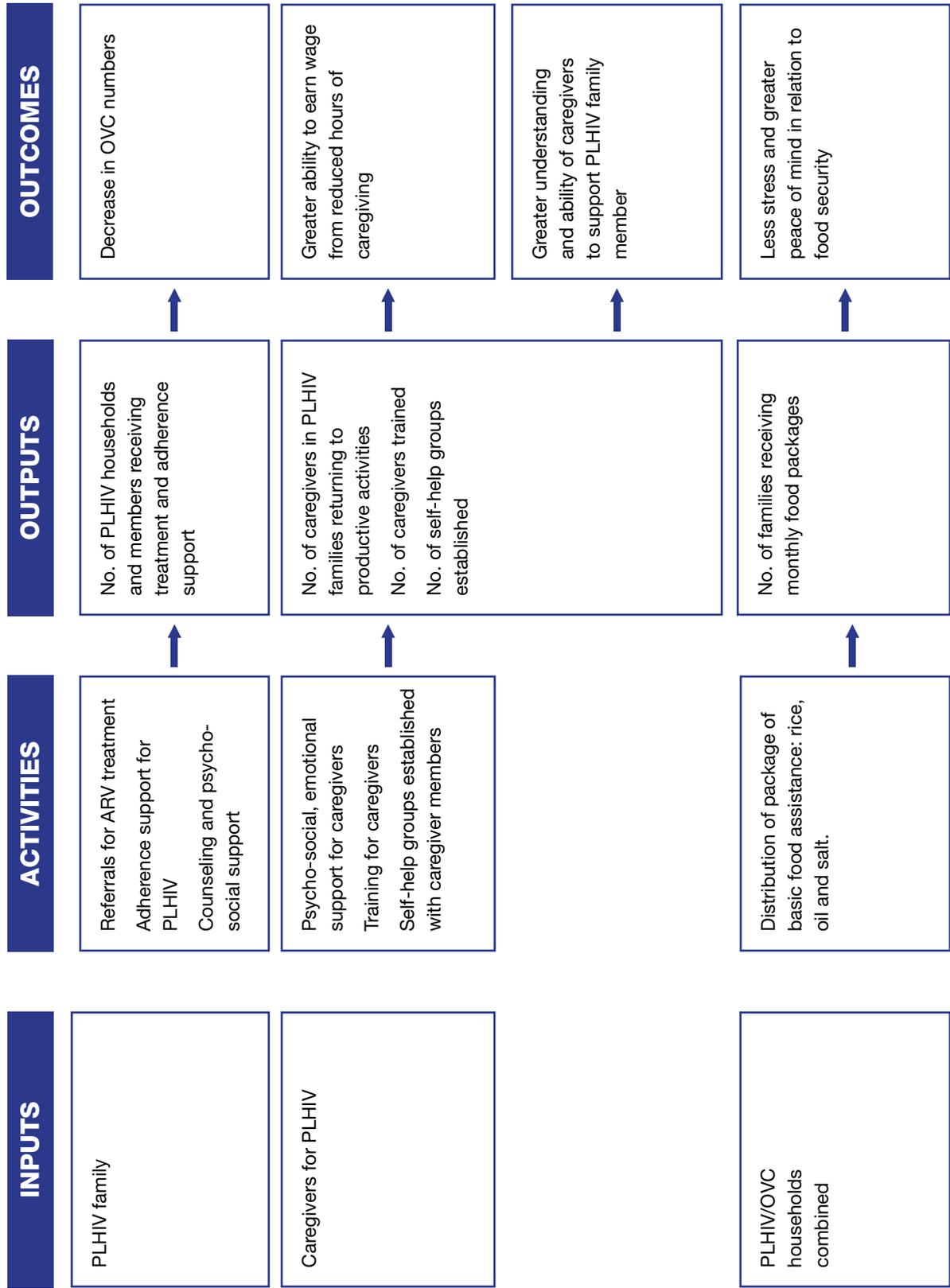
REFERENCES

1. Biswas K, Kummarikunta G, Biswas A, Tong L: **Social return on investment: CHAHA programme.** 2010.
2. Schwartlander B, Stover J, Hallett T, Atun R, Avila C, Gouws E, Bartos M, Ghys PD, Opuni M, Barr D et al: **Towards an improved investment approach for an effective response to HIV/AIDS.** Lancet 2011, 377(9782): 2031-2041.
3. Sopheab H, Chhea C, Tuot S: **Midterm review of the integrated care and prevention project regarding PLHIV and OVC.** Phnom Penh, Cambodia: KHANA; 2010.
4. UNDP: **Report on the Socio-Economic Impact of HIV/AIDS Epidemic at the Household Level in Cambodia, June 2010.** Phnom Penh: UNDP, Sanigest International, Center for Advance Studies; 2010.
5. KHANA: **KHANA Network Household Economic Livelihood Survey Analysis.** 2010.

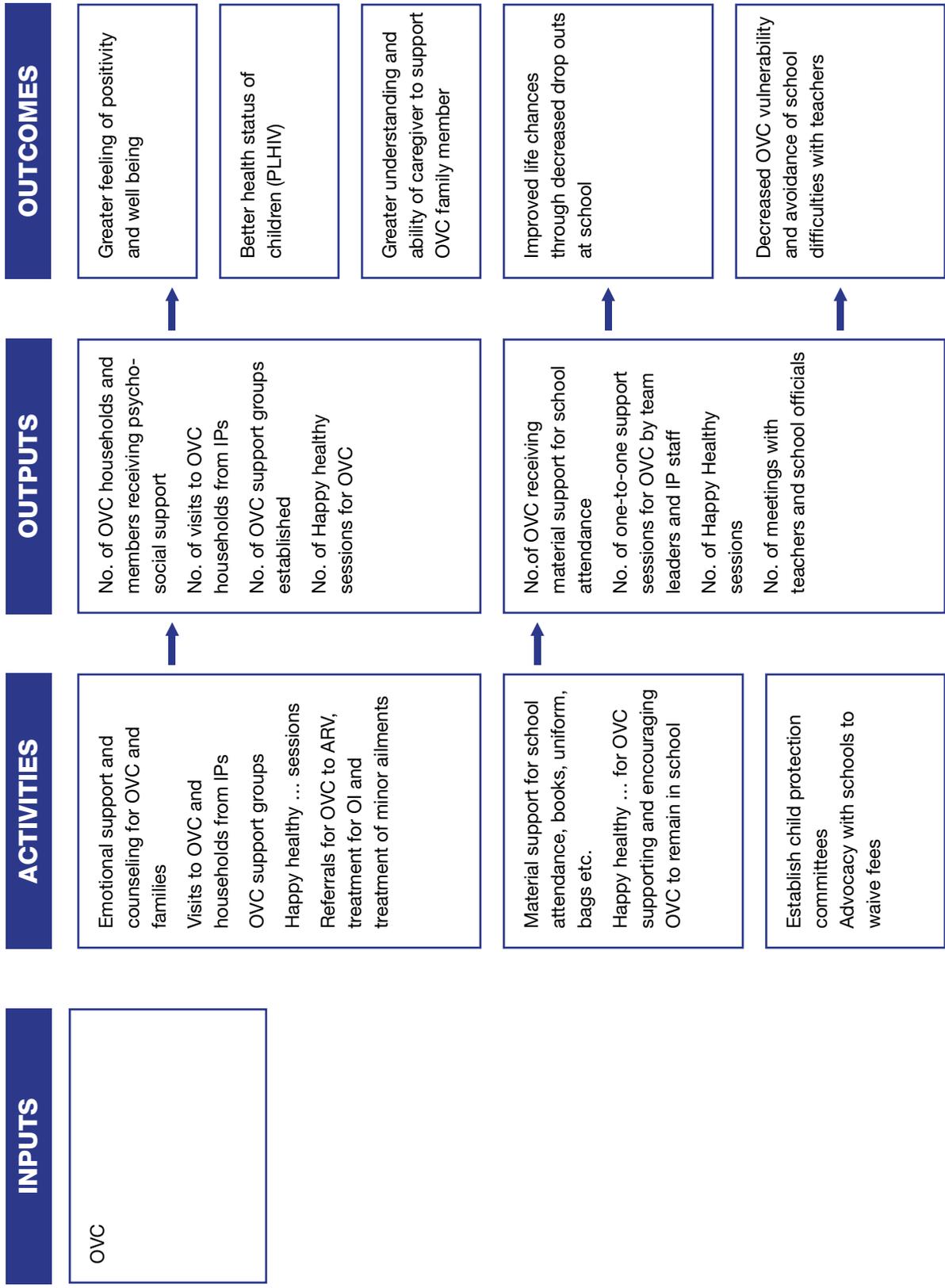
ANNEX 1: STAKEHOLDER IMPACT MAPS



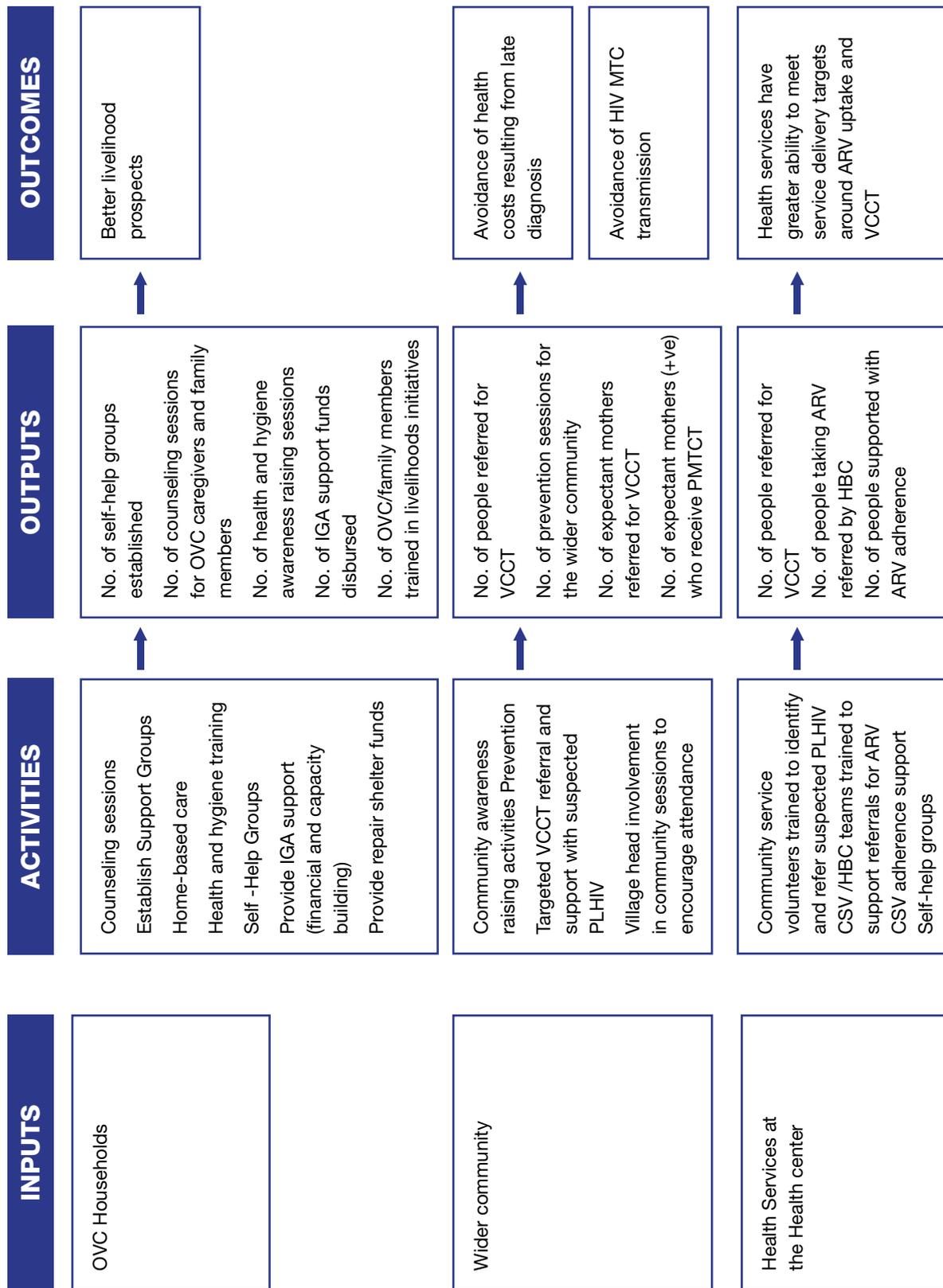
ANNEX 1: STAKEHOLDER IMPACT MAPS (CONT')



ANNEX 1: STAKEHOLDER IMPACT MAPS (CONT')



ANNEX 1: STAKEHOLDER IMPACT MAPS (CONT')



ANNEX 2: DESCRIBING OUTCOMES, INDICATORS AND FINANCIAL PROXIES

Beneficiary	Outcome description	Indicator	Financial proxy	Comments
PLHIV	Better livelihood prospects through IGA loans	No. of people who have been trained and used a loan for an income generating activity	Average amount of income gained through a typical IGA	Note this is different from the income gained for day labouring above. Please refer to the case study box for typical IGA projects supported. The average value generated per year was \$420.
	Better livelihood prospects through access to credit (SHG)	No. of people accessing microfinance credit for small business through self-help groups	Average amount of income that can be generated through establishing a small business	KHANA's household economic livelihoods survey 2010 estimates profits from small scale business ventures that result from self-help group loans is approximately \$18.13/week, or \$870/year.
	Increased level of debt	No. of failed IGAs	Repayment amount of loan with interest	Cases have been reported of failed schemes that have resulted in families going deeper into debt. This is a negative value created by the programme. In consultation there were clearly some cases of IGA projects failing after a brief period (the loss of livestock from death, pigs in particular). Individuals and families mentioned going further into debt as a result of trying to save the situation. This is particularly the case for the very poor households. More will be said about this in a case study and the recommendations. It has not been possible to ascertain the numbers of beneficiaries that this is true for, but it was felt important to note in the report.
	Inability to access Government poverty card – Equity Fund	Est. number of PLHIV qualifying for card	Value of services provided freely by card	Negative value It was reported that some PLHIV were not thought to be eligible by the village head as they already had access to NGO support, even if they were from the poorest households.

ANNEX 2: DESCRIBING OUTCOMES, INDICATORS AND FINANCIAL PROXIES (CONT')

Beneficiary	Outcome description	Indicator	Financial proxy	Comments
Caregivers for PLHIV	Greater ability to earn wage resulting from reduced hours of care giving	Est. percentage of caregivers in PLHIV family able to generate additional income	Increase in average yearly income	The socioeconomic impact of HIV at the household level in Cambodia report by the National AIDS Authority (2010) states that in rural situations caregivers' wage earning capacity drops by \$15/month when a household member is diagnosed with HIV.
PLHIV/OVC	Less stress and greater peace of mind in relation to food security	No. reporting food support helping them with their families' daily living	Average consumption over a year (balanced basket Cambodia) ³	Consumption (person/year) - 150 kg of rice - 30-35 kg of vegetables - 8 kg of pork - 6.5 kg of poultry - 3 kg of beef - 50-53kg of fish (FAO)
	Greater feeling of positivity and well-being	% OVC reporting they rarely felt despair or depression in the past month	Cost of sessions with a health service counsellor	The health service counsellor is paid \$800 on average per month. This works out to an hourly rate of approx \$5 per hour.
	Better health status and appetite	% of infected children receiving ART through facilitation and support of HBC team	Reduced cost of medical attention required for children on ART vs. those not on ART	Socio economic impact 2010 data reports the average cost of drugs (not including ARVs) for children is \$6.97 per month and \$3 for transport for HIV-affected households. We estimate that children on ART are less likely to have to attend medical services for treatment (saving 1 appointment per 3 months), making an average of 4 visits per year.
OVC	Improved life chances through decrease in level of school drop outs and improved chance of completing studies	% decrease OVC reporting they have temporarily stopped school to earn money in the past 6 months	Difference in earning power of someone with secondary level vs. uncompleted education (skills based employment vs. non skills based)	OVC at times are required to stop their schooling in order to help support the family. This can be due to poor health of caregivers/parents due to HIV who are unable to work through prolonged periods of illness. The financial proxy has to be based on national employment statistics - the difference in average annual salary of a junior Government worker and a day labourer is \$720 - \$358 / year.
	Reduced vulnerability of OVC and avoidance of school difficulties (with teachers) due to status of self and family	% reporting experience school difficulties	Avoidance of average informal fees paid by school children per year	Corruption is rampant, to the extent that school children often have to pay "additional fees" to teaching staff. Through the interventions of NGOs, OVC are generally exempt from this.

ANNEX 2: DESCRIBING OUTCOMES, INDICATORS AND FINANCIAL PROXIES (CONT’)

Beneficiary	Outcome description	Indicator	Financial proxy	Comments
OVC households	Better livelihood prospects through IGA	No. of OVC households supported with successful IGA loans	Average amount of income gained through a typical IGA	Note this is different from the income gained for day labouring above. Please refer to the case study box for typical IGA projects supported. The average value generated per year, regardless of the IGA activity, was \$420.
Wider community	Better livelihood generation	People accessing PLHIV revolving loans at a lower interest rate	Difference in cost of loan from commercial sector compared to revolving fund	
	Avoidance of health costs resulting from late diagnosis	No. of referrals for VCCT services found to be positive	Avoided burden of debt and asset loss caused by health costs prior to diagnosis, yearly spend	NCHADS second comprehensive report 2010 on HIV prevention and care programme states Q2 prevalence rate amongst those attending VCCT to be 0.3% Est. people presenting for late diagnosis would spend an average of 2 years with undiagnosed sickness, seeking medical attention. A conservative figure would be a spent of \$100 per month in treatments that is often paid for through loans, or the sale of family assets, such as rice fields, cattle, motorbike, etc.
	Avoidance of HIV transmission MTC	No. of avoided cases of HIV infection in infants resulting from PMTCT uptake	Cost benefit of avoided cases of CLHIV, cost per year - estimate	There is a 0.03 chance of a mother being HIV positive = $0.03 \times 2599 = 78$ positive mothers. PMTCT reduces the risk of MCT from 30% to 15% therefore $0.15 \times 78 = 11.7$ infected children avoided. Est. risk of a child being HIV+ from its mother is 30% WB, with PMTCT reduced to 15%. 15% of 78 infected mothers = 12 children avoided infections. Savings in cost based on 2010 prices = hospital in-patient costs $0.3 \times 12 \times \$82 +$ inpatient costs 12×5 episodes $\times \$8$. However, the cost saved for the health service from HIV cases averted of xx may represent more realistic value

ANNEX 2: DESCRIBING OUTCOMES, INDICATORS AND FINANCIAL PROXIES (CONT’)

Beneficiary	Outcome description	Indicator	Financial proxy	Comments
Health center	Increased use of services	No. of community service volunteers referring xxx people to health center	Cost of equivalent of 2 junior health service staff per health center	Est. cost of health staff \$60 x 12 months = \$720
Ministry of Health	Decrease in financial burden to health services of untreated PLHIV	Average number of OI episodes requiring treatment per PLHIV untreated	Average cost per person to health service of treating OI episodes	Home-based care was developed to provide HIV/AIDS care services, which reduce the burden on public health care facilities and provides a broad package of medical, psychological, and social support services to PLHA and their families ⁴ . No. of people accessing and adhering to ARV – this assumes these people would have significant health problems if they were not on ARV treatment.

4 The long run costs of HIV AIDS financing in Cambodia AIDS2031 Saphhon V, Chhea C, Sopheab H



ANNEX 3: CASE STUDIES

POVERTY PROGRAMMES MISSING THE VERY POOR PLHIV FAMILIES

A number of respondents attending the focus group discussions raised the issue of a new government anti-poverty scheme (currently being piloted in selected communes). It was difficult to get full details of how the scheme functioned, and a lot of the information we managed to pick up was from community consultation, based on hearsay and rumour. The 'poverty reduction' scheme involves the selection, by the village headman, of the poorest households in the community whose names are passed on to the commune level authorities. These households are entitled to a poverty card which enables them to access free-of-charge government healthcare support and all government services (i.e. school registration, national ID card, social welfare support). Respondents noted that they were unable to access the card, even if they were very poor, as they were already receiving support from the NGOs. Complaints were made that others in the village would object if they were to receive double benefit (as this was perceived), and others mentioned favouritism on the part of the village headmen in the selection of his family members or friends. It was clear to see how this form of selection, based on subjective assessment, could be manipulated.

We were concerned that this did represent a potentially harmful effect of the project on participants who would otherwise be eligible for the poverty card. Whilst we did attempt to quantify to what extent these examples were true and representative for our beneficiaries, it was not possible to get sufficiently reliable information, and our decision has been to note this as a follow on recommendation, rather than try to include the negative value in the economic model.

There are cases where despite the project's attempts to support PLHIV families and OVC, the type and concentration of support is just not sufficient. Speaking with one OVC key informant (aged 15) it was clear that families in extreme poverty may not necessarily be able to benefit from the form of support the project is able to offer.

*"I joined the project when I was 11 years old. My mother has HIV, she is still alive, but my father passed away. My mother sells her labour during the harvest season. NAPA helps me with my schooling, they have given me a bag, books, uniform. I join the monthly meetings and during this time NAPA educate us about our health, how to look after ourselves. We were given a pot for storage of drinking water. It is slightly better at school because before the children would call me names, say I was an AIDS child, and the teachers would as well... but now it is just the children. Our home and our living conditions are still very bad. Although I get encouragement and social support from NAPA we still have no house, we live in a chicken shed. Every day we have very little food, I have to ask the neighbours to borrow money to buy food. In my spare time the only thing I can do is try to find wood, my mother gets sick very often". OVC, **Prey Toteng Village, aged 15***

*"Some families when they are given a loan by NAPA to start up a small business, for example chicken rearing, their livestock just dies. They do not know how to properly take care of the birds. These poor people are very uneducated. Once their chickens have died they cannot repay back the loan..." **(Village headman)***

STIGMA AND DISCRIMINATION

*"HIV families are very poor. I have observed that they are the poorest families in the village. Often the husband, and then the wife pass away, leaving the family behind. When people become infected, and realise they are HIV they just used to wait to die. ... NAPA came with the project, identified suspected families, they encouraged them to test, paying their transport fees. They got blood tests and treatment, and we could see the health returning to those people. I play my part in this, I identify people in my village that may be looking pale, have weight loss, fatigue and diarrhoea. I try to encourage them to get tested – for people that appear fit and healthy, we do try to encourage testing, people are not so afraid of the disease now, we had a lot of community sensitisation and education from NAPA and now we know how HIV is spread." **(Village headman Ang polpel Commune)***

Interestingly examples were mentioned of the NGO workers themselves taking direct action and on hearing of a case of discrimination towards a PLHIV would visit the perpetrator to find out what happened and "educate them" on the issue of anti-stigma and discrimination towards PLHIV and their families. This appears to have been a successful approach.

*"The NGO staff goes directly to an infected person's house, and do counselling with them. They ask the PLHIV if they have faced any discrimination, and then find out who that person was. If they know who did it, they will go and see the individual at their home. Most people who discriminate are uneducated". **(FGD Serey Phoit village)***

ABILITY TO RETURN TO WORK AS A RESULT OF BETTER PHYSICAL AND MENTAL HEALTH

“My health is better than before because I am now on treatment. This means I can do some work in harvesting as a hired help, but I have other health problems and suffer from hypertension and convulsions, my health is always up and down. I cannot work very much in a full time job because I don't know whether I will be sick that day or not.”

THE CASE OF THE SOKHON FAMILY

Mr and Mrs Sokhon from Prey Toteng village are both in their mid 40s. They have 5 children. The oldest is 25 and the youngest only 9. This couple, previously considered relatively wealthy as they owned a restaurant and karaoke bar, shared their story with us as an illustration of what could (typically) happen to families before and following HIV diagnosis.

In 2005, Mr. Sokhon began to feel unwell. He developed a severe skin rash, was often feverish, and had a continual feeling that his veins were burning. He sought medical help at a private clinic. Initially it was suspected that he had cirrhosis as at that time he was a heavy drinker and smoker. The clinic clearly did not know what the problem was and over the course of 2 years he attended 3 different private practices. The fees for the medical consultations and treatment he was offered amounted to 400,000 Riels per visit (US\$100). Mr. Sokhon recounted that he visited the clinic once a week for 2 years. Calculating how much in total the family had spent on failed medical treatment he said it was between US\$10,000 to US\$12,000. The family was obliged to sell almost all of their assets to pay for this treatment. This included their car, a motorbike, their rice fields, and the equipment in their restaurant.



In desperation they finally turned to the government services and asked for information at the health center. At this point (2007) Mr Sokhon weighed 45kg, had lost all of his hair and had a very severe skin rash. He was given a blood test, found to be HIV positive and referred to Kosamak Hospital for treatment. Staff there advised him in how to take the medication and he was supported by someone he met at the hospital from an NGO (NAPA) working with an HIV and AIDS project. He wanted to discover more about how this NGO could assist his family as they were now at this point almost destitute. Mrs Sokhon was tested and found to be positive.

She was also put on ARV treatment. Importantly for the couple NAPA enrolled them into the self-help group, which was the start of really turning their lives around. It gave them hope, built their confidence and enabled them to start rebuilding what they had lost. After receiving training in livelihood development, business start-up and receiving a loan from the NGO, the Sokhons have diversified their livelihood strategy and are cultivating a variety of small-scale agricultural products including mangoes and poultry rearing (chickens and ducks). They have also recently started an aquaculture project in their back garden and are currently rearing 1,000 catfishes in their ponds.

“Before we were really discriminated against, when people saw how sick my husband was, our home business (restaurant and karaoke bar) was not able to survive because we lost all our clients. My husband at that time was so sick, very thin and he lost all his hair.... now some people are coming back to me and saying why don't you re-open your business again it used to be really good...we haven't got enough capital to do that, not yet anyway. One day we will be able to buy back our car, at least we have a bike now....” (Mrs. Sokhan)



ANNEX 4: ATTRIBUTION TABLE

Beneficiary	Outcome description	How the attribution proportion has been estimated, taking into account initiatives occurring in the area that may influence the extent to which the ICP programme contributed to this change.	% attribution estimation of the ICP programme
PLHIV	Improvement in family wellbeing and protection of key assets	It is assumed that other sources of help and support would be from family and neighbours, MFI, NGOs, money lenders, local banks Often however poor families lend money that must be laid back with high rates of interest. Attribution towards the project was estimated as high range.	High 80%
	Higher level of self esteem	The attribution rate for this is high as the project has a strong focus on self-help, mutual support and counselling for mental wellbeing. Beneficiaries report a direct link between the actions and support offered by the project and their positive state of mind and confidence. Others who may have contributed to this change include community members, pagoda support.	80%
	Better health status and appetite	The indicator for this outcome tracks health status change as a direct result of HBC teams giving referrals and ARV treatment support. HBC teams and CSVs also provide home based support to identify and treat less serious OIs, which impacts positively on health. Others contributing to this change include health service staff and themselves. Also information from friends, family, community contacts	70%
	Greater sense of belonging in the community and social life	This has a high level attribution for the reasons given during the beneficiary consultation, that the project enabled individuals to re-integrate into community life as a result of i) less self-imposed stigma and ii) reduction in community stigma.	90%
	Better livelihoods prospects	This relates to the livelihood potential created from IGA support from the project – the training in establishing and managing businesses, and the IGA loans available for PLHIV families for business start-up. Other means of accessing business start-up loans include VSL access, although this is not available to 75% of villages (see market survey research above on VSL), borrowing from money lenders in the village, or family and friends. HIV-affected households have little or no savings, and for those that do, the impact of HIV was a reduction in savings by an average of 30% over 12 months. Other finance opportunities could arise from MFI, NGOs, money lenders local banks, family and friends.	80%

ANNEX 4: ATTRIBUTION TABLE (CONT’)

Beneficiary	Outcome description	How the attribution proportion has been estimated, taking into account initiatives occurring in the area that may influence the extent to which the ICP programme contributed to this change.	% attribution estimation of the ICP programme
PLHIV family	Less OVC as parents surviving	<p>This outcome is strongly linked to the improved health of HIV positive parents. To calculate the outcome incidence we used the following assumptions: - survival rate after 12 months on ART 86.7% (2010 UNAIDS country progress report Cambodia).</p> <p>Orphan-years averted by per adult life-year gained due to ART using the Spectrum AIDS Impact Model [14] for each of 14 countries, including the 10 with the most Global Fund-supported ART patients and the 10 with the most Global Fund-supported services for orphans and other vulnerable children [18]. Across these 14 countries, between 0.32 and 0.76 orphan-years (average 0.5) are averted each year that an adult patient survives on ART.</p> <p>The attribution rate here is the same for better health status of HIV due to ARV treatment, as these are the beneficiaries referred and supported to take ARV by the project HBC teams and the CSVs.</p>	70% - 80%
Caregivers for PLHIV	Greater ability to earn wage resulting from reduced hours of care giving	<p>This is as a result of time saved by family carers of PLHIV and ability to use that time in a productive capacity. Better health of PLHIV and less time spent in very poor physical and mental health state results in less demands on carers. We are assuming that the project has played a significant part in this effect of freeing up of carer time for productive use.</p>	70%
PLHIV/OVC	Greater understanding and ability of caregiver to support PLHIV family member	<p>Direct project related support such as training and family counselling involving PLHIV and their carers has resulted in high attribution for this outcome. Other more limited counselling may have been received by the Pagoda monks, the village head, family and friends.</p>	80%
PLHIV/OVC	Less stress and greater peace of mind in relation to food security	<p>The project is directly responsible for leveraging in WFP nutritional support, through active advocacy and strategic partnering, for PLHIV families and OVC affected households.</p>	90%

ANNEX 4: ATTRIBUTION TABLE (CONT’)

Beneficiary	Outcome description	How the attribution proportion has been estimated, taking into account initiatives occurring in the area that may influence the extent to which the ICP programme contributed to this change.	% attribution estimation of the ICP programme
OVC	Greater feeling of positivity and well being	OVC in FGDs relate how they felt the project strongly influenced their feeling of well-being, through the encouragement and establishment of self-help groups, peer support and counselling. In addition material support has been provided for schooling, as well as healthy living.	80%
	Better health status and appetite	The indicator for this outcome tracks health status change as a direct result of HBC teams giving referrals and ARV treatment support. HBC teams and CSVs also provide home based support to identify and treat less serious OIs, which impacts positively on health.	80%
	Improved life chances through decrease in level of school drop outs and improved chance of completing studies.	The project has encouraged school attendance through psychological and material assistance. It cannot claim full attribution as there are other players that might influence ongoing school attendance, for example influential teachers, the parents themselves, siblings and peers.	70%
	Reduced vulnerability of OVC and avoidance of school difficulties (with teachers) due to status of self and family.	Advocacy with school officials and teachers to waiver any unofficial school fees was a direct strategy of the project.	90%
	Greater understanding and ability of caregivers to support OVC family member	The project works directly with family members of OVC, providing support, counselling and advice on issues related to child care, as a key strategy for child protection and well-being. For this reason the attribution portion is considered fairly high, as there are also others who can be identified within communities that would impact on this, possibly other family members, pagoda, village head.	70%

ANNEX 4: ATTRIBUTION TABLE (CONT’)

Beneficiary	Outcome description	How the attribution proportion has been estimated, taking into account initiatives occurring in the area that may influence the extent to which the ICP programme contributed to this change.	% attribution estimation of the ICP programme
OVC households	Better livelihoods prospects	Similar to above (PLHIV better livelihoods prospects)	80%
Wider community	Avoidance of health costs resulting from late diagnosis	This was considered a fairly high project attribution as project activities included the VCT referral and follow on adherence and psycho social counselling. It is possible that people would eventually self-refer for treatment, or seek support from others, i.e. health workers or other NGOs, but late diagnosis, as would likely be the case, is the factor which leads to the catastrophic initial health costs.	70%
	Avoidance of HIV transmission MTC	Similar to reasons given around ARV treatment	80%
Health center	Increased use of services	Has high attribution to the project because without the project CSVs there would be no replacement health service link with communities.	80%
Ministry of Health	Decrease in financial burden to health services of untreated PLHIV		

ANNEX 5: DEADWEIGHT ASSUMPTIONS BY BENEFICIARY

Beneficiary	Outcome description	What would have happened anyway, without project intervention? Assumptions.	% deadweight estimation i.e. what % would have happened without intervention
	Improvement in ability of families to meet needs in day to day living	<p>The KHANA mid-term review of the ICP programme in 2009 estimated that PLHIV families were only able to earn half of what was required to meet their daily needs. The ICP focus is very firmly on increasing PLHIV family income and enhancing productive capacity, as a result of health gains. There are a number of different means of obtaining an informal or formal loan in rural communities including NGOS, micro finance institutions, money lenders, local banks, family and friends. However, obtaining a loan does not equate to financial security – particularly as the poorest households would normally use loans for family consumption related costs, medical bills, food, rather than productive costs, pushing them further into debt.</p> <p>32% of people with loans normally have trouble in paying their loans over the past year⁵. The ICP project has enabled families to start paying back loans partially – but as reported not fully.</p>	10-20% Low to medium
PLHIV	Higher level of self esteem	Improved self-esteem is linked to multiple causes - according to beneficiaries the project has brought about tangible and positive changes in this regard, in particular through the counselling and self-help groups. Many beneficiaries reported feelings of total despair before their enrolment onto the project, and it is unclear as to who else, or what other forms of support may have improved this situation for PLHIV directly. It is therefore assumed that the community forms of support and coping may have occurred to a limited extent, but the deadweight is therefore assumed to be low.	10%- 20%
	Better health status and appetite	Improved health is directly related to ARV treatment and adherence, as well as better nutrition and self-care. Without the ICP project there are no structures at community level to provide this type of support to PLHIV, OVC and their families. Consultation with communities confirmed again and again that without ICP their health would have deteriorated to the point of death. Deadweight low /medium.	20%

ANNEX 5: DEADWEIGHT ASSUMPTIONS BY BENEFICIARY (CONT’)

Beneficiary	Outcome description	What would have happened anyway, without project intervention? Assumptions.	% deadweight estimation i.e. what % would have happened without intervention
PLHIV	Greater sense of belonging in the community and social life	This results from reduction (not elimination) of levels of stigma amongst community and family towards PLHIV. The ICP project was the only initiative providing awareness raising and targeted action towards eliminating stigma in communities. One would expect naturally decreasing attitudes of stigma resulting from greater knowledge of HIV transmission amongst general population, but the deadweight is estimated to be low.	10%
	Better livelihood prospects	KHANA livelihoods research has found that on average 20% of communities use loans to start up a small business or IGA. We are therefore using this figure as the deadweight of the % of PLHIV households that would have secured a loan for a business start-up even without the ICP project.	20%
PLHIV/ OVC	Greater food security	There are no other food or nutritional programmes in ICP project areas. The assumption is that the quantity of food for PLHIV and OVC households would not have increased without ICP/WFP. Deadweight estimate is therefore low.	10%
	Greater feeling of positivity and well being	There are very few other forms of psychosocial support within communities and no self-help groups for PLHIV or OVC for mutual support. The pagoda may be one source of blessing and meditation. The ICP project focus has been on improving emotional and mental health. Deadweight low.	10%
Family of PLHIV/ OVC	Better family relationships		

ANNEX 5: DEADWEIGHT ASSUMPTIONS BY BENEFICIARY (CONT')

Beneficiary	Outcome description	What would have happened anyway, without project intervention? Assumptions.	% deadweight estimation i.e. what % would have happened without intervention
OVC	Improved life chances through decrease in level of school drop outs and improved chance of completing studies.	Approx 12% ⁶ of OVC reported receiving school assistance from another source beyond the ICP project (NGO and other charity). Influence of family, friends, teachers and other community role models may have an effect here. Deadweight estimated to be medium.	30%
	Reduced vulnerability of OVC and avoidance of school difficulties (with teachers) due to status of self and family.	It is common practice for teaching staff to demand informal payments from students. CSVs have advocated on behalf of OVCs to waive these fees, but this is unlikely to have happened without the ICP project. Deadweight low	10%
Health center	Increased use of services	There is a natural tendency for increasing reliance on community based HBC and support to ease the burden of health services.	
Ministry of Health	Decrease in financial burden to health services of untreated PLHIV		



ANNEX 6: SROI FULL ECONOMIC MODEL

Stakeholder	No. of stakeholders	Outcome	Indicator description	Baseline	Endline
PLHIV	3930	Improved family wellbeing and protection of key assets	No. reporting the need to sell key assets in the past year	0.77	0.95
	3930	Higher levels of self esteem	No. PLHIV reporting higher levels of confidence/self esteem	0	0.93
	1052	Better health status and appetite	No. PLHIV received ART/TB/OI through facilitation and support of home care teams reporting improved health	0	0.9
	5912	Greater sense of belonging in community and social life	No. reporting reduced levels of discrimination against family by community	0.23	0.93
	280	Better livelihoods prospects through IGA loans	Support received for increasing family economics through IGA	0	0.57
	1031	Better livelihoods prospects through access to credit (SHG)	Access to micro finance through self-help groups	0	0.78
	4406	Greater understanding and ability of caregivers to support PLHIV family member	PLHIV satisfied with the HBC support and services received	0	0.97
Caregivers for PLHIV	4406	Greater ability to earn wage resulting from reduced hours of caregiving	Est. number of caregivers in PLHIV families able to generate income for family	0.08	0.18
PLHIV/OVC households combined (food security)	18615	Less stress and greater peace of mind in relation to food security	No. reporting food support helping them with their families daily living	0	0.85
OVC	2568	Greater feeling of positivity and well-being (OVC)	No. of OVC reporting they never or rarely felt despair or depression in the past month	0.5	0.9
	86	Better health status and appetite	No. of infected children received ART through facilitation and support of home care teams	0	1
	1907	Improved life chances through decrease in level of school drop outs and completion of education	Decrease in No. of OVC reporting they have temporarily stopped school to earn money in the past 6 months	0.4	0.9
	1907	Reduced vulnerability of OVC and avoidance of school difficulties (with teachers)	Decrease in No. of OVC reporting experiencing school difficulties	0.2	1
	2568	Greater understanding and ability of caregivers to support OVC family member	No. of OVC reported better care / understanding in household e.g. having enough food to eat in the past 6 months	0.4	0.8
OVC Households	167	Better livelihoods prospects through IGA	No. of OVC households supported with successful IGA loans	0	0.6
Wider community	10670	Avoidance of health costs resulting from late diagnosis	No. of referrals for VCCT services found to be positive	0	na
	2599	Avoidance of HIV transmission MTC	No. of avoided cases of HIV infection in infants resulting from PMTCT uptake	0	na
Health services at the health center level	734	Greater ability to meet service delivery targets round ARV, VCT	No. of CSVs supporting health service centers in community outreach	0	na

Deadweight	Attribution proportion	Financial proxy description	Proxy in \$ (Cambodian) for one year	Total Value Produced in \$ Cambodian over 5 year project period	Total Value in dollars (Cambodian equivalent)	NPV in \$ (Cambodian exchange rate)	Conversion to riels/1600 to convert to international \$
0.15	0.80	Cost of average ricefield	750	360,774	535,851	492,110	1,230,276
0.10	0.80	Cost of sessions with a health service counsellor in Government	120	315,783	469,028	430,741	1,076,853
0.20	0.80	Ability to work, rate for day labour for farming/factory work and number of days able to work	439	266,013	397,786	364,924	912,309
0.10	0.90	Cost of weddin, community function attendance per year	70	234,647	348,518	320,068	800,171
0.20	0.80	Average amount of income gained through a typical IGA	420	42,900	63,720	58,518	146,295
0.20	0.80	Average amount gained for a small informal businessl	50	25,734	71,501	64,495	161,239
0.15	0.80	equivalent cost of training in care	275	799,204	1,109,217	1,027,586	2,568,964
0.10	0.70	increase in ave yearly income	468	129,907	192,949	177,198	442,994
0.00	0.90	Cost of years worth of average food consumption - balanced (Cambodia)	265	3,773,726	4,603,947	4,329,108	10,822,771
0.10	0.80	Cost of a bicycle	50	36,979	54,925	50,441	126,103
0.20	0.80	Reduced cost of medical attention required for HIV+ve children on ART vs those not on ART	138	7,596	11,282	10,361	25,901
0.10	0.60	Difference in earning power of someone with completed education vs uncompleted (skills vs non skills based employment in Cambodia)	362	186,390	276,843	254,244	635,609
0.05	0.90	Avoidance of average informal fees paid by school children per year	30	39,132	59,348	54,376	135,939
0.20	0.70	equivalent cost of care in residential orphanage	550	316,378	469,910	431,552	1,078,879
0.20	0.80	Average amount of income gained through a typical IGA	420	26,934	40,005	36,739	91,847
0.20	0.70	Avoided burden of debt and asset loss caused by health costs prior to diagnosis, yearly spend	1200	215,107	317,327	291,740	729,350
0.10	0.80	Cost benefit of avoided case of CLHIV, cost per year - estimate	64.6	558	813	748	1,871
0.15	0.80	CSV equivalent to 1/3 of a health center staff (junior) equivalent	238	118,591	154,135	143,867	359,666
				Value	9,177,107	8,461,317	21,347,038
					total value generated	8,538,815	21,347,038
					total investment	4,357,934.00	10,894,835
					return on investment	1.96	1.96
					investment from EU minus WFP + community inputs	2,400,000	6,000,000



PHOTO CREDIT:

Cover page 5, 8, 11, 27, 34, 37, 57, 60 © Sovannary, KHANA

Page 4 © Kunthea, KHANA

Page 46, 48, 49 © Liza, Alliance



#33 Street 71, Sangkat Tonle Bassac, Khan Chamkarmon, Phnom Penh
P.O.Box 2311 Phnom Penh 3, Kingdom of Cambodia.

Tel: 023 211 505 | Fax: 023 214 049 | Website: www.khana.org.kh