

Policy Brief

Social Return on Investment for HIV services

Photo: UNDP

Introduction and background information

HIV situation in brief

The estimated number of people living with HIV (PLHIV) in the region of Eastern Europe and Central Asia (EECA)¹ between 2010 and 2019 has nearly doubled from 0.8 million to 1.7 million, while HIV prevalence rose correspondingly from 0.4 percent in 2010 to 0.9 percent in 2019 (UNAIDS, 2020a). Injecting drug use has traditionally been the predominant mode of HIV transmission in EECA, with 48 percent of infections occurring among people who inject drugs (PWID) as of 2019 (UNAIDS, 2020b). In addition, the prevalence of HIV has been high among other key populations at higher risk of HIV infection, such as sex workers, men who have sex with men (MSM) as well as the prison population (Table 1)². However, recently, heterosexual transmission has also been on the rise (ECDC, 2019a).

Table 1.

EECA: HIV prevalence among the adult population and selected key populations at higher risk to HIV

	adults (15-49)	people who inject drugs	sex workers	MSM	prison population
Albania	<0.1	1.4	0.7	2.0	0.5
Armenia	0.2	1.9	0.6	1.9	0.3
Azerbaijan	0.1	6.9	3.5	1.1	1.9
Belarus	0.5	30.8	7.0	9.8	8.5
Bosnia and Herzegovina	—	—	—	—	—
Georgia	0.4	2.3	0.9	16.2	0.1
Kazakhstan	0.3	7.9	1.4	6.5	3.6
Kosovo*	—	—	—	—	—
Kyrgyzstan	0.2	14.3	2.0	6.6	11.3
Moldova	0.7	13.9	3.9	9.0	3.8
Montenegro	<0.1	0.5	0.5	12.5	0
North Macedonia	—	—	—	—	—
Serbia	<0.1	1.8	1.6	8.3	—
Tajikistan	0.2	12.1	2.9	2.3	—

* Hereafter referred to in the context of UN Security Council Resolution 1244 (1999).

1 <https://www.eurasia.undp.org/content/rbec/en/home/about-us/about-the-region.html>

2 It's important to note that these are not mutually exclusive categories and there is some mobility between groups.

	adults (15–49)	people who inject drugs	sex workers	MSM	prison population
Turkey	—	—	—	—	—
Turkmenistan	—	—	—	—	—
Ukraine	1	22.6	5.2	7.5	7.2
Uzbekistan	0.2	5.1	3.2	3.7	0.5

Source: UNAIDS (2020a)

Data suggests that antiretroviral treatment (ART) coverage in the region is low. In over half of the countries in the region, just about half (or less) of

PLHIV are receiving antiretroviral therapy. Albania and Armenia are notable exceptions, with over 80 percent of PLHIV receiving ART (Chart 1).

Chart 1. EECA countries: Antiretroviral therapy coverage (% of people living with HIV), 2019



Source: World Development Indicators (2020). Antiretroviral therapy coverage indicates the percentage of all people living with HIV who are receiving antiretroviral therapy.

The HIV epidemic in Eastern Europe and Central Asia has been exacerbated by frequent co-infection with STIs, TB, hepatitis B, hepatitis C, and other infections. EECA has the highest incidence of TB and multidrug-resistant (MDR) TB, which is the most common indicative disease for AIDS (ECDC, 2019b). MDR TB prevalence is particularly high among newly detected cases across the countries in the region (ECDC, 2019b). Among people living with AIDS, TB co-infection is associated with a higher morbidity and mortality; and among people living with TB, HIV co-infection is associated with increased TB transmission to the general population (Corbett et al, 2003). Moreover, the disruptions of services and supplies caused by the on-going COVID-19 epidemic threatens to further exacerbate the HIV epidemic in the wider EECA region³.

Social contracting—definition

These worrying trends clearly suggest that more action is needed in order to halt the further spread of the epidemic as well as to further address the inequities in access to prevention, ART and care services among PLHIV and other KPs. This is becoming a pressing issue particularly since availability of donor financing across the countries in the region is decreasing. Over the last few years, the World Bank has re-classified most of the countries in the region as lower or upper middle-income countries. As a result, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and other international support for HIV programmes in the region has been decreasing, yet domestic funding for HIV prevention is not meeting the funding gap (UNAIDS, 2016). Moreover, while

3 <https://eeca.unfpa.org/en/news/helping-most-vulnerable-survive-double-pandemic-hiv-and-covid-19-eastern-europe-and-central>

there has been some progress in domestic funding for ART, less progress has been seen in funding of prevention activities, which based on UNAIDS recommendations should receive approximately one quarter of the overall investments (UNAIDS, 2020b). Against this background, social contracting could provide a basis for efficiently delivering HIV/TB services using governments (both, national and local) funds. It is defined as the process by which government resources are used to fund entities that are not part of government (e.g., NGOs) in order to provide services. Regardless of the terminology used, social contracting mechanisms typically involve a legally binding contract, in which the government agrees to pay an NGO for services rendered and the NGO agrees to provide agreed deliverables in exchange (UNDP, 2019). Thus, social contracting is different from the other NGOs funding streams and could be also described as ‘public financing and contracting of NGO-delivered services’. The process of social contracting is particularly important for the EECA region, where NGOs are the principal vehicle for service delivery to the key population. This is mainly influenced by a few factors: trust, improving navigation around the existing state provided services, as well as overcoming legal and other barriers (OSF, 2017).

Social contracting in the EECA—context, scope and scale

The existing evidence of social contracting suggests that there are a few conditions for an effective social contracting mechanism (UNAIDS, 2018). **The first condition** is the **existence of legal and administrative systems** permitting and facilitating social contracting. Currently, across the region, all countries fulfil this condition, either through the existence of a **clear national social contracting legis-**

lation or via streamlining social contracting **through the usual legislation on public procurement** (EHRA, 2020; AETS Consortium, 2018).

The second condition is the existence of **strong national leadership and funding from national authorities**. In **Ukraine**, for example, there has been a steady increase of state budget support on step-by-step plan, from 20 percent to 50 percent to 80 percent of all expenses of HIV services for key populations since 2018 (UNAIDS, 2020). Moreover, the **Ukrainian financing model** encourages **coupling of funding from both, national and sub-national budget sources** as an important way to ensure sustainability. For example, Kyiv and Odessa which signed up to UNAIDS’ Fast Track Cities initiative in 2016, are now implementing a range of innovations, including funding from private sources, decentralisation of treatment and social contracting to reach its target of 82 percent of people living with HIV in the city on treatment by 2021 (OSF, 2017).

The third condition, **allocating budget resources for HIV-specific activities**, ensures transparency, fairness and effectiveness in funding allocation, as a condition for an effective social contracting mechanism. Since 2017, North Macedonia has had a practice of **passing a national budget** with specific lines for HIV-programme funding, implying that the services provided to PLHIV and key affected populations are well prioritized by national or local governments (SOS Project Consortium, 2020). Moreover, since 2017, there has been a practice of social contracting between the Ministry of Health and NGOs on HIV prevention programmes (Zhao et al, 2020). According to data from the 2019 budget, about half of the HIV related prevention activities have been implemented by NGOs (see Box 1 below, which further illustrates the progress achieved in the case of North Macedonia).

Box 1. Social contracting: the case of North Macedonia

The case of North Macedonia illustrates some of the necessary steps that lead to improvement in the social contracting mechanisms. The watershed for North Macedonia was 2017, when Government decided to ensure sustainability, allocate funds and establish long-term contracting mechanisms for NGOs. Moreover, since 2018, the national budget allocates resources for HIV services for key affected populations (according to the latest figures about 50 percent of all budget resources are awarded to NGOs). Three years earlier, there were some significant activities that took place and paved the way for the 2017 watershed: (i) building consensus among stakeholders and political will; (ii) strong coalition of service delivery organizations; (iii) advocacy strategy; and (iv) funding for advocacy. Currently, 14 NGOs across 10 towns in the country are supported and their work mostly revolves around prevention interventions targeting the marginalized communities. Finally, the case of North Macedonia illustrated some of the key enablers for this progress in the area of social contracting thus including: political will, existing practice of social contracting in the area of social services as well as institutional capacity of the key government entity.

Finally, the fourth condition for an effective social contracting mechanism, is a need for **technical and managerial capacity of NGOs** involved in the social contracting process (Global Fund, 2019). In that respect, the Drug Policy Network Southeast Europe has been involved in improving NGO capacity across South-eastern Europe (**Serbia, Montenegro, Bosnia and Herzegovina**) in areas such as: technical assistance in the field of budget advocacy as well as budget advocacy and monitoring (Drug Policy Network SEE, 2020). Further in this area, there has been a regional consultation on social contracting to develop good practice/normative standards (OSF, 2017).

Social contracting in the EECA—challenges

Despite these achievements in the major areas that are *sine qua non* for an effective social contracting mechanism, there are some challenges across the countries in the region. First, despite the existence of legislation for social contracting, there are additional barriers to accessing HIV-related services (Global Fund, 2020). For example, in Belarus, while there are some changes to the national legislation allowing for social contracting of NGOs for prevention of HIV and other communicable diseases, some key population groups, including MSM, do not have regular and easy access to services procured using social contracting mechanisms (EHRA, 2020). Expert provided anecdotal evidence also points out to similar challenges in Kazakhstan. Furthermore, as evidenced by Table 2, in some of the countries of the region (e.g. Kyrgyzstan, Ukraine), there are legal restrictions requiring that HIV services only be provided in healthcare facilities, which makes the process of outsourcing and provision of services in community settings difficult.

Second, across the region, there are significant challenges regarding NGOs participation in the public procurement process. This is due to the fact that social contracting procedures discourage most NGOs from applying because they are complex and require a bidding and registration fee, complex legal registration, and initial prepayment of services (UNAIDS, 2020). Moreover, while the procurement processes include special provisions for small and medium enterprises, such special provisions for NGOs do not exist (AETS Consortium, 2018). Furthermore, despite the ongoing capacity building, very few NGOs in the region have sufficient financial and technical capacity to engage in public procurement processes (Gotsadze et al, 2019).

Finally, in addition to having less priority compared to state institutions, there are challenges with timelines in provision of services. While there have been improvements in some Central Asian Republics, where the funding available to NGOs is starting to be more closely aligned with the budget cycle, expert anecdotal evidence suggests inefficiencies in the annual social contracting cycle (SOS Project Consortium, 2020; EHRA, 2020).



Table 2. Selected EECA countries: Regulatory barriers to community-led service delivery

	Restrictions requiring that HIV services only be provided in health-care facilities	Restrictions on providing services to key populations	Overly restrictive criteria for eligibility for community-based service delivery	No regulatory barriers	Other	Comment
Belarus				X		
Kyrgyzstan	X	X	X			
Moldova				X		
Montenegro		X			X	(CSO/CBOs are not allowed to perform any kind of medical procedures, including doctor examination, testing, and even harm reduction program is still illegal and can be prosecuted by Criminal Law)
Serbia	X		X			
Tajikistan				X		
Ukraine	X				X	(Providing some community based health care services (HIV testing, ART, PReP) requires a medical license. NGOs claim that getting the medical license and meeting requirements are complicated procedure for them. In addition, some health care services can be provided only by public/ municipal health care facilities.)
Uzbekistan				X		

Source: UNAIDS National Commitments and Policy Instrument 2019

SROI methodology

Social contracting for HIV services can create significant social returns. In order to study the social returns arising from social contracting, we adapted and implemented the social return on investment (SROI) methodology to the context of HIV in the EECA region. Overall, the SROI methodology allows a deeper understanding of the social, health, environmental and economic values created by the process of social contracting by a range of stakeholders identified as primary beneficiaries. It 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 value⁴ to the direct beneficiaries of the programme (Banke-Thomas, 2015) (further details are provided in the appendix of the brief).

SROI methodology is slightly different compared to previous and ongoing studies of allocative efficiency across the region conducted with the Optima tool. As discussed elsewhere, methodologically, Optima's key feature is its ability to perform resource optimization to meet strategic HIV objectives, including HIV-related financial commitment projections and health economic assessments (Kerr et al, 2015). Specifically, Optima allows users to choose a set of objectives (such as minimizing new infections, minimizing HIV-related deaths, and/or minimizing long-term financial commitments) and then determine the optimal resource allocation (and thus programme coverage levels) for meeting those objectives. As such, Optima falls within the narrower scope of cost-effectiveness analysis.

4 In this instance, social value is a monetary equivalent of the social, health, environmental and economic outcomes achieved as a result of the social contracting activity.

Case studies of applying HIV SROI methodology in EECA

Four case studies from three countries (Belarus (2 case studies), Bosnia and Herzegovina, and North Macedonia) were selected in order to pilot the SROI methodology in the area of HIV related activities. The selection of the case studies was conducted after an open call to NGOs working on HIV prevention, treatment and care programmes. Moreover, the selection allowed a balanced mix of type of activities (e.g. activities covering PLHIV and key populations) as well as a good mix of countries. By doing so, these case studies provide an illustration of this, very first, application of the SROI methodology in the HIV and AIDS context in the wider EECA region.

Against this background, inputs in this exercise were provided from the following four partners: **Partnership in Health** (Bosnia and Herzegovina), **HERA** (North Macedonia), **Belarusian Red Cross** (Belarus) as well as **Pozitivnoe Dvizhenie** (Belarus). The inputs in terms of data and expertise received from the partners were instrumental in having enough substance to conduct this first ever HIV SROI exercises for the EECA region.

Brief description of the case studies

The objective of the activities in Bosnia and Herzegovina featured in this SROI work was the provision of HIV counselling to key populations (MSM, PWIDs and prison population) as well as the support of PLHIV with various social support measures (e.g. provision of food and personal hygiene products). In that respect, the main stakeholders encompassed the key populations at higher risk of HIV infection (MSM, PWIDs and prisoners), including PLHIV. From early 2018 until the end of 2018, almost 10,000 people from the key populations were counselled, while 69 PLHIV were targeted with social support. In **North Macedonia**, activities assessed encompassed mobile testing and counselling of key marginalized and key populations in the country (MSM, PWIDs and sex workers). In addition, the activities covered testing and counselling of young people. From the beginning of 2019 until the end of the year, about 2,500 people from the key communities were reached. The Belarusian Red Cross case study focused on provision of free testing and prevention activities for key populations and the provision of palliative care to PLHIV as well as additional services (e.g. distribution of free condoms and syringes). From the beginning of 2020 until the end of the year, over 5,000 people from marginalized communities and key populations were reached with the various prevention

activities, while 76 PLHIV received palliative care at home. The Belarus **Pozitivnoe Dvizhenie** case study activities encompassed helping PLHIV to access ART in two areas (Minsk and Gomel).

It is important to note that while the case studies illustrate the SROI application in two major types of activities (i.e. counselling/prevention activities and access to ART), the same methodological approach can be applied to a wider set of NGOs doing work in areas relevant to HIV and AIDS such as fighting stigma against key populations, providing livelihood support to selected key populations or advocacy/lobbying and activism.

Outputs and assumptions

Given that the case studies focused on two main types of activities (counselling and access to ART), there are two outcomes related to these activities: (i) averted infections as a result of the counselling provided to the marginalized and key populations; and (ii) improved health of PLHIV (due to improved palliative care, access to ART, subsistence needs covered). After assessing the activities' background information and consultations with the NGOs, no other outcomes were identified. One of the most important parts of the SROI involves monetizing of the outcomes. In this regard, when monetizing the outcomes and as per the SROI methodology we used: (a) average cost of ART for the averted infections; and (b) average minimum wage, for PLHIV in good health to join the labour market (Tong et al, 2012).

When considering the counselling of key populations, an additional set of assumptions was made. First, not all people that were counselled immediately adopt safer practices; moreover, even if they continue with unsafe practices, not all of them will be infected. So, to refine the numbers, the transmission infection rate per type of unsafe practice first was applied (e.g. unsafe sex, sharing needles) (PHA Canada, 2012). Furthermore, estimates from the literature on the reduction of HIV infections through counselling were relied upon (Hallett et al, 2009).

There are three additional steps in the process of SROI implementation. Firstly, an important part of the SROI is the **time horizon** of the effects of the stated activities mentioned above (so-called **drop-off**). In other words, while some of activities (e.g. counselling) last longer, others (e.g. help to PLHIV such as food or products for personal hygiene) have a limited duration and are expected to end as soon as the activity is completed. Hence, for the counselling, the assumption is that the effect will last for five years and that it will gradually reduce over time. In doing so, the following percentage reductions were applied to the

original value in year 1: 50 percent in year 2, 70 percent in year 3, 90 percent in year 4, and 100 percent in year 5. Secondly, the monetized outcomes ought to be adjusted for the effect of others on the final outcomes (so-called **attribution**). Thirdly, the monetized outcomes should be adjusted for the share of the final outcomes that would have happened without the activities mentioned above (so-called **deadweight**). While the deadweight is 0, attribution is assumed to be 10 percent. In other words, there might be other channels through which messages about safer practices could be distributed (radio, TV, print) (this assumption is applied in cases covering prevention activities).

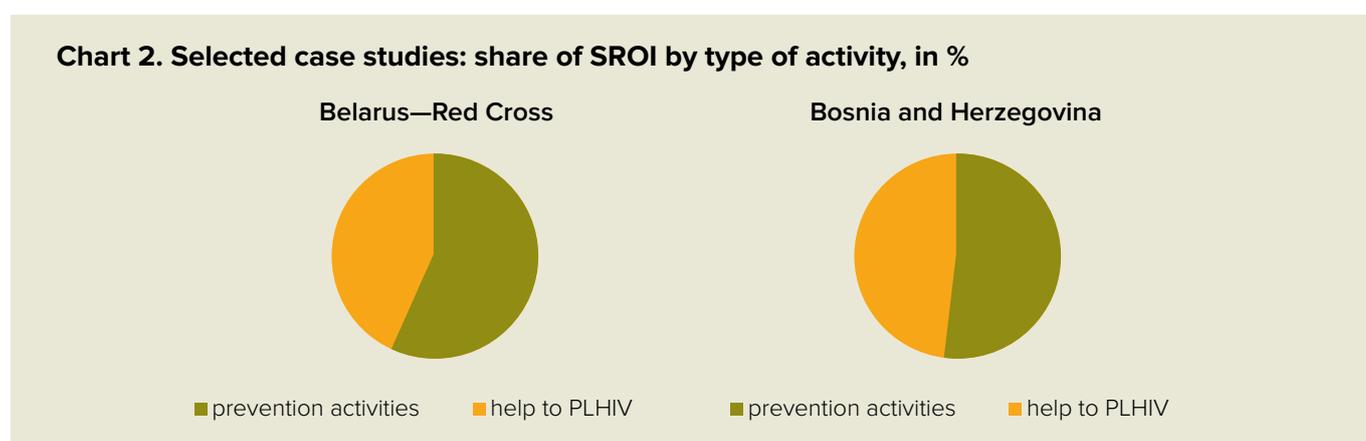
Finally, the monetized outcomes of the activities above (adjusted for attribution and deadweight) are expressed as a ratio to inputs/costs. The inputs/costs for the activities above were provided by the respective NGOs.

In order to ascertain the assumptions above as well as to collect additional information on the crucial elements of the exercise (e.g. attribution, deadweight, costs/inputs), a questionnaire was prepared and administered to the participating NGOs. The information of the questionnaire was further triangulated with a subsequent zoom call/discussion with representatives from the selected NGOs.

Results

When methodology was applied in the cases above, the results indicate that there are significant social returns associated with the implemented activities. More specifically, in the case of **Bosnia and Herzegovina**, the results suggest a total return of 630,000 BAM (approximately 400,000 USD). These benefits, as mentioned above capture things such as: avoided number of infections, improved quality of life among PLHIV, improved quality of life among the key population groups and other. The activities in **North Macedonia** result with a total social return of 5 million MKD (approximately 100,000 USD), which is significant, given the project cost of 3 million MKD. Finally, the cases in **Belarus** resulted with a social investment on investment of 622,000 BYN (240,000 USD) (Belorussian Red Cross) and 84,000 BYN (32,412 USD) (Poziitivnoe dvizhenie).⁵

Chart 2 below depicts the share of total social returns by the type of activities (counselling/HIV prevention among key populations as well as access to ART and psycho-social support for PLHIV). In both case studies, there is roughly an equal share of social return to investment created by the two types of activities.



For the activities that involve counselling/prevention activities to different key populations (MSMs, PWIDs) a further disaggregated analysis was conducted and *Chart 3* captures the share of SROI realized through counselling/prevention activities by different key populations in two of the selected countries (Bosnia and Herzegovina and North Macedonia). While the shares are slightly different in the two countries, they are a reflection of the nature of the epidemic as well as the focus of the prevention activities. In other words, the counselling/prevention activities are mainly focused on MSMs, a sub-group of the population where the HIV epidemic is spreading fastest. The share is also high among the other groups where the epidemic has been concentrated (e.g. sex workers and PWIDs in the case of North Macedonia as well as PWIDs and prisoners in case of Bosnia and Herzegovina).

⁵ The following exchange rates were used: 1 USD=1.7 BAM (Bosnia and Herzegovina); 1 USD=2.4 BYN (Belarus); 1 USD= 54 MKD (North Macedonia). The data pertains for 2020 and it is taken from the World Development Indicators (WDI, 2021)—<https://databank.worldbank.org/source/world-development-indicators>

THERE ARE SIGNIFICANT SOCIAL RETURNS ASSOCIATED
WITH THE IMPLEMENTED ACTIVITIES

In Bosnia and Herzegovina



Input—**179,259** BAM (approximately **113,815** USD)



Total social return of **630,000** BAM
(approximately **400,000** USD)

In North Macedonia



Input—**3.1** million MKD (approximately **62,000** USD)



Total social return of **5** million MKD
(approximately **100,000** USD)

In Belarus

Belarusian Red Cross



Input—**392,085** BYN (approximately **151,287** USD)



Total social return on investment of **622,000** BYN
(approximately **240,000** USD)

Pozitivnoe dvizhnenie

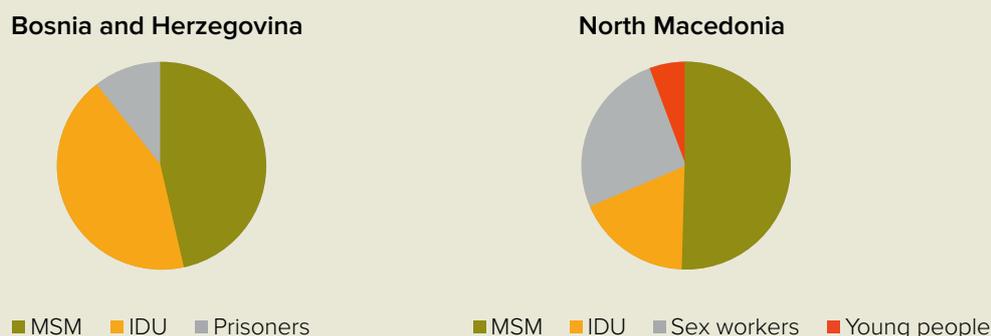


Input—**31,594** BYN (approximately **12,191** USD)



Total social return on investment of **84,000** BYN
(approximately **32,412** USD)

Chart 3. Selected case studies: share of SROI realised through HIV counselling/prevention, by beneficiary, in %



As discussed above, the final SROI is expressed as a ratio of the social returns of the undertaken activities and the cost required to implement them. Table 3 below captures the results of the SROI for HIV-related activities in the case studies. In addition to the main findings of the analysis, the table also captures the upper and lower bounds of the SROI based on the additional sensitivity analysis (details of the sensitivity analysis are provided in the appendix of the brief and they cover variations in the drop-off rate, attribution as well as the deadweight). There are a few broad findings that emerge as illustrated in Table 3.

First, in all of the selected activities, there are significant social returns which are realized as a result of their implementation. The SROI ratio

ranges from 1.5:1 in the case of North Macedonia to 3.5:1 in the case of Bosnia and Herzegovina. This is mostly due to the type of activities that are implemented. The case of Bosnia and Herzegovina encompasses both, psycho-social support to PLHIV as well as counselling/prevention activities among key populations.

Second, the sensitivity analysis indicates that the results are robust to changes in assumptions such as modification of the drop-off or attribution rate.

Finally, and given the similarity of the activities which are implemented (as well as similarities in assumptions), the SROIs across the different case studies are broadly comparable.

Table 3. Results of the SROI, by country

Country	SROI of HIV related activities	Sensitivity analysis	
		Lower bound	Upper bound
Bosnia and Herzegovina	1:3.5	1:3.1	1:4.1
North Macedonia	1:1.5	1:1.4	1:2.0
Belarus: Red Cross activities	1:1.6	1:1.4	1:1.9
Belarus: Pozitivnoe Dvizhenie	1:2.6	1:1.3	1:2.3

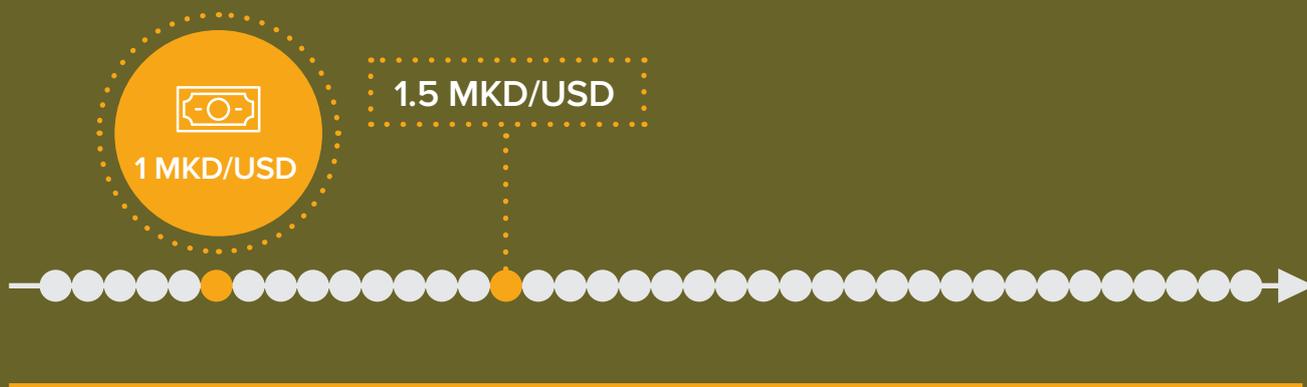
Limitations

The SROI approach is not without limitations, 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 could be challenged. An attempt was made to detail the assumptions, processes, and measurement of outcomes in order to fully document how figures were calculated or estimated. Given the ongoing situation with the COVID-19 pandemic, all of the consultations were conducted virtually over the phone or email, which is another limitation to this research. Ideally, the method should involve a face to face interaction with respondents and other stakeholders. With that said, some of the stakeholders (e.g. national authorities, healthcare professionals) were not involved in the SROI estimation exercises.

For every Bosnia and Herzegovina convertible mark (BAM)/USD invested in HIV-related prevention activities (including psycho-social support and counselling), the country will receive a social return on investment of 3.5 BAM/USD.⁶



In North Macedonia, every Macedonian denar (MKD)/USD covering mobile testing and counselling of key marginalized and key populations (Men who have sex with men, People who Inject Drugs and sex workers) generated a social return on investment of 1.5 MKD/USD.



In the case of Belarus, investing 1 Belarusian ruble/USD in the context of 2 assessed HIV-related projects translated into a total social return on investment of 1.6 and 2.6 respectively.



⁶ The ratios are obtained by dividing the social returns and inputs presented in both local currencies and USD on page 8.

Furthermore, given the methodology, we cannot make distinction between ‘need’ and ‘ability to pay’. Moreover, data constraints prevented further assessment of the probability of paying out of pocket (including informal payments) for some healthcare services. Finally, the exercise above was mainly focused on two types of activities (counselling/prevention and care services provided to PLHIV) which somewhat limits the generalizability of the results.

Conclusions and recommendations

Countries in EECA region have made significant progress in setting the foundation for effective social contracting mechanisms. All of the countries have legal structures that allow them to contract NGOs for the provision of various HIV-related activities as well as provide care and support to PLHIV. Moreover, as the literature review at the beginning of this brief suggests, countries in the region have also made progress on other key aspects of effective social contracting (e.g. political leadership, earmarking funding for HIV-related activities, increasing capacity among NGOs to participate in the social contracting process). Some challenges remain, ranging from legal obstacles, complex bidding processes as well as lack of technical capacity (by NGOs) to participate in the bidding processes.

Nevertheless, for the NGOs that do participate and obtain funding, as the case studies featured in this brief have shown, **activities that are conducted under the auspices of social contracting result in significant returns on investment**. As the case studies show, **for each USD invested, there is a return in social investment of between 2 to 3 USD**. These social returns, as indicated in the analysis include, inter alia, improved quality of life among PLHIV, numerous averted infections among key population groups, through counselling and distribution of needles and condoms, ultimately resulting in improved self-esteem and better quality of life among the key populations.

Based on this, a set of recommendations that stem from this first HIV SROI exercise in the **EECA region** are as follows:

- 1 While the case studies featured in this brief provide a flavour of the numerous economic and social benefits of the social contracting (going beyond the simple financial value), the next stage of the SROI analysis in the area of HIV should include a broader set of NGOs to provide additional activities (e.g. livelihood support to PLHIV, support to people with co-infections (e.g. HIV and TB), fighting stigma and discrimination) which may further increase the overall SROI;
- 2 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. In particular, a well-executed SROI can go a long way in capturing the benefits of various social contracting activities in a simple and unambiguous way;
- 3 Building on (ii), the SROI can be used in future lobbying activities by NGOs to emphasize the benefits brought about by social contracting. Moreover, using the results of future SROI in the area of HIV could further reduce existing obstacles to social contracting in HIV (for example, results of SROI can be used to show that some activities, like harm reduction can be effectively and efficiently delivered by NGOs in a non-clinical setting);
- 4 The easy quantification of the SROI results could also be used in bidding for funding, particularly when the funding is based on outputs or when there is performance based funding;
- 5 The results of the SROI analysis can also be used to emphasize the sustainability and medium-term effect of some activities implemented through social contracting. In the current case studies, we assume a drop-off period of 5 years, although in some other cases (e.g. providing livelihood support to key populations or fighting stigma and discrimination), the effects could be longer;
- 6 When using the SROI results to lobby for further expansion/scale up of social contracting, emphasis should be given to the so-called 'attribution' and 'deadweight'. In other words, given the concentrated epidemic and marginalization of key populations, the high returns on investment, as demonstrated in these case studies, would have not happened without the activities implemented through social contracting;
- 7 While this is an initial, pilot application of SROI methodology, future endeavours should be based on consultation with all stakeholders and beneficiaries (including some which were not featured in our analysis, e.g. the Government national or local authorities or healthcare workers);
- 8 The methodology for community/stakeholder consultation should be promoted/piloted in other areas where social contracting becomes an important vehicle for NGO financing (e.g. TB, co-infections between HIV and TB, harmful use of alcohol, ART co-morbidity with diseases of ageing such as cardiovascular disease).

References

1. AETS Consortium (2018) “Social Economy in Eastern Neighbourhood and in the Western Balkans: Synthesis report”, March, 2018.
2. Corbett, E.L., Watt, C.J., Walker, N., et al.: The growing burden of tuberculosis: global trends and interactions with HIV epidemic. *Arch. Intern. Med.* 163, 1009–1021 (2003).
3. EuroHIV: HIV/AIDS Surveillance in Europe. End-Year Report 2011. Institut de Veille Sanitaire, Saint-Maurice (2011).
4. European Centre for Disease Prevention and Control (2019a). HIV/AIDS Surveillance in Europe 2019.
5. European Centre for Disease Prevention and Control (2019b). Tuberculosis surveillance and monitoring in Europe 2019.
6. Gotsadze et al (2019) “The Challenges of Transition From Donor-Funded Programs: Results From a Theory-Driven Multi-Country Comparative Case Study of Programs in Eastern Europe and Central Asia Supported by the Global Fund”, *Global Health: Science and Practice* 2019, Volume 7, Number 2.
7. Open Society Foundation (OSF) (2017) “A global consultation on social contracting: working toward sustainable responses to HIV, TB, and malaria through government financing of programmes implemented by civil society”.
8. SOS Project Consortium (2020) “Country portfolio”, available in Russian.
9. Sulaberidze L, Gotsadze T, Gotsadze G. How to Sustain Public Health Gains in the SDG Era when Countries in European Region Transition from the Global Fund Support? Fifth Global Symposium on Health Systems Research, Oral Abstract Book. Liverpool, United Kingdom; 2018. <http://healthsystems-research.org/hsr2018/wpcontent/uploads/2018/10/OralAbstractBook-Final.pdf>.
10. UNAIDS, <http://aidsinfo.unaids.org/> dataset, retrieved on 10th of October, 2020a.
11. UNAIDS, 2020b. https://www.unaids.org/sites/default/files/media_asset/2020_global-aids-report_en.pdf.
12. UNAIDS National Commitments and Policy Instrument 2019, <http://lawsandpolicies.unaids.org/topicresult?i=619>, retrieved on 12th of October, 2020.
13. Zhao, Feng, Clemens Benedikt, and David Wilson, eds. 2020. Tackling the world’s fastest growing HIV epidemic: more efficient HIV response in Eastern Europe and Central Asia. Human Development Perspectives. Washington DC, World Bank.
14. The SROI Network (2012) “A guide to Social Return on Investment”.
15. Tong, L., H. Sopheab, Tuot S. (2012). Social Return on Investment “Doing more with less”: Evidence based operational research on the KHANA integrated care and prevention project in Cambodia. Phnom Penh, KHANA.
16. Public Health Agency of Canada (2012) “HIV transmission risk: a summary of the evidence”.
17. Hallett et al (2009) “The role of testing and counselling for HIV prevention and care in the era of scaling-up antiretroviral therapy”, *Epidemics*, Volume 1, Issue 2.
18. Global Fund (2019) “Update on sustainability, transition, and efficiency in the EECA region”, presentation.
19. UNDP (2019) “Guidance Note for the Analysis of NGO Social Contracting Mechanisms: the experience of Europe and Central Asia”.
20. EHRA (2020) “Ensuring sustainability of services for key populations in the EECA region: Taking stock of budget advocacy efforts to date”, Initial meeting of regional analysis and dialogue, December 2020.
21. USAID (2020) “2019 Civil Society Organization sustainability index”.
22. UNAIDS (2020) “Independent evaluation to the UN system response to AIDS in 2016–2019”.
23. UNAIDS (2018) “Donor transitions from HIV programs: What is the impact on vulnerable populations?, 2018”, UNAIDS, 2018.
24. UNAIDS (2016) ‘Prevention Gap Report’ [pdf].
25. Banke-Thomas et al (2015) “Social Return on Investment (SROI) methodology to account for value for money of public health interventions: a systematic review”, *BMC Public Health* (2015) 15:582.
26. Kerr CC, Stuart RM, Gray RT, Shattock AJ, Fraser-Hurt N, Benedikt C, Haacker M, Berdnikov M, Mahmood AM, Jaber SA, Gorgens M, Wilson DP. Optima: A Model for HIV Epidemic Analysis, Program Prioritization, and Resource Optimization. *J Acquir Immune Defic Syndr.* 2015 Jul 1;69(3):365-76. doi: 10.1097/QAI.0000000000000605. PMID: 25803164.

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