International HIV/AIDS Alliance

Supporting community action on AIDS in developing countries

# THE TRUE COST OF STIGMA

## Evaluating the Social Return on Investment of the stigma and discrimination component of the Alliance's Africa Regional Programme II

# Acknowledgements

The evaluation was conducted by consultant Robin Brady, in liaison with Alliance Secretariat Staff.

Many thanks to all those who took part in this evaluation and made such a valuable contribution including: ARP members (staff of Alliance Country Offices and Linking Organisations and ARP advisory group members), the regional stigma training team, stigma trainers, social return on investment focus group participants, Alliance secretariat staff, and donors.

This publication was made possible by the support of the Swedish International Development Cooperation Agency (Sida) and the Norwegian Agency for Development Cooperation (Norad). The contents are the responsibility of the International HIV/AIDS Alliance and do not necessarily reflect the views of Sida or Norad.




ISBN 978-1-905055-86-9

# Contents



Above: © 2006 Nell Freeman / Alliance

# Glossary

| | |
|---|---|
| AIDS | Acquired Immunodeficiency Syndrome |
| ARP 2 | Africa Regional Programme (Phase 2) |
| ARV | Antiretroviral |
| HIV | Human Immunodeficiency Virus |
| JCTR | Jesuit Centre for Theological Reflection |
| NGO | Nongovernmental organisation |
| NZP+ | Network of Zambian People Living with HIV/AIDS |
| PAF | People's Action Forum |
| PMTCT | Prevention of mother-to-child transmission |
| PPP | Purchasing power parity |
| PTA | Parent Teacher Association |
| RAPIDS | Reaching HIV/AIDS Affected People with Integrated Development and Support |
| SIDA | Swedish International Development Agency |
| SROI | Social Return on Investment |
| UNAIDS | The Joint United Nations Programme on HIV/AIDS |
| ZNAN ACER | Zambian National AIDS Network ART Community Education and Referral |
| PLHIV | People living with HIV |
| UNGASS | United Nations General Assembly Special Session on HIV/AIDS |

# Executive Summary

The International HIV/AIDS Alliance is piloting the Social Return on Investment (SROI) methodology as a way to measure value for money in its programmes. One of the pilots is this evaluation of the social return on investment of the stigma and discrimination component of the Alliance's Africa Regional Programme Phase 2 (ARP 2).

The study was carried out at two sites in Zambia during 2010 and used focus groups from each site to determine the stakeholders for the study, what happened to each stakeholder group, and what impact this had for the group. The evaluation also included independent research and analysis to ensure the data was robust, and in some cases this was collected through primary research.

The SROI evaluation included calculations for attribution of change to the programme, deadweight (what would have happened anyway), drop off (how long the change lasted) and calculated net present value across the change period of five years in order to establish the ratio of investment to social value delivered (the SROI ratio).

The following SROI ratios were achieved in the two study sites in Zambia:

| | Mumbwa | Mazabuka |
|---|---|---|
| SROI ratio | 1: 21.20 | 1: 13.75 |

The evaluation also highlighted that for people living with HIV and their families, the impact of reduced stigma is not always positive (in financial terms) and could increase their costs, driving them further into poverty. This finding is consistent with comments made in the 2010 Zambia UNGASS progress report.

However, the SROI calculations in this evaluation also indicated that over the five-year period, this negative value decreases; if this report had looked at a longer timeframe, positive value for people living with HIV and their families would have been shown. The challenge for the Alliance is to respond to this negative value in its programme management and to support (sometimes in partnership with other NGOs) people living with HIV and their families to increase the value being created for them.

## Recommendations

Because this evaluation was as much about the methodology as it was about the value for money of the stigma programme, the recommendations have been separated into two sections.

- **For the programme**

1. Further planning and consideration needs to be given to the impacts of the activities being planned. This is the main recommendation arising from this evaluation.
2. The stigma training toolkit and its associated training programmes are highly successful at training trainers, however this activity needs to be placed in an integrated context of prevention, enterprise and policy development in order to realise the potentially very significant impacts it could have.

3. The stigma training programme should have additional resources so it can follow up and support trainers over a longer timeframe (years) and ensure fuller retention of skills and understanding.
4. The programme needs to be designed to ensure better access to the intended beneficiary group (people living with HIV) so that value for money can be created for that group.

**For implementing SROI methodology in the Alliance**

1. A forecast SROI evaluation of all activity should be carried out before starting. This is the ideal, however further training and engagement with SROI among more staff across the Alliance would be necessary.
2. A theory of change needs to be put in place, together with a proper baseline, before any activity is undertaken.
3. Significantly improved monitoring and evaluation processes need to be put in place that can connect to financial records, so that both can be interrogated together.
4. Improved monitoring and evaluation training in-country needs to be undertaken so that teams on the ground can record essential data appropriately.

# SECTION 1: Introduction and Background

The International HIV/AIDS Alliance (the Alliance) is piloting a methodology based on valuing social and health outcomes against investment to demonstrate value for money and respond to the growing urgency to demonstrate aid accountability.

The social return on investment (SROI) methodology is one of a number of methods seen as suitable for simplification and adaptation by a Country Office to test the value for money of specific programmes.

SROI was developed from social accounting and cost-benefit analysis. It is an outcomes-based approach that measures a broader concept of value. It measures change in an accessible way by analysing the relationship between the resources and investment into a programme and the outcomes for stakeholders as a result of the programme.

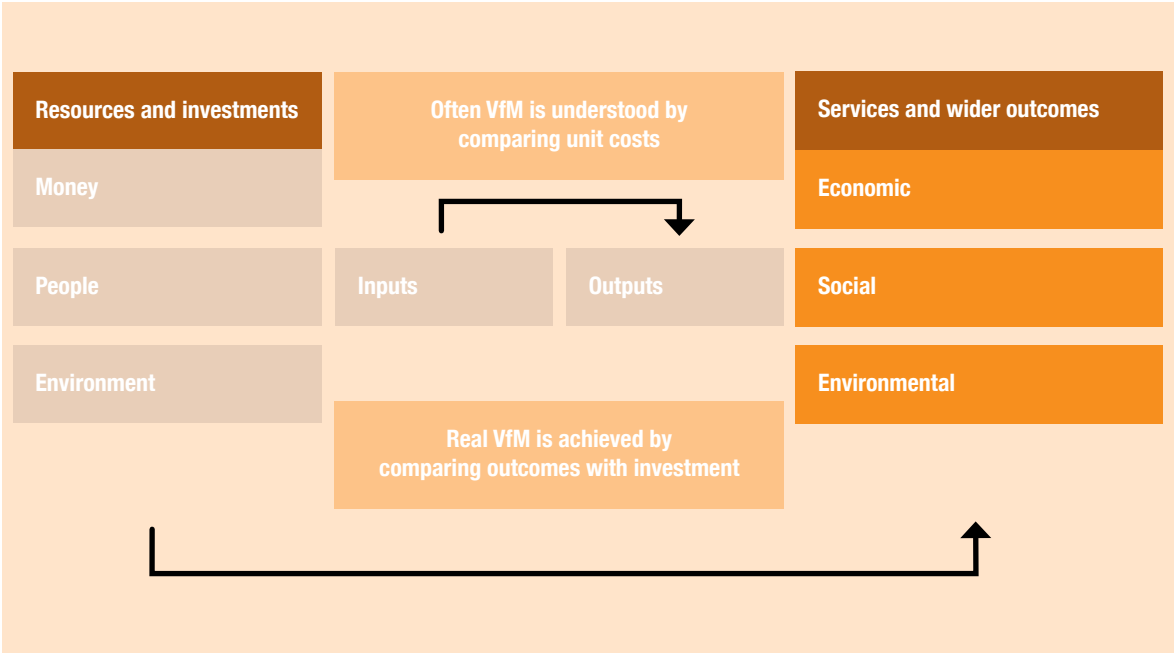



Figure 1: Understanding value for money (from New Economics Foundation position paper on value for money in international development, 2010)

SROI incorporates social, environmental and economic costs and benefits and so is of particular relevance to Alliance programmes and activities, which aim to achieve social and health changes that are currently difficult to value. SROI uses monetary values to represent outcomes, so a ratio of benefits to costs can be calculated. For example, a ratio of 1:4 indicates that an investment of $1 delivers $4 of social value.

# SECTION 2: The Project

The Alliance provides capacity building and development support to nongovernmental organisations (NGOs) and civil society organisations to help them scale up and strengthen HIV responses across the globe.

In Africa the Alliance has been running a regional programme across 15 countries, now in its second phase. The Africa Regional Programme Phase 2 (ARP 2) has three objectives:

- to reduce stigma and discrimination faced by people living with HIV and vulnerable groups
- to increase the access of vulnerable and stigmatised populations to effective prevention interventions
- to strengthen meaningful involvement of national and regional networks of people living with HIV in HIV policy development and implementation.

The programme, funded in part by the Swedish International Development Agency (Sida), started in late 2008. A baseline for the programme was conducted in early 2009 to capture information for each of the three programme objectives and determine programme impact on national and regional policy, stigma and discrimination, and the use of evidence-informed prevention strategies.

This evaluation has reviewed activity in two sites in Zambia that occurred between 2008 and 2010 to reduce stigma and discrimination faced by people living with HIV and vulnerable groups.

The original intention was to provide an SROI evaluation of the whole stigma and discrimination component of the ARP 2 across all 15 participating countries. However, this would have needed significantly more time and resources than were available. Instead it was agreed to focus on one country as a pilot study. As no other SROI study could be identified that had evaluated stigma and discrimination activities in an international development setting, a lot would be learned from both the process of the evaluation and the evaluation itself.

## Theory of change

One challenge in carrying out the SROI evaluations was that no formal theory of change had been developed for the ARP 2's stigma component. It identified a simple aim of reducing stigma and discrimination faced by people living with HIV and vulnerable groups. From the monitoring and evaluation log frame we can determine that there was an expectation that trainers would embed their learning into their activities, be drawn from both NGO and service-provider backgrounds, and be able to advocate for changes in policies and laws as a result. Through national training of trainers, teams would be established that could roll out the training, sometimes through district workshops. The indicators in the log frame focus on quantifiable data such as how many trainers were still working a year after being trained, how many policymakers had been reached, and how many individuals had been reached. This is all useful data, but none of it would help an evaluator to measure or identify change.

A likely theory of change model could have looked something like this:

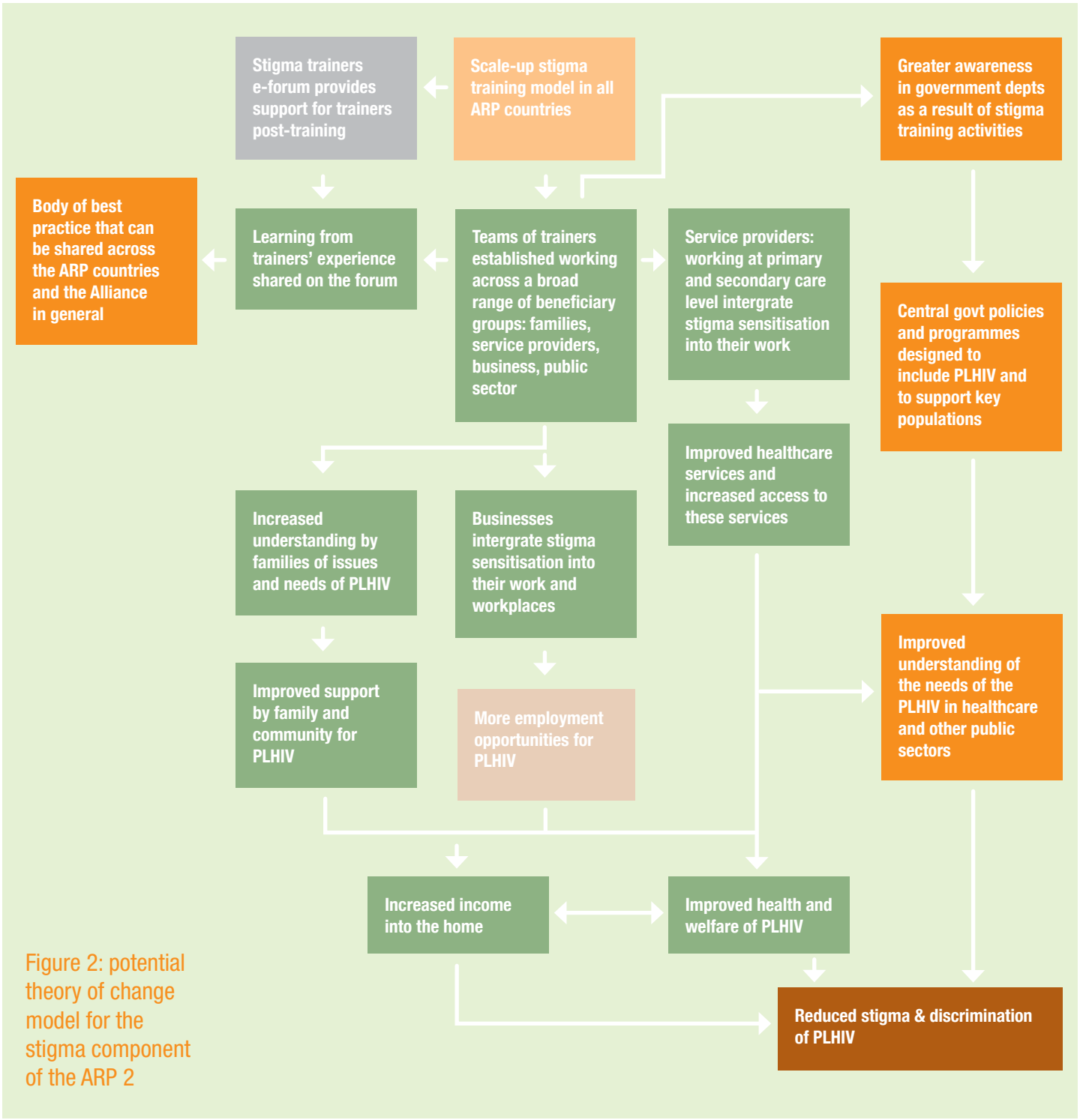



Figure 2: potential theory of change model for the stigma component of the ARP 2

Key:


**Impact:** Changes in lifestyle of PLHIV that reflect reduced stigma & discrimination
**Influence:** Changes in policies, regulations, systems, practice or public opinion
**Leverage:** Changes in spending (either public or private) as a result of the activity

This theory of change was developed by reviewing actual activity, focus group discussions, annual reports, the monitoring and evaluation log frame, and interviews with key informants. While some of the outcomes shown above have happened, some of them will not have happened (but could have, had the programme been more strategically focused). The key point here is that the Alliance's expectations of what could be achieved from the stigma and discrimination component were not as fully articulated as a formal theory of change would have required at the outset.

## The stigma component

The stigma and discrimination component is focused on the regional stigma training team based in Lusaka, Zambia. Its training model uses the stigma tool kit developed by the team incrementally over previous years to roll out a unique model of training trainers at a national level. It uses participative training methods, which are not used in the same way by other NGO's doing the same work. The team has trained trainers across Africa under the ARP and has developed a unique level of skill and ability. This component of the ARP has helped to deliver significant policy and advocacy impacts during the programme's lifetime.

This evaluation focuses on the activities that happened in Zambia during the period 2008–2010 under ARP 2. This included training trainers, ensuring that the trainers rolled out the training through the use of district workshops, and training treatment support workers who could provide health talks to the community at clinic sites. This combination of training activities has ensured greater impact than simply training trainers.

# SECTION 3: The Social Return on Investment Method

## Evaluation sites

In a meeting with the Alliance secretariat and the monitoring and evaluation officer from Alliance Zambia (a Country Office of the International HIV/AIDS Alliance) a number of potential evaluation sites were identified. Due to time constraints and accessibility from Lusaka, two sites were agreed upon in Mumbwa, Central Province, and Mazabuka, Southern province.

Mumbwa is a rural town that at one time hosted Zambia's first copper mine. The mine closed in 1971 and Dunavant, Zambia's leading cotton ginner, now operates in the area supporting small-holder farmers. Mumbwa town is small and poor. The market sells a significant amount of agricultural equipment and the focus groups confirmed that agriculture was a significant source of seasonal employment and food.

In contrast, Mazabuka is more urbanised and significantly larger than Mumbwa. The major sugar cane plantations, run by Illovo, are located all around the town and have contributed to its growing wealth. Wildlife tourism is beginning to take off in the area, but the town is prosperous almost exclusively on the back of the sugar cane market.

Monitoring and evaluation data from Alliance Zambia has indicated that significantly more ARP stigma activity took place in Mazabuka than in Mumbwa. This may in part be due to the greater economic importance and larger population of Mazabuka compared to the more rural, agriculturally dependent Mumbwa. The variations between the two sites, and the activities undertaken in each site, have resulted in some significant differences between the two evaluations and the eventual value for money at each site.

## Stakeholder engagement

Focus group discussions were undertaken in each site. The discussions considered outcome and impact, and unusually also included a 'lifestyle audit' because the amount of up-to-date independent financial data for each site was minimal. This financial data was essential for the SROI methodology to be successful.

The focus group participants included people living with HIV, families of people living with HIV, service providers that integrate stigma work into their activities, local community leaders, and local ARP stigma trainers. The key stakeholders identified by the focus groups in both sites were largely the same:

- The main stakeholder group identified was **people living with HIV** who are also the main beneficiary group in the Alliance's strategy. This group mainly contributes time to the programme – participating in training workshops and district workshops, listening to health talks at the clinic, and understanding their own self-stigma. Trainers in Mumbwa reached over 3,000 people directly through their activities. Outcomes for this group include a higher proportion of people living with HIV accessing antiretrovirals (ARVs); adults and children living with HIV staying in the family unit; and more people living with HIV finding work. In Mazabuka the trainers reached nearly 7,000 people. Here the number of people accessing ARVs also increased, as did the percentage of people living with HIV finding work as a result of the stigma activities.

- The **families of people living with HIV** are also a key stakeholder group. In Mumbwa the stigma programme reached over 55,000 families (this calculation is based on reports of the number of individuals, the size of an average family in the area and reported impact by other NGOs and organisations for the same group). Families also tend to input time into the programme, while outcomes for the family include a greater awareness of the needs of children with HIV and a greater willingness by husbands to participate in prevention of mother-to-child transmission (PMTCT) services.

**Mirium**

Miriam is bright, bubbly and always laughing. She radiates warmth and joy. But it wasn't always like that.

Before Miriam participated in the stigma sensitisation workshops run by the People's Action Forum (PAF) on behalf of the Alliance, she was shy and worried about what would happen when she told her family that she was HIV-positive. She was so stressed that she had missed some of her treatments.

"Going to the workshop gave me my confidence back! I felt I could now start to talk to my family and my children about my HIV. That this was not something to be ashamed of!

"My family now support me and understand when I am sick and help me to feel better."

- **Healthcare service providers and health institutions** were clearly identified as a stakeholder of the programme. This stakeholder group inputs both time and drugs to treat both HIV and opportunistic infections. However, as these costs are picked up by other funders and the Zambian government, the outcomes for this stakeholder group are both positive and negative. The treatment support workers who have been trained through the stigma training programme are able to help with basic patient administration and ensure that when the patient does see the clinical officer, they can focus on the medical issue at hand. Conversely, the reduced stigma attached to taking ARVs has increased the number of people coming forward for treatment. While this is a good thing, it has also meant longer waiting times at the clinic.

**Johnathan**

"It's better now that the treatment support workers are here", Jonathan told me in his small clinic outside Mazabuka. With hundreds of patients lined up outside, the treatment support workers have changed the way he talks to his patients.

"They used to come here and not want to talk about ARVs, 'can you give me something for the pain', they said. But now that we have the health talks and the treatment support workers, my patients are better informed and actually ask for treatment. In the past it could take three months to get someone onto treatment because they were afraid. Now it is four weeks!"

- The focus groups also acknowledged that **other NGOs** are a key stakeholder as they often facilitate training and district workshops and receive support from the Alliance. NGOs such as PAF and the Network of Zambian People living with HIV (NZP+) had representatives at the focus group discussions who confirmed that NGOs had benefited through increased capacity from the activities undertaken with them.

- In Mazabuka the focus group also identified that **the trainers** themselves were a stakeholder group who put significant amounts of time into the programme. The trainers also gained knowledge about stigma and experience in training other people. This has made it easier for some of the trainers to find better paying jobs with other NGOs. While this may be an unintended consequence of the stigma programme, it has had an impact; trainers are using their skills elsewhere and taking their training experience with them, thereby broadening the Alliance's indirect impact in country. However, it also means that there are fewer active trainers in the Alliance programme.

Although community leaders represented the community in the focus groups, when the impact map was drawn up the community was left out as a stakeholder because the changes that were measured for individuals and families were determined to be valid for the community too.

Similarly for healthcare service providers and institutions, while they participated in the focus groups they were excluded from the eventual evaluation as they are not the core beneficiary group that this programme component is aimed at. But it is important to note that value has been generated for healthcare providers by the programme (through treatment support workers), even though this was not intended and has not cost the Alliance any additional expense.

It is also important to note that this pilot evaluation used only a small stakeholder sample on which to base the calculations used for establishing incidence. Should the Alliance choose to roll out this form of evaluation in the future, it should use larger samples and stakeholder groups.

### Naomi & Judith

"Becoming a trainer has been a very important thing for me," says Naomi. She is a doctor and now also a trainer.

"Learning and applying these skills has changed my life. I have learned to be more selective with my language and I am aware of the impact my words could have on someone else. I even use this training in my private life. It is my guiding principle."

Sitting next to her, Judith says that becoming a trainer changed her life. "Stigma is a challenge when you are training others, but the positive feedback that you get from the people in the workshop really makes a difference! You can see people changing before your eyes."

Both Judith and Naomi have gone on to find other work as a result of becoming trainers. Judith is particularly proud of the training she helped put together for the Muslim Association. Although everything had to be vetted and checked first, they were able to use the stigma training toolkit and adapt the training to the Islamic faith.

## Results of the stigma survey

The original value for money brief was to undertake an SROI evaluation on the whole stigma component. There was insufficient time and resource to do this and so it was agreed to run the SROI evaluation on Zambia only. However as part of the overall ARP 2 evaluation, the global stigma trainers survey was re-run. This provided an opportunity to test some of the findings from the focus groups run in Zambia as part of the SROI evaluation across other countries within the regional programme. This way it would be possible to determine whether there was the potential for similar findings in other countries. If so, this would suggest potential for applying SROI across the whole regional programme with the possibility of getting measurable results at a regional level as well as at a country level. A regional application of SROI could assist in setting strategic direction for the Alliance's response in Africa.

Table 1: Selected findings from the global stigma trainers survey

| | | Anglophone | Francophone |
|---|---|---|---|
| Q15. Do you feel that as a result of the activities you have undertaken, people living with HIV are able to work or be employed or earn money for their families more often? | Yes | 100% (5) | 57.1% (4) |
| | No | - | 42.9% (3) |
| Q16. How often can people living with HIV earn money for their families? | Earn the same as before | 16.7% (1) | - |
| | Earn more than before | 50% (3) | 50% (2) |
| | Never stopped working | 33.3% (2) | 50% (2) |
| Q17. Do you feel that as a result of the activities that you have undertaken more people living with HIV are more confident to access ARVs? | Yes | 100% (6) | 57.1% (4) |
| | No | - | 42.9% (3) |
| Q.18 How many of the people you have worked with are confident and accessing ARVs? | Most | 33.3% (2) | 100% (4) |
| | Some | 66.6% (4) | - |
| | Only a few | - | - |
| Q19. Do you agree with the following statement? 'Because there is now reduced stigma, more people are happy to go to the clinic and so waiting times to see a clinical officer have increased somewhat.' | True | 100% (6) | 83.3% (5) |
| | False | - | 16.6% (1) |
| Q.20 Have the skills that you have learnt as a result of being a stigma trainer allowed you to work for other NGOs and institutions doing the same or similar work? | Yes | 100% (6) | 83.3% (5) |
| | No | - | 16.6% (1) |

Note: figure in brackets is the number of respondents.

The survey was run in French and English with some striking differences between the results for Anglophones and Francophones. It is possible that responses are based more on local conditions than any effect that the training may or may not have had.

The results of questions 19 and 20 are the most consistent across both the Zambian evaluation and the wider stigma survey, suggesting that across Africa, health care capacity is an issue. The results of question 20 also underline the findings of the evaluation that the main beneficiary group from a value for money point of view has been the trainers, who are able to find better paying work as a result of gaining new skills.

## Impact maps

Two impact maps have been compiled, one for each site (see Appendix A and B). They outline the inputs, outputs, indicators, impacts, financial proxies and economic modelling (attribution, deadweight, and drop off) for each stakeholder group in order to arrive at a social return on investment figure. The content of the maps was determined by the focus group discussions, interviews with key informants and primary research in Zambia.

It is important to note, however, that the return on investment figure is not the full story. The evaluation also highlighted many unintended consequences that require further consideration and in some cases a response (see recommendations for future programme planning on page 24).

## Outcome incidences and indicators

The focus group discussions helped to determine what the outcomes of the stigma training activities were at each site and gave some thought to measuring these outcomes. (Appendix D contains the brief for the focus group discussions.) However, as there was no theory of change and the overall monitoring and evaluation plan did not consider social change, each outcome had to be verified against an independent source. In some cases this also meant that an indicator had to be reviewed if it was later found to be inappropriate. Independent sources included: the Zambian Central Statistical Office; UNAIDS; UNICEF; NationMaster.com; UNAIDS/WHO/UNICEF reports 2008–2010; other independent research reports; independent interviews with clinical officers, nurses and trainers; and quantitative output data from Alliance Zambia's monitoring and evaluation officer.

The indicators eventually used in both SROI indicator maps were extrapolated from both Alliance indicators and general indicators used in international monitoring and evaluation of HIV impact. These indicators helped to focus the evaluation within each site and raised more questions that had to be answered before the evaluation could proceed. These new questions were answered through interviews and primary research; no additional focus groups were held.

## Monetising outcomes

One of the evaluation's main challenges in Zambia was the lack of reliable financial data for financial proxies. Undertaking a lifestyle audit with each focus group helped to identify both similarities and differences between the urban and rural settings that could be taken into account. Some financial data was available from the Zambian office of statistics, but not all of this was up-to-date and not all had taken account of current economic conditions, which had favoured Zambia over the previous 12 months.

However there were other sources, such as the basic needs basket from the Jesuit Centre for Theological Reflection (JCTR) that were up-to-date and relevant. Other sources of financial data included the annual reports on universal access from UN bodies and Alliance Zambia itself. All the outcomes, indicators and financial proxies used in both sites have been listed. There is overlap between the two, but this was intentional as there is currently a drive to establish standardised indicators for use in international development monitoring and evaluation, which would inform methodologies such as SROI.

It should also be noted that not all the impacts described are positive on the beneficiaries. For example, a reduction in stigma meant that more people remained within the family unit. While this is desired and beneficial, it does impact on the family's expenses, increasing food bills and the use of candles and other energy sources. People living with HIV also have specific nutritional needs that should be met and this can place an additional burden on the family. These unintended consequences should not be ignored.

Zambia's 2010 UNGASS country progress report highlights that while there is no direct relationship between poverty and HIV infection rates, there is plenty of evidence to suggest that for each affected household and person, HIV has associate economic pressures that tend to increase poverty. The cost of care can exhaust the already limited resources of the family and the Zambian public welfare system does not have the resources to respond to the scale of the problem.

This highlights quite clearly that the unintended consequences of reducing stigma in a community include additional pressure on the family group to support people living with HIV and orphans and vulnerable children. A key recommendation of this evaluation is that impacts are considered carefully at the beginning and at regular intervals during a programme, and that mitigating activities are put in place to address negative impacts (through the Alliance or partnerships).

Table 2: Outcomes, indicators and financial proxies in Mumbwa

| Stakeholders | Outcomes | | | |
|---|---|---|---|---|
| | Description | Indicator | Financial proxy | Source |
| People living with HIV | Remain within the family group and are supported by and included in families | Increased self-esteem and sense of well-being | Value of a new traditional outfit for a woman | Primary research |
| | More people working | Increase in the number of people in employment | Average annual wage for one person (hard labour) | Primary research |
| Family members of people living with HIV who have been affected by stigma training | There is an awareness of the needs of HIV-positive children | Percentage of children accessing ARVs | Annual cost of candles used with children in the house | Primary research |
| | Husbands now attend PMTCT and family planning services. Increased family cohesion - fewer divorces | Percentage of men who attend PMTCT services who accept an HIV test | Average income per household (since family income preserved through lower divorce rate) | Zambian office of statistics |
| Other NGOs that have delivered the training and district workshops | Trainers roll out the training | Number of people reached | Cost of reaching an individual | Alliance Zambia |

Table 3: Outcomes, indicators and financial proxies in Mazabuka

| Stakeholders | Outcomes | | | |
|---|---|---|---|---|
| | Description | Indicator | Financial Proxy | Source |
| People living with HIV | More people working | Increased number of people in employment | Average annual wage for one person (hard labour) | Primary research |
| | Increased access to ARVs, increased adherence to ARV treatment, improved health | % decrease in the number of clinic visits for opportunistic infections | Annual cost of a taxi journey to the clinic | Zambian Office of Statistics |
| Family of people living with HIV | There was increased understanding of the needs of people living with HIV, reduced fear of transmission | % of families providing care for people living with HIV | Increased food bill for a family of six over 12 months | JCTR Basic Needs Basket |
| | Orphans and other vulnerable children were no longer withheld from school and not isolated in the community | % increase in orphans and other vulnerable children attending school in the area | Cost of a school uniform for a primary school child | JCTR Basic Needs Basket |
| Trainers | More people living with HIV were trained as trainers | % increase in the numbers trained from 2007-2010 | Average annual income for a trainer | Alliance Zambia |
| | Due to high quality of training, trainers were able to find better paying jobs | Number of trainers in employment at other providers | Average annual income for a trainer | Alliance Zambia |
| NGOs | Trainers roll out the training | Number of people who are reached | Cost to reach an individual | Alliance Zambia |

## Monetising self-esteem

In the table above I have applied a financial value to self-esteem and this will no doubt be controversial. Self-esteem is subjective and emotive and means many different things to different people, so attaching a financial proxy to such an ethereal concept will by its very nature be inadequate. However, the focus groups reported that improved self-esteem was a very real outcome of the stigma sensitisation workshops. So I had to attempt to identify how improved self-esteem increased value for some of the world's financially poorest people. In Mumbwa, during the lifestyle audit discussion, the women noted that purchasing material and getting a traditional outfit made was something that they did to make themselves feel better. Smart clothing played an important role in self-esteem generally among the focus group participants and was often a source of gentle humour between the men and women in the group.

Because women and girls carry the majority of the HIV burden in Africa, it seemed appropriate to use a financial measure that reflected this. Hence I selected the value of a traditional outfit as the financial proxy for self-esteem in Mumbwa.

## Impact

In the SROI methodology impact is determined by calculating how much of the Alliance's activity can be responsible for the change observed in the beneficiary group, how long this change persists, how much of that duration can be attributed to the Alliance's activities, and how much would have happened even if the Alliance's activities had not happened.

## Attribution

The overall aim of the ARP 2's stigma component was to reduce stigma and discrimination experienced by people living with HIV and vulnerable groups. Because stigma experienced by individuals is generated within the communities they live, the Alliance's approach was to roll out training to community leaders, health and social welfare workers, and the general population in targeted areas. This makes attribution quite a challenge.

What became evident during the focus groups and subsequent research into the impact reported by other NGOs operating in the same area was that there had to be significant overlap of operations between NGOs to justify the numbers each reported compared to the overall population figures for each site. Even allowing for significant population growth over the past ten years, there simply were not enough people in each location for each organisation to have worked with a different group of people. In addition, some organisations are very open about the use of partnerships in their programmes, making duplication of reported impact a real possibility.

During the focus group discussions, the beneficiaries reported that the stigma sensitisation activities were crucial in changing their attitudes and behaviour. During the exercise to determine attribution and deadweight, the beneficiaries did not believe that any other NGO would have delivered training resulting in the same stigma reduction, despite being able to name a number of other organisations in the area carrying out similar work.

While we know that the Alliance's approach to stigma and discrimination is unique and has not been duplicated. We also know that other organisations' stigma activities do not always include training of any kind. But the fact remains that other organisations are addressing stigma in the same communities as the Alliance. It is possible that the beneficiaries are participating fully in the activities of a number of organisations and NGOs and report back favourably to each organisation, allowing each to claim impact. This is not malicious or meant to mislead, and may well be a true reflection of the impact that each organisation is having. It does, however, underline that no one organisation can claim exclusive influence over all its beneficiaries.

However it is true to say that some of the people who participated in Alliance activities would have been more influenced by those activities. For example, those the Alliance has trained (trainers and treatment support workers) will have a higher attribution than members of the community; the time period that the change can be attributed to the Alliance's activities will also vary between trainers and the community.

Further independent research was carried out on the other organisations operational in the area, and the results were used in the determination of how much attribution and deadweight was applicable for each outcome (see Appendix G for a list of organisations).

Mindful of this crossover, a highly conservative approach has been used to determine attribution. This is also because there were no baseline figures for Mumbwa or Mazabuka (or even Zambia as a whole) to help determine how many people had been targeted with ARP activity and how many people were anticipated to respond exclusively to the Alliance's stigma activity. While the total number of people participating was known, we assumed that not all the participants were changing their behaviour exclusively as a result of the Alliance's activity.

An attribution percentage was determined by calculating the average ratio of trainers to community members, based on the monitoring data provided by Alliance Zambia. These figures were then cross-referenced with the reported impact from other organisations operating in the area to determine the robustness of the ratio. The ratio was then applied to the updated population figures for each site. This resulted in an attribution ratio for people living with HIV and their families of 14% in Mumbwa and 10% in Mazabuka, and a ratio of 25% for healthcare providers and other NGOs providing training in both sites.

The trainers demonstrated the highest attribution – a result of being trained in skills and activities that they would not have had the opportunity otherwise to participate in. This is especially true given the training methodology, which we know is not used by other organisations in the area. 100% of the trainers reported better knowledge of stigma, while 8% have got other work as a result of their training (from Alliance Zambia observations).

High attribution tends to indicate an issue with sustainability, and it was repeatedly reported that some trainers now have less to do because the funding for training activities has gone down. Other trainers have continued to work both for the Alliance and other NGOs using their training, while a third group is inactive because funds have run out. At least two NGOs reported reduced activity, as they can no longer afford to undertake training workshops – so they have better capacity than before, but less activity.

This could indicate that further work needs to be done to develop 'entrepreneurial' skills for the trainers to help more of them take on ownership of the training programme and develop activities themselves rather than relying on the Alliance to provide the opportunities to practise their skills. This has been successful in other countries where the stigma training programme has been operating.

## Deadweight

Deadweight ratios were benchmarked against national rates because local rates were not available for many of the indicators. These rates included an increase in employment, increased access to ARVs, increase in the number of orphans attending school, reported administration capacity, and waiting times at clinics. In the case of orphans and other vulnerable children (including those living with HIV) attending school, the focus groups reported that without the stigma activity it would have been very unlikely they would have participated in education. This is not only because of the stigma that they would have received at school, but also because of the stigma that their parents and guardians felt. In this instance deadweight is reported as zero.

Deadweight for the trainers is also reported as zero, for the reasons discussed under attribution: without the Alliance's activity, it is unlikely that they would have received comparable training elsewhere.

## Drop-off

For this evaluation I have used a standard period of five years for most outcomes to calculate drop-off. However, the length of time that an outcome lasts is likely to vary greatly from one stakeholder group to another and often within stakeholder groups depending on an individual's engagement with the outcome activity. For example, a patient who attends a clinic frequently will hear health talks more often and have messages reinforced more often than someone who only attends the clinic occasionally.

Similarly, a trainer who has more opportunity to use their training will retain the skills longer than one with less opportunity. In some cases this is outside of the trainer's control. Alliance Zambia reported that there is a core group of trainers who are still training as part of their current job. However, there is also a group of trainers who do not train as there is no funding available, and a

group who train on a voluntary basis despite the lack of funds. In this case, drop off has been set very high for those trainers who do not go on to find other employment, as their ability to use the training is based on opportunity. Those who do go on to find other employment have a lower drop off rate as the experience in their new roles will also have an impact on the benefit that they experience.

I have taken into account the likely regular contact between beneficiaries and future ARP and ARP-like activities, ongoing priorities of healthcare providers, and the possibility of other NGOs attracting funding as a result of the increased capacity created from their involvement with the ARP programme.

Table 4: Drop off rates across both sites

| Drop off | |
|---|---|
| People living with HIV | 0.7 |
| Families of people living with HIV | 0.7 |
| Trainers | 1 |
| Trainers | 0.5 |
| Other NGOs | 0.5 |

## Total impact

The total impact of the programme has been determined by taking into account attribution, deadweight and drop off, and calculating the discount rate over the period for which the impact is likely to last.

Training people to train others and providing skills that are intended to lead to significant behaviour change could result in complete change across a whole community. This was testified to in the focus group in Mumbwa, when the headman confirmed that the whole community was now involved in promoting voluntary HIV counselling and testing and supporting people living with HIV. So how do you put a timeframe on such change?

Clearly longitudinal data tracking the community over the time period being evaluated would have been valuable to identify how long an impact lasts. This data did not exist for this evaluation, so I applied a standard five-year evaluation period to the activities. The changes described in the evaluation actually happened over a period of three years, so to forecast forward potential value for money over five years the total impact has to be divided by three. For some activities the period of impact was reduced, where the trainer would have to make use of their newly acquired skills in order to benefit from an impact, for example. This could be outside of their control if they do not have a permanent job or if their employer restricts the amount of time they can give to training others. In these cases the period in which the impact lasts is clearly shorter and I have only calculated this impact over one year.

It is clear from the impact maps that despite all the positive impacts that the stigma training can have on the trainers themselves and the NGOs being supported, the positive impacts for the

community and individuals have to be weighed against the unintended negative impacts that reducing stigma can produce. As mentioned under the 'monetising outcomes' section, these impacts are felt in the daily lives of the families and people living with HIV:

- Increased adherence to ARVs requires improved nutritional intake. This can have an impact on the family's monthly food bill, increasing their monthly bill significantly (see the JCTR basic needs basket, Appendix F).
- Where a child can return to school the additional expenses associated with school attendance need to be considered. Schooling is free in Zambia, however the cost of the school uniform and other materials is not.

Because these are additional costs, where financial indicators are used the impact is shown as negative. I am not suggesting that activities that reduce stigma should not be undertaken, that families should not look after their loved ones or indeed that children should not go to school. What does need to happen is forward planning so that such negative impacts are considered or at least identified during the programme and solutions sought to address these impacts. Over time these negative impacts will reduce as different impacts take effect. What is important from a programme planning point of view is to acknowledge that such negative value will occur and to put in place partnerships or agreements with other organisations to support affected families.

With hindsight another obvious impact is the length of time that patients wait to see a clinical officer. The focus groups reported that before the stigma training activities waiting times at the clinic were long for people with opportunistic infections, while the waiting time for the ARV treatment clinic was shorter. After the stigma training activities the waiting times for opportunistic infections declined and the waiting times for the treatment clinic increased – the individuals who were waiting in one queue now waited in another. So the waiting time to see a clinical officer for ARV treatment had increased significantly, but the experience of the patient remained poor.

# SECTION 4: SROI Ratio and Sensitivity Analysis

## SROI ratio

Having established attribution, deadweight and drop-off, it was necessary to establish net present value before the SROI ratio could be determined.

To establish net present value I applied the Zambian Central Bank Discount Rate. The discount rate of 11.37% (NationMaster.com) has been used for all five years due to the absence of longitudinal data that could have informed a more nuanced calculation. This is important as future SROI forecasts and evaluations could potentially change the overall SROI ratio if more sophisticated monitoring over a longer period of time is used.

The discount rate is a financial concept based on future cash flow in lieu of the present value of the cash flow. The divisor in the discount rate formula is the resultant future value, including income. The concept of a discount rate differs from that of an interest rate, most notably in that the divisor in the interest rate formula is the original investment. A high discount rate is often preferred by governments attempting to stimulate an economy; a higher discount rate makes money cheaper for banks, giving them greater lending power.

**For every interest rate, there is a corresponding discount rate, given by the following formula:**

$$d = \frac{i}{1 + i}$$

and inversely,

$$i = \frac{d}{1 - d}$$

In addition, purchasing power parity (PPP) has been taken into account. PPP is a theory of long-term equilibrium exchange rates based on relative price levels of two countries. PPP is founded on the law of one price; the idea that in the absence of transaction costs, identical goods will have the same price in different markets. The concept deduces exchange rates between currencies by finding goods available for purchase in both currencies and comparing the total cost for those goods in each currency.

Applying PPP is important in order to ensure that we do not over value or undervalue goods in different economies by using a day-to-day exchange rate. After all, the US$ will buy significantly more in Zambia than the Zambian Kwacha, which could skew the findings of the SROI evaluation. PPP is applied right at the end of the process. As a result the net present value for both sites is:

- Net present value for Mumbwa: $274,016.36
- Net present value for Mazabuka: $444,334.48

The financial inputs for each site were determined based on the cost of the activities carried out in each site:

Table 5: Financial inputs for both sites

| ORGANISATION | ZNAN-ACER | |
|---|---|---|
| | Total grants | Training of ART agents in stigma reduction |
| **Quarter 1**<br>Peoples Action Forum – Mazabuka | Kwacha<br>8,153,000.00 | Kwacha<br>8,153,000.00 |
| **Quarter 2**<br>People's Action Forum – Mumbwa | 10,332,000.00 | 10,332,000.00 |
| **Quarter 3**<br>PAF Mumbwa<br>Peoples Action Forum – Mazabuka<br>Peoples Action Forum – Mazabuka<br>People's Action Forum – Mazabuka<br>People's Action Forum – Mazabuka | 11,042,000.00<br>12,340,000.00<br>27,330,000.00<br>7,222,500.00<br>8,635,000.00 | 11,042,000.00<br>12,340,000.00<br>27,330,000.00<br>7,222,500.00 |
| **Quarter 4**<br>Peoples Action Forum – Mazabuka<br>People's Action Forum – Mumbwa<br>Positive Women Network – Mazabuak | 29,945,000.00<br>9,804,000.00<br>11,780,000.00 | 9,804,000.00 |
| **NO COST EXTENSION**<br>Peoples Action Forum – Mazabuka<br>Peoples Action Forum – Mumbwa | 57,265,000.00<br>49,916,000.00 | 27,320,000.00<br>49,916,000.00 |
| **TOTAL** | **235,611,500.00** | **155,306,500.00** |
| **TOTAL PER SITE**<br>Mumbwa<br>Mazabuka | Kwacha<br>70,052,000.00<br>82,365,500.00 | US$<br>14,748<br>17,340 |

| Financial input for both sides | | |
|---|---|---|
| Mumbwa | 70,052,000.00 | 14,748 |
| Mazabuka | 82,365,500.00 | 17,340 |

There is some discrepancy between the monitoring data for ARP 2 activity at each site and the figures above. This suggested taking a conservative approach to calculating the inputs relevant to the ARP 2 activities in each site to ensure that we did not over claim impact and attribution. As a result, the financial input figure for each site was based on the average cost of running one workshop. This was calculated using the figures for the training of ART agents in stigma reduction. The calculations behind the ratios are contained in the impact maps (shown on pages 28 & 30 of this report and in the excel spreadsheet called SROI ZAMBIA STIGMA PROGRAMME V1). The input figure used is the cost of a training workshop x10 for Mazabuka and x 4 for Mumbwa, this is the average cost of training ART agents in stigma reduction over both sites. An average figure was used because Alliance Zambia could not provide more reliable data on actual activity per site. The costs that are used are shown in the impact maps referenced above.

The social return on investment ratio for each site is therefore:

| | Mumbwa | Mazabuka |
|---|---|---|
| SROI ratio | 1:21.20 | 1:13.75 |

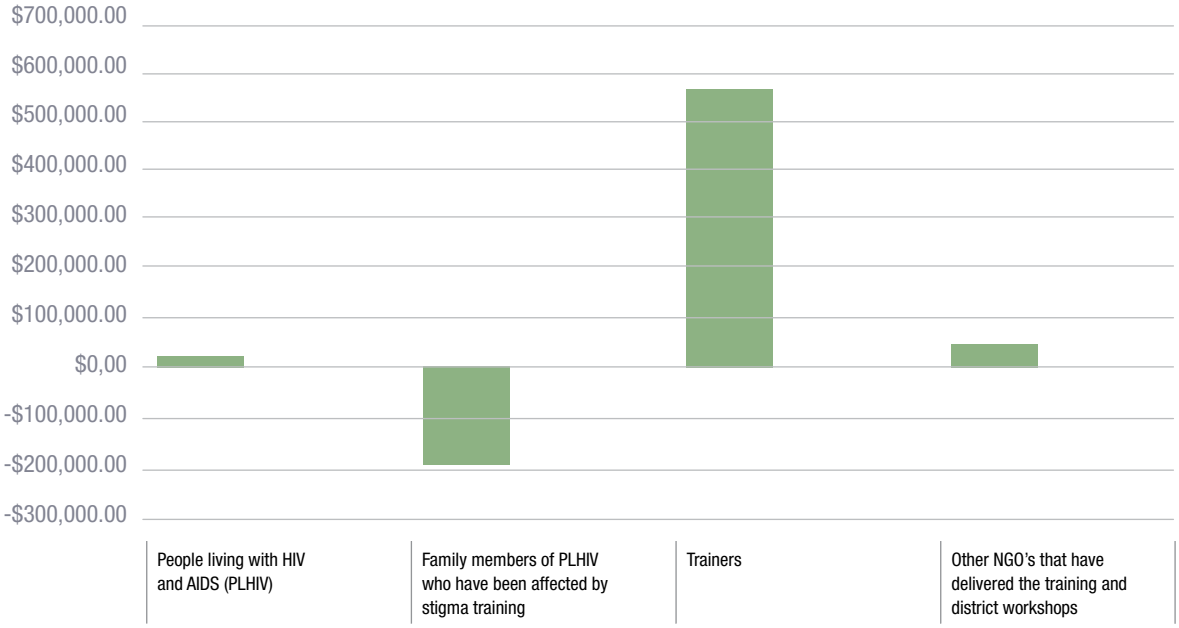
While these ratios are substantial and imply a significant impact, we must remember that the intention of the programme was to effect significant behaviour change across the whole community, not a previously identified sub-set of the community. Additionally, the impact recorded for families of people living with HIV in Mazabuka, and one of the outcomes for families in Mumbwa, is negative. This means a significantly higher impact could be achieved if more consideration was given to unintended consequences.

Also note that this evaluation should not attempt to achieve a ratio that would be appropriate in a developed country, rather than in one of the poorest in the world (with a discount rate of 11%, for example). This is a more general lesson for SROI evaluations as part of international development in poorer countries where external investment into a programme is significant even by the standards of wealthy developed countries, and where different standards of living will also impact on how much value can be generated from a programme that attempts to engage with the whole community. To my knowledge, an evaluation that considers the social value of stigma and discrimination activities has never been done before, and to attempt to get a ratio that echoes other programmes in a first world setting might be misleading.

## Value created per stakeholder group

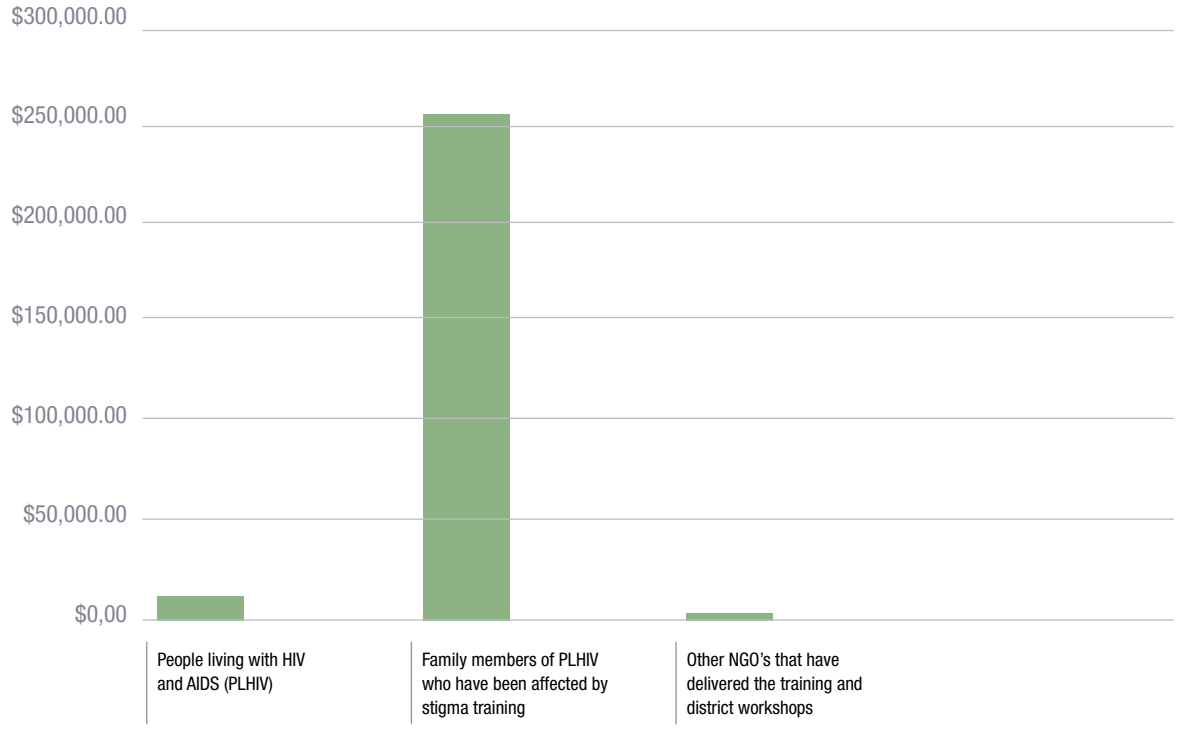
In Mazabuka it was clear that the trainers (who did not feature as a stakeholder group in Mumbwa) had the most value created. This was also reflected in the responses from trainers in other countries. Families in Mazabuka, on the other hand, have actually lost value because of the impact of HIV on the family group.

Figure 3:
Net present value by outcome: Mazabuka




In Mumbwa, by contrast, the families have seen real value being created.

Figure 4:
Net present value by outcome: Mumbwa




The difference between the two sites reflects the responses of focus group participants. However, we also know from other non-value for money studies that the burden borne by families as a result of HIV in the home is significant and that HIV in a household can lead to greater poverty.

## Negative value

Finding short-term negative value is not impossible, nor necessarily an issue of concern. Both this evaluation and the Zambian government have identified that the burden of care can increase poverty in the short term for families. Table 6 below shows the forecast across five years of the impact on the families in Mazabuka. You can see that the negative impact reduces over time. So if this had been a forecast evaluation, the Alliance could have planned to address this impact alongside other agencies.

Table 6: Impact forecast

| Beneficiary | Outcome and description of the change that happened | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|---|---|---|
| Family of people living with HIV | Better care of people living with HIV in the home | There was increased understanding of needs of people living with HIV, reduced fear of transmission | -$215,779 | -$64,734 | -$19,420 | -$5,826 | -$1,748 |
| | Children with HIV can go to school | Orphans and other vulnerable children were no longer withheld from school and not isolated in the community | -$26,557 | -$7,967 | -$2,390 | -$717 | -$215 |

## Sensitivity analysis

A sensitivity analysis is useful to identify those elements that if varied would significantly change the results in an evaluation. Because of the ratio's achieved in this evaluation it was important to interrogate the financial proxies for both positive and negative value creation and drop off rates.

I found that significant variances of the drop off rate had very little effect on the overall ratio, although it did vary the value created for each group, in particular increasing the value for families and individuals. This is important as it highlights how vulnerable this group still is to external support and how important it is to develop interventions that the family and the individual can take full ownership of and develop on their own.

However, changing the financial proxies did give a ratio similar to what you would expect to see in an evaluation in a developed country 1: 7.49. Although achieving this ratio was at considerable cost to families and individuals over a longer period. I attempted to identify additional positive financial impacts for families and individuals, but this was not easy as very few positive financial proxies exist in one of the poorest countries in Africa. This underlines the key point that additional planning and consideration needs to be given to the impact of programme activities.

# SECTION 5: Recommendations

## For the programme

- Further planning and consideration needs to be given to the impacts of the activities being planned. This is the main recommendation arising from this evaluation.
- The stigma training toolkit and its associated training programmes are highly successful at training trainers, however this activity needs to be placed in an integrated context of prevention, enterprise and policy development in order to realise the potentially very significant impacts it could have.
- The stigma training programme should have additional resources so it can follow up and support trainers over a longer timeframe (years) and ensure fuller retention of skills and understanding.
- The programme needs to be designed to ensure better access to the intended beneficiary group (people living with HIV) so that value for money can be created for that group.

## For implementing SROI methodology in the Alliance

- A forecast SROI evaluation of all activity should be carried out before starting. This is the ideal, however further training and engagement with SROI among more staff across the Alliance would be necessary.
- A theory of change needs to be put in place, together with a proper baseline, before any activity is undertaken.
- Significantly improved monitoring and evaluation processes need to be put in place that can connect to financial records, so that both can be interrogated together.
- Improved monitoring and evaluation training in-country needs to be undertaken so that teams on the ground can record essential data appropriately.

# References used for literature search and assumptions for secondary data and testing veracity of focus group assertions

Zambia National HIV/AIDS/STI/TB Council (2009), Zambia Mode of Transmission report.

Churches Health Association of Zambia Website

HelpAge International (2008), Regional Consultative Meeting Report on HIV and AIDS Prevention and Treatment for Older Persons, September.

JCTR (2009), Jesuit Centre for Theological Reflection Basic Needs Basket, Monze, November.

Numbeo.com, Cost of living in Zambia, available at: http://www.numbeo.com/cost-of-living/country_result.jsp?country=Zambia

Population Council (2009), RAPIDS Evaluation Final Report 2005-2009 Key Findings, (Revised 2010)

Population Council (2008), Food on the Table: the role of livelihood strategies in maintaining nutritional status among ART patients in Kenya and Zambia.

Rosen, Sydney and Long, Lawrence (2006), How Much Does It Cost to Provide Antiretroviral Therapy for HIV/AIDS in Africa? Center for International Health and Development, Boston University.

Unicef (2010), Zambia Consolidated Results Report 2007-2010.

Unicef (2009), State of the World's Children, Special Edition, celebrating 20 years of the convention on the rights of the child, Statistical Tables.

WHO / UNAIDS / Unicef (2010), Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector, progress report 2010.

WHO / UNAIDS / Unicef (2009), Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector, progress report 2009.

WHO / UNAIDS / Unicef (2008), Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector, progress report 2008.

Zambian Ministry of Health / National AIDS Council (2010), Zambia Country Report, monitoring the declaration of commitment on HIV and AIDS and the Universal Access, Biennial Report.

Zambian Central Statistical Office (2010), Projected mid-year population 2000–2009.

Zambian Central Statistical Office (2005), Labour Force Survey 2005 - Summary Report.

Zambian Central Statistical Office (2003), Zambia 2000 Census of Population and Housing - Summary Report.

Zambian Central Statistical Office (2003), Zambia 2000 Census of Population and Housing, Housing and Household Characteristics Analytical Report.

Zambian Central Statistical Office, Website, available at: http://www.zamstats.gov.zm/lcm.php#01

# Appendices

A. Impact Map for Mumbwa

B. Impact Map for Mazabuka

C. Basic Needs Basket example

Other appendices available upon request

D. ARP Evaluation focus groups for Mumbwa and Mazabuka

E. SROI FDG Brief

F. SROI Questionnaire for the Stigma Training Team

G. Organisations operational in Mumbwa and Mazabuka

# Appendix A: Impact Map for Mumbwa

| Stakeholders | Intended / unintended changes | Inputs | | Outputs | The outcomes (what changes) | | | | | | | | Deadweight | Attribution | Drop off | Impact |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Description | Value $ | | Description | Indicator | Source | Quantity | Duration | Financial Proxy | Value $ | Source | % | % | % | |
| Who do we have an effect on? Who has an effect on us? | What do you think will change for them? | What do they invest? | | Summary of activity in numbers | How would you describe the change? | How would you measure it? | Where did you get the information from? | How much change was there? | How long does it last? | What proxy would you use to value the change? | What is the value of the change? | Where did you get the information from? | What would happen without the activity? | Who else contributed to the change? | Does the outcome drop off in future years? | (Quantity x financial proxy) – deadweight – displacement – attribution |
| People living with HIV and AIDS (PLHIV) | Disclosure to family members | Time | 0 | 3087 | Remain within the familiy group and are supported by and included in Families | Increased self-esteem and sense of well-being | Focus group discussion | 67% | 3 years | Value of a new traditional women's outfit | 35 | Primary research | 0% | 14% | 70% | $10,089.24 |
| | Able to work more | | | | More people working | Increase in the number of people in employment | Focus group discussion / NationMaster.com | 5.5% | 3 years | Average annual wage for one person (hard labour) | 2728 | Primary research | 2% | 14% | 70% | $45,155.20 |
| Family members of PLHIV who have been affected by stigma training | Support PLHIV within the family group | Time | 0 | 55292 | There is an awareness of the needs of HIV+ children | Percentage of children accessing ARV's | Focus group discussion | 5% | 3 years | Annual cost of candles used with children in the house | -322 | Primary research | 1% | 14% | 70% | -$99,702.53 |
| | | | | | Husbands now attends PMTCT and Family planning services. Increased family cohesion – fewer divorces | Percentage of men who attend PMTCT who accept an HIV test | Focus group discussion | 4% | 3 years | Average income per household (since family income preserved through lower divorce rate) | 3876 | Zambian office of statistics | 10% | 14% | 70% | $1,080,131.43 |
| Healthcare service provider | Additional administrative support from treatment supporters | Time | Govt & other donors | 32 attended training | Although healthcare service providers do experience a benefit from the programme, they are not the core beneficiary. This stakeholder group benefits from the introduction of treatment support workers in their clinics; who provide healthtalks and basic patient administration. Clinical officers report that consultation with their patients are improved as a result of the impact of the treatment support workers. | | | | | | | | | | | |
| | Increased direct treatment of HIV | Drugs to treat opportunistic infections and HIV | | 55 patients seen for ARV's per day (13,200 per year) | | | | | | | | | | | | |
| Other NGO's that have delivered the training and district workshops | Increased capacity of the organisation | Time | Cost is the same as for ARP2 Stigma component as it provides the funds | 4 Training workshops | Trainers roll out the training | Number of people reached | Alliance Zambia | 3087 | 3 years | Cost of reaching an individual | 12 | Alliance Zambia | 25% | 25% | 50% | $6,948.00 |
| ARP 2 Stigma Component | Increased number of people sensitised to stigma and discrimination around HIV and AIDS | Grant from SIDA | 12926.316 | 4 training workshops | Material outcomes for stakeholders above only. All outcomes for this stakeholder considered above | | | | | | | | | | | |
| | | | Grants for district workshops | No district workshops | | | | | | | | | | | | |

| | |
|---|---|
| People living with HIV and AIDS (PLHIV) | $14,489.89 |
| Family members of PLHIV who have been affected by stigma training | $257,153.65 |
| Other NGO's that have delivered the training and district workshops | $2,372.81 |

| | |
|---|---|
| Total | $1,042,621.34 |

# Appendix A: Impact Map for Mumbwa continued

| Stakeholders | Calculating Social Return | | | | | | |
|---|---|---|---|---|---|---|---|
| | Discount rate (%) | | 11.73% | | | | |
| Who do we have an effect on? Who has an effect on us? | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Total Value | Present Value |
| People living with HIV and AIDS (PLHIV) | $3,363.08 | $1,008.92 | $302.68 | $90.80 | $27.24 | $4,792.73 | $4,109.12 |
| | $15,051.73 | $4,515.52 | $1,354.66 | $406.40 | $121.92 | $21,450.23 | $18,390.71 |
| Family members of PLHIV who have been affected by stigma training | -$33,234.18 | -$9,970.25 | -$2,991.08 | -$897.32 | -$269.20 | -$47,362.03 | -$40,606.63 |
| | $360,043.81 | $108,013.14 | $32,403.94 | $9,721.18 | $2,916.35 | $513,098.43 | $439,913.54 |
| Healthcare service provider | | | | | | | |
| Other NGO's that have delivered the training and district workshops | $2,316.00 | $1,158.00 | $579.00 | $289.50 | $144.75 | $4,487.25 | $3,684.49 |
| ARP 2 Stigma Component | | | | | | | |
| **Total** | **$347,540.45** | **$104,725.33** | **$31,649.20** | **$9,610.56** | **$2,941.07** | **$496,466.61** | **$425,491.24** |

| | | PPP applied |
|---|---|---|
| **Total Present Value (PV)** | **$496,466.61** | **$319,724.50** |
| **Net Present Value** | **$425,491.24** | **$274,016.36** |
| **Social Return $ per $** | **$32.92** | **$21.20** |

# Appendix B: Impact Map for Mazabuka

| Stakeholders | Intended / unintended changes | Inputs | | Outputs | The outcomes (what changes) | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Description | Value £ | | Description | Indicator | Source | Quantity | Duration | Financial Proxy | Value $ | Source |
| Who do we have an effect on? Who has an effect on us? | What do you think will change for them? | What do they invest? | | Summary of activity in numbers | How would you describe the change? | How would you measure it? | Where did you get the information from? | How much change was there? | How long does it last? | What proxy would you use to value the change? | What is the value of the change? | Where did you get the information from? |
| PLHIV | Increased opportunity to get a job | Time | 0 | 6865 | More people working | Increased number of people in employment | Focus Group Discussion / Zambian Office of Statistics | 5.5% | 3 years | Average annual wage for one person (hard labour) | 2728 | Primary research |
| | Able to be open about their status | | | | Increased accesss to ARV's, increased adherence to ART, improved health | % decrease in the number of clinic visits for opportunistic infections | Focus Group Discussion cross referenced with UNAIDS data | 45% | 3 years | Annual cost of a taxi journey to the clinic | 189 | Zambian Office of Statistics |
| Family of PLHIV | Better care of PLHIV in the home | Time | 0 | 122951 | There was increased understanding of needs of PLHIV, reduced fear of transmission | % of families providing care for PLHIV | Focus Group Discussion / Zambia 2010 UNGASS report | 90% | 3 years | Increase food bill for a family of six over 12 months | -81 | Jesuit Centre for Theological Reflection Basic Needs Basket |
| | Children with HIV can go to school | | | | Children and OVC's were no longer withheld from school and not isolated in the community | % increase in OVC's attending school in the area | Focus Group Discussion / UNICEF 2008 - 2010 | 12% | 3 years | Cost of a school uniform for a primary school child | -54 | Jesuit Centre for Theological Reflection Basic Needs Basket |
| Health Institutions | Increased access to ARV's | Drugs | For this evaluation the cost is neutral as the govt (& other donors) pay for this | 1,200 on ARV's | Health institutions are not considered the core beneficiary group. However they do benefit from the stigma sensitsation activities by the introduction of treatment support workers to the clinics, who provide health talks to the clients waiting in line to see the clinical officers. These treatment workers also provide some basic patient administration. | | | | | | | |
| | Longer waiting times | Time | | 3 hours average waiting time | | | | | | | | |
| | Increased work load | | | 200 patients seen per day | | | | | | | | |
| Trainers | Increased knowledge of stigma | Time | 0 | 174 trained between 2008 - 2010 | More PLHIV were trained as trainers | % increase in the numbers trained from 2007 - 2010 | ARP Annual Review / Alliance Zambia | 100% | 1 year | Average annual income for a trainer | 12000 | Alliance Zambia |
| | Ability to get better paying job | | | Est 14 found new jobs | Due to high quality of training, trainers were able to find better paying jobs | Number of trainers in employment at other providers | Alliance Zambia | 0.08 | 3 years | Average annual income for a trainer | 36000 | Alliance Zambia |
| NGO's | Increased capacity | Time | Cost is the same as for ARP2 Stigma component as it provides the funds | 8 training workshops | Trainers roll out the training | Number of people who are reached | Alliance Zambia | 6865 | 3 years | Cost to reach an individual | 12 | Alliance Zambia |
| ARP 2 Stigma Component | Increased number of people sensitised to stigma and discrimination around HIV and AIDS | Grant from SIDA | 32315.789 | 8 training workshops | Material outcomes for stakeholders above only. All outcomes for this stakeholder considered above | | | | | | | |
| | | | | 2 district workshops | | | | | | | | |

| | |
|---|---|
| People living with HIV and AIDS (PLHIV) | $20,514.66 |
| Family members of PLHIV who have been affected by stigma training | -$190,685.00 |
| Trainers | $572,304.46 |
| Other NGO's that have delivered the training and district workshops | $42,200.36 |

# Appendix B: Impact Map for Mazabuka continued

| Stakeholders | Deadweight | Attribution | Drop off | Impact | Calculating Social Return | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | % | % | % | | Discount rate (%) | | 11.73% | | | | |
| Who do we have an effect on? Who has an effect on us? | What would happen without the activity? | Who else contributed to the change? | Does the outcome drop off in future years? | (Quantity x financial proxy) – deadweight – attribution | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Total Value | Present Value |
| PLHIV | 2% | 10% | 70% | $71,727.17 | $23,909.06 | $7,172.72 | $2,151.82 | $645.54 | $193.66 | $34,072.80 | $29,212.88 |
| | 40% | 10% | 70% | $6,487.43 | $2,162.48 | $648.74 | $194.62 | $58.39 | $17.52 | $3,081.74 | $2,642.18 |
| Family of PLHIV | 25% | 10% | 70% | -$647,337.02 | -$215,779.01 | -$64,733.70 | -$19,420.11 | -$5,826.03 | -$1,747.81 | -$307,506.66 | -$263,645.99 |
| | 0% | 10% | 70% | -$79,672.25 | -$26,557.42 | -$7,967.22 | -$2,390.17 | -$717.05 | -$215.12 | -$37,846.97 | -$32,448.74 |
| Health Institutions | | | | | | | | | | | |
| Trainers | 0% | 100% | 100% | $2,088,000.00 | $696,000.00 | $0.00 | $0.00 | $0.00 | $0.00 | $696,000.00 | $622,930.28 |
| | 0% | 20% | 50% | $501,120.00 | $167,040.00 | $83,520.00 | $41,760.00 | $20,880.00 | $10,440.00 | $323,640.00 | $265,741.24 |
| NGO's | 25% | 25% | 50% | $123,570.00 | $41,190.00 | $20,595.00 | $10,297.50 | $5,148.75 | $2,574.38 | $79,805.63 | $65,528.51 |
| ARP 2 Stigma Component | | | | | | | | | | | |
| | **Total** | | | **$2,063,895.33** | **$687,965.11** | **$39,235.53** | **$32,593.66** | **$20,189.60** | **$11,262.63** | **$791,246.53** | **$689,960.37** |

| | | PPP Applied |
|---|---|---|
| **Total Present Value (PV)** | **$791,246.53** | **$509,562.77** |
| **Net Present Value** | **$689,960.37** | **$444,334.48** |
| **Social Return $ per $** | **$21.35** | **$13.75** |

# Appendix C: Jctr Basic Needs Basket: Monze

## (A) Cost of basic food items for a family of six in Monze

| Commodity | Kwacha | Quantity | Total |
|---|---|---|---|
| Mealie meal (breakfast) | 61,500 | 3 x 25 Kg bags | 184,500 |
| Beans | 9,300 | 2 Kgs | 18,600 |
| Kapenta (Siavonga) | 52,700 | 2 Kgs | 105,400 |
| Dry Fish | 40,000 | 1 Kg | 40,000 |
| Meat (mixed cut) | 16,300 | 4 Kgs | 65,200 |
| Eggs | 8,100 | 2 Units | 16,200 |
| Vegetables (greens) | 3,000 | 7.5 Kgs | 22,500 |
| Tomato | 2,300 | 4 Kgs | 9,200 |
| Onion | 5,500 | 4 Kgs | 22,000 |
| Milk (Sour) | 8,000 | 2.5 litres | 32,000 |
| Cooking oil (2.5 litre bottle) 2 | 8,500 | 4 litres | 45,600 |
| Bread | 5,000 | 1 loaf/day | 150,000 |
| Sugar | 5,400 | 8 Kgs | 43,200 |
| Salt | 3,300 | 1 Kg | 3,300 |
| Tea (Tips 250g) | 4,100 | 500 g | 8,200 |
| **Sub-total** | | | **K765, 900** |

## (B) Cost of essential non-food items

| | | | |
|---|---|---|---|
| Charcoal | (25Kg bag) | 13,700 180 Kgs | 98,640 |
| Soap (Lifebuoy) | 2,500 | 10 tablets | 25,000 |
| Wash soap (Boom) | 4,100 | 4 X 400g | 16,400 |
| Jelly (e.g. Vaseline) | 8,000 | 1 x 500 ml | 8,000 |
| Electricity (medium density) | 113,000 | | 113,000 |
| Water & Sanitation (med – fixed) | 60,000 | | 60,000 |
| Housing (3 bedroom) | 600,000 | | 600,000 |
| **Sub-total** | | | **K921, 040** |
| **Total for Basic Needs Basket** | | | **K1, 686,940** |

# Appendix C continued

| Totals from previous months | Nov 08 | Dec 08 | Jan 09 | Feb 09 | Mar 09 | Apr 09 | May 09 | Jun 09 | Jul 09 | Aug 09 | Sep 09 | Oct 09 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | - | - | 1,559,00 | 1,628,110 | 1,630,510 | 1,668,960 | 1,674,620 | 1,662,210 | 1,651,440 | 1,641,840 | 1,628,100 | 1,634,800 |

## (C) Some other additional costs

| **Item** | **Kwacha** | **Item** | **Kwacha** |
|---|---|---|---|
| Education | | Health | |
| Grades 1-7 (PTA+Project/year) | K25, 000 – K45, 000 | Consultation Fee | K2, 500 |
| Grades 8-9 (User+PTA/year) | K75, 000 – K255, 000 | Mosquito Net (pregnant /↓5) | |
| Grades 10-12 (User+PTA/year) | K510, 000 – K530, 000 | Lab tests (e.g., malaria) | |
| School Uniform | K55, 000 – K115, 000 | Fuel (cost at the pump) | |
| Transport (bus fare round trip): | | Petrol (per litre) | K6, 073 |
| | - | Diesel (per litre) | K5, 744 |
| | - | Kerosene (per litre) | K4, 025 |

## (D) A comparison of costs of basic needs across zambia in November

| Lusaka | Kasama | Kitwe | Luanshya | Kabwe | Livingstone | Mongu | Solwezi | Ndola |
|---|---|---|---|---|---|---|---|---|
| 2,254,630 | 1,424,270 | 1,962,180 | 1,407,490 | 1,527,020 | 1,849,391 | - | 2,003,330 | 1,685,214 |

This survey was conducted from **28th to 30th November 2009** by the Social Conditions Programme of the Jesuit Centre for Theological Reflection. Average prices were calculated on the basis of surveys conducted at Main Market, Town centre, Manungu Market, and Site and Service Market. Additional information was obtained from ZESCO, the Southern Water and Sewerage Company and schools, clinics and houses around Monze. The November Basic Needs Basket is approximately US$361 based upon an average middle exchange rate of 4669 Kwacha per US$ at the end of November. Please note that other monthly costs would include personal care, clothing, recreation, etc.

Jesuit Centre for Theological Reflection, P.O. Box 37774, 10101 Lusaka, Zambia
Tel: 260-211-290-410 Fax: 260-211-290-759 E-mail: socialjctr@jesuits.org.zm Internet: www.jctr.org.zm
Location: Luwisha House, Plot 5880 Great East Road (opposite UNZA main gate), Lusaka

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

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

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

www.aidsalliance.org

International HIV/AIDS Alliance
(International secretariat)
Preece House
91-101 Davigdor Road
Hove, BN3 1RE
UK

Telephone: +44(0)1273 718900
Fax: +44(0)1273 718901
mail@aidsalliance.org
Registered charity number: 1038860