LEARNING SERIES

THE SOCIAL RETURN ON INVESTMENT OF HEALTH CENTRE ADVISORY COMMITTEES
The benefits of investing in HCACs

Strengthening accountability mechanisms at community level is a key approach to addressing the serious drug accountability gap in Malawi. Of particular concern is the level of drug theft, and evidence which suggests that most abuse occurs at health facilities, often in collusion with health care workers.

Between June 2016 and September 2018, the UKAid-funded Malawi Health Sector Programme – Technical Assistance component (MHSP-TA) designed and implemented a community based accountability pilot study with Health Centre Advisory Committees (HCACs) as the entry point. The objectives were to strengthen HCACs' functionality and effectiveness, improve facility functionality, increase drug accountability, and improve the responsiveness of duty bearers and government, as well as embedding HCACs within the decentralised health system.

MHSP-TA developed draft HCAC terms of reference and a comprehensive training manual. Eleven HCACs in three Districts were revitalised and participated in a five-day training and monthly mentoring for six months[1]. The final evaluation of the pilot study was very positive and showed that all key objectives were achieved[2].

An additional dimension of the evaluation was to identify the estimated monetary value (benefit) of having HCACs which are trained and functional. In other words, does training and mentoring HCACs give a good return on investment? Understanding this is particularly important within a resource constrained environment such as Malawi's health sector.

METHOD

The social return on investment (SROI) (Box 1) focused on four intervention HCACs in Rumphi District (Lura, Mwazisi, Bolero and Mlowe – a Christian Health Association of Malawi (CHAM) site). The SROI aimed to answer the following questions:

- What is the cost/incremental cost of training and mentoring HCACs compared to the present system of no support?
- What is/are the benefit(s)/incremental benefit(s) of training and mentoring HCACs?

Box 1: Social return on investment (SROI) recognises that interventions often result in social and environmental as well as economic outcomes. An SROI translates these broad concepts into monetary values. Using participatory methods, it measures change in ways that are relevant to the people experiencing it. This creates a fuller picture of the range of benefits resulting from the investment and gives value to these. The benefits and their value are identified and agreed by the beneficiaries and verified with other key stakeholders. (Social Value UK, 2015, and Measuring Value, 2008)

- What is the estimated monetary value of the benefit/incremental benefit of trained and functional HCACs?
- Does training and mentoring HCACs (or having trained and functioning HCACs) present a good return on investment?

The methodology had eight stages:

1. Identification and involvement of stakeholders
2. Mapping outcomes
3. Evidencing outcomes and giving them a value
4. Calculating impact
5. Calculating SROI value
6. Sensitivity analysis
7. Payback period
8. Verification and assurance

Fieldwork consisted of highly participatory focus group discussions (FGD) covering stages 2 – 4 above.

At the end of the fieldwork, the SROI team met with the District Health Management Team (DHMT) to obtain their perceptions of changes resulting from the pilot study, and share and validate the information obtained from the FGDs (stage 8).

A key stage of the data collection is working with participants to agree and define the outcomes (the benefits of training and mentoring HCACs), appropriate indicators (what to measure) and valuing the benefits (attaching a monetary value to the benefit). Some key criteria for selecting indicators are that they are measurable, verifiable, meaningful, and capable

1 For information see MHSP (2017) 'Drug accountability, Health Centre Advisory Committees and Enhancing Community Participation in Health'

2 CDM (2018) Endline evaluation of MHSP-TA HCAC capacity development and mentoring pilot programme

of assessing trends over time. Two examples, one straight-forward and one more complex are:

1. Benefit: Improved ability to generate resources.
   Indicator: Amount of resources mobilised (in-kind and cash) from sources other than duty bearers.
2. Benefit: Improved access to health services (due to facilities no longer closing early).
   Proxy indicator: Cost of treatment of complicated malaria cases averted.

The value of benefit 1 is fairly easily calculated by identifying what resources have been mobilised and then identifying what they would have cost if supplied by government e.g. a number of HCACs built placenta pits, latrines and/or bathrooms.

The value of benefit 2 involves more stages: Identifying approximately how many additional people will attend the facility and a common reason for people attending the facility - malaria. Participants then agree on typical numbers of severe cases and the cost of private treatment. If these cases are, instead, treated at the facility then these costs are averted (avoided). The selection of malaria and cost of treatment was verified and agreed with government at the validation meeting.

The monetary value of every indicator identified by each FGD at every facility is averaged out to allow for any over/under estimating by individual FGD groups.

Analysing the data obtained during the focus group discussions also involves several stages (Box 2). At each of these stages the average score was used, to avoid under/over estimations unduly influencing the findings.

Box 2: SROI analysis – Data analysis stages

Deadweight: The amount of benefit that would have happened even if the HCAC pilot project had not taken place.

Displacement: How much of the benefit led to an unintended negative outcome.

Attribution: The amount of benefit that could be attributed to other organisations, or initiatives.

Drop-off: The diminishing value of the benefit over time (5 years was agreed as appropriate by participants).

Payback period: How long it will take for the value of the social returns from the HCAC pilot project to exceed the investment.

FINDINGS

A wide range of benefits were reported because of the HCAC training and mentoring. These included HCACs successfully lobbying for resources. Commonly, water systems were in poor condition or utility bills were unpaid leading to a lack of water/electricity at facilities. Many HCACs repaired systems or persuaded the DHMT to pay the bills resulting in uninterrupted supplies.

HCACs received training on drug monitoring. Once they started utilising the drug monitoring tools, facility staff also adopted these new skills. This has further improved drug management at facilities.

The range of improvements to health facilities brought about by HCAC efforts have led to higher morale among staff and this, in turn, has improved their relationship with community members.

Community members reported that, because of improved accountability, access to health facilities had increased because of longer opening hours, reduced waiting times and improved relationships with health facility staff.

During data analysis, the monetary value of each benefit and its indicator were included only once, even if they were identified by many stakeholders. This avoided double counting of benefits. The value of one key indicator is shown below:

Benefit	Indicator	Value (Mk)
Improved ability to generate resources	Amount of resources mobilised from non-duty bearers	21,910,966

After taking into consideration the deadweight, displacement, attribution and drop off for each benefit, Table 2 shows the projected HCAC project impact for five years:

Table 2: Costed 5-year impact

Year	Amount
1	80,035,711
2	68,540,303*
3	59,382382*
4	54,704,413*
5	41,770,648*
Total	**304,433,460**

*Discounted by 16%

When the cost of the project was deducted, and converted into a ratio, the SROI ratio was Mk8.45 : Mk1. This means that for every 1Mk invested by the HCAC pilot, a social value of Mk8.45 was created, with a payback period of 4 months. This positive social return of Mk8.45 shows that investing in HCAC training and mentoring presents a good return on investment.

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