Social Returns on Investment (SROI) Analysis on Scaling Up the Nutrition Competencies of Frontline Workers in Kenya, Uganda and Tanzania

FINAL REPORT

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Acknowledgment

This report was produced as part of the ECSA-HC project that aimed at strengthening technical capacity of front line workers through development of the regional In-service training packages and Pre-service model curricula.

Many people contributed to this report, and their contribution are gratefully acknowledged. Special thanks should go to the staffs of the Department of Economics, University of Dar es Salaam, more specifically Dr. Jehovaness Aikaeli, Dr. Innocent Pantaleo, Dr. Kenneth Mdadila, Dr. Hamza Mkai and Dr. John Mduma for conducting the study that produced this report. Assistance from Dr. Margaret Kabahenda and Ms. Semalie Namukose of the Ministry of Health in Uganda; Ms. Grace Moshi of the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDEC) in Tanzania; and Ms. Gladys Mugambi and Ms. Caroline Arimi of Ministry of Health in Kenya is appreciated. Without these individuals, it would have been quite difficult for the researchers to meet and interact with the interviewees. There were several frontline workers both at the communities and health facilities who participated as interviewees, many thanks to every one of you. Without the responses of the community members who had received services of the frontline workers and openly responded to interview questions, the analysis would be incomplete, thus we extend heartfelt gratitude to them. Lastly, the comments of all the participants of the validation workshops in Kenya, Uganda and Tanzania turned to be valuable in enriching the final report and are appreciated.
Abstract
Understanding the need for scaling up nutritional competencies in Kenya, Uganda and Tanzania following the technical capacity gaps, ECSA-HC undertook a deliberate move to implement a project aimed at strengthening technical capacity of front line workers through development of the regional In-service training packages and Pre-service model curricula. Understanding the need for enhancing nutrition knowledge, any scaling up efforts need awareness and analysis of the benefit and cost in order to establish viability of committing more resources to such undertaking. Most of capacity building encompasses social benefit than profitability, an element that necessitated the use of a “Social Return on Investment” (SROI) approach in establishing the prospective return on implementation of the capacity development for nutrition initiatives. This SROI study has been done as a specialized form of cost-benefit analysis which incorporates significant aspects of stakeholder-driven evaluation. It places a monetary value on the social impact (the benefit) of an activity, and compares this with the cost incurred in creating that benefit.

Both qualitative and quantitative SROI techniques were applied in analyses with an objective of establishing the social value of the ECSA’s Programme on Technical Capacity Building for Nutrition. The results of the study indicated that without improved nutrition and health knowledge imparted by the project, services outcomes of the frontline workers would not have reached the levels observed in the facilities and communities of focus in this study. Customer care, competencies, communication skills and commitment of the frontline workers who attended the Nakuru pilot training was proved to have increased. Although there were other factors that contributed to service improvement of frontline workers’ services than actually the ECSA’s initiative alone, the project features as one of important contributors to notable achievements the workers who participated.

Quantitative SROI values were robust and generally impressive as the computed figures show substantial gain from each invested dollar, i.e. for every dollar of investment in the ECSA Scaling up of nutrition competency for frontline workers, USD 13 of social value was created. According to experiences from the literature, this is socially a substantial amount of the project value. Overall, these results indicate that if the project was not implemented, the social outcomes of services provided by the respective frontline workers would not have been the same. In short, implementation of this project had significant socially verifiable returns and it is recommended that Kenya, Uganda and Tanzania enhance their efforts at adopting the model curriculum and training more frontline workers.
**List of Abbreviation**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>APHRC</td>
<td>African Population Health Research Centre</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>COMSEC</td>
<td>Commonwealth Secretariat</td>
</tr>
<tr>
<td>CPH</td>
<td>Centre for Public Health</td>
</tr>
<tr>
<td>CSOs</td>
<td>Civil Society Organizations</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>ECSA-HC</td>
<td>East, Central and Southern Africa-Health Community</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>FAO</td>
<td>Food and Agriculture Organization</td>
</tr>
<tr>
<td>FCF</td>
<td>Foresters Community Finance</td>
</tr>
<tr>
<td>FGDs</td>
<td>Focus Group Discussions</td>
</tr>
<tr>
<td>HBS</td>
<td>Household Budget Survey</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/Acquired Immuno Deficiency Syndrome</td>
</tr>
<tr>
<td>KII</td>
<td>Key Informant Interviews</td>
</tr>
<tr>
<td>MIYCN</td>
<td>Maternal Infant and Young Child Nutrition</td>
</tr>
<tr>
<td>MoHCDGEC</td>
<td>Ministry of Health, Community Development, Gender, Elderly and Children</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non-Government Organizations</td>
</tr>
<tr>
<td>SEU</td>
<td>Social Enterprise Unit</td>
</tr>
<tr>
<td>SP</td>
<td>Strategic Plan</td>
</tr>
<tr>
<td>SROI</td>
<td>Social Return on Investment</td>
</tr>
<tr>
<td>ToT</td>
<td>Trainer of Trainees</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>USD</td>
<td>United States Dollars</td>
</tr>
<tr>
<td>WB</td>
<td>World Bank</td>
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<tr>
<td>WFP</td>
<td>World Food Programme</td>
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<td>WHO</td>
<td>World Health Organization</td>
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1. Introduction

1.1. Background

Inadequate nutrition in humans has an adverse effect in both social and economic development. These adverse effects range from maternal and child mortality, poor education performance and low productivity, *inter alia*. It has been established that 45% (approximately 1.3 million) of infant and child mortality worldwide emanate from poor nutrition. As a global concern, the WHO in its World Health Assembly outlined six goals aimed at reducing stunting in under-5 children, anemia for women of reproductive age, low birth weight, children overweight, increase breast feeding in the first 6 months up to 50%, and/or reduce and maintain childhood wasting to less than 5%. These are targeted to be achieved by year 2025. The UN current development agenda under the Sustainable Development Goals (SDGs) has put emphasis on nutrition issues particularly under goal number two “ZERO HUNGER”. It should be noted that, attainment of goal number two has direct implication on goal three “GOOD HEALTH AND WELLBEING”. There have been efforts at national level in developed and developing countries, the East African Countries in particular ranging from policies, strategies and action plans to improve nutrition level. These efforts have been supported by various stakeholders including the United Nation agencies (UNICEF, WHO, WFP and FAO), Bilateral donors (USAID, EU, DFID and WB), Non-Government Organizations (Both International and Local) and Civil Society Organizations (CSOs).

Nutrition status and its impact vary substantially among the three core economies of East Africa: Kenya, Tanzania and Uganda. Uganda Household Budget Survey (HBS) 2016 indicates that, about one in three women aged 15-49 (32%) are anaemic. It also shows that half of children aged 6-59 months (53%) suffered from some degree of anemia. In addition, 33 percent of children under 5 years of age in Uganda were vitamin A deficient (*National Nutrition Guideline for Uganda*).

In Kenya, DHS (2014) findings show that, 26% of children under age 5 are stunted, 4% are wasted, and 11% are underweight. 90% of children have ever been breastfed and 61% of children less than age 6 months are exclusively breastfed. Findings indicate further that, only 22% of children are fed in accordance with the three-recommended infant and young child feeding practices. On the other side, DHS results from Kenya show that 90% of women age 15-49 are thin or undernourished (BMI < 18.5 kg/m2), 33% of women are either overweight or obese (BMI ≥25 kg/m2) and 10% being obese (BMI ≥30 kg/m2). Only 8% of women took iron tablets daily for 90 or more days during the pregnancy of their last birth and only 31% of women took de-worming medication during their last pregnancy.

In Tanzania, according to DHS, 2016; one in three children under five are stunted. This has been more common among children who were very small at birth (51%). Wasting which signifies acute malnutrition is at (5%). In addition, DHS findings show that 14% of children are
underweight or too thin for their age. Results further indicate that 58% and 45% of children and women respectively are anaemic.

Lack of specialized workers (Nutritionist in particular) and competent and well trained frontline workers contribute to these nutrition deficiencies. A regional capacity assessment conducted in 2011 by Hellen Keller international and other partners revealed that the absence of relevant competencies on nutrition at the frontline is one of the greatest barriers to scaling up nutrition interventions in East Africa.

ECSA-HC a regional organization and key health stakeholder is currently implementing a regional project aiming at strengthening capacities of frontline workers on nutrition in the region. Key to note in the Eastern and Southern region of Africa is that, there have been very few nutrition specialists deployed by both public and non-public sectors.

Understanding the need for enhancing nutrition knowledge and competencies, any scaling up efforts need awareness and analysis of the benefit and cost in order to establish viability of committing more resources. Most of capacity building encompasses social benefit than profitability, an element that necessitated the use of Social Return on Investment (SROI) approach in establishing the prospective return of implementation at country level. SROI is a specialized form of cost-benefit analysis which incorporates significant aspects of stakeholder-driven evaluation. It places a monetary value on the social impact (the benefit) of an activity, and compares this with the cost incurred in creating that benefit.

1.2. Organization of the Report

The rest of the report is organised as follow; part 2 is the overall objective of this and SROI Analysis. Part 3 gives the detailed methodology as to how the analysis is carried out. Part 5 establishes the scope and identifies stakeholders, while Parts 6 and 7 map outcomes and present impact values, respectively. Part 8 concludes the study.

1.3. The Research Team

The East, Central and Southern Africa-Health Community (ECSA-HC) contracted Department of Economics of the University of Dar es Salaam to undertake a Social Returns on Investment (SROI) Analysis on Scaling up the Nutrition Competencies of Frontline Workers in Kenya, Uganda and Tanzania. The Department of Economics constituted a team of five researchers to undertake the assignment; these are Dr. Jehovaness Akaeli Urassa (Team Leader), Dr. Innocent Muganyizi Pantaleo, Dr. Hamza Anselm Mkai, Dr. Kenneth Mdadila and Dr. John Kedi Mduma.
In order to successfully accomplish this work, the Team worked in close collaboration with Ms. Rosemary Mwaisaka, Ms. Nomsa Mulima and Ms. Doreen Marandu of ECSA-HC, Dr. Margaret Kabahenda and Ms. Semalie Namukose of the Ministry of Health in Uganda, Ms. Grace Moshi of the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) in Tanzania and Ms. Gladys Mugambi and Ms. Caroline Arimi of Ministry of Health in Kenya.

1.4. About East, Central and Southern Africa-Health Community (ECSA-HC)

East, Central and Southern Africa Health Community (ECSA-HC) is an inter-governmental health organization that fosters and promotes regional cooperation in health among Member States and beyond. ECSA-HC was established in 1974, and has nine active Member States; Kenya, Lesotho, Malawi, Mauritius, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. ECSA-HC is mandated by the Member States to implement programmes aimed at encouraging efficiency and relevance of health services, towards the attainment of the highest standards of physical, mental and social wellbeing of the people of the region. Through partnerships with different institutions, ECSA's activities have also spread to other countries in Africa (i.e. Botswana, Burundi, Eritrea, Ethiopia, Mozambique, Namibia, Rwanda, South Sudan, Seychelles, South Africa and Somalia) to address common health challenges facing the region.

Governance structure of ECSA-HC has five organs, namely: The ECSA-HC health community is governed through five main organs including: (i) ECSA Conference of Health Ministers - this is the highest governing body and which meets annually to review policy matters, national health strategies and to define regional health priorities; (ii) The Advisory Committee – is composed of Permanent Secretaries of the Ministries of Health of Member States, it functions as the Board of Management of the Secretariat; (iii) The Directors’ Joint Consultative Committee – is the highest technical committee composed of Permanent Secretaries, Directors of Health Services, Deans of Medical Schools and other health institutions and heads of Health research institutions; (iv) Programme Experts’ Committees – is a technical committees that draws on expertise from Member States programme managers, external advisors, professional associates and consultants from the region; and (v) The ECSA-HC Secretariat – is the secretariat which is headed by the Director-General,
located in Arusha in the United Republic of Tanzania and is responsible for implementation of the ECSA Health Community's programmes.

For some years now, ECSA-HC has collaborated with partners in the areas of Human resources for Health, Maternal New-born and Child Health, Reproductive Health, HIV/AIDS and Tuberculosis, Nutrition, and health Systems Strengthening.

**Summary of ECSA-HC Technical Capacity Building for Nutrition Project**

Technical Capacity Building for Nutrition Project was piloted in three countries; Kenya, Uganda and Tanzania. The Project objective was to strengthen the ability of the Governments of these countries to build the technical capacity of their front-line workers for the delivery of essential nutrition interventions at health facilities and community level. The rationale for this Project was hinged on the observed problem of limited progress on improving the nutrition situation in Kenya, Uganda and Tanzania, which was recognized by their governments as they committed to scaling up nutrition interventions. One of the main challenges for scaling up nutrition interventions has been the lack of technical capacity of front line workers with limited capacity or knowledge on the "what" and the "how" to deliver key nutrition interventions. This therefore, underpinned the focus of the Project. Building technical capacity for nutrition Project activities was thought in line with the priorities of the 3 governments including plans for scaling up nutrition interventions. Kenya's primary document outlining the consensus on policies, reform measures, projects and programmes, "Kenya Vision 2030"; both “Uganda Visions for 2025 & 2040” and “Tanzania Vision 2025” recognize the importance of nutrition for human development and economic productivity across sectors, and this has been mentioned in the short and medium term national programmes in pursuit of achievement of improved quality of life and wellbeing towards realizing the national visions. Further, all three countries have developed national nutrition action plans, have done costing for the implementation plans and these have been endorsed by highest level of government, respectively.

The Project had three components spelled as: (i) **Building capacity for in-service training on nutrition for community and health workers**; which aimed at supporting development of two in-service nutrition training programmes, one for health facility workers and another for community based workers. Intention was to ensure availability of comprehensive in-service nutrition training packages for health facility workers and community workers; (ii) **building capacity for pre-service training on nutrition for community and health workers**. This in order
to improve the ability of countries to include relevant and high quality training on nutrition in the pre-service training curricula of the various cadres of health workers; (iii) Knowledge exchanges and advocacy for curricula development and adoption. This component consists of various activities to share experiences and lessons learned by stakeholders from Kenya, Uganda and Tanzania, and ensure that the materials produced in components 1 and 2 will be adopted by relevant institutions under support of the governments to guarantee translation of any new knowledge on nutrition into action on the ground.

2. Objectives of SROI Analysis

2.1. Overall Objective
The overall objective of the SROI analysis is to establish whether it is beneficial to scale up competencies of the frontline workforce in the three core economies of East Africa to support implementation of nutrition interventions. The results from the SROI also form the basis for policy decision-making on investing in scaling up nutrition competencies of frontline workforce in other countries in Eastern, Central and Southern Africa. This arises from the broader objective of the project of improving nutrition service delivery with ultimate goal of improving nutrition status in the three East Africa economies aiming ultimately to have well-nourished nations and its associated advantage in both social and economic aspects. Section 1.2.2 of the project document clearly states that “adoption of curricula and training strategy by nursing schools and community worker training programs, and the eventual outcome indicators (improvement in nutrition outcomes for the poor) are the ultimate cumulative aim”.

2.2. Specific Objectives

i. Identify key stakeholders for project intervention;
ii. Identify key intervention outcomes both in the medium and long term;
iii. Mapping of outcome and establishing the theory of change;
iv. Establishing the value of outcome and computing the NPV and the SROI; and,
v. Recommend the possibility of enhancing the intervention beyond preparing the training manuals/model curriculum.

3. Methodology

3.1. Introduction
This assignment was aimed at carrying out a SROI analysis of incorporating nutrition into the pre-service and in-service trainings of frontline workers in Tanzania, Kenya and Uganda. The exercise was undertaken in a period of four months starting 1st of July, 2017. The work was conducted in close coordination with ECSA team and Ministry of Health Focal Persons in three countries. The focal persons’ primary responsibility among others was to assist the research team to get the permit of working with the frontline workers who attended the training workshops in Nakuru and Dar es Salaam. The focal persons were also responsible for providing all the information related to the adoption of the curriculum and coordination of the scaling up processes.
In order to establish the SROI values of the associated net benefits of the intervention, the SROI team developed a conceptual framework including associated assumptions. The associated assumptions informed the process of firming up the theory of change. Moreover, as part of developing the analytical approach, preliminary scoping interviews with one of the focal persons in Tanzania were conducted. These interviews assisted the team in understanding the status of implementation and adoption of the regional nutrition training packages for In-service and Pre-service model nutrition curriculum. The scoping exercise assisted in understanding the nature of nutrition trainings and possible attribution issues since the team were informed of the existence of other stakeholders who have been undertaking nutrition trainings to frontline line workers on specific topics.

By function, SROI is methodology used to value the impact of a program through examining the social, economic and sometimes environmental impact of an intervention. The SROI approach involves number principles as presented in the guide (SROI Network 2012) and in a number of other guides. The principles are:

1. Involve stakeholders;
2. Understand what changes;
3. Value what matters;
4. Include only what is material;
5. Avoid over-claiming;
6. Be transparent; and,
7. Verify the results.

In this study, despite some challenges, efforts were made to ensure adherence to the above principles. To accomplish the SROI work, the researchers:

1. Established Scope and identified key stakeholders;
2. Mapped the outcome with a view to developing the theory of change;
3. Established values of the outcomes/evidencing outcomes; and,
4. Provided the results.

Figure 1: SROI Stages
3.2. Technical approach

In collecting data for conducting SROI analysis, this study used a multi-method Q-square approach. This involved qualitative interview including Focus Group Discussions (FGDs) with community members, Key Informant Interviews (KIIs) with frontline workers and consultation and discussions, both formal and informal with other people such as officials from ECSA-HC, Line Ministries, Ministries of Health from the 3 countries and Training Institutions on Nutrition deemed having important information regarding the development and adoption of ECSA’s model curriculum. A questionnaire was administered to frontline workers that have received Training (as ToT) especially those who could not be reached physically and results from KII, FGD and questionnaires were quantified using several assumptions in order to obtain the informative values. Desk reviews complemented the results obtained through the above discussed approaches. The use of a particular data collection approach depended on the nature of the financial proxy that was required for giving the values. Checklists are attached as Annex 2.

Various questions were included in the checklists/questionnaires ranging from willingness to pay/accept for nutrition services, direct questions on perceived benefits and losses to be incurred as a result of intervention and expected changes in household expenditure that will result from getting the services provided by the trained frontline workers. Due to time and financial constraints, large sample willingness to pay/accept studies could not be feasible, thus we opted to use the Value Game Technique to obtain the value the community attached to the services provided by the trained frontline workers. This could be given a proxy of the consultation fees charged for nutrition services, however, these fees were not easily obtained due to the fact that in these countries nutrition services are mostly provided for free or in subsidized rate by nutritionist in government facilities and by non-governmental organization. The Value Game approach show how stakeholders value the outcomes they expect to experience relative to other items they also value that have market place values (prices).
Table 1: Focus Group Discussions conducted in Tanzania and Uganda

<table>
<thead>
<tr>
<th>Country</th>
<th>Place of FGDs</th>
<th>Number of Participants</th>
<th>Number and Sex</th>
<th>Nature of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uganda</td>
<td>Mulago</td>
<td>6</td>
<td>All Female</td>
<td>Mothers with Malnutrition Kids who recovered and are about to be discharged</td>
</tr>
<tr>
<td>Uganda</td>
<td>Mbarara</td>
<td>9</td>
<td>8 Female 1 Male</td>
<td>Parents attending follow up Nutrition Services after children recovered</td>
</tr>
<tr>
<td>Tanzania</td>
<td>Dar es Salaam</td>
<td>10</td>
<td>6 Female 4 Male</td>
<td>People with HIV cases attending Clinic</td>
</tr>
<tr>
<td>Tanzania</td>
<td>Bagamoyo</td>
<td>11</td>
<td>7 Female 4 Male</td>
<td>Community Members who received nutrition trainings</td>
</tr>
<tr>
<td>Tanzania</td>
<td>Mlandizi</td>
<td>5</td>
<td>All Female</td>
<td>Mothers who received nutrition advices for their Children</td>
</tr>
<tr>
<td>Tanzania</td>
<td>Njombe</td>
<td>8</td>
<td>All Female</td>
<td>Community Members who received nutrition trainings</td>
</tr>
<tr>
<td>Tanzania</td>
<td>Mkuranga</td>
<td>6</td>
<td>All Female</td>
<td>Mothers with new born Babies</td>
</tr>
<tr>
<td>Tanzania</td>
<td>Shinyanga</td>
<td>4</td>
<td>All Female</td>
<td>Parents attending follow up Nutrition Services after children recovered</td>
</tr>
</tbody>
</table>

Lastly, a desk review involved a careful and thorough review of the literature to get an in-depth understanding of how and what has been done so far regarding the project implementation processes in the three countries and outside. Apart from the information obtained in discussion with stakeholders, the review of literature assisted in developing the key indicators, the possible proxies and all social effects. The understanding of these key elements together with understanding the key stakeholders was crucial for the research team to describe the approach and methodology and establish the values of various outcomes.

In any project interventions, there might be issues outside the project objectives that may contribute to what is observed. With this understanding efforts were made to factor in the counterfactual influences. Counterfactual is what would have happened to the participants in an intervention had they not received the intervention. We knew that in order to show that the intervention caused the observed changes we needed to simultaneously show that if the project had not been implemented; the observed changes would not have occurred or would be different. Measuring what would have happened requires entering an imaginary world in which the intervention was never introduced to this group (counterfactual). Given the nature of intervention approach of this project, it was not easier to observe the true counterfactual, but the best that was done was to estimate it by constructing or mimicking it. Thus, attempts were made to ensure that deadweight and attribution effects are estimated. Thus, the checklist included questions that investigated the extent of attribution of the project.
The stream of benefits were discounted in this study hence necessitating finding a discount rate and time horizon for discounting. This is because most of the outcomes especially in health intervention are observed in medium and long term. To establish the time horizon, each outcome under each stakeholder were analysed and the duration under which the outcome was expected to be observed was estimated and used for analysis. In the absence of any empirical evidence to guide the actual discounting rate, existing inflation rates were used for respective countries.

Data collection started in Tanzania followed by physical visit to Uganda. Due to logistical challenges, researchers could not visit Kenya during October 2017 for conducting FGDs but managed to administer the questionnaire through emails and phone calls. Starting the data collection exercise in Tanzania was deliberate since the Team of Researchers resides in Tanzania, thus the Tanzania experience were regarded the main element at providing feedback and solution to field work challenges hence simplifying the work in Uganda and Kenya where the researchers had few days of stay. This approach was very useful in finalization of this work.

3.3. Limitations and Challenges encountered in Conducting Field Survey and Data collection

A number of challenges were encountered during this study. Nonetheless, given experience of the team in undertaking similar studies, and wherever possible, thoughtful solutions were established and implemented to make it a success. In summary, the following challenges were encountered:

i. **Time limitation:** Given the scope of the study of covering three countries and a number of regions in the same countries, logistically, this required much more time than what was available for the field visits. Nonetheless, the team found a way to compensate for a limited time.

ii. **Logistical Challenges:** Scattered locations of respondents where the team had to spend much time to move from one location to the other while faced with time limitation. Delay in disbursement of funds put the team under pressure to secure own money in order to ensure that undertaking of the activities remain within the schedule. Also, a number of stakeholders who participated in Nakuru workshop either no longer use the contacts they provided during the workshop or do not frequently use those contact addresses. This delayed in reaching such beneficiaries in relation to the study. In extreme cases the team was unable to reach them altogether.

iii. **Election and political unrest in Kenya:** This made it impossible for the team to travel to Kenya for safety reasons. Consequently, it was not possible for the team to probe some issues related to nutrition, which cannot be captured by questionnaire but can only be captured by face to face interaction and focus group discussions. Nonetheless, the team made efforts to obtain information from Kenya’s stakeholders using electronic questionnaires and telephone.
iv. **Bureaucracy in getting clearance for undertaking interviews:** Given the standard bureaucracy present in public institutions (in all three countries) and coupled with time limitation, it created additional pressure to the team in sorting out logistical issues. For instance, it was clear that in Kenya, it takes more than one week to clear all the bureaucratic matters given the current set up of governance in the country.

v. **Communication problems:** Language barrier proved challenging in Uganda. While the team is conversant with English and Kiswahili. Most of local communities in Uganda are conversant with neither of the two languages. The team had to depend on a translator to be able to communicate with the subjects especially on Focused Group Discussions. In a way, this required allocating much more time for each FGD and reducing the quality of responses in a process of translating.

vi. **Attaching financial values to unquantifiable items:** Attaching financial values of some social aspects, which in return are meaningful in SROI analysis proved challenging especially due to the nature of the intervention, the team were not afforded with possibilities of conducting large sample survey at community level hence resorted to Value Game Approach. Also the team could not assess community health outcomes as part of intervention outcomes due to the time after intervention. Lastly, not being able to conduct FGD in Kenya necessitated using more assumptions in order to capture information for Kenya.

### 3.4 Ethical Approval

Ethical approval for this work was obtained from the Ministry of Health in Uganda and from the President’s Office-Regional Administration and Local Government in Tanzania under the assistance of the respective country focal persons. Before conducting the Focus Group Discussions oral consent and permission were sought from participants.

### 4. Establishing Scope and identifying key stakeholders

A scope in SROI analysis is an explicit statement about the boundary of what is being considered. The issues that need to be considered include purpose of the SROI analysis, audience of the results, available resources, activities to be included and available time for the intended work. In addition, stakeholders are defined as people or organizations that experience change, whether positive or negative, intentional or non-intentional.

Our approach started with a meeting with the focal person in Tanzania and skype discussions with the ECSA-HC Team. The aim of this initial meeting and discussions was to deliberate further on the technical aspects of this task with a view of underpinning the objectives of the work, scope of work and understanding of key elements with regard to implementation of the project. In this case, preliminary mapping of the key stakeholders was drawn. Also, all relevant materials and literature with regard to the project were mobilized at this stage.

Later, a draft Inception Report was developed and presented in a one-day meeting in Arusha to the ECSA-HC Team. This meeting was very useful at concretizing the methodology and list
of stakeholders. At this stage, the decision to whether there is need to include the final (primary) beneficiaries of the project outcome (i.e. people getting the services of the frontline workers) among the stakeholders in SROI analysis was made. The approaches that were cost saving in terms of financial and time resources were agreed. At the end the stakeholders to be included in data collection were agreed upon by the Research Team and the ECSA-HC Team. The Scope, Stakeholder’s mapping and Decision Making Framework is provided in Table 2.
Table 2: Scope of analysis

<table>
<thead>
<tr>
<th>S/N</th>
<th>Possible Stakeholder</th>
<th>How do they or are affected by the project(^1)</th>
<th>Included/ Excluded</th>
<th>Reason for Inclusion/Exclusion (Rationale)</th>
<th>Method of Involvement i.e. Interview, KII, FGD, Survey Questionnaire, Workshop, Call, Email</th>
<th>When</th>
</tr>
</thead>
</table>
| 1   | ECSA-HC             | • Successful implementation of the fourth and fifth strategic objectives which are; "to strengthen the capacity of Member States for prevention and control of communicable and non-communicable diseases in the ECSA-HC region"; and "to contribute to the improvement of nutrition, food safety and food security in order to attain good health status in ECSA-HC region".  
• Increased recognition by development partners and member states for its efforts to facilitate the knowledge generation and sharing across the ECSA-HC region on various issues related to nutrition | Included | • ECSA has the overall responsibility of ensuring the successful implementation of the project through facilitating knowledge exchanges, preparing pre-service and in-service training curriculum and modules, delivering the same for respective country adoption, monitoring and sharing experience of implementation of the developed knowledge products. | Interview, Phone and Skype Calls, Questionnaire via Email, Validation Workshop | August-October, 2017 |
| 2   | Line Ministries-Ministry of Health from the | • The ministries will have the tools that support the implementation of nutrition | Included | • These are included because of their envisaged role of ensuring adoption of the modules | Face to face Interviews, KII, Calls, Email, | September-October, 2017 |

\(^1\) Some of the expected benefits and costs are provided in Annex 3
<table>
<thead>
<tr>
<th>S/N</th>
<th>Possible Stakeholder</th>
<th>How do they or are affected by the project</th>
</tr>
</thead>
</table>
| 3   | 3 countries          | action plans and promote key nutrition behaviour.  
|     |                      | • There will also be benefit from improved workplace practices and procedures, productivity gains and greater employee flexibility and mobility  
|     |                      | • There will also be saved costs from recruiting external skilled workers  
|     |                      | • This will also simplify organization and facilitate adoption and Training of Trainers |
|     |                      | included/Excluded |
|     |                      | Included/Excluded |
|     |                      | Reason for Inclusion/Exclusion (Rationale) |
|     |                      | Method of Involvement i.e. Interview, KII, FGD, Survey Questionnaire, Workshop, Call, Email |
|     |                      | When |
| 3   | Direct Project Participants—Frontline Workers that have received Training (as ToT) | Improved Income  
|     |                      | Improved knowledge and competencies on key nutrition issues relevant to their context/daily works  
|     |                      | Sense of satisfaction in service provision  
|     |                      | Increased stress and burden in engaging with people on issues beyond their normal jurisdiction  
|     |                      | They will have the tools that |
|     |                      | included |
|     |                      | These are expected to be beneficiary of enhanced knowledge hence well positioned to provide feedback on the need for enhanced capacity building  
<p>|     |                      | This is also the group that will be in direct contacts with people hence have a very important role in ensuring that the nutrition knowledge is well disseminated to the community |
|     |                      | Validation Workshop |
|     |                      | Interview, KII, Call, Validation Workshop and Questionnaire |
|     |                      | September-October, 2017 |</p>
<table>
<thead>
<tr>
<th>S/N</th>
<th>Possible Stakeholder</th>
<th>How do they or are affected by the project</th>
<th>Included/Excluded</th>
<th>Reason for Inclusion/Exclusion (Rationale)</th>
<th>Method of Involvement i.e. Interview, KII, FGD, Survey Questionnaire, Workshop, Call, Email</th>
<th>When</th>
</tr>
</thead>
</table>
| 4   | Community Members/Users of Health Facilities                                       | enhance how they support people on nutrition matters during their daily works  
• Improved workplace practices and procedures, productivity gains and greater employee flexibility and mobility  
• There will also be improved work ethic and lifelong earning  
• Improved communication and customer service skills | Included | • These are people receiving day to day services of the frontline workers hence are among of the direct beneficiary of improved hospital services and enhanced knowledge of the front line workers.  
• In this work this group will provide feedback on whether there are changes in service delivery especially when measuring intermediate outputs and they will highlight how they value the services of the trained frontline workers.  
• These will be picked from FGD | September-October, 2017 |
<table>
<thead>
<tr>
<th>S/N</th>
<th>Possible Stakeholder</th>
<th>How do they or are affected by the project</th>
<th>Included/ Excluded</th>
<th>Reason for Inclusion/Exclusion (Rationale)</th>
<th>Method of Involvement i.e. Interview, KII, FGD, Survey Questionnaire, Workshop, Call, Email</th>
<th>When</th>
</tr>
</thead>
</table>
| 5   | Training Institutions on Nutrition | • The project will provide them with tools that will be used for improvement of their curriculum  
• Facilitate the adoption/adaption of the developed in service package  
• Provide a pool of trainers of trainees | Included | • These are included because of their role on advocating for enhanced nutrition knowledge among health workers and to new students admitted in their colleges and institutions  
• Since they are in teaching institutions they have a role in promoting the use of the Pre-service curriculum then their inclusion and getting their sense of value assist in knowing the expected future benefits of a comprehensive training package | Interview, Call, Questionnaire via Email, Validation Workshop | September-October, 2017 |
| 6   | Donor Community | • Successful implementation of their strategic objectives  
• Increased recognition for their efforts to facilitate the knowledge generation and sharing on various issues related to nutrition | Excluded | • Although responsible for provision of funding, appropriate implementation will only serve little to their daily undertakings. | |
<table>
<thead>
<tr>
<th>S/N</th>
<th>Possible Stakeholder</th>
<th>How do they or are affected by the project</th>
</tr>
</thead>
</table>
| 7   | Nutritionist/Nutrition Officers/Dieticians who did not attend any of the trainings | • Reduced stress and burden in engaging with people since they will have a helping hand with required skills and competences  
• Reduced burden of supervision with the expected improved quality of service provision  
• They will have the tools that enhance how they support people on nutrition matters during their daily  
• There will also be improved workplace practices and procedures, productivity gains and greater employee flexibility and mobility  
• Increased labour force competition |

<table>
<thead>
<tr>
<th>Included/ Excluded</th>
<th>Reason for Inclusion/Exclusion (Rationale)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excluded</td>
<td>• These were not directly involved in the project implementation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Method of Involvement i.e. Interview, KII, FGD, Survey Questionnaire, Workshop, Call, Email</th>
</tr>
</thead>
</table>
5. Engage Stakeholders

Undertaking the SROI analysis requires frequent engagement of stakeholders. Thus, stakeholders need to be involved from the inception stages to finalization of the exercise. Before and after Inception reporting, a scoping exercise was conducted to Tanzania stakeholders especially the focal person at the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC). This exercise was very important and informed the Kenya and Uganda methodology. The country focal persons were engaged throughout the SROI process with a view to continually offering advice and comments on the methodology, potential outcomes and sources of data and plan for feedback presentation to key stakeholders. The scoping exercise assisted to identify and clarify what the SROI analysis would measure and how. During this scoping stage, the purpose, audience, background, resources, activities, population groups, and the timescale to be considered for the evaluation period were agreed upon. During data collection, the Team of Researchers conducted preliminary analysis and verified information and in some cases further information were sought from various stakeholders. After the data collection, a validation workshop, which for SROI studies is an important element for engaging stakeholders, was held in all the three countries and the comments received were used to enrich the report.

6. Mapping the outcome with a view to developing the theory of change

The expected theory of change was discussed within the research team after review of the literature on SROI analysis of nutrition and training projects, review of the project document, discussions with key stakeholders and after scrutinizing the response from FGD and questionnaires.

6.1. Literature review

Social Return on Investment (SROI)\(^2\) approach is commonly used in assessing social and economic outcomes related to programs including nutrition\(^3\), alcoholic health impacts

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\(^2\) The calculation for the SROI is described in this section. Expressed as a ratio of return, it is derived from dividing the impact value by the value of the investment

\(^3\) “Social Return on Investment Evaluation Report Maternal Infant and Young Child Nutrition Project” extensively covers the subject for the case of Kenya
(Banke-Thomas et al. 2015), health and education (CPH, 2013; Martinez et al. 2013), financing small scale loans (FCF, 2013) and social enterprises (SEU, 2010). The key indicators of interest under the SROI include: the SROI rate; deadweight loss; attribution; displacement and drop off. These indicators provide a worthiness of undertaking a program including nutrition programs in terms of the potential social values and economic gains that can be generated.

Studies examining social returns of investment on nutrition have focuses on training frontline workers and community health subjects (see for instance APHRC et al. 2016). Although not quantified, the Conditional Cash Transfer of Tanzania has shown positive outcomes of interventions on health of the community with notable wealth gains in terms of livestock ownership useful for income-generating activities (IIIE, 2017).

In terms of SROI on nutrition, studies generally report a rate above one with notable variations across programs and across countries. The SROI in this regard ranges from 2 to 71, suggesting that local context influences the possible benefits of investing in a nutrition program. Related to training frontline workers on nutrition, the study by CPH (2013) finds an SROI rate of GBP 3.20 on providing training to frontline workers on health and education program. And in the context of CPH, the figure comprises annual salary of a worker with associated costs and the social benefits it brings to targeted community members. Study on Maternal Infant and Young Child Nutrition (MIYCN), a nutritional program in Kenya, finds an SROI of USD 71 representing among highest return on recently conducted studies, this study has reviewed. Other findings of the MIYCN study show that: exclusive breastfeeding increased from 2 percent to 55 percent in the period prior and post intervention; prevalence of stunting for children aged 6-12 months reduced by 3 percent.

Computation of displacement, deadweight loss and drop off has proven challenging in a number of studies. CPH (2013) for instance set the displacement and drop off at zero percent since there were no such cases in period covered in the study. Further, in absence of deadweight and attribution figures CPH assumed a base rate of 50%. In case of Kenya, MIYCN assumed a rate of 5 percent to guide again a possibility of over claim and lack of evidence to allow to estimate drop-off per outcome forced the study to assume a rate of 20 percent on the same, which is derived from the assumption that value of intervention will be zero after 5 years (APHRC et al. 2016). Nonetheless, Martinez and Hayes (2013) finds a deadweight loss of between 10 percent and 50 percent for several of its components reported while MIYCN study for Kenya reported deadweight loss ranging from 5 percent to 100 percent.

6.2. **Theory of Change**

According to APHRC et al. (2016) a Theory of Change is a specific and measurable description of a social change initiative that forms the basis for strategic planning, on-going decision making and evaluation. It represents the belief about causal relationships between certain actions and desired outcomes.
As highlighted before, the expected theory of change was discussed within the research team after review of the literature on SROI analysis of nutrition and training projects, review of the project document, discussions with key stakeholders and after scrutinizing the response from FGD and questionnaires.

Starting from the project document, a fair assessment of the project’s success should be the one done based on the planned outputs including development and adoption of model curriculum. The curriculum developed by ECSA-HC has integrated comprehensively all elements of nutrition and competencies required by frontline workers to enable quality nutrition service delivery. Thus, the regional harmonized training packages and curricula provide an integrated approach and is envisaged that it will save time and resources and enhance nutrition competencies.

From various discussions, we expect the project in the long-run to bring out the society with Children, adolescents, women and men who are better nourished leading to healthier and more productive lives that contribute to economic growth and sustainable development. The knowledge gained by frontline workers enhances their practical knowledge and improves how they handle practical sessions. Also, frontline workers’ knowledge on counselling processes and on how to offer appropriate health services especially on disease prevention and nutrition is improved. The trained frontline workers if they use and impart the knowledge widely, the society will witness adoption of appropriate nutrition behaviours and practices that will improve the health status of the people and reduce the risk and maternal deaths in the three countries.

The focus group discussions revealed that the nutrition knowledge obtained from frontline workers is expected to make mothers and families in general more knowledgeable and skilled in maternal and child nutrition and care, hence improved maternal and child feeding and care practices. This improved behaviour will make mothers and children healthier hence reduce the health expenditures and stress resulting from always sick mothers and children. The healthier families are also expected to increase the amount of time available for productive activities hence increased household income. It is expected that there will be reduced health costs but increased costs for buying nutritious foods. However, the increased food purchase costs are outweighed by the reduced health costs, reduced time on caring for the sick and increased family bond, social cohesion and reduction of the rate of husbands abandoning their family due to excessive sickness.

6.3. Establish values of the outcomes

SROI analysis involves providing the financial values of the costs and benefits of implementing a particular project. In that respect, the outcomes need to be quantified. The outcome can be measurable and non-measurable. For the non-measurable, the financial proxies were determined and quantified using different approaches.

At this stage, the following were done:
   i. Identify all stakeholder’s investments or inputs;
   ii. Identify activity outputs and outcomes for all stakeholders (after developing a theory of change);
iii. Develop indicators to measure the extent/existence of identified outcomes;
iv. Develop financial proxies to value identified outcomes; and,
v. Find out financial values to identified outcomes.

The financial proxies and associated assumptions are summarized in Table 3.

Photo 9: Some of the Community Members playing Value Game during the Focus Group Discussions; From Left are participants at Shinyanga, Tanzania and others group at Mulago Hospital, Kampala Uganda
Table 3: Establishing financial proxies

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Inputs</th>
<th>Outputs</th>
<th>Outcomes</th>
<th>Indicator</th>
<th>Financial Proxy</th>
<th>Assumption</th>
<th>Where did you get the information from?</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECSA</td>
<td>Total Intervention Cost</td>
<td>Pre-Service and In-Service Manuals Developed and Adopted</td>
<td>Outcome 1.1. Increased recognition by development partners and Member states due to successful implementation of SP</td>
<td>Number of New Donor ready to fund/funding and existing donor who has extended funding as a result of successful implementation of SP</td>
<td>Net Revenue Generated/to be generated as a result of ECSA program</td>
<td>The amount of donor funds received for this project times rate of change of the funding structure before this project</td>
<td>ECSA Questionnaire/Authors calculations</td>
</tr>
<tr>
<td>Training Institutions</td>
<td>Number of Students Increased due to referral resulting from improved curriculum and Teaching Practice</td>
<td>Outcome 2.1. Increased recognition by donors and students seeking more nutrition knowledge at all levels including certificate, diploma and degree level</td>
<td>Number of New students applying and admitted on the Nutrition Programmes</td>
<td>Number of New students applying and admitted on the Nutrition Programmes</td>
<td>Fee Structure</td>
<td>The number of students is based on the admitted number of students in nutrition courses for the Universities staffs who participated in the ECSA Trainings</td>
<td>Institution Questionnaires</td>
</tr>
</tbody>
</table>

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*Easter, Central and Southern Africa Health Community (ECSA-HC)*

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<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Inputs</th>
<th>Outputs</th>
<th>Outcomes</th>
<th>Indicator</th>
<th>Financial Proxy</th>
<th>Assumption</th>
<th>Where did you get the information from?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministries</td>
<td>Cost of adopting and capacity building of more staff</td>
<td>Number of Frontline Workers trained and capacity enhanced</td>
<td>Outcome 3.1: Increased willingness of government and Donors to Fund Frontline Workers training on Nutrition</td>
<td>Amount of Fund given/committed by the Government and Donors</td>
<td>The amount the Government is planning to commit for enhancing nutrition knowledge to front line workers.</td>
<td>The base for Tanzania is the Uganda estimated costs and for Kenya is half the Uganda amount since they are ahead in nutritionist number.</td>
<td>Ministry Questionnaire</td>
</tr>
<tr>
<td>Frontline Workers</td>
<td>Number of Direct Participants attended and benefitted in the use of ECSA training Manual</td>
<td>Number of sick person attended</td>
<td>Outcome 4.1: Improved communication and professional development including practical skills of delivery of service</td>
<td>Number of sick person attended</td>
<td>Market Rate Consultation Fee for Nutrition services</td>
<td>That if the services have improved so would be the number of people willing to pay to access the services. The fee is multiplied by the number of sick attended per annum</td>
<td></td>
</tr>
<tr>
<td>Stakeholder</td>
<td>Inputs</td>
<td>Outputs</td>
<td>Outcomes</td>
<td>Indicator</td>
<td>Financial Proxy</td>
<td>Assumption</td>
<td>Where did you get the information from?</td>
</tr>
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<td>----------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outcome 4.2: Increased willingness to work to Attend Nutrition Courses</td>
<td>Number of Frontline Workers who indicated WP to attend the Courses</td>
<td>Amount of Money they are Willing to Pay if requested to do so</td>
<td>The amount a person is willing to pay indicates his/her valuation of the importance of the training</td>
<td>FWs Questionnaire</td>
<td></td>
</tr>
<tr>
<td>Community Members</td>
<td>Increased willingness to be attended by Front line workers</td>
<td>Outcome 5.1: Improved satisfaction of the service delivered by Front line worker</td>
<td>Values placed on each frontline worker</td>
<td>Willingness to Accept losing one of the valuable asset as a replacement of the service</td>
<td>Amount of any valuable item a person is willing to sacrifice in order to get the service of the frontline worker</td>
<td>Value Game</td>
<td></td>
</tr>
<tr>
<td>Knowledge Gained</td>
<td></td>
<td>Outcome 5.2: Improved Nutrition and Health knowledge</td>
<td>Willingness to incur more costs on nutrition</td>
<td>Value of Nutritious Food consumed by household per annum</td>
<td>If the person has knowledge and is valued, will not hesitate to increase the amount of money required for purchase of nutritious foods</td>
<td>Community Members Questionnaires</td>
<td></td>
</tr>
</tbody>
</table>
Thereafter, the data were collected and compiled depending on the nature of the financial proxy using the approaches discussed in the Methodology section. Afterward, the Team of Researchers used its combined skills to process and analyse data and information extracted and collected from different sources.

The analysis involved determining the financial values and proxies, calculating the impact and calculating the SROI and conducting sensitivity analysis (finding out at what happens to make SROI 1:1). To obtain the impact per each outcome and stakeholder, the deadweight, displacement, attribution and drop off values were deducted from the financial proxy values. We attached the duration in each outcome and this assisted in estimating the Net Present Value (NPV) of the Impact using the following formula:

\[
NPV = \sum_{i} \frac{Impact_{value}}{(1+r)^n} - inputs \quad \text{and,}
\]

\[(2) \quad \text{SROI} = \frac{Present\ Value}{Value\ of\ Inputs} \]

\[(3) \quad \text{Net SROI} = \frac{Net\ Present\ Value}{Value\ of\ Inputs} \]

7. Presenting the Impact Values

The impact in this work will be presented in different ways. The perceived impacts are presented per outcome. Later, the quantitative values are calculated based on Equation 1 to Equation 3 are presented.

7.1. Qualitative Response

The following are the perceived results per outcome.

Outcome 1.1. Increased recognition by development partners and Member states due to successful implementation of Strategic Plan (SP)

The findings show that ECSA-HC has gained some degree of profile-raising when it comes to Nutrition intervention. This may in future increase the potential to attract more funding from donors for such initiatives. Below is qualitative extraction from ECSA-HC Questionnaire:

“Although it is difficult to estimate the total amount that we may attract in the future, ECSA-HC still expects some revenue flow in the future as a result of successful implementation of this project. The implementation has enhanced donors’ perception to ECSA-HC as a regional health organization with potential to convene member states and beyond to define their policies, strategies, share lessons/best practices and come up with common solutions which suits all countries context. Although ECSA-HC can still attract more funds even without implementing this project yet the project has helped ECSA to respond to 2017/22 strategic plan, specifically Strategic Objective 1” (ECSA-HC Questionnaire)
Outcome 2.1. Increased recognition by donors and students seeking more nutrition knowledge at all levels including certificate, diploma and degree level

The project has increased recognition by donors and students of the institutions offering nutrition courses at certificate, diploma and degree level. This was revealed during the KII interviews with officials at higher education institutions. Below is an extract of the discussion.

“The process of reviewing the curricula takes time and need involvement of several stakeholders including convincing the regulatory bodies to accept the changes. The way this model curricula for pre-service is designed it offers opportunity to include a comprehensive syllabus in tertiary education since in most training institute the syllabus offers just component of the nutrition contents. After, seeing and attending the ECSA-HC sessions at Dar es Salaam some of the issues are now included in our teaching practice hence overtime there are possibility of attracting more donor funds and increased number of students” (Interview with participants from Makerere University and Kyambogo University conducted at different sessions)

Outcome 3.1: Increased willingness of government and Donors to Fund Frontline Workers trainings on Nutrition

The findings show that governments of the three core economies are supporting the capacity building initiatives and efforts are at advanced stages to adopt the model curriculum. Below is an extract from discussions with Ministry of Health Focal Persons.

“In Uganda and Tanzania there are few Nutritionists hence the governments are now planning for enhancing the nutrition training for frontline health workers as a short term measure. In the long term plans are put in place in these countries to recognize nutritionist among the cadre of government officials and thereafter employ more nutritionists. The countries have adopted the ECSA-HC Model curricula and currently are planning to use the updated manuals for trainings. There is a very big support from the Governments and donors to support these initiatives” (Interview with Focal Persons in Tanzania and Uganda conducted at different sessions)

Outcome 4.1: Improved communication and professional development including practical skills of delivery of service

The trained frontline worker were found to have improved communication and practical skills in delivery of the services. They informed the research team that the training has made them change the way they do things:

“The training improved frontline worker communication and practical skills. Before would think he/she knows everything but when we were subjected to practical tests we were surprised that despite our experience our final score was very low hence showing us the weaknesses in handling practical sessions. Thus, after that we have changed our approaches. One frontline worker said –Knowing
so much about something is also dangerous as it reduces focus and ending up making mistakes hence the ECSA-HC Manual reminded us on being focused and simplified especially during the practical sessions” (Interview with Frontline Workers in Tanzania and Uganda conducted at different sessions)

**Outcome 4.2: Increased willingness to work and to Attend Nutrition Courses**

The findings also show that most of frontline workers are willing to recommend a course of similar contents if someone wishes to take a refresher course on nutrition. The extract below is from discussions with various frontline workers.

“If there are chances of recommending for a similar course I would not hesitate to do so since the course was found to be very useful to most of us. The course provides a room to refresh but for those without prior knowledge it would have been of more value since it is designed in a very simplified way and with focus to practical issues” (Interview with Frontline Workers in Tanzania and Uganda conducted at different sessions)

**Outcome 5.1: Improved satisfaction of the service delivered by Front line worker**

Community members were found to be satisfied with improved service delivery by Front line worker. This is evidenced by the extract from various FGDs:

“Most of these workers communicate well when compared to others since in most cases staffs under them are polite. If others are the ones available most indicated that they rather go back home first and wait the time the respective frontline workers are on duty station” (Interview with Community Members in Tanzania and Uganda conducted at different sessions)

**Outcome 5.2: Improved Nutrition and Health knowledge**

The findings show that as a result of being attended by nutritionist, the nutrition and health behaviours have changes significantly. The extract below is from FGD at various places.

“Most of people had basic knowledge on nutrition especially with regard to balanced diet. However, few knew how to adhere to these requirements when it came to food preparation and eating. Most of the participants were making mistakes on how they prepare their food and how they prepare their child before breast feeding. Attending the sessions with the frontline workers has enhanced their knowledge and as a result people are willing to commit more money in purchasing foodstuffs. Currently, most of them have begun to adhere to the frontline worker’s advice on hygiene and nutrition” (Interview with Community Members in Tanzania and Uganda conducted at different sessions)

**7.2. Quantitative Impact Findings**

This part gives the findings from various calculations comparing the inputs used in this investment, the outcome and the impact. The calculation of figures is based on the actual data obtained from the survey, literature and also based on a number of assumptions. The
SROI calculation requires one to determine the deadweight, displacement, attribution and drop off. Deadweight refers to the extent to which the outcome would have happened without the intervention. All frontline workers (except one with No response) who responded to our question as to whether the changes would have occurred without ECSA training said NO. In this case, the deadweight was at 5% except for the Ministries, ECSA and Training institutions. Attribution is based on the fact that part of the change can be attributed by others. In the changes they experienced, the respondents were asked to give percentages which they perceived to be a result of ECSA efforts. The average (61%) from all responses forms the attribution of the intervention. Displacement refers to the activities which are displaced as a result of the intervention. There was no evidence of any activities displaced by ECSA and the displacement estimated at zero percent. Since the outcomes can be influenced by other factors, we are sure that they will decrease over the period. Since the time period given for this analysis is four years\(^4\), the outcome is expected to be zero in the fourth year and in this case the drop-off was estimated at 25%.

The Social Return on investment (SROI) ratio is given by the value of total outputs divided by the total value of the inputs used. Following our calculations, assumptions and the data given, the total value generated by the investment was USD 3,067,600. We used the 6% which is the average inflation rate of the three countries\(^5\) for September 2017. The Total Present Value for the project was USD 10,483,045 and the Net Present Value is USD 9,662,715.\(^6\) The SROI ratio is therefore USD 10,483,045/820,330 = USD 13: USD 1. The interpretation of these results is that, for every dollar of investment in the ECSA Scaling up Nutrition Competency for Frontline Workers project, USD 13 of social value was created. Table 4 below summarize these results\(^7\). These results are not surprising on account of literature reviewed. In the literatures, SROI ranges from 2 to 71, suggesting that the local context influences the possible benefits of investing in a nutrition program. Related to training frontline workers on nutrition, the study by CPH (2013) finds an SROI rate of GBP 3.20 on providing training to frontline workers on health and education program.

\(^4\) Most of Capacity building programmes ranges from 3 to 5 years of implementation hence the basis for our choice.

\(^5\) Inflation rate was at 7.1, 5.3 and 5.3 respectively for Kenya, Uganda and Tanzania

\(^6\) NPV is Total Present Value minus the total value of all inputs

\(^7\) Details are provided in Annex 1
<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>The Outcomes</th>
<th>Impact</th>
<th>Year 0</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECSA</td>
<td>Outcome 1.1. Increased recognition by development partners and Member states due to successful implementation of SP</td>
<td>341,613</td>
<td>341,613.15</td>
<td>341,613.15</td>
<td>256,209.87</td>
<td>192,157.40</td>
<td>144,118.05</td>
</tr>
<tr>
<td>Training Institutions</td>
<td>Outcome 2.1. Increased recognition by donors and students seeking more nutrition knowledge at all levels including certificate, diploma and degree level</td>
<td>-13,249</td>
<td>-13,249.26</td>
<td>-13,249.26</td>
<td>-9,936.95</td>
<td>-7,452.71</td>
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<td>Ministries</td>
<td>Outcome 3.1: Increased willingness of government and Donors to Fund Frontline Workers training on Nutrition</td>
<td>772,525</td>
<td>772,525.05</td>
<td>772,525.05</td>
<td>579,393.79</td>
<td>434,545.34</td>
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<td>Frontline Workers</td>
<td>Outcome 4.1: Improved communication and professional development including practical skills of delivery of service</td>
<td>1,822,178</td>
<td>1,822,177.64</td>
<td>1,822,177.64</td>
<td>1,366,633.23</td>
<td>1,024,974.92</td>
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<td>Outcome 4.2: Increased willingness to work to Attend Nutrition Courses</td>
<td>12,775</td>
<td>12,775.18</td>
<td>12,775.18</td>
<td>9,581.38</td>
<td>7,186.04</td>
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<td>Community Members</td>
<td>Outcome 5.1: Improved satisfaction of the service delivered by Front line worker</td>
<td>41,162</td>
<td>41,162.06</td>
<td>41,162.06</td>
<td>30,871.55</td>
<td>23,153.66</td>
<td>17,365.24</td>
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<td>Outcome 5.2: Improved Nutrition and Health knowledge</td>
<td>90,596</td>
<td>90,596.27</td>
<td>90,596.27</td>
<td>67,947.21</td>
<td>50,960.40</td>
<td>38,220.30</td>
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<td><strong>TOTAL</strong></td>
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<td>3,067,600</td>
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<td>3,067,600</td>
<td>2,300,700</td>
<td>1,725,525</td>
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<td><strong>PV of each year</strong></td>
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<td>3,067,600</td>
<td>2,893,962</td>
<td>2,047,615</td>
<td>1,448,784</td>
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<td><strong>Total PV</strong></td>
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<td><strong>NPV</strong></td>
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<td>9,662,715</td>
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<td><strong>SROI</strong></td>
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<td><strong>Net SROI</strong></td>
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<td><strong>Discount Value</strong></td>
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<td><strong>Total Cost (USD)</strong></td>
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It is usually the case to establish whether the SROI results would have significant variations should the circumstances changes. In this case, we conducted the sensitivity analysis using some few key impact related variables. Results from the sensitivity analysis indicate the insignificant variation from the original results. Table 5 gives the summary of the sensitivity analysis showing the base and new case scenario plus the new SROI ratio.

**Table 5: Base and New Case Scenario**

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<th></th>
<th>Base Case</th>
<th>New Case</th>
<th>New Ratio</th>
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<td>Attribution</td>
<td>39%</td>
<td>25%</td>
<td>USD 20:1</td>
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<td>Drop off</td>
<td>25%</td>
<td>30%</td>
<td>USD 12:1</td>
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<tr>
<td>Displacement</td>
<td>0%</td>
<td>10%</td>
<td>USD 8:1</td>
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8. Conclusion and Recommendations

The SROI study was conducted for three countries Kenya, Uganda and Tanzania with an objective of establishing the social value of ECSA-HC Programme on Technical Capacity Building for Nutrition. As discussed, the standard technical approaches to SROI analysis were applied to investigate empirically the contribution to the communities of the three countries. While we acknowledge some limitations to this undertaking including the difficulty of accessing some key information from Kenya, this undertaking was successful.

According to qualitative analysis done in this study, without improved nutrition and health knowledge that was imparted by the ECSA-HC project, services outcomes of the involved frontline workers would not have reached the levels observed in the visited facilities and communities focused for this study. The respondents were clearly able to make a difference between the services provided by workers who attended Nakuru training and those who did not, at least over the recent past. Customer care, competence, communication skills and commitment of the frontline workers was proved to have increased.

Although there were other factors that contributed to services improvement than actually the ECSA’s initiative alone, the project features as one of important contributors to notable improvement of services at the facilities and communities of focus. This outcome indicates increased willingness of the three countries’ government to scale up training of frontline workers; and willingness of the workers to pay for such trainings. Nonetheless, the only constraint to payment for the courses was lack of financial resources.

Quantitative SROI values were generally impressive as statistics indicate reasonable gain from each invested dollar, i.e. for every dollar of investment in the ECSA Scaling up of nutrition competency for frontline workers; USD 13 of social value was created. According to experiences from the literature, this is socially a substantial amount of the project value. Results from the sensitivity analysis indicate the insignificant variation from the original results that is showing high reliability of the results that if the project was not implemented, the social outcomes would not have been the same. In a nutshell, implementation of this project had significant socially verifiable returns. It is therefore recommended that the three
countries namely Kenya, Tanzania and Uganda enhance their efforts in adopting the model curricula in their respective countries and train more frontline workers.
Reference

1. Aduragbemi Oluwabusayo Banke-Thomas, Barbara Madaj, Ameh Charles and Nynke van den Broek (2015). Social Return on Investment (SROI) methodology to account for value for money of public health interventions: a systematic review


4. IIIE (2017). What is the impact of a community-managed conditional cash transfer programme in Tanzania? Intervention on health and education through conditional cash transfer


### Annex 1: Outcome Map

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<thead>
<tr>
<th>Source</th>
<th>Indicator</th>
<th>Description</th>
<th><strong>Source of data</strong></th>
<th><strong>Sample size used</strong></th>
<th><strong>Number of persons</strong></th>
<th><strong>Quantity</strong></th>
<th><strong>Financial Theory</strong></th>
<th><strong>Value in SROI</strong></th>
<th><strong>Value with moral support</strong></th>
<th><strong>Value with financial support</strong></th>
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<tbody>
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<td><strong>ECSA</strong></td>
<td>Nutrition</td>
<td>Improved household dietary skill of women</td>
<td>1,626,729</td>
<td>147,214</td>
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<td>9.00</td>
<td>Total Present Value (PV)</td>
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<td>27,169.78</td>
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Annex 2: Checklist – Stakeholders/Institutions

East, Central and Southern Africa – Health Community (ECSA-HC)

Social Returns on Investment (SROI) Analysis on Scaling Up the Nutrition Competencies of Frontline Workers in Kenya, Uganda and Tanzania

Interview Guide – Community Members

Introduction

The team from University of Dar Es Salaam have been contracted by ECSA-HC to conduct a Social Return of Investment analysis of scaling up nutrition competencies of frontline workers in Uganda, Kenya and Tanzania. The results from the SROI analysis will form the basis for policy decision making on scaling up nutrition competences of front line workers in other countries in Eastern, Central and South Africa.

On behalf of the team member I am requesting you to participate in this interview and be assured that the information given will be highly confidential and used solely for this study and not otherwise.

Issues

1. Place: _____________________________________________________
2. Date of Interview: ________________________________

3. What is your understanding on the term “Nutrition”: ____________________________
4. Have you ever been attended by a Nutritionist? If yes, on what specific issues?
5. If no, do you think of attending a specialist on Nutrition?
   a) YES....... 
   b) NO....... 
   5.1. If yes, are you ready to incur any costs for this?

6. Have you ever been attended by ________? a) YES..... b) NO.....
7. Can you remember how many times?___________ (No of Times)
8. How do you compare the services of ____________ now with his/her services in the previous years? ________________________ (extra sheets can be used)
9. In his/her services does he/she introduce you in nutrition related information/issues?
10. Are you satisfied by the services over time? a) YES ..... a) B............
11. For the past few years/months, how do you compare the services of _______ with the rest of the staffs who have attended you in terms of overall services?
12. On nutrition issues? ____________________________
13. Was the nutrition knowledge obtained new or was just to add/refresh to what you already knew before?
14. With your level of nutrition knowledge, do you think even without being attended by _________ you would still have gained more nutrition knowledge? Or do you think without presence of _________ at this place still the nutrition and health service in general would have improved?
15. Is there any additional cost you have spent in order to get the services of _________?
a) YES...... b) NO......
16. If YES, How much? _______________ (in Local currency) Does it differ with the cost when attended by other staffs? If yes, by how much?
17. How much time to you spend getting the services of _____? (in hrs)
18. How does it differ with the time you spend when getting the services of other staffs? How many times per month/annum do you seek the services of _________?
19. How many times per month/annum do you seek the services of other staffs?
20. What do you think _________ does well that no one else does?
21. What other gains do you get by being attended by _________?
22. If someone asks you to pay for the services of ______ how much will you or are you willing to pay for his/her services? How does this differ to the amount you are willing to pay for the services of other staffs?
23. Have you ever evaluated yourself on what changes do you think have resulted or will result from being attended by _________? By other staffs?
24. Why are these changes important for you? Can we measure these or May you estimate the costs saved as a result of these changes or the amount you would be willing to pay to achieve these changes?
25. What percent of these changes you think is attributed/may is attributed by being attended by _________?
26. Would you have achieved the same even without attending the course?
27. If you have not been attended by _______ on nutrition issues, are you willing to attend the nutrition specialist? If yes and you are given a chance to be attended by any nutritionist but required to cover in full the costs of your attendance, how much would you be willing to commit to be attended?
28. Have you ever received any nutritional services by someone else other than ________?
29. We are requesting you to participate in our value game, may please give us some time? If yes, please:
i. Individually please list at least three to four material items that can last at least a year.
ii. Provide the monetary worth of the listed items
iii. Then list the same items in order of priority? From what would make them happiest to least happy.
iv. Then place “satisfaction of the service provided by _____” within the ranked outcomes, again in order of priority.

v. Rank the material items according to their monetary worth for one year, from the most expensive to the least expensive.

vi. Basing on your ranks we will provide the value of “satisfaction of the service provided by _____” and put in its original positions.

vii. Tell us whether you agree with the value of “satisfaction of the service provided by _____”.
Social Returns on Investment (SROI) Analysis on Scaling Up the Nutrition Competencies of Frontline Workers in Kenya, Uganda and Tanzania

Interview Guide - Frontline Workers

Introduction
The team from University of Dar es Salaam have been contracted by ECSA-HC to conduct a Social Return of Investment analysis of scaling up nutrition competencies of frontline workers in Uganda, Kenya and Tanzania. The results from the SROI analysis will form the basis for policy decision making on scaling up nutrition competences of front line workers in other countries in Eastern, Central and South Africa.

On behalf of the team member I am requesting you to participate in this interview and be assured that the information given will be highly confidential and used solely for this study and not otherwise.

Issues
30. Name of Organization/Institution: ______________________________
31. Name of respondent: ______________________ Date of Interview _________________
32. Designation ________________ Sex __________________
33. In your job description, are you supposed to handle nutritional related issues? (Tick the Appropriate)
   a) YES.....
   b) NO .....  
33.1. If YES; what are these nutrition related issues? (Mention at least two-you can use additional sheets)
____________________________________________________________________
33.2. If NO, do you think attending a capacity building course on nutrition issues is relevant to you?
   a) YES.....
   b) NO .....  
33.2.1. If YES; are you ready to use the knowledge in your daily duties?
   a) YES....... 
   b) NO .......
34. Have you ever attended trainings/seminars/workshops/programme on nutrition apart from the one at Nakuru?
   a) YES ..... 
   b) NO ..... (If no go to qn 6)
34.1. If **YES**; What were the main objectives of the organizer of the Event? 
(extra sheet can be used)

34.2. Apart from benefiting from it, had this training added workload in your daily duties?
   a) **YES**
   b) **NO**

34.3. Do you have any idea of what was the cost for each training/seminar/workshop/programme conducted?
   a) **YES**
   b) **NO**

34.3.1. If YES; How Much? ........................................... (in USD or Local Currency)
34.3.2. Who was the Sponsor/organizer? ...........................................................

35. Was the nutrition knowledge obtained (from Nakuru Session) new or was just to add/refresh to what you already knew before? ______________________________

36. Who did you pass over your duties while you were attending the trainings? 
   __________

36.1. Did they receive extra pay by taking over your duties?
   a) **YES**
   b) **NO**

36.2. If yes, please give the estimate of the extra pay; ______________ (USD or Local Currency)

37. How many official hours are you supposed to spend at work? __________ (No of Hours)

37.1. While on duty station, do you earn any extra income apart from your salary?
   a) **YES**
   b) **NO**

37.1.1. If yes, please give the estimate of the extra monthly pay; __________ (USD or Local Currency)

38. While outside your official duties, do you earn extra income from other sources?
   a) **YES**
   b) **NO**

38.1. If **YES**, please give the estimate of the extra monthly pay; __________ (USD or Local Currency)

39. While away in training (Nakuru) do you think it made you lose some income that you would have earned by staying in your duty station?
   a) **YES**
   b) **NO**

39.1. If yes, how much would you have gained by staying (both official and from other sources)? ______________ (USD or Local Currency)

39.2. Apart from direct cost and other expenses not payable to you as a participant, did you have any other financial gain from attending the course?
   a) **YES**
   b) **NO**
40. What contextual underpinning of the training outcomes specific to your working environment?

__________________________________________________________________________

(Extra sheet can be added)

41. Do you have off-days in your work per week/month?
   a) YES....
   b) NO.....
41.1. If YES, how many days? _______________ (in days)
41.2. Are there any possibilities that you can volunteer or being forced to attend to work while in your off days?
   a) YES......
   b) NO....... (go to 12.3)
41.2.1. If YES, can you estimate how many days per month you attend work while in your off-days? __________ (in Days) (indicate whether volunteer, or requested)

41.3. If NO, would you be willing to provide extra time to work while in your off-days?
   a) YES.....
   b) NO......
41.3.1. If YES, how much would you be willing to accept for the additional hour of your off-day/extra time spent at work?

42. If you were the final beneficiary of the services of a trained official (FW) at NAKURU, how much would you be willing to pay for consultation per hour from the service provider? ________________ (USD or Local currency per hour)

43. Have you ever evaluated yourself on what changes do you think have resulted or will result from attending this training or these types of trainings?
   a) YES......
   b) NO......
43.1. If YES what are these changes?

43.2. Why are these changes important to you? __________________ (can be summarized in extra sheet)

43.3. Can you give the value of these changes in term of cost saved __________ or amount you would be willing to pay? __________ (USD or Local currency per hour)

43.4. What percent of these changes do you think is attributed/may be attributed by you attending the nutrition training (like ECSA In service nutrition training) _______________ (in percentage)

43.5. Would you have achieved the same even without attending the course/training?
   a) YES.....
   b) NO......

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8 These can be in 1. Working capacity 2. Less time in accomplishing a number of duties 3. Acceptance rates by your colleagues 4. Communication and advocacy capacity 5. Increased stress 6. Increased workload 7. Job flexibility 8. Mobility e.t.c
43.6. Is there any new **training or duties** that you have been engaged in which is a result of you attending the NAKURU Training?
   
   a) YES......
   
   b) NO....... *(go to 14.5.20)*

43.6.1. If **YES**, is there any financial gain you obtained in that and how much?

43.6.2. If **NO**, do you expect any involvement in new training or duties in the future as a result of successful attendance of the course and why?
   
   a) YES......
   
   b) NO......

43.6.2.1. If **YES**, can you give the estimate of how much you may receive as financial gain of attending a new course or duty? *(in USD or Local Currency)*

44. How do fellow staffs and people you serve perceive you and your services especially when compared to a period before you attended the NAKURU -ECSA training? *(can be summarized in extra sheet)*

45. Do you think you would still have received more recognition from fellow staffs and people you serve even without attending this training?
   
   a) YES......
   
   b) NO......

45.1. How much and at what percent of increase? ____________ *(in percentage)*

46. Assume now you have been given the chance to attend this training course on nutrition using the **in service** packages developed by ECSA; How much would you be willing to pay in full *(for the same period)* to attend this training if you were able and required to pay for it by yourself? ____________________________ *(give your valuation in USD or local Currency)*

47. How many people **(with nutrition related needs)** do you attend per day *(average number)*

48. Is there any activity that you think may still influence the outcome regardless of the training?
   
   a) YES.....
   
   b) NO.....

48.1. If **YES**, mention few ____________________________

49. Have you received any other nutrition related training from other stakeholders?
   
   a) YES......
   
   b) NO......

49.1. If **YES**, What were the objectives of the training?

49.2. When did you attend? ________________ *(days/month/year)*
East, Central and Southern Africa – Health Community (ECSA-HC)

Social Returns on Investment (SROI) Analysis on Scaling Up the Nutrition Competencies of Frontline Workers in Kenya, Uganda and Tanzania

Interview Guide- ECSA

Introduction
The team from University of Dar es Salaam have been contracted by ECSA-HC to conduct a Social Return of Investment analysis of scaling up nutrition competencies of frontline workers in Uganda, Kenya and Tanzania. The results from the SROI analysis will form the basis for policy decision making on scaling up nutrition competences of front line workers in other countries in Eastern, Central and South Africa.

On behalf of the team member I am requesting you to participate in this interview and be assured that the information given will be highly confidential and used solely for this study and not otherwise.

Issues
50. Name of Organization/Institution: ______________________________
51. Date of Interview: ______________________________

52. The organization has provided support to meet the project objectives: What is the duration of the project? ________________ (Years, Months etc)

53. How is the project implemented? ________ (extra sheet can be used)

54. How many staff were involved during the implementation? ___________ (Numbers)

55. May you provide the total cost of implementation committed to date and that is expected to be committed by end of the project by your organization in order to achieve the intended project objectives ____________ (the budget showing each coast item)

56. What contextual underpinning of this project outcomes specific to ECSA’s working environment ________________ (extra sheet can be used)

57. Are there any staffs in your organization fully committed to work on the project?
   a) YES....... 
   b) NO....... (go to 8.2)
57.1. If **YES**, does this form part of the cost provided in 6?
   a) **YES**.....
   b) **NO**.....

57.2. If his/her costs are not part of 6, can you provide the cost of his/her engagement *(in term of salary or other benefits)*

58. Is there any staff(s) in your organization who is engaged on the project in part time basis?
   a) **YES**......
   b) **NO**......

58.1. If **YES**, does this form part of the cost provided in 6?
   c) **YES**.....
   d) **NO**.....

58.2. If this costs are not part of 6, can you provide percentage of salary and allowances to cover for his/her part time engagement *(in term of salary or other benefits)*

58.2.1. Can you provide us with the estimates of the values of these costs for the whole project duration? ____________________ *(in USD or local Currency)*

59. Have you ever conducted evaluation after the *training/seminar/workshop* to see whether they had the expected impact?
   a) **YES**...... *(Share the evaluation Report).*
   b) **NO**......

60. If you were the final beneficiary of the services of a **trained official (FW)** at NAKURU, how much would you be willing to pay for consultation per hour from the service provider? ____________________ *(USD or Local currency per hour)*

61. Since your organization has started implementing this project, is there any project that your organization has attracted as result of this project?
   a) **YES**......
   b) **NO**......

61.1. If **YES**, What net revenue excluding the revenue of this project has your organization attracted since this project was launched?

61.2. Can you estimate the number of donors who have provided revenue at ECSA as a result of implementing the project?

61.3. If no donor funds have been received as of now, do you expect any revenue flow in the future as a result of successful implementation of this project?
   a) **YES**......
   b) **NO**......
61.3.1. If YES, give the estimate of how much you may receive from new donor or existing donors ________________ (in USD or local Currency)
61.3.2. If NO, what might be the reason? ________ (extra sheet can be used)

62. What amount of donor fund ECSA received (in Nutrition related activities/programs) per annum before the implementation of this project? ________________ (in USD or local Currency)

63. Is there any donor who have ever provided the fund and renewed their support after initial support?
   a) YES.....
   b) NO......

64. How do donors perceive your organization especially when compared to a period before ECSA started implementing this project? ________________ (extra sheet can be used)

65. Do you think the organization would have still received more fund even without implementing this project?
   a) YES.....
   b) NO......
   65.1. How much and at what percent of increase?

66. What changes⁹ in your organization do you think have resulted or will result from implementing this project? ________________ (extra sheet can be used)

67. Why are these changes important for your organization? __________ (extra sheet can be used)
   67.1. Can you evaluate these changes in term of costs saved as a result of these changes or in term of the amount ECSA would be willing to pay to achieve these? ________________ (in USD or local Currency)

68. Is there any activity(s) that you think may still influence the outcome of this project? and how important are these to the project?
   a) YES.....
   b) NO......
   68.1. If YES, mention few_________
   68.2. Give the percentage of their contribution toward achieving the outcome __________ (in percentage)

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⁹ These can be in organizational capacity, costs in writing proposals over time, number of days in writing and complete proposals, less use of external support in accomplishing a number of duties, acceptance rates, communication and advocacy capacity etc.
East, Central and Southern Africa – Health Community (ECSA-HC)

Social Returns on Investment (SROI) Analysis on Scaling Up the Nutrition Competencies of Frontline Workers in Kenya, Uganda and Tanzania

Interview Guide—Institutions/organizations

Introduction

The team from University of Dar es Salaam have been contracted by ECSA-HC to conduct a Social Return of Investment analysis of scaling up nutrition competencies of frontline workers in Uganda, Kenya and Tanzania. The results from the SROI analysis will form the basis for policy decision making on scaling up nutrition competences of front line workers in other countries in Eastern, Central and South Africa.

On behalf of the team member I am requesting you to participate in this interview and be assured that the information given will be highly confidential and used solely for this study and not otherwise.

Issues

69. Name of Organization/Institution: ______________________________

70. Date of Interview: ______________________________

71. Has your organization received support/ worked with ECSA to enhance capacity on nutrition issues?
   a) YES....
   b) NO.....

71.1. What was the duration of that support? ___________ (days, months or years)

71.2. What kind of support did you receive? __________________

71.3. How many staff members involved? _____ (Numbers)

72. What is your view on the ECSA-HC Pre-Service model curricular?

73. What contextual underpinning of this project outcome specific to your institutions’ working environment? ____________ (extra page can be used)

74. Have you ever conducted evaluation after the pre-service workshop to see whether they had the expected impact/ or will have the intended impact if the package integrated in the teaching curricula?
   a) YES......
b) NO........

75. You are part of the member attended the validation workshop on the pre-service package developed by ECSA. What do you think will be the appropriate fees for trainee/student who is expected to receive this kind of model package per semester / or academic year? __________________________ (USD or local currency)

76. What changes in your organization do you think will result from adopting and teaching using this model curriculum? __________________________ (extra sheet can be used). 

77. Why are these changes important for your organization? ____________ (extra sheet can be used).

78. Can you evaluate these changes in term of costs saved as a result of these changes or in term of the amount your institution would be willing to pay to achieve these changes? __________________________ (in USD or local Currency)

79. What are the plan for adopting the curriculum in your institutions? ________________________________

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10. These can be in organizational capacity, less use of external support in accomplishing a number of duties, acceptance rates, communication and advocacy capacity, improved workplace procedures etc
East, Central and Southern Africa – Health Community (ECSA-HC)

Social Returns on Investment (SROI) Analysis on Scaling Up the Nutrition Competencies of Frontline Workers in Kenya, Uganda and Tanzania

Interview Guide - Ministries

Introduction
The team from University of Dar es Salaam have been contracted by ECSA-HC to conduct a Social Return of Investment analysis of scaling up nutrition competencies of frontline workers in Uganda, Kenya and Tanzania. The results from the SROI analysis will form the basis for policy decision making on scaling up nutrition competences of front line workers in other countries in Eastern, Central and South Africa.

On behalf of the team member I am requesting you to participate in this interview and be assured that the information given will be highly confidential and used solely for this study and not otherwise.

Issues
80. Name of Organization/Institution: ______________________________
81. Date of Interview: ___________________________________________

82. Has the Ministry received any support/project from ECSA to enhance capacity on nutrition issues?
   c) YES....
   d) NO.....
82.1. What was the duration of that support? ____________ (days, months or years)
82.2. What kind of support did you receive? __________________
82.3. How many staff members involved? _____ (Numbers)
82.4. Was there any costs incurred by your institutions?
   a) YES......
   b) NO....... 
82.5. IF YES, what kind of cost and how much was that cost? ____________ (in USD or domestic currency)
83. What contextual underpinning of this project outcome specific to your institutions’ working environment? ________________ (extra page can be used)
84. Is there any staff in the ministry who was engaged during the ECSA support period on the part time basis?
   a) YES......
   b) NO......

84.1. If yes, what percent of his/her salary & allowance & other costs is estimated to compensate for his engagement time? ____________ (in USD or domestic currency)

85. How does the Ministry take care of the gaps resulting from one of the staffs attending ECSA the training/workshop etc? ________________ (extra page can be used)

85.1. Are there monetary values involved such as paying extra duty allowances or overtime for those who take cover?
   a) YES......
   b) NO......

85.1.1. If yes, how much? ________________ (in USD or domestic currency)

86. Have you ever conducted evaluation after the training/seminar/workshop to see whether they had the expected impact?
   c) YES...... (share the evaluation Report)
   d) NO.......

87. If you were among the Frontline workers and you are given a chance to attend the training on nutrition using the in-service package developed by ECSA/and adopted by the government; and you are able and required pay by yourself, how much would you be willing to pay attend such a course? ________________ (USD or local currency)

88. If you were among the Frontline workers and you are given a chance to attend the training on nutrition using the pre-service package developed by ECSA; and you are able and required pay by yourself, how much would you be willing to pay attend such a course? ________________ (USD or local currency)

89. Since you are among the participating ministry partly as technical and now adopted the curricular developed with ECSA support, is there any project that the ministry has attracted as result of this project?
   a) YES......
   b) NO......

89.1. If YES, What were the project objectives?

89.2. Can you give the estimate the costs/value of this project? __________ (USD or local currency)

89.3. What net Fund excluding the fund from ECSA support since this project was launched?

89.4. May you estimate the number of donors who have provided fund at your organization after adopting the curricular?
89.4.1. If no donor funds have been received as of now, do you expect any 
future fund flow as a result of successful implementation/and adoption of 
this harmonized curricular for in service and pre-service? 
a) YES......
b) NO......

89.4.2. If yes, can you give the estimate of how much you may receive from 
new donor or existing donors? ______________________ (USD or local currency)

89.4.3. If NO, what do you think are the reasons?________ (extra sheet can be used)

90. What amount of donor fund the ministry received per annum on nutrition related 
activities before you engagement with ECSA? ______________________ (USD or local 
currency)

91. Is there any donor who have ever provided the fund on nutrition issues and renewed 
their support after initial support?
a) YES......
b) NO......

92. How do donors perceive the ministry especially when compared to a period before ECSA 
started supporting you and adoption of the curriculum?__________________ (extra sheet can 
be used).

93. Do you think the ministry would have still received more fund even without the ECSA 
support and adoption of the curricula?
a) YES....... 
b) NO.......

93.1. How much and at what percent of increase? ______________ (in percentage)

94. What changes11 in your ministry do you think have resulted or will result from 
implementing and adoption of this support? ______________________ (extra sheet can be used).

95. Why are these changes important for your organization?________ (extra sheet can be used). 

95.1. Can you evaluate these changes in term of costs saved as a result of these 
changes or in term of the amount your institution would be willing to pay to 
achieve these? ______________________ (in USD or local Currency)

96. Is there any activity (s) that you think may still influence the outcome of this project? and 
how important are these to the project? 
c) YES.....
d) NO......

96.1. If YES, mention few __________

96.2. Give the percentage of their contribution toward achieving the outcome __________ 
(in percentage)

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11 These can be in organizational capacity, less use of external support in accomplishing a number of duties, acceptance 
rates, communication and advocacy capacity, improved workplace procedures etc
97. In scaling up nutrition initiative, does the ministry plan to enhance capacity of more staffs other than the one who were originally planned?
   a) YES.....
   b) NO......

97.1. If yes, how many staffs do the ministry plan to include to scaled up capacity building? ___________ (Numbers)

97.2. What is an approximate cost of scaling up? __________ (in USD or local Currency)

97.3. Who are expected participants/partners? __________ (in USD or local Currency)

97.4. How much will your organization be willing to accept from one participant as part of the costs for enhancing the capacity? (in USD or local Currency)

98. What are the plan for adopting the curriculum and enhancing capacity building for frontline workers in your country ______________________________