

# Impact Evaluation of Thailand-UNFPA South-South and Triangular Cooperation and Safe Birth for All Project



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All research findings in this report reflect only the author's personal opinion, which does not necessarily agree with the official position of the United Nations Population Fund (UNFPA) on the same topic.

**Research Report**  
**Impact Evaluation of Thailand-UNFPA South-South and Triangular  
Cooperation and Safe Birth for All Project**

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รายงานวิจัยฉบับสมบูรณ์  
การประเมินผลกระทบโครงการความร่วมมือไตรภาคีแบบใต้-ใต้และโครงการ  
การพัฒนาและส่งเสริมการเกิดอย่างมีคุณภาพและถ้วนหน้า

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จัดทำโดย รองศาสตราจารย์ ดร. ทัชเฉลิม สุทธิพงษ์ประชา  
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## Executive Summary

The burden of maternal morbidity and mortality is borne not only by mothers and their children, but also by their respective families and communities. Expanding reproductive, maternal, newborn, and child health (RMNCH) services—particularly antenatal care and skilled childbirth services—is an important strategy to achieve the United Nations Population Fund’s (UNFPA) transformative goals and the Sustainable Development Goals (SDGs). This report presents an analysis of the social returns of two South-South and Triangular Cooperation (SS/TC) projects by the United Nations Population Fund (UNFPA) Thailand Country Office and its partner government agencies from Thailand and Lao PDR: the “Safe Birth for All” and “Midwifery Capacity Development” projects. All the stakeholders were consulted to understand all the possible impacts (or changes) due to the projects. These outcomes were given a financial value based on the value of the benefits or costs saved through a reduction of negative and undesirable outcomes for the stakeholders. When the financial costs were not applicable, proxies were used to measure the value, informed by research and stakeholder consultation. This method ensures that all the important outcomes were measured and included in the project impact assessment. Measurable indicators were developed to assess whether the change has happened, how much of the change could be accounted for by each project, and how long the impact lasts.

Based on the social return on investment (SROI) analysis, the “Safe Birth for All” project resulted in 2,100 pregnant women receiving early antenatal care in their first trimester and 4,100 at-risk pregnant women and their families receiving COVID-19 antigen tests. In the target areas, 2,230 adolescent mothers (6.30 percent) gained access to family planning and long-acting reversible contraceptives (LARC), and 30,000 teens could access the virtual health self-assessment platform supported by the project. The “Midwifery Capacity Development” project provided opportunities for 52 participants (42 midwifery educators and 10 midwifery education administrators) from Lao PDR to attend training courses at Khon Kaen University. Upon project completion, 93 percent of the participants had higher self-confidence about their profession. The project also led to a 63-percent increase in the project participants’ capacity to contribute to their organizations, a 29-percent increase in employability prospects for the project participants, and a 24-percent increase in the project participants’ capacity to

contribute to their communities. Further, this study identified that 6,235 midwives between 2016 and 2022 across Lao PDR received training from the midwifery educators who participated in this project. As a result, 43,780 women of reproductive age (e.g., pregnant women, adolescent girls, young mothers) could gain access to improved RMNCH services.

Further, the SROI analysis demonstrated that investment in SS/TC projects on RMNCH generated high social returns. For the “Safe Birth for All” project, every one dollar in investment led to US\$ 35.93 of social value. Also, every one dollar that was invested in the “Midwifery Capacity Development” project for Lao midwifery educators and midwifery education administrators created US\$ 13.03 of social value. Based on a systematic review of SROI studies by Banke-Thomas et al. (2015), the range of SROIs found from RMNCH programs were between 1.73 and 21.20. The SROI ratio from the “Safe Birth for All” project was higher than this range, while the “Midwifery Capacity Development” project generated SROI that fell within this range.

In terms of relevance and effectiveness, the two SS/TC projects on RMNCH were demand-driven initiatives that were designed, developed, and executed according to each country’s social context and health needs. The “Midwifery Capacity Development” project equipped the Lao midwifery educators with all the necessary teaching skills that satisfied the International Confederation of Midwives and the World Health Organization’s (ICM-WHO) standards. Trained midwifery educators had higher self-confidence and were able to impart their midwifery knowledge and skills to midwives and nursing students in their areas. The trained midwifery education administrators and their institutions also benefited from the training curriculum and from more knowledgeable and confidence midwifery teachers. As a result of this project, Lao PDR’s improved midwifery workforce accelerated the progress of realizing the UNFPA’s transformative goals and SGDs (Goal 3 “Good Health and Wellbeing”). Similarly, the SS/TC on RMNCH in Thailand—the “Safe Birth for All” project—represents a promising platform for UNFPA to mobilize financial support from private and non-profit organizations. Not only did the project helped women of reproductive age in the rural areas gain access to quality RMNCH services, it also provided the rural birth attendants in Thailand with the opportunity to improve their skills and knowledge.

From the above findings, it is recommended that:

1. This SROI analysis lends strong support to the continuation of the two SS/TC initiatives. For the design of a future SS/TC initiative with a high social return, UNFPA Thailand Country Office ought to consider two following features: (1) Any health-related interventions should be demand-based. Stakeholders, particularly the primary beneficiaries, must be involved in the project design and implementation; and (2) Thailand's strengths, expertise, and resources must be developed and used to their full potential. UNFPA Thailand Country Office ought to work with Thailand International Cooperation Agency (TICA) on constantly updating its catalog of training curriculum and SS/TC assistance packages for developing countries.

2. UNFPA Thailand Country Office should explore collaborative opportunities with other philanthropic organizations and government agencies (e.g., Ministry of Interior and local administrative organizations). The Ministry of Interior and local administrative organizations in particular have expanded their health-related functions, including primary care provision, due to the national government's decentralization policy. Engaging with the interior ministry and local governments would not only help to mobilize more resources for the SS/TC initiatives, but also facilitate scaling up of access to RMNCH services in other remote areas.

3. UNFPA Thailand Country Office could also embed and promote multi-agency practice at an operational level to inform service planning and delivery. Potential partner agencies include, but are not limited to, the military, schools, and youth councils that operate under the aegis of the Ministry of Social Development and Human Security.

4. Refresher training were extensively mentioned throughout the focus group discussions with participants from the "Safe Birth for all" and "Midwifery Capacity Development" projects. This would help participants review and reinforce their knowledge from the initial training. UNFPA Thailand Country Office could collaborate with the implementing agencies (e.g., Khon Kaen University in the "Safe Birth for All" project) in developing a virtual knowledge exchange platform and in using online learning tools to provide refresher training for participants in the SS/TC initiatives.

5. While SROI analysis is a powerful tool to measure the changes experienced by stakeholders in the SS/TC initiatives, more systematic monitoring and evaluation of long-term outcomes could provide more insight into the consequences – both positive and negative – of the interventions. UNFPA Thailand Country Office should first help its partner agencies, particularly in the Thai government, to embed the SROI analysis in monitoring and evaluating the SS/TC initiatives. Second, an open monitoring and evaluation system empowered by digital technology should be developed to allow for real-time tracking of the SS/TC activities and development outcomes.

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## List of Abbreviations and Symbols

ABR	Adolescent Birth Rate
CBA	Cost-benefit Analysis
CEA	Cost-effectiveness Analysis
CUA	Cost-utility Analysis
DOH	Department of Health of Thailand
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development
Lao PDR	Lao People's Democratic Republic
LARC	Long-acting Reversible Contraception
MMR	Maternal and Mortality Rate
REDF	Roberts Enterprise Development Fund
RMNCH	Reproductive, Maternal, Newborn, and Child Health
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SROI	Social Return on Investment
SS/TC	South-South and Triangular Cooperation
SBA	Skilled Birth Attendants
TBA	Traditional Birth Attendants
TICA	Thailand International Cooperation Agency
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
VfM	Value for Money
VHV	Village Health Volunteer
WTP	Willingness to Pay

# Chapter 1

## Introduction

Regular utilization of reproductive, maternal, newborn, and child health (RMNCH) services helps achieve a significant reduction in maternal morbidity and mortality (Kifle et al., 2017). When mothers receive inadequate maternity care and become ill or malnourished, their children also face high morbidity and mortality risks (Tinker, 2000). However, the burden of maternal morbidity and mortality is borne not only by mothers and their children, but also by their respective families and communities (Nathan et al., 2015). Thus, expanding RMNCH services—particularly antenatal care and skilled childbirth services—has been an important global movement to improve pregnancy outcomes and reduce maternal mortality (Steinbrook et al., 2021). In order to save and support vulnerable adolescent girls and young women during critical times, RMNCH should be continuous and comprehensive, encompassing health promotion, disease prevention, screening, diagnosis, to childbirth in the care of properly trained healthcare professionals.

This chapter begins with an overview of the background and rationale behind the social return on investment (SROI) analysis of the two RMNCH service projects funded by the United Nations Population Fund (UNFPA) Thailand Country Office and its partners. The research objectives, conceptual framework, and methodology are also discussed.

### 1.1 Background and Rationale

Since the International Conference on Population and Development (ICPD) in 1994, remarkable progress has been made in reproductive, maternal, newborn, and child health (RMNCH) in developed and developing countries. Yet, inequitable access to essential RMNCH services in developing countries complicates progress for certain population groups, such as vulnerable adolescent girls and young women in poor and rural communities. As past research indicates, the major epidemiological factors leading to maternal morbidity and mortality are hemorrhage, hypertension, and sepsis (Ali et al., 2011; Say et al., 2014). In developing countries, inadequate antenatal care, low healthcare-seeking behavior among adolescent girls and young women, and a shortage of skilled healthcare professionals were

the important reasons for the high maternal and infant mortality in the first two decades of the 21<sup>st</sup> century (Berhan & Berhan, 2013).

RMNCH services require significant public investments and can cause undue fiscal burdens on the government sector in developing countries. However, recent studies have made a strong economic case for investment in RMNCH services by demonstrating the positive impacts on individual and community health and well-being (Hladik et al., 2009; Singh et al., 2013). Thus, international donor agencies, private firms, and non-governmental organizations (NGOs) have adopted a variety of financial measures to enable developing countries to provide high-quality RMNCH care for the marginalized populations in rural areas. For instance, Thailand and Lao People's Democratic Republic (Lao PDR) have forged sustainable partnerships with United Nations Population Fund (UNFPA) on a number of programs/projects to improve RMNCH services in their respective countries. For example:

- 1. The Safe Birth for All program** – began from October 1, 2020 to December 31, 2021. The project covered eight districts in three provinces along the Thailand-Myanmar border, which were selected as high-potential areas for maternal death. UNFPA Thailand country office collaborated with Reckitt and the Department of Health of Thailand (DOH) on this project to improve reproductive rights for vulnerable women, girls, and adolescents. Three interventions were implemented: (1) improving the national and sub-national maternal health surveillance system, (2) building institutional capacity development on maternal health care and service in normal situations and during the COVID-19 pandemic, and (3) promoting the replication of good practices and innovations in other high-risk areas and countries through South-South and Triangular Cooperation (SS/TC).
- 2. The SS/TC Midwifery capacity development program** – took place from 2015-2017 in Lao PDR and focused on developing needs-based and participatory midwifery curricula, including: (1) a four-month course for managers of midwifery schools and colleges, and (2) a six-month training for two batches of midwifery educators. Midwifery education materials and monitoring guidelines were developed throughout the program.

In an era where transparency and accountability are of paramount importance for every organization, there is an increasing need and demand from society to provide an account of the socio-economic value from all the organizational activities and investments (Maldonado & Corbey, 2016). Traditional investment appraisal techniques, such as Net Present Value (NPV), Internal Rate of Return (IRR), and Return on Investment (ROI), take a narrow financial focus by excluding from the calculation any costs or revenues deemed irrelevant to an investment project (Bamber & Parry, 2014). For instance, ROI, which can be estimated using a ratio between the NPV of benefits and the NPV of costs, only accounts for pecuniary value derived from market prices, while neglecting the value from investments advancing the public good (Vishwanath, 2007; Gargani, 2017). As such, a country's capacity development program for healthcare professionals in another country may help to foster their sense of ownership and empowerment. However, these positive effects may not be readily reflected in a traditional investment appraisal like ROI. In an even worse scenario, when applying a traditional investment appraisal approach to an SS/TC capacity development program, these effects are referred to as "qualitative" and may result in a negative NPV for the donor countries.

Nevertheless, with a pressing demand from society to incorporate the unquantifiable or "qualitative" effects, alternative program assessment approaches have been developed to account for the financial and non-financial effects of value creation in the short, medium, and long term, as well as the potential negative effects that cannot be translated into monetary terms. Social Return on Investment (SROI) is one of these alternative approaches intentionally designed to capture the "social value" generated by investment programs (Krlev, Muscher, & Mulbert, 2013). Formulated by the Roberts Enterprise Development Fund (REDF) in the United States, SROI was first used to assess the social value of the Fund's employment service program (Millar & Hall, 2013). The original purpose of SROI was to analyze the unreported benefits of work integration programs typically overlooked by the traditional investment appraisal method (Banke-Thomas et al., 2015). Similar to ROI, SROI still compares the NPV of benefits to the NPV of the investments, but it does so by assessing the diverse range of value generated beyond the narrow pecuniary dimension (Gargani, 2017). Thus, a more holistic concept of value was adopted in the SROI framework by emphasizing the financial value of a program, as well as the unmonetizable value that stakeholders experience through changes

in their lives. As Nicholls and colleagues (2012) note, SROI is “a framework for measuring and accounting for a much broader concept of value; it seeks to reduce inequality and environmental degradation and improve wellbeing by incorporating social, environmental, and economic costs and benefits” (p. 8).

Using the SROI framework, this report attempts to evaluate the two RMNCH programs funded by the DOH, the Lao PDR Ministry of Health, and UNFPA Thailand Country Office. Apart from analyzing the socioeconomic value created by the two programs, this study also offers recommendations gathered from program participants in Thailand and Laos PDR for the UNFPA Thailand Country Office and its partner countries.

## **1.2 Research Objective (s)**

1.2.1 To use the Social Return on Investment (SROI) framework to assess the impacts of two RMNCH programs: (1) the Safe Birth for All program by DOH and UNFPA Thailand country office, and (2) the Lao PDR midwifery program funded by Thailand-UNFPA South-South and Triangular Cooperation.

1.2.2 To provide recommendations for the UNFPA Thailand Country Office and its partner agencies on program improvement and potential collaboration opportunities.

## **1.3 Conceptual Framework**

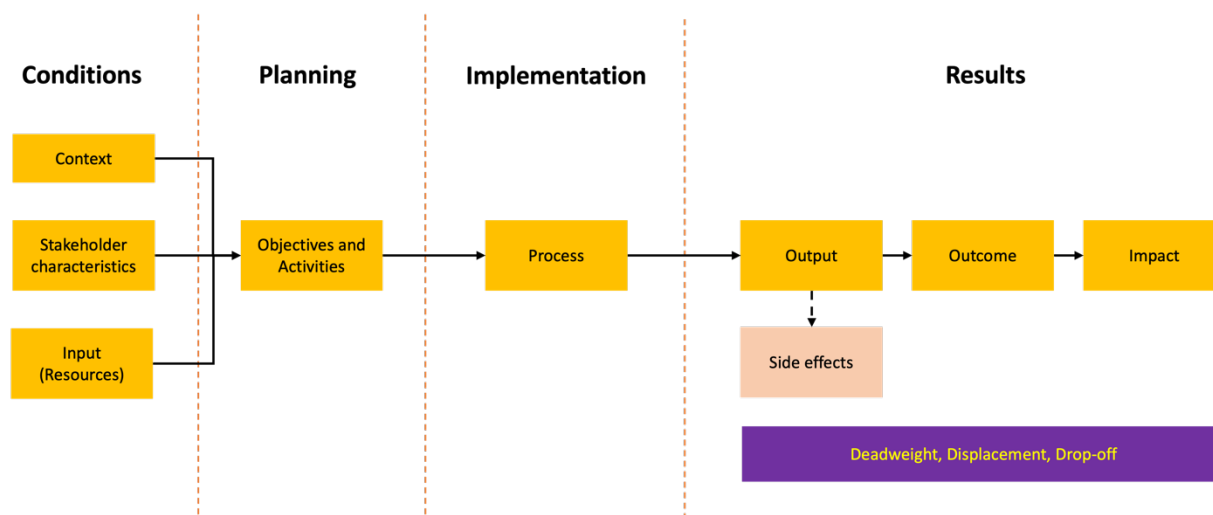
One of the key challenges of contemporary public policy is the need to reconcile the growing social needs and increasingly pressing demands for transparency with budget constraints. Taxpayers, donors, investors, and volunteers who contribute to the government and not-for-profit programs require information about the “Value for Money (VfM)” to ensure effectiveness, efficiency, and better resource allocation (Taylor & Bradbury-Jones, 2011). Conventional evaluative frameworks, such as cost-effectiveness analysis (CEA), cost-utility analysis (CUA), and cost-benefit analysis (CBA), have been widely used to evaluate public health interventions (NICE, 2013). Recently, the SROI framework has been promoted as a holistic approach to validating VfM of public health programs (Rotheroe & Richards, 2007; Millar & Hall, 2013). Taking into account the social, environmental, and economic aspects of the impact generated by public health programs, SROI places stakeholders at the center of the evaluative process and incorporates the quantification techniques of conventional

evaluative frameworks, such as CEA, CUA, and CBA (Banke-Thomas et al., 2015; Ravulo et al., 2019). Moreover, apart from assessing the programs/projects that have already occurred, SROI can also be used to predict how much value will be generated if the programs/projects accomplish their intended objectives (Banke-Thomas et al., 2015).

As mentioned earlier, SROI was initially employed in the analysis of the Roberts Enterprise Development Fund's (REDF) project in the 1990s. Based on this analysis, two types of value created by the REDF project were assessed: economic value and social value. The first is defined by the market prices of inputs and outputs, while the latter focuses on things that do not have direct market prices (e.g., self-worth, empowerment, knowledge). Since then, the SROI guidelines have been evolving and modified in different organizational, national, and academic contexts (Lawlor, Neitzert, & Nicholls, 2008; Brouwers, Prins, & Salverda, 2010). At present, it is a widely accepted understanding that SROI is characterized by stakeholder engagement (Nicholls et al., 2009). As Nicholls and colleagues (2009) point out, stakeholders are not only confined to investors or donors, but include people who experience change as a result of the investments being analyzed. With special emphasis on stakeholder engagement, SROI is an inclusive process whereby even less empowered groups of stakeholders can participate in the investment appraisal (Yates & Marra, 2017). Stakeholder engagement is also consistent with the "Healthy Public Policy" movement, which seeks to steer government in all its sectors towards improving health and well-being for people, and the "whole-of-society" approach to health, which attempts to mobilize all societal segments towards healthy lifestyles.

Apart from the ROI concept from financial analysis, SROI builds on the theory of change – "an outcome-based approach which applies critical thinking to the design, implementation and evaluation of initiatives and programs intended to support change in their contexts" (Vogel, 2012: p. 3). The theory of change produces an impact map or an impact chain, which identifies the conditions, plan, implementation process, and results of a social investment program/project (Figure 1-1). In this theory, the relationships between inputs, outputs, outcomes, and impacts are analyzed by using key indicators and ROI to demonstrate the actual impact of a program/project being assessed.





**Figure 1-1. Theory of Change or Impact Map**

**Note: Adapted from Vogel (2012)**

Certain dimensions of the value created by a social investment program/project may not have market prices. In SROI, financial proxies are used to establish this so-called social value. Several techniques are available to measure these financial proxies:

- 1. Contingent valuation** – involves asking people directly how they value things. In other words, this technique assesses people's willingness to pay for a hypothetical thing;
- 2. Revealed preference (or hedonic pricing)** – infers the value of a hypothetical thing from the price of a related market-traded good. For example, we can calculate how people value different aspects of their lives by considering wage differentials that people require to take on risky jobs;
- 3. Travel cost method** – recognizes that people are willing to travel some distance to consume goods or receive services to which they attach an economic (or social) value. This can be translated into monetary terms to estimate the benefits of those goods and services; and
- 4. Average housing spending** – reveals how people value non-traded good and services (e.g., leisure, health, safety). This type of data typically comes from annual government surveys.

Without overclaiming the effects of an investment program/project, SROI adopts four discounting factors (Arvidson et al., 2013):

1. **Deadweight** – a measure of the outcome that would have happened even in the absence of a program/project. Often calculated as a percentage, deadweight can be measured by making reference to comparison groups or benchmarks;
2. **Displacement** – a measure of how much the outcome of a program/project displaced other outcomes or the possible unintentional outcomes of social investment. In other words, displacement refers to the possibility that some benefits for one stakeholder group can be problematic for other groups;
3. **Attribution** – an assessment of how much of the outcome was created by other programs/projects; and
4. **Drop-off** – an account of how long the effects of social investment last. Drop-off is usually calculated by deducting a fixed percentage from the remaining level of outcome.

The results of SROI analyses are expressed in a ratio of the NPV of benefits and investment. Though not an actual financial return, this ratio makes social value visible to investors, taxpayers, donors, and volunteers (i.e., Value for Money – VfM). An SROI ratio of 1:1 means that for every dollar/baht invested in a project, one dollar/baht has been created for the project stakeholders. With a ratio of 2:1, two dollars/baht were created for every dollar/baht spent on a project. As Hammelmann and colleagues (2017) argue, although not all aspects of social value are monetizable (or quantifiable), how SROI analyses are performed varies based on each type of investment and the context within which investment projects are executed. Beyond the ratio, the SROI analyses furnish a story of qualitative and quantitative changes experienced by a diversity of stakeholders.

SROI has been chosen to assess the Safe Birth for All and Lao PDR midwifery programs in this report because it measures impact at many levels compared to conventional evaluative approaches and features a strong narrative element in incorporating the assessment of social impact and change (Ravulo et al., 2019). Qualitative and quantitative techniques used in SROI contribute towards the identification of costs and benefits that

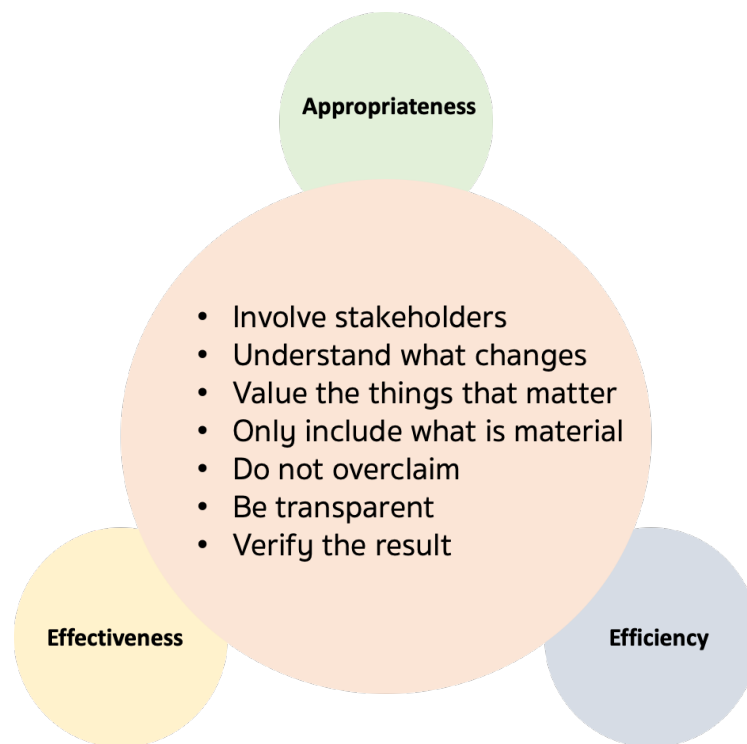
monetize social changes caused by policy interventions (Edwards & Lawrence, 2021). SROI's ability to monetize social changes is unique and offers a holistic account of how changes occur (Edwards, Charles, & Lloyd-Williams, 2013). The SROI's narrative focus also allows for an understanding of the social changes experienced by stakeholders (Ashton, et al., 2020).

SROI emphasizes three key indicators (i.e., appropriateness, effectiveness, and efficiency) and includes seven steps as follows (Figure 1-2) (Ravulo et al., 2019):

1. **Involve stakeholders.** Stakeholders or participants in a program/project indicate what is considered meaningful to them within their contexts and how the program/project should be measured and valued;
2. **Understand what changes.** The changes that happen as a result of the program/project are not limited to positive and intended changes. Each change (program/project outcome) is measured through indicators to validate program/project effectiveness;
3. **Value the things that matter.** Outcomes, such as increased motivation and self-confidence, are assigned financial proxies in order to monetize the program/project outcomes;
4. **Only include what is material.** Material outcomes are outcomes that are important enough to consider when making decisions about resource allocation. If material outcomes are not considered, there is a risk that an organization allocates resources to unimportant activities. An important activity has many different stakeholders, each of which experiences different program/project outcomes. This step ensures that only outcomes that are material (important) to each stakeholder are included in the SROI research;
5. **Do not overclaim.** An example of overclaiming would be attributing increased motivation to a program/project when in fact stakeholders' motivation comes from external factors. To avoid overclaiming, the concept of deadweight is used. Deadweight refers to the amount, expressed as a percentage, of the outcomes that would have happened without a program/project. Another concept to prevent overclaiming is drop-off,

which measures how the program/project impacts depreciate over time. This is based on the assumption that over time, other factors affect the stakeholders more than the program/project itself;

6. **Be transparent.** SROI reflects the honest perspectives of stakeholders, as well as the perspectives of those who want to demonstrate that a program/project is effective. Also, the SROI research traces how the processes of change are linked to the program/project outcomes, while highlighting the economic, environmental, social, and other impacts of the program/project; and
7. **Verify the result.** Findings must be shared with stakeholders who take part in the SROI research.



**Figure 1-2. Seven Steps of the Social Return on Investment (SROI) Method**

**Note: Adapted from Ravulo et al. (2019).**

## 1.4 Data Collection and Analysis

The data collection method and analysis in this study are based on the seven steps in the conceptual framework. Before proceeding with these seven steps, the researcher will review policy documents related to the two programs and the literature on RMNCH.

**1.4.1 Step 1: Involve Stakeholders.** Approximately 20-30 stakeholders from each program are recruited for this study, including healthcare professionals and program beneficiaries.

**1.4.2 Step 2: Understand what changes.** Quantitative data from secondary sources will be analyzed. Additionally, stakeholders recruited for this study will be asked to provide qualitative reflections of the programs, specifically how the programs change their livelihood. The responses will be collated and analyzed using the theory of change map.

**1.4.3 Step 3: Value the things that matter.** For each group of stakeholders, two questions will be used to determine the important program/project outcomes: (1) what area (s) have improved? and (2) what areas have changed? Each question contains several items, which the stakeholders will rate on a scale of “1” (Not Sure) to “4” (A Lot).

**1.4.4 Step 4: Include only what is material.** Based on the qualitative responses from Step 2 and the responses from Step 3, each important outcome will be monetized to a financial proxy.

**1.4.5 Step 5: Do not overclaim.** This step ensures that this study claims only what the two programs are responsible for. Each of the outcomes from Step 4 will be given a certain amount of deadweight (i.e., what would happen without the program?) and attrition (i.e., who else is contributing to the change?)—both measured as percentages.

**1.4.6 Step 6: Be transparent.** All findings from Steps 2-5 will be entered into a specially designed “Social Value Map” table (See Annex 1) that calculates the SROI ratio for each program. This table reflects not only the monetary value of the programs, but also the important social and environmental impacts of the two programs.

**1.4.7 Step 7: Verify the result.** A two-page policy brief will be sent to the responsible agencies (e.g., DOH, Lao PDR Ministry of Health, UNFPA Thailand Country Office). The

purpose of this policy brief is to engage the stakeholders and increases transparency of the SROI process.

## **Chapter 2**

# **Social Return on Investment (SROI) Analysis of the “Safe Birth for All” Project**

The “Safe Birth for All” project grew out of a public-private partnership between the UNFPA Thailand Country Office, Reckitt Thailand Indochina Office, and the Department of Health of Thailand (DOH). The partnership offers a unique opportunity for mobilizing resources and professional skills across all sectors and national boundaries to provide sustainable and effective reproductive, maternal, newborn, and child healthcare (RMNCH) in remote and impoverished areas. Safe childbirth is an important RMNCH service for the marginalized populations and became interrupted in the rural areas in developing countries during the COVID-19 pandemic. The “Safe Birth for All” project aims to mitigate the life-threatening effects of the COVID-19 pandemic on women and girls’ access to RMNCH services. This goal is consistent with the United Nations’ Sustainable Development Goals (SDGs) and the UNFPA’s transformative results of zero preventable maternal deaths and ending unmet needs for family planning.

This chapter begins with the project background and details about inputs. After summarizing the project achievements, the subsequent section explains results of a social return on investment (SROI) analysis of the “Safe Birth for All” project.

### **2.1 Project Background**

The Safe Birth for All project – formally referred to as “Safe Birth for All: Ensuring Safer Births within the framework of Universal Health Coverage (UHC)” – began on October 1, 2020 and ended on December 31, 2021. Prioritizing reducing preventable maternal deaths in the Thailand-Myanmar border region, the project was implemented during the COVID-19 to improve access to RMNCH services for the vulnerable women, girls, and adolescents. Three key interventions introduced by this project were as follows (UNFPA Thailand Country Office, 2018):

1. Improving the national and subnational maternal health surveillance system, including the Maternal and Mortality Rate (MMR) surveillance system, perinatal death surveillance system, and adolescent pregnancy surveillance system,
2. Improving institutional capacity development on maternal healthcare and service in regular circumstances and adapted for the COVID-19 situation, and
3. Promoting the replication of good practices and innovations in other high-risk areas and other countries through South-South and Triangular Cooperation (SS/TC).

**Table 2-1. Policy interventions and key activities under the “Safe Birth for All” project**

Intervention (s)	Activity (-ies)
1. Improving the national and subnational maternal health surveillance system, including the Maternal and Mortality Rate (MMR) surveillance system, perinatal death surveillance system, and adolescent pregnancy surveillance system	<ul style="list-style-type: none"> <li>• Reviewing the situation</li> <li>• Identifying three tracking systems on MMR Initiating a digital platform for teens on adolescent sexual and reproductive health Establishing perinatal surveillance guidelines</li> <li>• Conducting policy advocacy activities with 366 health officers and health-related staff at the sub-national and national levels on services and surveillance systems for all high-risk MMR areas</li> <li>• Using experiences and good practices from the eight selected districts</li> </ul>
2. Improving institutional capacity development on maternal healthcare and service in regular circumstances and adapted for the COVID-19 situation	<ul style="list-style-type: none"> <li>• Revising the traditional birth attendants (TBAs) training curriculum</li> <li>• Retraining and re-skilling of 209 TBAs in maternal health care</li> <li>• Strengthening the maternal health care network by building capacity for maternal and child risk assessments and referral systems</li> <li>• Producing media content and learning materials to educate and promote safe birth for all</li> </ul>



**Table 2-1. Policy interventions and key activities under the “Safe Birth for All” project**

Intervention (s)	Activity (-ies)
	<ul style="list-style-type: none"> <li>• Providing delivery kits and COVID-19 hygiene kits for pregnant women and their family members.</li> </ul>
3. Promoting the replication of good practices and innovations in other high-risk areas and other countries through South-South and Triangular Corporation (SS/TC)	<ul style="list-style-type: none"> <li>• Capitalizing on good practices and lessons learned</li> <li>• Identifying policy recommendations</li> <li>• Co-creating innovations in maternal health care and services for hard-to-reach areas and during the COVID-19 pandemic</li> <li>• Sharing good practices with health networks and health policymakers through the SSTC initiatives.</li> </ul>

Note: Adapted from UNFPA Thailand Country Office (2018)

The target areas of project implementation were high-risk districts along the Thailand-Myanmar border in Chiang Mai, Mae Hong Son, and Tak provinces. Within these three provinces, the selected high-risk districts included Omkoy (Chiang Mai province), Mae Sa Rieng (Mae Hong Son province), and six districts in Tak province. The primary project beneficiaries were Thai and non-Thai women of reproductive age, while the secondary beneficiaries were SBAs and TBAs (Table 2-2).

**Table 2-2. Expected primary and secondary beneficiaries of the “Safe Birth for All” project**

Beneficiary (-ies)	Expected Number (s)
1. Primary beneficiaries	<ul style="list-style-type: none"> <li>• Approximately 210, 000 women of reproductive age (Thai and non-Thai)</li> <li>• Approximately 30,700 pregnant women and adolescent mothers (Thai and non-Thai)</li> </ul>
2. Secondary beneficiaries	<ul style="list-style-type: none"> <li>• 550 skilled birth attendants (SBAs) in 8 hospitals in the 3 provinces</li> <li>• 500 traditional birth attendants (TBAs) in the 3 provinces</li> <li>• 50 policymakers in charge of the maternal health policy at the national and regional levels</li> </ul>

These eight districts were selected due to an increasing number of repeated pregnancies among adolescents due to unmet need for family planning and long-acting

reversible contraception (LARC). Also, limited healthcare facilities, poverty, and immigration status prevented pregnant women and adolescents, particularly the foreign aliens, from gaining access to quality RMNCH services. This lack of access to RMNCH services was further complicated by the COVID-19 pandemic. Funding for this project was derived from Reckitt Thailand and Indochina (US\$ 380,000) and in-kind contributions by DOH<sup>1</sup> and UNFPA<sup>2</sup> (US\$ 115,463). This brings a total investment to US\$ 495,463.

## 2.2 Summary of Project Achievements

The end-of-project evaluation found that approximately 30,000 women of reproductive age benefited from the project. The benefits can be divided into the output and outcome levels as follows:

2.2.1 At the output level, the “Safe Birth for All” project resulted in;

- (1) 2,100 pregnant women received early antenatal care in their first trimester;
- (2) 4,100 at-risk pregnant women and their families received COVID-19 antigen tests;
- (3) 2,230 (or 6.30 percent of adolescent mothers in the target areas) gained access to family planning and LARC;
- (4) 30,000 teens accessed the virtual health self-assessment platform;

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<sup>1</sup> Based on an interview with the DOH representative, DOH made the following in-kind contribution: project management (30 percent of the project manager’s staff time and 20 percent of the project assistant’s staff time), public communication (20 percent of the communication officer’s staff time), and general administration and finance (30 percent of the financial associate’s staff time). The following DOH officials’ salaries were used to quantify these in-kind contributions: a senior professional officer’s annual salary of US\$ 18,000 (Project manager), a clerical officer’s annual salary of US\$ 15,000 (Communication officer and financial associate), and a professional officer’s annual salary of US\$ 16,875.

<sup>2</sup> The UNFPA Thailand Country Office’s report indicates that the UNFPA contribution to the “Safe Birth for All” project included: 50 percent of the project manager’s staff time, 30 percent of the communication specialist’s staff time, 30 percent of the program associate’s staff time, and 20 percent of the administration and finance associate’s staff time. The annual salary for a P-3 contract (US\$ 75,000) was used to calculate the financial value of the UNFPA Thailand Country Office’s in-kind contribution.

(5) 209 TBAs received training on how to apply the maternal health care protocol and guidelines to the local contexts; and

(6) 3 national surveillance systems (i.e., perinatal death surveillance system, MMR surveillance system, and digital adolescent birth rates surveillance tool) were established and improved.

#### 2.2.2 The project outcomes were:

(1) Pregnant women and adolescent mothers' confidence in taking care of their health,

(2) Safe pregnancy and delivery,

(3) Healthier babies,

(4) Decreased financial loss from pregnancy- and delivery-related complications,

(5) Decreased financial loss from COVID-19 infection,

(6) Decreased financial loss from COVID-19 infection,

(7) Avoided COVID-19 deaths,

(8) Avoided unintended pregnancies,

(9) Teens' confidence and ability to make informed choices about their reproductive health,

(10) Decreased workload due to healthier mothers and newborns,

(11) Increased confidence in providing RMNCH services,

(12) Increased confidence in using modern medical knowledge to assist childbirth in the local circumstances,

(13) Increased stress due to the difficulties posed by the work, and

(14) Precise and real-time policies and programs on RMNCH service design.

2.2.3 At the impact level, the rate of repeated pregnancies among adolescents in the target areas decreased from 21.52 percent in December 2020 to 18.21 percent in December 2021. In Chiang Mai province, the maternal mortality rate (MMR) radically declined from 45.85 maternal deaths/100,000 live births in 2020 to 15.85 in 2021. Meanwhile, the MMR in Tak

province decreased from 45.85 maternal deaths per 100,000 live births in 2020 to 15.85 in 2021. In sum, MMRs in the two provinces after the project completion were lower than the national average of 16 maternal deaths per 100,000 live births. Further, the project features innovative practices that relies on digital technology to support RMNCH services during the COVID-19 pandemic. Telemedicine and a series of capacity enhancement programs for the local health personnel, including traditional birth attendants (TBAs), ensure safe pregnancy and delivery for the vulnerable populations.

## **2.3 Social Return on Investment (SROI) Analysis**

### **2.3.1 Establishing Scope and Identifying Stakeholders**

Prior to data collection, the researcher determine which stakeholders were the primary and secondary beneficiaries of the “Safe Birth for All” project. As previously explained, the primary beneficiaries were “service recipients,” including women of reproductive age, pregnant women, and adolescent mothers. The secondary beneficiaries were “service providers,” including TBAs and SBAs. A comparison (control) group was also surveyed. Data collected from this cohort represented the counterfactual or “deadweight” for the SROI calculations. This cohort was a random sample of households in communities within the Dan Chang district in Suphanburi province, which is situated outside the target areas for this project. The selected communities in the Dan Chang district share the same demographic, geographical, and socioeconomic features as the participating communities in Chiang Mai, Tak, and Mae Hong Son provinces.

### **2.3.2 Mapping Project Outcomes**

Prior to data collection, the project objectives were re-ordered according to the theory of change to provide guidance for the design of data collection instruments. However, after data collection, the impact map was modified to reflect the stakeholders’ experiences with the project. After data collection, one additional outcome and one additional impact were added to the impact map. Table 2-3 explains the conditions, planning, implementation, and results of the “Safe Birth for All” project. The researcher also classified the outputs and outcomes from this project by stakeholder group in Table 2-4.

**Table 2-3. Theory of Change for the “Safe Birth for All” project**

Condition (s)	Strategy (-ies)	Activity (-ies)	Output (s)	Outcome (s)
<p><b>Context</b></p> <ul style="list-style-type: none"> <li>Rural, mountainous region with limited access to RMNCH services</li> <li>COVID-19 pandemic</li> </ul> <p><b>Stakeholders</b></p> <ul style="list-style-type: none"> <li><i>Primary stakeholders:</i> women of reproductive age, pregnant women, and adolescent mothers</li> <li><i>Secondary stakeholders:</i> SBAs, TBAs, policymakers in charge of maternal health policy</li> </ul> <p><b>Inputs</b></p> <ul style="list-style-type: none"> <li>Financial donations: US\$ 380,000</li> <li>In-kind contributions: US\$ 115,464</li> </ul>	<ul style="list-style-type: none"> <li>Support innovative demand-based RMNCH services for pregnant women and young mothers during the COVID-19 pandemic and other emergency situations</li> </ul>	<ul style="list-style-type: none"> <li>Reviewing the situation</li> <li>Identifying three tracking systems on MMR</li> <li>Initiating a digital platform for teens on adolescent sexual and reproductive health</li> <li>Establishing perinatal surveillance guidelines</li> <li>Conducting policy advocacy activities with 366 health officers and health-related staff at the sub-national and national levels on services and surveillance systems for all high-risk MMR areas</li> <li>Using experiences and good practices from the eight selected districts</li> </ul>	<ul style="list-style-type: none"> <li><b>OP1:</b> 2,100 pregnant women received early antenatal care in their first trimester</li> </ul>	<ul style="list-style-type: none"> <li><b>OC1.1:</b> Pregnant women and adolescent mothers’ confidence in taking care of their health</li> <li><b>OC1.2:</b> Safe pregnancy and delivery</li> <li><b>OC1.3:</b> Healthier babies</li> <li><b>OC1.4:</b> Decreased financial loss from pregnancy- and delivery-related complications</li> </ul>
			<ul style="list-style-type: none"> <li><b>OP2:</b> 4,100 at-risk pregnant women and their families received COVID-19 antigen tests.</li> </ul>	<ul style="list-style-type: none"> <li><b>OC2.1:</b> Decreased financial loss from COVID-19 infection</li> <li><b>OC2.2:</b> Avoided COVID-19 deaths</li> </ul>
			<ul style="list-style-type: none"> <li><b>OP3:</b> 2,230 (6.30 percent of adolescent mothers in the target areas) gained access to family planning and LARC.</li> <li><b>OP4:</b> 30,000 teens accessed the virtual reproductive health self-assessment platform.</li> </ul>	<ul style="list-style-type: none"> <li><b>OP3:</b> Avoided unintended pregnancies</li> <li><b>OC4:</b> Teens’ confidence and ability to make informed choices about their reproductive health</li> </ul>
	<ul style="list-style-type: none"> <li>Support institutional capacity development for SBAs, TBAs, nurses, and midwives on provision of RMNCH services, LARC, counselling, and care guidance</li> </ul>	<ul style="list-style-type: none"> <li>Revising the traditional birth attendants (TBAs) training curriculum</li> <li>Retraining and re-skilling of 209 TBAs in maternal health care</li> <li>Strengthening the maternal healthcare network by building capacity for maternal and</li> </ul>	<ul style="list-style-type: none"> <li><b>OP5:</b> 173 SBAs received refresher training on maternal health care and LARC.</li> </ul>	<ul style="list-style-type: none"> <li><b>OC5.1:</b> Decreased workload due to healthier mothers and newborns</li> <li><b>OC5.2:</b> Increased confidence in providing RMNCH services</li> </ul>
			<ul style="list-style-type: none"> <li><b>OP6:</b> 209 TBAs received training on how to apply the maternal health care protocol and guidelines to the local contexts.</li> </ul>	<ul style="list-style-type: none"> <li><b>OC6.1:</b> Increased confidence in using modern medical knowledge to assist childbirth in the local circumstances.</li> <li><b>OC6.2:</b> Increased stress due to the difficulties posed by the work</li> </ul>

Table 2-3. Theory of Change for the “Safe Birth for All” project

Condition (s)	Strategy (-ies)	Activity (-ies)	Output (s)	Outcome (s)
		child risk assessments and referral systems • Producing media content and learning materials to educate and promote safe birth for all • Providing delivery kits and COVID-19 hygiene kits for pregnant women and their family members.		
	• Promote good practices and advocacy for the use of innovations and telemedicine in safe birth programs	• Capitalizing on good practices and lessons learned • Identifying policy recommendations • Co-creating innovations in maternal health care and services for hard-to-reach areas and during the COVID-19 pandemic • Sharing good practices with health networks and health policymakers through the SSTC initiatives	• <b>OP7</b> : 3 national surveillance systems were established and improved: perinatal death surveillance system, MMR surveillance system, and digital adolescent birth rates (ABR) surveillance tool	• <b>OC7</b> : Precise and real-time policies and programs on RMNCH service design

**Table 2-4. Outputs and Outcomes by Stakeholder Group (Safe Birth for All project)**

Stakeholder	Output	Outcome
<b>Primary Beneficiary</b>		
Pregnant women and adolescent mothers	<ul style="list-style-type: none"> <li>• <b>OP1:</b> 2,100 pregnant women received early antenatal care in their first trimester</li> </ul>	<ul style="list-style-type: none"> <li>• <b>OC1.1:</b> Pregnant women and adolescent mothers' confidence in taking care of their health</li> <li>• <b>OC1.2:</b> Safe pregnancy and delivery</li> <li>• <b>OC1.3:</b> Healthier babies</li> <li>• <b>OC1.4:</b> Decreased financial loss from pregnancy- and delivery-related complications</li> </ul>
	<ul style="list-style-type: none"> <li>• <b>OP2:</b> 4,100 at-risk pregnant women and their families received COVID-19 antigen tests.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>OC2.1:</b> Decreased financial loss from COVID-19 infection</li> <li>• <b>OC2.2:</b> Avoided COVID-19 deaths</li> </ul>
	<ul style="list-style-type: none"> <li>• <b>OP3:</b> 2,230 (6.30 percent of adolescent mothers in the target areas) gained access to family planning and LARC.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>OC3:</b> Avoided unintended pregnancies</li> </ul>
Women of reproductive age	<ul style="list-style-type: none"> <li>• <b>OP4:</b> 30,000 teens accessed the virtual reproductive health self-assessment platform.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>OC4:</b> Teens' confidence and ability to make informed choices about their reproductive health</li> </ul>
<b>Secondary Beneficiary</b>		
SBAAs	<ul style="list-style-type: none"> <li>• <b>OP5:</b> 173 SBAAs received refresher training on maternal health care and LARC.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>OC5.1:</b> Decreased workload due to healthier mothers and newborns</li> <li>• <b>OC5.2:</b> Increased confidence in providing RMNCH services</li> </ul>
TBAAs	<ul style="list-style-type: none"> <li>• <b>OP6:</b> 209 TBAAs received training on how to apply the maternal health care protocol and guidelines to the local contexts.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>OC6.1:</b> Increased confidence in using modern medical knowledge to assist childbirth in the local circumstances.</li> <li>• <b>OC6.2:</b> Increased stress due to the difficulties posed by the work</li> </ul>
Policy makers in charge of maternal health policy	<ul style="list-style-type: none"> <li>• <b>OP7:</b> 3 national surveillance systems were established and improved: perinatal death surveillance system, MMR surveillance system, and digital adolescent birth rates (ABR) surveillance tool</li> </ul>	<ul style="list-style-type: none"> <li>• <b>OC7:</b> Precise and real-time policies and programs on RMNCH service design</li> </ul>

### 2.3.3 Evidencing the Outcomes and Attaching Values to Each Outcome

#### (1) Data collection

(1.1) **Documentary research** was used as an initial data collection method to identify project outputs/outcomes for the impact map. Several government documents, UNFPA reports, and research articles were the primary sources of data for identifying the financial proxies for each outcome.

(1.2) **Focus group discussions** were the main qualitative method to identify important outcomes and financial proxies for certain outcomes. A questionnaire was used to help focus group participants determine how to measure the project outcomes based on their experiences.<sup>3</sup> For some outcomes that did not have market values, the researcher relied on a modified version of “SROI value game” in the questionnaire to explore the participants’ willingness to pay (WTP). Values provided were based on the focus group participants’ experiences of changes and their perceptions about the lasting and future impacts of the project. Two focus group discussions were conducted, and participants included:

- a. 11 primary beneficiaries (five pregnant women, two adolescent mothers, four women of reproductive age), and
- b. 20 secondary beneficiaries (five nurses, five midwives, four TBAs, and six village health volunteers (VHVs)).

(1.3) **Unstructured interviews** were held with the DOH regional officers who were involved in the project, provincial health officials who helped coordinate activities, and two directors of subdistrict health promoting hospital in the target area (Mae Sa Riang district). A total number of 11 informants were interviewed for this study.

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<sup>3</sup> See Appendix I for the questionnaire (See Appendix III for the English version).



(1.4) A **survey** was conducted among a random sample of 51 hill tribe households from Dan Chang district in Suphanburi province, which were selected as a comparison group.<sup>4</sup> The survey data were used to calculate the deadweight values of each outcome.

(1.5) **Revealed preference technique** was used in situations where indicators for certain outcomes could not be obtained from the focus group participants. The use of this technique was necessary due to the time limitation of each focus group discussion and because the researcher did not fully appreciate the extent of the impact until after completing the data collection process. Estimated valuations were based on prices of related market-traded goods that generate a similar benefit to what was described by the focus group participants.

## (2) **Determining how long the outcomes last**

The duration of each outcome was assessed in the questionnaire by asking the participants who engaged in focus group discussions to estimate how long the impact would last. A maximum duration of five years was assumed for this study, although some of the outcomes could have a lifelong impact (e.g., pregnant women receiving early antenatal care in their first trimester, or safe pregnancy or delivery). Since no evidence could substantiate the lifelong impact of such outcomes, the duration was limited to five years.

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<sup>4</sup> See Appendix II for the questionnaire (See Appendix IV for the English version).

**Table 2-5. Estimated Duration of Outcomes and the Underlying Assumptions (Safe Birth for All project)**

Outcome (s)	Duration	Assumption (s)
<b>Pregnant women and adolescent mothers</b>		
OC1.1: Pregnant women and adolescent mothers' confidence in taking care of their health and their babies'	3 years	In the questionnaire, participants reported this change would last forever. However, as the researcher thinks this is likely to happen during the first three years of the child's life, the duration of OC1.1 was limited to three years.
OC1.2: Safe pregnancy and delivery	3 years	In the questionnaire, participants reported this change would last forever. However, the personnel, facilities, and equipment would need upgrades every three years.
OC1.3: Healthier babies	5 years	This is likely to have a lasting impact due to improved RMNCH services.
OC1.4: Decreased financial loss from pregnancy- and delivery-related complications	1 year	This change would be limited to the intervention's duration.
OC2.1: Decreased financial loss from COVID-19 infection	1 year	This change would be limited to the intervention's duration.
OC2.2: Avoided COVID-19 deaths	1 year	This change would be limited to the intervention's duration.
OP3: Avoided unintended pregnancies	5 years	This change is likely to persist beyond the intervention's duration due to the knowledge and a support network initiated by this project.
<b>Women of reproductive age</b>		
OC4: Teens' confidence and ability to make informed choices about their reproductive health	5 years	This change is likely to persist beyond the intervention's duration due to the knowledge and a support network initiated by this project.
<b>SBA's</b>		
OC5.1: Decreased workload due to healthier mothers and newborns	5 years	This change is likely to persist beyond the intervention's duration.
OC5.2: Increased confidence in providing RMNCH services	5 years	This change is likely to persist beyond the intervention's duration.
<b>TBA's</b>		
OC6.1: Increased confidence in using modern medical knowledge to assist childbirth in the local circumstances.	5 years	This change is likely to persist beyond the intervention's duration.
OC6.2: Increased stress due to the difficulties posed by the work	1 year	This change is likely to be limited to the intervention's duration. After they have become acclimatized to the new protocol/guidelines, the street would significantly reduce.
<b>Policymakers in charge of maternal health policy</b>		
OC7: Precise and real-time policies and programs on RMNCH service design	5 years	This change is likely to persist beyond the intervention's duration.

**(3) Attaching values to each outcome**

Some of the outcomes had market values, but for those that did not have market values, an SROI value game exercise was used in the questionnaire to explore focus group participants' WTP. In the value game exercise, participants were asked to list items that have a market value and place the outcome of interest within the list. An average was calculated of the items below and above the outcome of interest. This value of the outcome was validated by checking back with the participants to see if they would be willing to pay the minimum amount reflected by the cheaper item below the outcome of interest, or if the cost or value of the outcome actually represented how much they would pay to get the outcome of interest.

**Table 2-6. Description of the Financial Proxy for Each Outcome (Safe Birth for All project)**

Outcome (s)	Financial Proxy (-ies)
<b>Pregnant women and adolescent mothers</b>	
OC1.1: Pregnant women and adolescent mothers' confidence in taking care of their health and their babies'	WTP to be confident
OC1.2: Safe pregnancy and delivery	Cost of postpartum care
OC1.3: Healthier babies	WTP to have healthy baby
OC1.4: Decreased financial loss from pregnancy- and delivery-related complications	Amount saved by avoiding pregnancy- and delivery-related complications
OC2.1: Decreased financial loss from COVID-19 infection	Cost of treatment for COVID-19 infection
OC2.2: Avoided COVID-19 deaths	WTP to be alive and healthy
OP3: Avoided unintended pregnancies	Cost of prenatal, perinatal, and postnatal care * number of unintended pregnancies or WTP to avoid having unintended pregnancies
<b>Women of reproductive age</b>	
OC4: Teens' confidence and ability to make informed choices about their reproductive health	WTP to be confident
<b>SBA</b> s	
OC5.1: Decreased workload due to healthier mothers and newborns	Cost of treatment * number of treatments (saved) or WTP to have decreased workload
OC5.2: Increased confidence in providing RMNCH services	WTP to be confident
<b>TBA</b> s	
OC6.1: Increased confidence in using modern medical knowledge to assist childbirth in the local circumstances	WTP to be confident
OC6.2: Increased stress due to the difficulties posed by the work	WTP to be less stressed

**Table 2-6. Description of the Financial Proxy for Each Outcome (Safe Birth for All project)**

Outcome (s)	Financial Proxy (-ies)
<b>Policymakers in charge of maternal health policy</b>	
OC7: Precise and real-time policies and programs on RMNCH service design	WTP to have focused and flexible national-level policies/programs and budgets for maternal health

### **2.3.4 Establishing Social Impact**

Once each outcome was identified and mapped in the impact map, the value of each outcome was mapped for each stakeholder group to generate SROI impact calculation maps. To avoid overclaiming the project benefits, discounting factors were added to the calculations of each impact to reduce or constrain the values of social returns. For example, a deadweight of five percent was deducted from the value of convenient access to RMNCH services, based on testimonies of convenience by the comparison (non-project) sample in the Suphanburi province. This was largely due to the Ministry of Public Health’s initiative that sought to bolster the quality of primary care services, which encompass certain RMNCH services offered by the “Safe Birth for All” project. The value was also reduced by a rounded 10 percent for attribution due to the Ministry of Interior and local governments’ involvement in sexual and reproductive health (SRH) programs after the Parliament passed the Act for Prevention and Solution of the Adolescent Pregnancy Problem, B.E. 2559. The value was also reduced by a rounded 10 percent for attribution, because one of the nine communities had already started protecting some land for regeneration. The relevance and magnitude of each discounting factor was judged separately for each outcome, rather than using blanket percentages. The discounting factors applied to each impact of the “Safe Birth for All” project are as follows:

#### **(1) Deadweight**

In this study, deadweight values of outcomes in Table 2-7 were drawn from data gathered from the comparison group where the “Safe Birth for All” project did not take place. Deadweights are what would have happened anyway in the absence of the policy interventions. The questionnaire asked the comparison group whether each of the statement (outcomes from the “Safe Birth for All” project) was limited, remained the same, or improved from October 1, 2020 - December 31, 2021. Based on Table 2-7, deadweights (the “improved” percentages) ranged from 3.9 percent - 17.6 percent with an average of 10 percent.

**Table 2-7. Deadweight values of each outcome from “Safe Birth for All” project (n = 51)**

Outcome (s)	1 Limited	2 About the same	3 Improved
• <b>OC1.1:</b> Pregnant women and adolescent mothers’ confidence in taking care of their health and their babies’	23 (45.1%)	21 (41.2%)	7 (13.7%)
• <b>OC1.2:</b> Safe pregnancy and delivery	20 (39.2%)	23 (45.1%)	8 (15.7%)
• <b>OC1.3:</b> Healthier babies	19 (37.3%)	26 (51.0%)	6 (11.8%)
• <b>OC1.4:</b> Decreased financial loss from pregnancy- and delivery-related complications	20 (39.2%)	24 (47.1%)	7 (13.7%)
• <b>OC2.1:</b> Decreased financial loss from COVID-19 infection	25 (49.0%)	21 (41.2%)	5 (9.8%)
• <b>OC2.2:</b> Avoided COVID-19 deaths	19 (37.3%)	26 (51.0%)	6 (11.8%)
• <b>OC3:</b> Avoided unintended pregnancies	29 (56.9%)	18 (35.3%)	4 (7.8%)
• <b>OC4:</b> Teens’ confidence and ability to make informed choices about their reproductive health	12 (23.5%)	30 (58.8%)	9 (17.6%)
• <b>OC5.1:</b> Decreased workload due to healthier mothers and newborns	11 (21.6%)	36 (70.6%)	4 (7.8%)
• <b>OC5.2:</b> Increased confidence in providing RMNCH services	18 (35.3%)	31 (60.8%)	2 (3.9%)
• <b>OC6.1:</b> Increased confidence in using modern medical knowledge to assist childbirth in the local circumstances	27 (52.9%)	22 (43.1%)	2 (3.9%)
• <b>OC6.2:</b> Increased stress due to the difficulties posed by the work	23 (45.1%)	25 (49.0%)	3 (5.9%)
• <b>OC7:</b> Precise and real-time policies and programs on RMNCH service design	26 (51.0%)	22 (43.1%)	3 (5.9%)

**(2) Displacement**

While no negative externality from this project was reported during the focus group discussions, one of the key informants facetiously expressed her concern about “how can we dispose of those used rapid antigen tests from the households?” Used rapid antigen tests were considered biohazardous wastes and required proper management and disposal, which the project did not clearly address. Thus, a speculative 25 percent displacement effect was added to take this negative externality into account for OC2.1 (Decreased financial loss from COVID-19 infection) and OC2.2 (Avoided COVID-19 deaths).

**(3) Attribution**

Based on the focus group discussions and key informant interviews, the Ministry of Public Health’s policy focus on primary care also played an important role in improving pregnant women and adolescent mothers’ access to RMNCH services. In fact, the “Safe Birth for All” project relied on the same facilities, tools, and healthcare professionals as the ministry’s primary care centers. For instance, directors the participating primary care

centers in Mae Hong Son province reported that prior to the “Safe Birth for All” project, the centers already provided RMNCH services for their clients, but to a limited extent. In the questionnaire, participants in the focus group discussions and key informants were asked to rate how much the public health ministry’s primary care policy contributed to OC1.1-OC1.4. As can be seen in Table 2-8, the attribution rates ranged from 5 percent – 15 percent.

**Table 2-8. Attribution of the outcomes OC1.1 – OC1.4 (Safe Birth for All project)**

<b>Outcome (s)</b>	<b>Attribution Rate (s)</b>
<b>OC1.1:</b> Pregnant women and adolescent mothers’ confidence in taking care of their health and their babies’	5%
<b>OC1.2:</b> Safe pregnancy and delivery	11.6%
<b>OC1.3:</b> Healthier babies	15.1%
<b>OC1.4:</b> Decreased financial loss from pregnancy- and delivery-related complications	7.5%

**(4) Drop off**

The effect of each outcome will decline over time, and outcomes are likely to be influenced by other factors. While no evidence was found to allow for an estimated drop-off rate per outcome, a drop-off rate of 20 percent was assumed for this SROI analysis, which was based on the assumption that the effect of the “Safe Birth for All” project will be zero after five years.

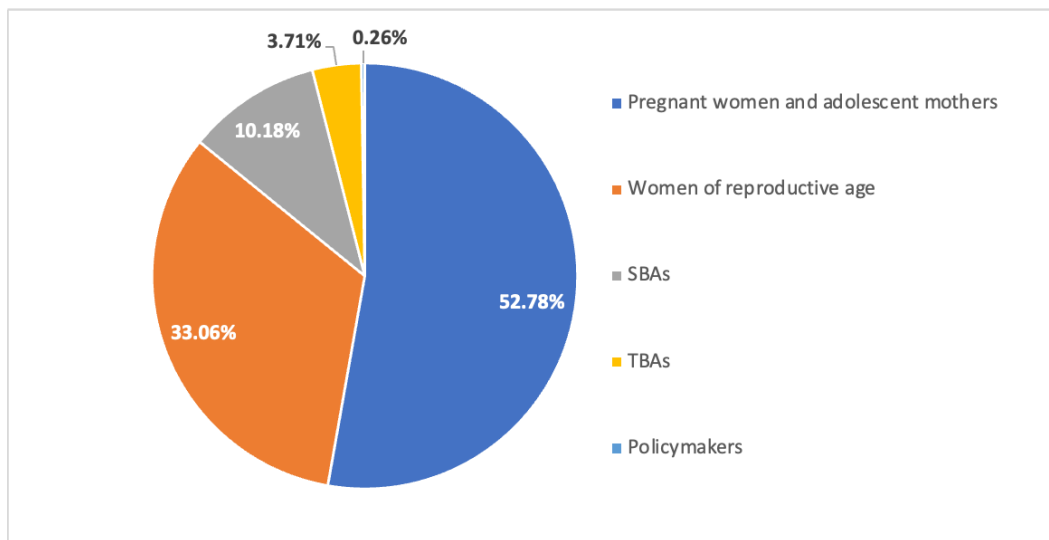
**(5) Discount rate**

A discount rate was applied to values of the outcomes having a duration of more than one year. A discount rate of 6 percent was adopted in this SROI analysis, which was based on Thailand’s inflation rate in 2022.

### 2.3.5 Social Return Calculation

#### (1) SROI Ratio

The SROI ratio was calculated by comparing the investments (inputs) and the total adjusted value of outcomes.<sup>5</sup> Based on this SROI analysis, the total value created by the “Safe Birth for All” project was US\$ 3,988,175. When adjusted for the discounting factors (deadweight, displacement, and attribution) and an inflation rate of 6 percent, the total present value for the project was US\$ 17,801,761 (Table 2-9). Therefore, the SROI ratio is  $\frac{US\$ 17,801,761}{US\$ 495,463} = \frac{US\$ 35.93}{US\$ 1}$ . This ratio suggests that for every dollar of investment in the “Safe Birth for All” project, US\$ 35.93 of social value was created. The stakeholders that benefited the most were pregnant women and adolescent mothers (52.78 percent), followed by women of reproductive age (33.06 percent), SBAs (10.18 percent), TBAs (3.71 percent), and national and regional policymakers in charge of maternal health policy (0.26 percent) (Figure 2-1).



**Figure 2-1. Breakdown of the Total Adjust Value of Outcomes per Stakeholder Group (Safe Birth for All project)**

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<sup>5</sup> The total adjusted value of outcomes = total values \* deadweight \* displacement \* attribution \* discount rate (inflation adjustment)

**Table 2-9. Summary of the Findings of Social Returns (Safe Birth for All project)**

Stakeholder	Total Adjusted Value of Outcomes	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Total PV
• Pregnant women and adolescent mothers	2,105,080	2,105,080	1,985,925	1,767,466	1,483,998	1,175,466	878,376	9,396,311
• Women of reproductive age	1,318,550	1,318,550	1,243,915	1,107,080	929,526	736,271	550,185	5,885,527
• SBAs	405,969	405,969	382,990	340,859	286,192	226,691	169,397	1,812,098
• TBAs	148,075	148,075	139,693	124,327	194,387	82,684	61,787	660,953
• Policymakers in charge of maternal health	10,501	10,501	9,907	8,817	7,403	5,864	4,382	46,873
<b>Total</b>	<b>3,988,175</b>	<b>3,988,175</b>	<b>3,762,429</b>	<b>3,348,549</b>	<b>2,811,506</b>	<b>2,226,976</b>	<b>1,664,126</b>	<b>17,801,761</b>

Note (s): 1. All values in US\$  
 2. Discount rate of 6%



**Table 2-10. Social returns by stakeholder and outcome**

Stakeholder (s)	Outcome (s)	Adjusted Value of Outcome (s)*
• Pregnant women and adolescent mothers	OC1.1: Pregnant women and adolescent mothers' confidence in taking care of their health and their babies'	287,450
	OC1.2: Safe pregnancy and delivery	796,740
	OC1.3: Healthier babies	875,000
	OC1.4: Decreased financial loss from pregnancy- and delivery-related complications	145,890
• Women of reproductive age	OC2.1: Decreased financial loss from COVID-19 infection	374,050
	OC2.2: Avoided COVID-19 deaths	342,710
	OC3: Avoided unintended pregnancies	301,980
	OC4: Teens' confidence and ability to make informed choices about their reproductive health	299,810
• SBAs	OC5.1: Decreased workload due to healthier mothers and newborns	194,355
	OC5.2: Increased confidence in providing RMNCH services	211,614
• TBAs	OC6.1: Increased confidence in using modern medical knowledge to assist childbirth in the local circumstances	98,456
	OC6.2: Increased stress due to the difficulties posed by the work	49,619
• Policymakers in charge of maternal health	OC7: Precise and real-time policies and programs on RMNCH service design	10,501

Note (s): \*All adjusted values in US\$

Based on Table 2-10, Outcome 1.3 “Healthier babies” had the highest adjusted value of US\$ 875,000, followed by Outcome 1.2 “Safe pregnancy and delivery” (US\$ 796,740) and Outcome 2.1 “Decreased financial loss from COVID-19 infection” (US\$ 374,050). These numbers imply that the “Safe Birth for All” project not only benefited pregnant women and adolescent mothers, but also helped to reduce neonatal morbidity and mortality, thereby improving children’s developmental outcomes. Further, it is important to note that OC6.2 “Increased stress due to the difficulties posed by the work” amounted to US\$ 49,619 of social value. Despite its financial small value, The UNFPA Thailand Country Office and the Thai government should pay attention to the TBAs’ discomfort in handling more cases as a result of the SS/TC initiative.

## (2) Sensitivity Analysis

Sensitivity analysis was used to test the assumptions and variables in the SROI analysis by comparing the base and new scenarios. The researcher checked the estimates of deadweight, displacement, attribution, drop off, discount rate, and value of the outcome

determined by the SROI value game. The sensitivity analysis demonstrated that the SROI ratios based on the base and new scenarios fluctuate from US\$ 16:1 (Deadweight) to US\$ 68:1 (Value of the outcome using value game – multiplied by 2) (Table 2-11). The SROI ratio is most sensitive to variations in the value of outcomes based on value game exercises, deadweight, and attribution.

**Table 2-11. Base Case and New Case Scenarios (Safe Birth for All project)**

	<b>Base Case</b>	<b>New Case</b>	<b>New SROI Ratio</b>
• <b>Deadweight</b>	3.9% - 17.6%	30%	US\$ 15: 1
• <b>Displacement</b>	25%	No displacement	US\$ 36: 1
• <b>Attribution</b>	5% - 15%	30%	US\$ 17: 1
• <b>Drop off</b>	20%	50%	US\$ 18: 1
• <b>Discount rate</b>	6%	2.8%	US\$ 42:1
• <b>Value of the outcome using value game</b>	On average US\$ 125	Value divided by 2	US\$ 18:1
• <b>Value of the outcome using value game</b>	On average US\$ 125	Value multiplied by 2	US\$ 68:1

## **Chapter 3**

# **Social Return on Investment (SROI) Analysis of the “Midwifery Capacity Development ” Project**

Midwives are capable of making major contributions to the realization of universal health coverage (UHC) and the Sustainable development Goals (SDGs) (Arjuebor et al., 2019). SDGs contain a radical agenda for improving health that extends beyond the boundary of the current hospital- and illness-based health systems. This concept of “health beyond clinical health” requires profound shifts in professional education and practice. Yet, despite the centrality of midwives and other healthcare professions in advancing health and wellbeing, they consistently experienced myriad challenges, such as shortages and maldistribution, low levels of retention and high levels of migration, and ineffective management (Aiken et al., 2004). To address these challenges, the Thai government have been collaborating with UNFPA on South-South and Triangular Cooperation (SS/TC) activities that strengthen the maternal health workforce and promote universal access to reproductive, maternal, newborn, and child health (RMNCH) services. The first section of this chapter provides background information on the SS/TC project on midwifery capacity development in Lao People’s Democratic Republic (Lao PDR). Afterwards, the chapter summarizes the project achievements that are classified into output, outcome, and impact levels. The final section elaborates on the social return on investment (SROI) analysis of the project.

### **3.1 Project Background**

Adequate human resources are central to a large-scale attempt to increase the reach of RMNCH services. Human resource availability also determines a health system’s absorptive capacity and the pace of scaling up. The Midwifery Capacity Development project had an overarching goal of improving the Lao midwifery educators and midwifery education administrators’ capacities that match the International Confederation of Midwives and World Health Organization (ICM-WHO) standards, as well as the local context. The project began in 2015 with the assessment of needs of Lao PDR’s midwifery schools and colleges, as well as the needs of Lao midwives and related healthcare professionals. After conducting the needs

assessment, a high-level study visit of Lao officials was organized, and Khon Kaen University (Faculty of Nursing) was selected as the training institution and technical provider. A demand-based curriculum was developed for the three batches of Lao human resources: a batch of managers of midwifery schools and colleges and two batches of midwifery educators from 11 midwifery educational institutions. A total of 52 participants consisted of midwifery preceptors, teachers, and education administrators. Participatory monitoring and evaluation were periodically performed to assess the relevance, effectiveness, efficiency, and sustainability of the project. Based on the evaluation findings and recommendations, activities were adjusted to best match Lao PDR’s contexts and demands. Midwifery education manuals, teacher guidelines, evaluation, and monitoring reports were produced throughout the project duration.

Four agencies were directly involved in the delivery and management of the project: Thailand International Cooperation Agency (TICA), UNFPA, Lao PDR Government, and the Faculty of Nursing at Khon Kaen University. The latter served as the main implementing agency and coordinator for the training process. Table 3-1 describes the activities carried out by each agency.

**Table 3-1. Activities carried out by each agency directly involved in the Midwifery Capacity Development project**

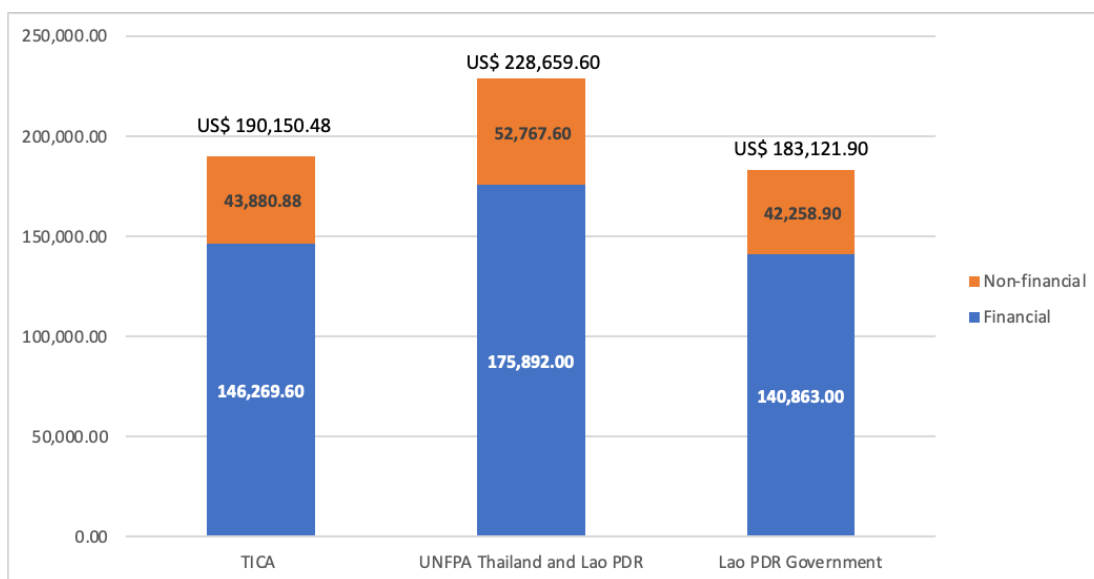
Agency (-ies)	Activity (-ies)
<ul style="list-style-type: none"> <li>• Thailand International Cooperation Agency (TICA)</li> </ul>	<ol style="list-style-type: none"> <li>(1) Three needs assessments in Lao PDR</li> <li>(2) Presentation of the results from the need assessments and validation of needs with Lao officers</li> <li>(3) Study visit by 12 Lao policy makers on midwifery structure and programs to Thailand</li> <li>(4) Strengthening of midwifery educators in Lao PDR, training for midwifery and clinical teachers               <ol style="list-style-type: none"> <li>(4.1) First batch (in June-December 2016)                   <ul style="list-style-type: none"> <li>• 18 participants for 6 months</li> <li>• 10 participants for 4 months</li> <li>• Monitoring and follow-up (two times)</li> </ul> </li> <li>(4.2) Second batch (June-November 2017)                   <ul style="list-style-type: none"> <li>• 24 participants for six months</li> <li>• Monitoring the progress of training course (2 times)</li> </ul> </li> </ol> </li> </ol>

**Table 3-1. Activities carried out by each agency directly involved in the Midwifery Capacity Development project**

Agency (-ies)	Activity (-ies)
<ul style="list-style-type: none"> <li>• UNFPA Thailand Country Office and UNFPA Lao PDR</li> </ul>	<ol style="list-style-type: none"> <li>(1) Worked with TICA and Lao PDR government in organizing and funding all the activities under the SS/TC project on Safe Motherhood for Lao PDR's Institutional Midwifery Capacity Development</li> <li>(2) Worked with TICA and UNFPA to organize a workshop on ICM-WHO Core Competency for Midwifery Standards for International Short Courses on Midwifery and Maternal Health</li> <li>(3) Supported the training courses to strengthen midwifery educators from Lao PDR -- the first batch of a six-month training for 18 midwifery and clinical teachers</li> </ol>
<ul style="list-style-type: none"> <li>• Lao PDR Government</li> </ul>	<p>Supported and facilitated all processed from needs assessment to monitoring and evaluation</p>
<ul style="list-style-type: none"> <li>• Faculty of Nursing, Khon Kaen University</li> </ul>	<ol style="list-style-type: none"> <li>(1) Produced teaching manuals, guidelines, and other materials</li> <li>(2) Reviewed the revised midwifery curriculum for Lao PDR and analyzed its application</li> <li>(3) Organized and provided training to the participants: 10-18 participants in the first batch and 24 participants in the second batch</li> <li>(4) Led the monitoring and evaluating process for the Lao PDR's Institutional Capacity on Midwifery Education</li> </ol>

Note: UNFPA Thailand Country Office (2018).

In terms of the financial and non-financial resources for this project, the total amount of investment was US\$ 601,931.98. Major funders were TICA, UNFPA Thailand and Lao PDR, and the Lao PDR government, and their contributions to the project were US\$ 190,150.48, US\$ 228,659.60, and US\$ 183,121.90, respectively (Figure 3-1). In determining the value of in-kind contributions, we asked each funding agency's representative for the estimate of the agency's non-financial contribution as a percentage of the financial contribution. The estimates ranged from 28.50-30.50 percent with an average of 30 percent.



**Figure 3-1. Values of financial and non-financial resources from funding agencies**

### 3.2 Summary of Project Achievements

At the output level, the UNFPA Thailand Country Office’s SROI analysis in 2022 found that 52 participants (42 midwifery educators and 10 midwifery education administrators) from Lao PDR completed the training course at Khon Kaen University. In addition, 7 teaching manuals, guidelines, and other related materials were produced by the Faculty of Nursing at Khon Kaen University.

At the outcome level, the 2022 report suggested that the Midwifery Capacity Development project resulted in:

- A 93-percent increase in the project participants’ self-confidence in the midwifery profession,
- A 63-percent increase in the project participants’ capacity to contribute to their organizations,
- A 29-percent increase in employability prospects for the project participants, and
- A 24-percent increase in the project participants’ capacity to contribute to their communities

Also, based on the researcher's survey of the midwifery educators who participated in the training curriculum, 6,235 midwives between 2016 and 2022 across Lao PDR received training from these educators. During the same period, 43,780 women of reproductive age (e.g., pregnant women, adolescent girls, young mothers) could gain access to improved RMNCH services.

At the impact level, it is anticipated that an investment in the institutional capacity development in Lao PDR's health system would help the country enhance universal health coverage and realize SDGs, especially SDG3 (Good health and well-being). Further, a demand-based training curriculum for the midwifery educators and education administrators serves as an example of how to effectively design educational and training activities for health workforce in developing countries.

### **3.3 Social Return on Investment (SROI) Analysis**

#### **3.3.1 Establishing Scope and Identifying Stakeholders**

The main assumption underlying this SROI analysis was that the "Midwifery Capacity Development" project had led to an improvement in the midwifery educators and midwifery education administrators' capacities (i.e., the primary benefit) and an improvement in RMNCH services (i.e., the secondary benefit). The next step in this SROI analysis was to determine which stakeholders were the primary and secondary beneficiaries of the project. The primary beneficiaries were the midwifery educators and midwifery education administrators who participated in the training course at Khon Kaen University. The secondary beneficiaries were nursing students, midwives (both SBAs and TBAs), Lao citizens who are recipients of the RMNCH services, and policymakers in charge of maternal health policy in the Lao PDR government. Instead of using a comparison (control) group, the researcher resorted to a less robust method to determine the deadweight for the SROI analysis because the project covers the entire country, and it was difficult to find an area where Lao midwives and citizens did not benefit from this project. As such, focus group discussions, interviews, and surveys were used to collect data on the counterfactual (or deadweight) from the primary and secondary beneficiaries.

### 3.3.2 Mapping Project Outcomes

The researcher produced an impact map according to the theory of change to guide the design of data collection instruments. The researcher started by organizing the outputs and outcomes from this project by stakeholder group in Table 3-2. Further, based on the theory of change, the conditions, strategies, activities, outputs, and outcomes of the “Midwifery Capacity Development” project were explained in Table 3-3.

**Table 3-2. Outputs and outcomes from the “Midwifery Capacity Development” project**

Stakeholder (s)	Output (s)	Outcome (s)
<b>Primary beneficiaries</b>		
<ul style="list-style-type: none"> <li>• <b>Midwifery educators</b></li> </ul>	<p><b>OP1:</b> 42 participants completed the demand-based training curriculum at Khon Kaen University</p>	<p><b>OC1.1:</b> Participants’ enhanced competency and knowledge on midwifery education  <b>OC1.2:</b> Participants’ enhanced motivation and integration of expertise with their employment within the nursing and midwifery schools and hospitals  <b>OC1.3:</b> Positive feeling and improved self-confidence and self-esteem</p>
<ul style="list-style-type: none"> <li>• <b>Midwifery education administrators</b></li> </ul>	<p><b>OP2:</b> 10 participants completed the demand-based training curriculum at Khon Kaen University</p>	<p><b>OC2:</b> Effective administration of midwifery education</p>
<b>Secondary beneficiaries</b>		
<ul style="list-style-type: none"> <li>• <b>Midwives and nursing students in Lao PDR</b></li> </ul>	<p><b>OP3:</b> 3,235 midwives and nursing students received training from midwifery educators</p>	<p><b>OC3.1:</b> Midwives’ enhanced competency and knowledge on midwifery  <b>OC3.2:</b> Positive feeling and improved self-confidence and self-esteem</p>
<ul style="list-style-type: none"> <li>• <b>Lao Citizens</b></li> </ul>	<p><b>OP4:</b> 43,780 citizens gained access to RMNCH services provided by midwives and nurses</p>	<p><b>OC4.1:</b> Women’s increased confidence in taking care of their health  <b>OC4.2:</b> Safe pregnancy and delivery  <b>OC4.3:</b> Healthier babies  <b>OC4.4:</b> Decreased financial loss from pregnancy- and delivery-related complications</p>
<ul style="list-style-type: none"> <li>• <b>Policymakers in charge of maternal health policy in the Lao PDR government</b></li> </ul>	<p><b>OP5:</b> 13 SS/TC activities related to the Midwifery Capacity Development project</p>	<p><b>OC5:</b> Enhanced national capacity and competency in midwifery education</p>



Table 3-3. Theory of Change for the “Midwifery Capacity Development” project

Condition (s)	Strategy (-ies)	Activity (-ies)	Output (s)	Outcome (s)
<p><b>Context</b></p> <ul style="list-style-type: none"> <li>• Developing country</li> <li>• High-risk MMR country</li> <li>• Shortage of midwives and nurses for RMNCH services</li> </ul> <p><b>Stakeholders</b></p> <ul style="list-style-type: none"> <li>• <i>Primary stakeholders:</i> midwifery educators and midwifery education administrators</li> <li>• <i>Secondary stakeholders:</i> midwives and nurses in Lao PDR, Lao citizens, policymakers in charge of maternal health policy in Lao PDR</li> </ul> <p><b>Inputs</b></p> <ul style="list-style-type: none"> <li>• Financial donations: US\$ 463,024.60</li> <li>• In-kind contributions: US\$ 138,907.38</li> </ul>	<ul style="list-style-type: none"> <li>• Support institutional capacity development for midwifery educators and midwifery education administrators</li> </ul>	<ul style="list-style-type: none"> <li>• Three needs assessments in Lao PDR</li> <li>• Presentation of the results from the need assessments and validation of needs with Lao officers</li> <li>• Study visit by 12 Lao policy makers on midwifery structure and programs to Thailand</li> <li>• Strengthening of midwifery educators in Lao PDR, training for midwifery and clinical teachers</li> <li>• Supported the training courses to strengthen midwifery educators from Lao PDR -- the first batch of a six-month training for 18 midwifery and clinical teachers</li> <li>• Produced teaching manuals, guidelines, and other materials</li> <li>• Reviewed the revised midwifery curriculum for Lao PDR and analyzed its application</li> <li>• Organized and provided training to the participants: 10-18 participants in the first</li> </ul>	<ul style="list-style-type: none"> <li>• <b>OP1:</b> 42 participants completed the demand-based training curriculum at Khon Kaen University</li> <li>• <b>OP2:</b> 10 participants completed the demand-based training curriculum at Khon Kaen University</li> </ul>	<ul style="list-style-type: none"> <li>• <b>OC1.1:</b> Participants’ enhanced competency and knowledge on midwifery education</li> <li>• <b>OC1.2:</b> Participants’ enhanced motivation and integration of expertise with their employment within the nursing and midwifery schools and hospitals</li> <li>• <b>OC1.3:</b> Positive feeling and improved self-confidence and self-esteem</li> <li>• <b>OC2:</b> Effective administration of midwifery education</li> </ul>

Table 3-3. Theory of Change for the “Midwifery Capacity Development” project

Condition (s)	Strategy (-ies)	Activity (-ies)	Output (s)	Outcome (s)
	<ul style="list-style-type: none"> <li>Promote the ICM-WHO midwifery education standards as a requirement of midwifery core competencies towards the reduction of maternal and newborn deaths in Laos</li> </ul>	<p>batch and 24 participants in the second batch</p> <ul style="list-style-type: none"> <li>Support and facilitate all processed from needs assessment to monitoring and evaluation</li> <li>Worked with TICA and Lao PDR government in organizing and funding all the activities under the SS/TC project on Safe Motherhood for Lao PDR’s Institutional Midwifery Capacity Development</li> <li>Worked with TICA and UNFPA to organize a workshop on ICM-WHO Core Competency for Midwifery Standards for International Short Courses on Midwifery and Maternal Health</li> <li>Led the monitoring and evaluating process for the Lao PDR’s Institutional Capacity on Midwifery Education</li> </ul>	<ul style="list-style-type: none"> <li><b>OP3:</b> 3,235 midwives and nursing students received training from midwifery educators</li> <li><b>OP4:</b> 43,780 citizens gained access to RMNCH services provided by midwives and nurses</li> <li><b>OP5:</b> 13 SS/TC activities related to the Midwifery Capacity Development project</li> </ul>	<ul style="list-style-type: none"> <li><b>OC3.1:</b> Midwives’ enhanced competency and knowledge on midwifery</li> <li><b>OC3.2:</b> Positive feeling and improved self-confidence and self-esteem</li> <li><b>OC4.1:</b> Women’s increased confidence in taking care of their health</li> <li><b>OC4.2:</b> Safe pregnancy and delivery</li> <li><b>OC4.3:</b> Healthier babies</li> <li><b>OC4.4:</b> Decreased financial loss from pregnancy- and delivery-related complications</li> <li><b>OC5:</b> Enhanced national capacity and competency in midwifery education</li> </ul>

### 3.3.3 Evidencing the Outcomes and Attaching Values to Each Outcome

#### (1) Data collection

(1.1) **Documentary research** was used to produce the first version of the impact map before gathering data from stakeholders. The UNFPA reports, several government documents from Thailand and Lao PDR, and research articles on midwifery education and maternal health were the primary sources of data for identifying the financial proxy for each project outcome.

(1.2) **Focus group discussions** were conducted with the primary beneficiaries (i.e., midwifery educators and midwifery education administrators) to determine financial proxies for the outcomes that do not have the market values. A questionnaire was used to facilitate the focus group discussions by helping participants find the appropriate financial proxies for certain outcomes.<sup>6</sup> In this questionnaire, the researcher relied on a modified version of “SROI value game” in the questionnaire to explore the participants’ willingness to pay (WTP). The values provided were based on the focus group participants’ experiences of changes and their perceptions about the lasting and future impacts of the midwifery capacity development project. Three focus group discussions were conducted, and participants included:

- a. Focus group I - primary beneficiaries (25 midwifery educators and 5 midwifery education administrators),
- b. Focus group II – secondary beneficiaries (8 midwives/nursing students and 4 citizens), and
- c. Focus group III – secondary beneficiaries (7 midwives/nursing students and 6 citizens).

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<sup>6</sup> See Appendix V for the questionnaire (See Appendix VI for the English version).

**(1.3) Unstructured interviews** were held with staff members from the UNFPA Lao PDR and the Faculty of Nursing at Khon Kaen University. A total number of three informants were interviewed for this study.

**(1.4) Revealed preference technique** was also used to find the financial proxies for certain outcomes that could not be obtained from the focus group discussions and key informant interviews. Estimated values for these outcomes were based on prices of related market-traded goods that generate a similar benefit to what was described by the focus group participants.

**(2) Determining how long the outcomes last**

Data collected from the focus group discussions were also used to determine the duration of each outcome. Focus group participants were asked to estimate how long each outcome would last. Even though some of the project outcomes were likely to have a lifelong impact based on the related literature (e.g., safe pregnancy and delivery, healthier babies), a maximum duration of five years was assumed for this SROI analysis. Since no evidence could verify the lifelong impact of these outcomes, the duration was limited to five years.

**Table 3-4. Estimated duration of outcomes and the underlying assumptions (Midwifery Capacity Development Project)**

Outcome (s)	Duration	Assumption
<b>Midwifery educators</b>		
<b>OC1.1:</b> Midwifery educators' enhanced competency and knowledge on midwifery education	5 years	In the questionnaire, participants reported this change would last forever. However, most participants in focus group discussions pointed out that periodic refresher training was needed every five years.
<b>OC1.2:</b> Participants' enhanced motivation and integration of expertise with their employment within the nursing and midwifery schools and hospitals	5 years	Similarly, participants reported that periodic refresher training was needed every five years to maintain and increase their motivation.
<b>OC1.3:</b> Positive feeling and improved self-confidence and self-esteem	5 years	Based on the focus group discussions, positive feeling and improved self-confidence and self-esteem were also expected to decline within three years. The duration of this outcome was also five years.

**Table 3-4. Estimated duration of outcomes and the underlying assumptions (Midwifery Capacity Development Project)**

Outcome (s)	Duration	Assumption
<b>Midwifery education administrators</b>		
OC2: Effective administration of midwifery education	5 years	This outcome was likely to last five years. Afterwards, the administrators should receive refresher training or a new training curriculum.
<b>Midwives and nursing students in Lao PDR</b>		
OC3.1: Midwives' enhanced competency and knowledge on midwifery	2 years	All midwives during the focus group discussions required refresher training every two years to maintain the level and quality of RMNCH services.
OC3.2: Positive feeling and improved self-confidence and self-esteem	2 years	The midwives' positive outlook towards their profession, self-confidence, and self-esteem were reported to decline after two years.
<b>Lao Citizens</b>		
OC4.1: Women's increased confidence in taking care of their health	3 years	In the questionnaire, participants reported this change would last forever. However, their confidence depended on more than one factor. Other important factors included personnel, facilities, and equipment that need upgrades every three years.
OC4.2: Safe pregnancy and delivery	5 years	This is likely to have a lasting impact due to improved RMNCH services.
OC4.3: Healthier babies	5 years	This is likely to have a lasting impact due to improved RMNCH services.
OC4.4: Decreased financial loss from pregnancy- and delivery-related complications	1 year	This change would be limited to the intervention's duration.
<b>Policymakers in charge of maternal health policy in the Lao PDR government</b>		
OC5: Enhanced national capacity and competency in midwifery education	5 years	This change is likely to persist beyond the intervention's duration.

### (3) Attaching values to each outcome

Some of the outcomes had market values, but for those that did not have market values, an SROI value game exercise was used in the questionnaire to explore focus group participants' WTP. In the value game exercise, participants were asked to list items that have a market value and place the outcome of interest within the list. An average was calculated of the items below and above the outcome of interest. This value of the outcome was validated by checking back with the participants to see if they would be willing to pay the minimum amount reflected by the cheaper item below the outcome of interest, or if the

cost or value of the outcome actually represented how much they would pay to get the outcome of interest.

**Table 3-5. Description of the Financial Proxy for Each Outcome (Midwifery Capacity Development Project)**

Outcome (s)	Financial Proxy (-ies)
<b>Midwifery educators</b>	
OC1.1: Midwifery educators' enhanced competency and knowledge on midwifery education	WTP to be competent and knowledgeable about the ICM- WHO standards
OC1.2: Participants' enhanced motivation and integration of expertise with their employment within the nursing and midwifery schools and hospitals	WTP to be highly motivated and have more employment opportunity within the midwifery and nursing schools/hospitals
OC1.3: Positive feeling and improved self-confidence and self-esteem	WTP to have positive feelings and improved self-confidence/self-esteem
<b>Midwifery education administrators</b>	
OC2: Effective administration of midwifery education	WTP to have an effective management system of midwifery/nursing training and education
<b>Midwives and nursing students in Lao PDR</b>	
OC3.1: Midwives' enhanced competency and knowledge on midwifery	WTP to be competent in midwifery
OC3.2: Positive feeling and improved self-confidence and self-esteem	WTP to be confident
<b>Lao Citizens</b>	
OC4.1: Women's increased confidence in taking care of their health	WTP to be confident
OC4.2: Safe pregnancy and delivery	Cost of postpartum care
OC4.3: Healthier babies	WTP to have healthy baby
OC4.4: Decreased financial loss from pregnancy- and delivery-related complications	Amount saved by avoiding pregnancy- and delivery-related complications
<b>Policymakers in charge of maternal health policy in the Lao PDR government</b>	
OC5: Enhanced national capacity and competency in midwifery education	WTP to have an enhanced national capacity and competency in midwifery education

### 3.3.4 Establishing Social Impact

Once the projects outcome were identified in the impact map, the value of each outcome was matched with each stakeholder group to analyze the SROI. To avoid overclaiming the project benefits, discounting factors were added to the calculations of each impact to reduce or constrain the values of social returns. The relevance and magnitude of each discounting factor was judged separately for each outcome, rather than using blanket percentages. The discounting factors applied to each impact of the "Safe Birth for All" project are as follows:

### (1) Deadweight

Deadweights are what would have happened anyway in the absence of the policy interventions. The survey questionnaire distributed to participants in the focus group discussions contained a hypothetical question: “Would each of the project outcomes have improved, worsened, or remained the same, if there was no Midwifery Capacity Development project?” Based on Table 3-6, deadweights (the “improved” percentages) ranged from 1.8 percent – 9.1 percent with an average of four percent.

**Table 3-6. Deadweight values of each outcome from “Midwifery Capacity Development” project (n = 55)**

Outcome (s)	1 Limited	2 About the same	3 Improved
• <b>OC1.1:</b> Midwifery educators’ enhanced competency and knowledge on midwifery education	31 (56.4%)	21 (38.2%)	3 (5.5%)
• <b>OC1.2:</b> Participants’ enhanced motivation and integration of expertise with their employment within the nursing and midwifery schools and hospitals	33 (60.0%)	20 (36.4%)	2 (3.6%)
• <b>OC1.3:</b> Positive feeling and improved self-confidence and self-esteem	35 (63.6%)	16 (29.1%)	4 (7.3%)
• <b>OC2:</b> Effective administration of midwifery education	38 (69.1%)	12 (21.8%)	5 (9.1%)
• <b>OC3.1:</b> Midwives’ enhanced competency and knowledge on midwifery	33 (60.0%)	21 (38.2%)	1 (1.8%)
• <b>OC3.2:</b> Positive feeling and improved self-confidence and self-esteem	29 (52.7%)	25 (45.5%)	1 (1.8%)
• <b>OC4.1:</b> Women’s increased confidence in taking care of their health	31 (56.4%)	22 (40.0%)	2 (3.6%)
• <b>OC4.2:</b> Safe pregnancy and delivery	40 (72.7%)	13 (23.6%)	2 (3.6%)
• <b>OC4.3:</b> Healthier babies	35 (63.6%)	18 (32.7%)	2 (3.6%)
• <b>OC4.4:</b> Decreased financial loss from pregnancy- and delivery-related complications	42 (76.4%)	12 (21.8%)	1 (1.8%)
• <b>OC5:</b> Enhanced national capacity and competency in midwifery education	22 (40.0%)	32 (58.2%)	1 (1.8%)

### (2) Displacement

Based on the focus group discussions and key informant interviews, no negative externality from this project was reported. Thus, no displacement rate was taken into consideration in this SROI analysis.

### (3) Attribution

Based on the focus group discussions, the Lao PDR Ministry of Health also adopted several maternal health programs during the same period as the SS/TC Midwifery Capacity Development project. These programs could have also contributed to the outcomes identified in this SROI analysis. In the questionnaire, participants in the focus group discussions and key informants were asked to rate how much other maternal health programs executed by the Lao PDR Ministry of Health had contributed to the project outcomes.<sup>7</sup> As can be seen in Table 3-7, the attribution rates ranged from 9.1 percent – 16.4 percent.

**Table 3-7. Attribution of the outcomes (n = 55) (Midwifery Capacity Development project)**

Outcome (s)	Attribution Rate (s)
• OC1.1: Midwifery educators’ enhanced competency and knowledge on midwifery education	8 (14.5%)
• OC1.2: Participants’ enhanced motivation and integration of expertise with their employment within the nursing and midwifery schools and hospitals	7 (12.7%)
• OC1.3: Positive feeling and improved self-confidence and self-esteem	9 (16.4%)
• OC2: Effective administration of midwifery education	8 (14.5%)
• OC3.1: Midwives’ enhanced competency and knowledge on midwifery	5 (9.1%)
• OC3.2: Positive feeling and improved self-confidence and self-esteem	6 (10.9%)
• OC4.1: Women’s increased confidence in taking care of their health	10 (18.2%)
• OC4.2: Safe pregnancy and delivery	9 (16.4%)
• OC4.3: Healthier babies	8 (14.5%)
• OC4.4: Decreased financial loss from pregnancy- and delivery-related complications	6 (10.9%)
• OC5: Enhanced national capacity and competency in midwifery education	5 (9.1%)

### (4) Drop off

No evidence was found to allow for an estimated drop-off rate per outcome from the “Midwifery Capacity Development” project. Therefore, like the “Safe Birth for All” project, a similar drop-off rate of 20 percent was assumed for this SROI analysis, which was based on the assumption that the effect of the “Safe Birth for All” project will be zero after five years.

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<sup>7</sup> The questionnaire in Appendix V asked the participants to indicate whether or not other program/policy interventions executed by the Lao PDR government or other organizations influenced the outcomes created by the “Midwifery Capacity Development” program.



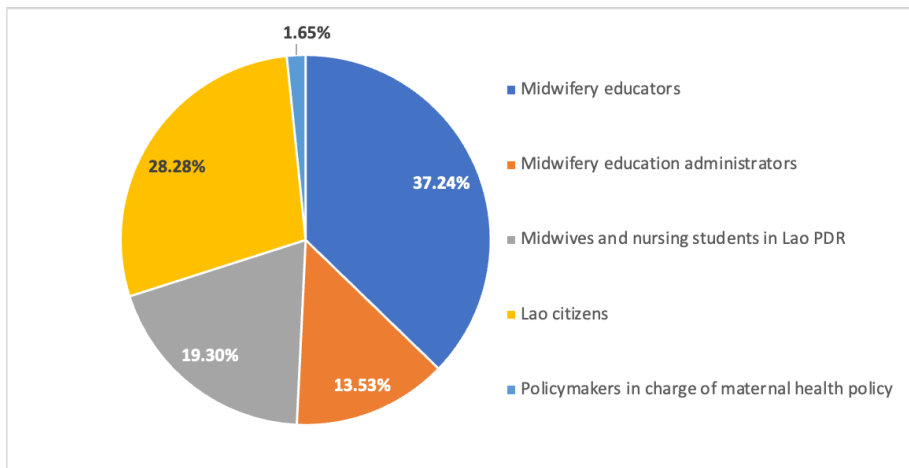
**(5) Discount rate**

A discount rate was applied to values of the outcomes having a duration of more than one year. However, inflation in Lao PDR jumped from 6.2 percent in January 2022 to 39.2 percent in December 2022. As such, a discount rate of 22.7 was used in this SROI analysis, which was based on an average of the inflation rates throughout 2022.

**3.3.5 Social Return Calculation**

**(1) SROI Ratio**

The SROI ratio was calculated by comparing the investments (inputs) and the total adjusted value of outcomes.<sup>8</sup> Based on this SROI analysis, the Midwifery Capacity Development project created a total value of US\$ 2,776,757. When adjusted for the discounting factors and an inflation rate of 22.7 percent, the total present value for the project was US\$ 7,844,752 (Table 3-8). Therefore, the SROI ratio is  $\frac{US\$ 7,844,752}{US\$ 601,931.98} = \frac{US\$ 13.03}{US\$ 1}$ . This ratio suggests that for every dollar of investment in the Midwifery Capacity Development project, US\$ 13.03 of social value was created. The stakeholders that benefited the most were midwifery educators (37.24 percent), followed by Lao citizens (28.28 percent), midwives and nursing students in Lao PDR (19.30 percent), midwifery education administrators (13.53 percent), and policymakers in charge of maternal health policy (1.65 percent) (Figure 3-2).



**Figure 3-2. Breakdown of the Total Adjust Value of Outcomes per Stakeholder Group (Midwifery Capacity Development project)**

<sup>8</sup> The total adjusted value of outcomes = total values \* deadweight \* displacement \* attribution \* discount rate (inflation adjustment)

**Table 3-8. Summary of the Findings of Social Returns (Midwifery Capacity Development project)**

Stakeholder	Total Adjusted Value of Outcomes	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Total PV
• Midwifery educators	1,034,062	1,034,062	842,756	559,774	303,026	133,691	48,070	2,921,379
• Midwifery education administrators	375,604	375,604	306,116	203,328	110,068	48,561	17,461	1,061,137
• Midwives and nursing students in Lao PDR	536,011	536,011	436,847	290,162	157,075	69,299	24,918	1,514,311
• Lao citizens	785,400	785,400	640,098	425,165	230,157	101,542	36,511	2,218,872
• Policymakers in charge of maternal health policy	45,680	45,680	37,229	24,728	13,386	5,906	2,124	129,053
<b>Total</b>	<b>2,776,757</b>	<b>2,776,757</b>	<b>2,263,046</b>	<b>1,503,156</b>	<b>813,712</b>	<b>358,998</b>	<b>129,083</b>	<b>7,844,752</b>

Note (s) : 1. All values in US\$  
 2. Discount rate of 22.7%

**Table 3-9. Social returns by stakeholder and outcome (Midwifery Capacity Development Project)**

Stakeholder (s)	Outcome (s)	Adjusted Value of Outcome (s)*
• Midwifery educators	OC1.1: Midwifery educators' enhanced competency and knowledge on midwifery education	335,078
	OC1.2: Participants' enhanced motivation and integration of expertise with their employment within the nursing and midwifery schools and hospitals	312,510
	OC1.3: Positive feeling and improved self-confidence and self-esteem	386,474
• Midwifery education administrators	OC2: Effective administration of midwifery education	375,604
• Midwives and nursing students in Lao PDR	OC3.1: Midwives' enhanced competency and knowledge on midwifery	206,010
	OC3.2: Positive feeling and improved self-confidence and self-esteem	330,001
• Lao Citizens	OC4.1: Women's increased confidence in taking care of their health	203,296
	OC4.2: Safe pregnancy and delivery	219,810
	OC4.3: Healthier babies	179,281
	OC4.4: Decreased financial loss from pregnancy- and delivery-related complications	183,013
• Policymakers in charge of maternal health policy	OC5: Enhanced national capacity and competency in midwifery education	45,680

Note (s): \*All adjusted values in US\$

When breaking down the social returns of the “Midwifery Capacity Development” project by stakeholder and outcome, it was found that the outcome with the highest adjusted value was Outcome 1.3 “Positive feeling and improved self-confidence and self-esteem” (US\$ 386,474), followed by Outcome 2 “Effective administration of midwifery education” (US\$ 375,604) and Outcome 1.1 “Midwifery educators’ enhanced competency and knowledge on midwifery education” (US\$ 335,078). This suggests that consistent with the main objective, the project had direct positive effects on the midwifery educators and midwifery education administrators.

## (2) Sensitivity Analysis

In this section, sensitivity analysis was performed to check the estimates of deadweight, displacement, attribution, drop off, discount rate, and value of the outcome determined by the SROI value game. The sensitivity analysis demonstrated that the SROI ratios based on the base and new scenarios fluctuate from US\$ 7:1 (Displacement) to US\$ 34:1

(Value of the outcome using value game – multiplied by 2) (Table 3-10). The SROI ratio is most sensitive to variations in the value of outcomes based on value game exercises, drop off, and displacement.

**Table 3-10. Base Case and New Case Scenarios (Midwifery Capacity Development project)**

	<b>Base Case</b>	<b>New Case</b>	<b>New SROI Ratio</b>
• <b>Deadweight</b>	1.8% - 9.1%	10%	US\$ 10: 1
• <b>Displacement</b>	No displacement	10%	US\$ 7: 1
• <b>Attribution</b>	9.1% - 16.4%	30%	US\$ 9: 1
• <b>Drop off</b>	20%	50%	US\$ 6: 1
• <b>Discount rate</b>	22.7%	6%	US\$ 11:1
• <b>Value of the outcome using value game</b>	On average US\$ 68	Value divided by 2	US\$ 8:1
• <b>Value of the outcome using value game</b>	On average US\$ 68	Value multiplied by 2	US\$ 34:1

## Chapter 4

### Conclusion and Recommendations

This chapter summarizes the results of the Social Return on Investment (SROI) analyses from the two previous chapters and compare them against the results of previous SROI analyses on reproductive and maternal health programs. Recommendations on how to improve and sustain the South-South and Triangular Cooperation (SS/TC) initiatives are provided at the end of this chapter.

#### 4.1 Summary of the SROI Analyses

4.1.1 This SROI analysis identified how the two RMNCH projects—the “Safe Birth for All” and “Midwifery Capacity Development” projects—fit into the United Nations Population Fund’s (UNFPA) transformative goals and the United Nations’ Sustainable Development Goals (SDGs), as well as the evidence from Thailand and Lao PDR in terms of outcomes for pregnant women, women of reproductive age, healthcare personnel, and policymakers in charge of each country’s maternal health policy. All the stakeholders were consulted to understand all the possible impacts (or changes) due to the projects. These outcomes were given a financial value based on the value of the benefits or costs saved through a reduction of negative and undesirable outcomes for the stakeholders. When the financial costs were not applicable, proxies were used to measure the value, informed by research and stakeholder consultation. This method ensures that all the important outcomes were measured and included in the project impact assessment. Measurable indicators were developed to assess whether the change has happened, how much of the change could be accounted for by each project, and how long the impact lasts.

4.1.2 This SROI analysis found that the “Safe Birth for All” project resulted in 2,100 pregnant women receiving early antenatal care in their first trimester and 4,100 at-risk pregnant women and their families receiving COVID-19 antigen tests. In the target areas, 2,230 adolescent mothers (6.30 percent) gained access to family planning and long-acting reversible contraceptives (LARC), and 30,000 teens could access the virtual health self-assessment platform supported by the project.

4.1.3 Based on this analysis, the “Midwifery Capacity Development” project provided opportunities for 52 participants (42 midwifery educators and 10 midwifery education administrators) from Lao PDR to attend training courses at Khon Kaen University. Upon project completion, 93 percent of the participants had higher self-confidence about their profession. The project also led to a 63-percent increase in the project participants’ capacity to contribute to their organizations, a 29-percent increase in employability prospects for the project participants, and a 24-percent increase in the project participants’ capacity to contribute to their communities. Further, this study identified that 6,235 midwives between 2016 and 2022 across Lao PDR received training from the midwifery educators who participated in this project. As a result, 43,780 women of reproductive age (e.g., pregnant women, adolescent girls, young mothers) could gain access to improved RMNCH services.

4.1.4 This analysis demonstrated that investment in SS/TC projects on RMNCH generated high social returns. For the “Safe Birth for All” project, every one dollar in investment led to US\$ 35.93 of social value. Also, every one dollar that was invested in the “Midwifery Capacity Development” project for Lao midwifery educators and midwifery education administrators created US\$ 13.03 of social value. Based on a systematic review of SROI studies by Banke-Thomas et al. (2015), the range of SROIs found from RMNCH programs were between 1.73 and 21.20. The SROI ratio from the “Safe Birth for All” project was higher than this range, while the “Midwifery Capacity Development” project generated SROI that fell within this range (Table 4-1).

**Table 4-1. Comparison of the SROI findings against the range of SROIs from other sexual and reproductive health studies**

Study (-ies)	SROI ratio (s)
• Safe Birth for All project	35.93
• Midwifery Capacity Development project	13.03
• Other sexual and reproductive health studies*	1.73-21.20

Note (s): \* Findings from Banke-Thomas et al. (2015)

4.1.5 The two SS/TC projects on RMNCH were demand-driven initiatives that were designed, developed, and executed according to each country’s social context and health needs. The “Midwifery Capacity Development” project equipped the Lao midwifery educators with all the necessary teaching skills that satisfied the International Confederation of Midwives and the World Health Organization’s (ICM-WHO) standards. Trained

midwifery educators had higher self-confidence and were able to impart their midwifery knowledge and skills to midwives and nursing students in their areas. The trained midwifery education administrators and their institutions also benefited from the training curriculum and from more knowledgeable and confidence midwifery teachers. As a result of this project, Lao PDR's improved midwifery workforce accelerated the progress of realizing the UNFPA's transformative goals and SDGs (Goal 3 "Good Health and Wellbeing"). Similarly, the SS/TC on RMNCH in Thailand—the "Safe Birth for All" project—represents a promising platform for UNFPA to mobilize financial support from private and non-profit organizations. Not only did the project help women of reproductive age in the rural areas gain access to quality RMNCH services, it also provided the rural birth attendants in Thailand with the opportunity to improve their skills and knowledge.

## **4.2 Limitations**

The limitations of this SROI analysis stemmed from the complexity of assessing future health benefits and the challenges in valuing non-market outcomes. The researcher decided to forego the future health benefits and limit the duration of this SROI analysis to five years. While this decision may underestimate future health benefits of a project, data unavailability did not allow for extending this analysis beyond five years. Also, the willingness to pay (WTP) via social value games was adopted to monetize outcomes that did not have suitable market values, such as confidence and positive feelings. While the social value games helped minimize subjectivity and permitted the researcher to easily reach a consensus in each focus group on monetizing outcomes with non-market prices, the sensitivity analysis of each SS/TC project indicated that the SROI ratios were most sensitive to the values generated by social value games.

## **4.3 Recommendations**

4.3.1 This SROI analysis lends strong support to the continuation of the two SS/TC initiatives. For the design of a future SS/TC initiative with a high social return, UNFPA Thailand Country Office ought to consider two following features:

(1) Any health-related interventions should be demand-based. Stakeholders, particularly the primary beneficiaries, must be involved in the project design and implementation; and

(2) Thailand's strengths, expertise, and resources must be developed and used to their full potential. UNFPA Thailand Country Office ought to work with Thailand International Cooperation Agency (TICA) on constantly updating its catalog of training curriculum and SS/TC assistance packages for developing countries.

4.3.2 In terms of SS/TC initiatives with an RMNCH focus, UNFPA Thailand Country Office should explore collaborative opportunities with other philanthropic organizations and government agencies (e.g., Ministry of Interior and local administrative organizations). The Ministry of Interior and local administrative organizations in particular have expanded their health-related functions, including primary care provision, due to the national government's decentralization policy. Engaging with the interior ministry and local governments would not only help to mobilize more resources for the SS/TC initiatives, but also facilitate scaling up of access to RMNCH services in other remote areas.

4.3.3 UNFPA Thailand Country Office could also embed and promote multi-agency practice at an operational level to inform service planning and delivery. Potential partner agencies include, but are not limited to, the military, schools, and youth councils that operate under the aegis of the Ministry of Social Development and Human Security.

4.3.4 Refresher training were extensively mentioned throughout the focus group discussions with participants from the "Safe Birth for all" and "Midwifery Capacity Development" projects. This would help participants review and reinforce their knowledge from the initial training. UNFPA Thailand Country Office could collaborate with the implementing agencies (e.g., Khon Kaen University in the "Safe Birth for All" project) in developing a virtual knowledge exchange platform and in using online learning tools to provide refresher training for participants in the SS/TC initiatives.

4.3.5 While SROI analysis is a powerful tool to measure the changes experienced by stakeholders in the SS/TC initiatives, more systematic monitoring and evaluation of long-term outcomes could provide more insight into the consequences – both positive and negative – of the interventions. UNFPA Thailand Country Office should first help its partner agencies,



particularly in the Thai government, to embed the SROI analysis in monitoring and evaluating the SS/TC initiatives. Second, an open monitoring and evaluation system empowered by digital technology should be developed to allow for real-time tracking of the SS/TC activities and development outcomes.

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# Appendix I

แบบสอบถามประเมินผลตอบแทนการลงทุนทางสังคม  
โครงการพัฒนาและส่งเสริมการเกิดอย่างมีคุณภาพและถ้วนหน้า  
ภายใต้โครงการความร่วมมือไตรภาคีแบบใต้-ใต้ของกองทุนประชากรแห่งสหประชาชาติ  
(สำหรับกลุ่มเป้าหมายในพื้นที่เป้าหมายของโครงการ)

**ตอนที่ 1 ข้อมูลทั่วไป**  
โปรดทำเครื่องหมาย ✓ ในข้อที่สอดคล้องกับท่านมากที่สุด

1.1 ตำแหน่ง  บุคลากรกระทรวงสาธารณสุข/โรงพยาบาล/โรงพยาบาลส่งเสริมสุขภาพตำบล  
 บุคลากรสังกัดองค์กรปกครองส่วนท้องถิ่น  
 อาสาสมัครสาธารณสุขประจำหมู่บ้าน (อสม.)  
 ประชาชน

1.2 ท่านได้รับผลกระทบจากโครงการพัฒนาและส่งเสริมการเกิดอย่างมีคุณภาพและถ้วนหน้า (Safe Birth for All) อย่างไร (เลือกได้มากกว่า 1 ข้อ)

ได้รับผลกระทบโดยตรง เนื่องจากเข้าร่วมการฝึกอบรมของหน่วยงานที่รับผิดชอบโครงการ

ได้รับผลกระทบโดยตรง เนื่องจากตัวท่านเองหรือบุคคลในครอบครัวได้รับประโยชน์จากโครงการ เช่น ได้รับบริการดูแลรักษาจากผดุงครรภ์หรือบุคลากรทางด้านสาธารณสุขในพื้นที่

ได้รับผลกระทบทางอ้อม กรุณาอธิบาย.....

## ตอนที่ 2 ความยั่งยืนของผลกระทบจากโครงการพัฒนาและส่งเสริมการเกิดอย่างมีคุณภาพและถ้วนหน้า

กรุณาระบุระยะเวลา (ไม่เกิน 5 ปี) ของแต่ละผลลัพธ์ของโครงการพัฒนาและส่งเสริมการเกิดอย่างมีคุณภาพและถ้วนหน้า

ผลลัพธ์	ระยะเวลา (กรณาระบุเป็นจำนวนปี)
1. ความเชื่อมั่นของสตรีมีครรภ์และมารดาวัยรุ่นในการดูแลสุขภาพตนเองและบุตร	
2. การตั้งครรภ์และคลอดที่ปลอดภัย	
3. ทารกที่มีสุขภาพดีแข็งแรง	
4. ค่าใช้จ่ายที่ประหยัดได้อันเนื่องมาจากการหลีกเลี่ยงความเสี่ยงในการตั้งครรภ์ ภาวะแทรกซ้อน และปัญหาในการคลอดบุตร	
5. ค่าใช้จ่ายที่ประหยัดได้จากการหลีกเลี่ยงการติดเชื้อ COVID-19	
6. การหลีกเลี่ยงการเสียชีวิตจากโรค COVID-19	
7. การหลีกเลี่ยงการตั้งครรภ์ที่ไม่พึงประสงค์	
8. ความเชื่อมั่นของวัยรุ่นและความสามารถในการวางแผนครอบครัวและการดูแลอนามัยเจริญพันธุ์	
9. ภาระงานที่ลดลงเนื่องจากมารดาและทารกที่มีสุขภาพดี	
10. ความเชื่อมั่นในการให้บริการอนามัยเจริญพันธุ์	
11. ความเชื่อมั่นในการนำความรู้การแพทย์สมัยใหม่ช่วยหลีกเลี่ยงการคลอดบุตรอย่างปลอดภัย	
12. ความเครียดที่เพิ่มขึ้นจากให้บริการ	
13. นโยบายและโครงการเกี่ยวกับอนามัยเจริญพันธุ์ที่มีความแม่นยำและเท่าทันสถานการณ์	

## ตอนที่ 3 การประเมินมูลค่าของผลลัพธ์โดยใช้แนวคิด “ความเต็มใจจ่าย (Willingness to Pay: WTP)”

ขั้นตอนที่ 1 กรุณาเรียงลำดับความสำคัญของสิ่งต่อไปนี้สำหรับท่าน

ลอตเตอรี่ที่ถูกรางวัลเลขท้าย 3 ตัว

ที่ดินติดแหล่งน้ำชลประทาน 10 ไร่

บ้าน 2 ชั้นพร้อมที่ดิน

รถยนต์ 4 ประตู 1 คัน

อาหารฟรี 3 มื้อตลอดชีวิต

ทุนการศึกษาสำหรับบุตรหลาน

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ขั้นตอนที่ 2 กรณาระบุจำนวนเงินสำหรับสิ่งของในขั้นตอนที่ 1 โดยจำกัดเพดานมูลค่าที่ 50,000 บาท

สิ่งของ (เรียงตามลำดับความสำคัญในขั้นตอนที่ 1)	มูลค่า (บาท)
1.	
2.	
3.	
4.	
5.	
6.	

ขั้นตอนที่ 3 กรณามูลค่าทางการเงินของผลลัพธ์ต่อไปนี้เป็นจากโครงการพัฒนาและส่งเสริมการเกิดอย่างมีคุณภาพและก้าวหน้า

ผลลัพธ์	มูลค่า (บาท)
1. ความเชื่อมั่นของสตรีมีครรภ์และมารดาวัยรุ่นในการดูแลสุขภาพตนเองและบุตร	
2. ทารกที่มีสุขภาพดีแข็งแรง	
3. การหลีกเลี่ยงการเสียชีวิตจากโรค COVID-19	
4. การหลีกเลี่ยงการตั้งครรภ์ที่ไม่พึงประสงค์	
5. ความเชื่อมั่นของวัยรุ่นและความสามารถในการวางแผนครอบครัวและการดูแลอนามัยเจริญพันธุ์	
6. ความเชื่อมั่นในการให้บริการอนามัยเจริญพันธุ์	
7. ความเชื่อมั่นในการนำความรู้การแพทย์สมัยใหม่ช่วยเหลือการคลอดบุตรอย่างปลอดภัย	
8. ความเครียดที่เพิ่มขึ้นจากให้บริการ	
9. นโยบายและโครงการเกี่ยวกับอนามัยเจริญพันธุ์ที่มีความแม่นยำและเท่าทันสถานการณ์	

ตอนที่ 4 ผลกระทบจากโครงการและแผนงานอื่นที่มีลักษณะใกล้เคียงกับโครงการพัฒนาและส่งเสริมการเกิดอย่างมีคุณภาพและก้าวหน้า

4.1 กรณาระบุโครงการและแผนงานอื่นที่มีลักษณะใกล้เคียงกับโครงการพัฒนาและส่งเสริมการเกิดอย่างมีคุณภาพและก้าวหน้าและมีผลลัพธ์ใกล้เคียงกัน

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4.2 กรณาระบุสัดส่วนผลกระทบจากโครงการและแผนงานที่ท่านระบุในข้อ 4.1 โดยประมาณการเป็นร้อยละ (%)

ผลลัพธ์	ผลกระทบจากโครงการและแผนงานอื่น (ร้อยละ)
1. ความเชื่อมั่นของสตรีมีครรภ์และมารดาวัยรุ่นในการดูแลสุขภาพตนเองและบุตร	
2. การตั้งครรภ์และคลอดที่ปลอดภัย	
3. ทารกที่มีสุขภาพดีแข็งแรง	
4. ค่าใช้จ่ายที่ประหยัดได้เนื่องมาจากการหลีกเลี่ยงความเสี่ยงในการตั้งครรภ์ ภาวะแทรกซ้อน และปัญหาในการคลอดบุตร	
5. ค่าใช้จ่ายที่ประหยัดได้จากการหลีกเลี่ยงการติดเชื้อ COVID-19	
6. การหลีกเลี่ยงการเสียชีวิตจากโรค COVID-19	
7. การหลีกเลี่ยงการตั้งครรภ์ที่ไม่พึงประสงค์	
8. ความเชื่อมั่นของวัยรุ่นและความสามารถในการวางแผนครอบครัวและการดูแลอนามัยเจริญพันธุ์	
9. ภาระงานที่ลดลงเนื่องจากมารดาและทารกที่มีสุขภาพดี	
10. ความเชื่อมั่นในการให้บริการอนามัยเจริญพันธุ์	
11. ความเชื่อมั่นในการนำความรู้การแพทย์สมัยใหม่ช่วยเหลือการคลอดบุตรอย่างปลอดภัย	
12. ความเครียดที่เพิ่มขึ้นจากให้บริการ	
13. นโยบายและโครงการเกี่ยวกับอนามัยเจริญพันธุ์ที่มีความแม่นยำและเท่าทันสถานการณ์	

## Appendix II

แบบสอบถามประเมินผลตอบแทนการลงทุนทางสังคม  
โครงการพัฒนาและส่งเสริมการเกิดอย่างมีคุณภาพและก้าวหน้า  
ภายใต้โครงการความร่วมมือไตรภาคีแบบใต้-ใต้ของกองทุนประชากรแห่งสหประชาชาติ  
(สำหรับกลุ่มเป้าหมายในพื้นที่เปรียบเทียบ)

<b>ตอนที่ 1 ข้อมูลทั่วไป</b> โปรดทำเครื่องหมาย ✓ ในข้อที่สอดคล้องกับท่านมากที่สุด <b>ตำแหน่ง</b> <input type="checkbox"/> บุคลากรกระทรวงสาธารณสุข/โรงพยาบาล/โรงพยาบาลส่งเสริมสุขภาพตำบล <input type="checkbox"/> บุคลากรสังกัดองค์กรปกครองส่วนท้องถิ่น <input type="checkbox"/> อาสาสมัครสาธารณสุขประจำหมู่บ้าน (อสม.) <input type="checkbox"/> ประชาชน
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### ตอนที่ 2 สถานการณ์ปัจจุบันด้านอนามัยเจริญพันธุ์และอนามัยแม่และเด็กในพื้นที่ของท่าน

ในระยะเวลา 1-2 ปีที่ผ่านมา สถานการณ์ด้านอนามัยเจริญพันธุ์และอนามัยแม่และเด็กในพื้นที่ของท่านเป็นเช่นไร กรุณาทำเครื่องหมาย ✓ ในข้อที่สอดคล้องกับท่านมากที่สุด

ผลลัพธ์	แย่ลง	เหมือนเดิม	ดีขึ้น
1. ความเชื่อมั่นของสตรีมีครรภ์และมารดาวัยรุ่นในการดูแลสุขภาพตนเองและบุตร			
2. การตั้งครรภ์และคลอดที่ปลอดภัย			
3. ทารกที่มีสุขภาพดีแข็งแรง			
4. ค่าใช้จ่ายที่ประหยัดได้อันเนื่องมาจากการหลีกเลี่ยงความเสี่ยงในการตั้งครรภ์ ภาวะแทรกซ้อน และปัญหาในการคลอดบุตร			
5. ค่าใช้จ่ายที่ประหยัดได้จากการหลีกเลี่ยงการติดเชื้อ COVID-19			
6. การหลีกเลี่ยงการเสียชีวิตจากโรค COVID-19			
7. การหลีกเลี่ยงการตั้งครรภ์ที่ไม่พึงประสงค์			
8. ความเชื่อมั่นของวัยรุ่นและความสามารถในการวางแผนครอบครัวและการดูแลอนามัย เจริญพันธุ์			
9. ภาระงานที่ลดลงเนื่องจากมารดาและทารกที่มีสุขภาพดี			
10. ความเชื่อมั่นในการให้บริการอนามัยเจริญพันธุ์			
11. ความเชื่อมั่นในการนำความรู้การแพทย์สมัยใหม่ช่วยเหลือการคลอดบุตรอย่างปลอดภัย			
12. ความเครียดที่เพิ่มขึ้นจากให้บริการ			
13. นโยบายและโครงการเกี่ยวกับอนามัยเจริญพันธุ์ที่มีความแม่นยำและเท่าทันสถานการณ์			



**Appendix III**  
**Social Return on Investment (SROI) Survey**  
**“Safe Birth for All” Project**  
**Under the UNFPA South-South and Triangular Cooperation**  
**For Use in the Target Areas**

**Part 1 General Information**

- 1.1 Indicate your role in your community by placing ✓ in the appropriate box
- Healthcare professional in hospital/subdistrict health promoting hospital
  - Local government official
  - Village health volunteer
  - Citizen
- 1.2 Indicate how you have been affected by the “Safe Birth for All” project by placing ✓ in the appropriate box
- Direct beneficiary as trainee
  - Direct beneficiary as citizen recipient of services
  - Indirect beneficiary. Please explain.....
- .....

**Part 2 Duration of the Project Outcomes**

In your view, indicate the direction of each outcome (A maximum of 5 years)

Outcome (s)	Duration (year)
1. Pregnant women and adolescent mothers’ confidence in taking care of their health and their babies’	
2. Safe pregnancy and delivery	
3. Healthier babies	
4. Decreased financial loss from pregnancy- and delivery-related complications	
5. Decreased financial loss from COVID-19 infection	
6. Avoided COVID-19 deaths	
7. Avoided unintended pregnancies	
8. Teens’ confidence and ability to make informed choices about their reproductive health	
9. Decreased workload due to healthier mothers and newborns	
10. Increased confidence in providing RMNCH services	
11. Increased confidence in using modern medical knowledge to assist childbirth in the local circumstances	
12. Increased stress due to the difficulties posed by the work	
13. Precise and real-time policies and programs on RMNCH service design	

**Part 3 Willingness to Pay (WTP)**

Step 1 Arrange the following commodities in order of importance

- |                 |                          |                           |
|-----------------|--------------------------|---------------------------|
| Winning lottery | Irrigated land           | A double-storey house     |
| A car           | Free meal for a lifetime | Scholarships for children |

**Step 2** Indicate the monetary value of each commodity from Step 1 (A maximum of 50,000 Baht)

Commodity (-ies)	Value (Baht)
1.	
2.	
3.	
4.	
5.	
6.	

**Step 3** Indicate the monetary value of each project outcome (A maximum of 50,000 Baht)

Outcome (s)	Duration (year)
1. Pregnant women and adolescent mothers' confidence in taking care of their health and their babies'	
2. Healthier babies	
3. Avoided COVID-19 deaths	
4. Avoided unintended pregnancies	
5. Teens' confidence and ability to make informed choices about their reproductive health	
6. Increased confidence in providing RMNCH services	
7. Increased confidence in using modern medical knowledge to assist childbirth in the local circumstances	
8. Increased stress due to the difficulties posed by the work	
9. Precise and real-time policies and programs on RMNCH service design	

### Part 3 Attribution Evaluation

4.1 Indicate the programs/projects with similar objectives and activities as the "Safe Birth for All" project.

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4.2 Evaluate the impact of the programs/projects in 4.1 using percentages.

Outcome (s)	Impact (%)
1. Pregnant women and adolescent mothers' confidence in taking care of their health and their babies'	
2. Safe pregnancy and delivery	
3. Healthier babies	
4. Decreased financial loss from pregnancy- and delivery-related complications	
5. Decreased financial loss from COVID-19 infection	
6. Avoided COVID-19 deaths	
7. Avoided unintended pregnancies	
8. Teens' confidence and ability to make informed choices about their reproductive health	
9. Decreased workload due to healthier mothers and newborns	
10. Increased confidence in providing RMNCH services	
11. Increased confidence in using modern medical knowledge to assist childbirth in the local circumstances	
12. Increased stress due to the difficulties posed by the work	
13. Precise and real-time policies and programs on RMNCH service design	

**Appendix IV**  
**Social Return on Investment (SROI) Survey**  
**“Safe Birth for All” Project**  
**Under the UNFPA South-South and Triangular Cooperation**  
**For Use in the Comparison Area**

**Part 1 General Information**

Indicate your role in your community by placing ✓ in the appropriate box

- Healthcare professional in hospital/subdistrict health promoting hospital
- Local government official
- Village health volunteer
- Citizen

**Part 2 Maternal and Child Health Situation in Your Area**

How has the maternal and child health situation in your area been over the past 1-2 years? Please answer by placing ✓ in the appropriate box

Outcome (s)	Limited	About the Same	Improved
1. Pregnant women and adolescent mothers' confidence in taking care of their health and their babies'			
2. Safe pregnancy and delivery			
3. Healthier babies			
4. Decreased financial loss from pregnancy- and delivery-related complications			
5. Decreased financial loss from COVID-19 infection			
6. Avoided COVID-19 deaths			
7. Avoided unintended pregnancies			
8. Teens' confidence and ability to make informed choices about their reproductive health			
9. Decreased workload due to healthier mothers and newborns			
10. Increased confidence in providing RMNCH services			
11. Increased confidence in using modern medical knowledge to assist childbirth in the local circumstances			
12. Increased stress due to the difficulties posed by the work			
13. Precise and real-time policies and programs on RMNCH service design			

## Appendix V

ແບບສອບຖາມປະເມີນຜົນກະທົບທາງສັງຄົມ  
ເພື່ອສຶກສາຜົນຕອບແທນການລົງທຸນທາງສັງຄົມ  
ໂຄງການເຜີກອົບລົມຄູເຜີກຜະດຸງຄັນ (ໂຄງການພັດທະນາສັກກະຍະພາບຄູເຜີກຜະດຸງຄັນ)

<b>ຕອນທີ 1 ຂໍ້ມູນທົ່ວໄປ</b>	
1.1 ຕຳແໜ່ງ	<input type="checkbox"/> ຜະດຸງຄັນ <input type="checkbox"/> ຄູເຜີກຜະດຸງຄັນ <input type="checkbox"/> ຜູ້ບໍລິຫານ <input type="checkbox"/> ປະຊາຊົນ
1.2 ຖ້າເຈົ້າເປັນຄູເຜີກຜະດຸງຄັນແລະຜູ້ບໍລິຫານ ເຈົ້າເຂົ້າຮ່ວມ ໂຄງການເຜີກອົບລົມຜະດຸງຄັນຂອງ TICA ເມື່ອປີໃດ.....	
1.3 ປະຈຸບັນເຮັດວຽກຢູ່ທີ່ໃດ	
ໂຮງໜີ້/ວິທະຍາໄລ/ໂຮງຮຽນ.....	
ເມືອງ.....	
ແຂວງ.....	

### ຕອນທີ 2 ຄວາມຍືນຍົງຂອງຜົນຕອບແທນຈາກການລົງທຸນທາງສັງຄົມ

ກະລຸນາລະບຸໄລຍະເວລາ (ບໍ່ເກີນ 5 ປີ) ຂອງຜົນຕອບແທນຈາກໂຄງການພັດທະນາສັກກະຍະພາບຄູເຜີກຜະດຸງຄັນ

ຜົນຕອບແທນ	ໄລຍະເວລາ (ປີ)
• ຄູເຜີກຜະດຸງຄັນມີຄວາມຮູ້ເລື່ອງຜະດຸງຄັນແລະການສອນຜະດຸງຄັນຫຼາຍຂຶ້ນ	
• ຄູເຜີກຜະດຸງຄັນມີຄວາມເຊື່ອມັ່ນໃນວິຊາຊີບແລະຄວາມສາມາດໃນການເຮັດວຽກທີ່ໂຮງໜີ້ ວິທະຍາໄລ ແລະໂຮງຮຽນເຜີກຜະດຸງຄັນ	
• ຄູເຜີກຜະດຸງຄັນມີຄວາມຄິດເຊີງບວກແລະຄວາມເຊື່ອມັ່ນໃນໂຕເອງ	
• ຜູ້ບໍລິຫານສາມາດ ບໍລິຫານການຮຽນການສອນຜະດຸງຄັນຢ່າງມີປະສິດທິພາບ	
• ຜະດຸງຄັນມີຄວາມຮູ້ແລະຄວາມສາມາດຫຼາຍຂຶ້ນ	
• ຜະດຸງຄັນມີຄວາມຄິດເຊີງບວກແລະຄວາມເຊື່ອມັ່ນໃນໂຕເອງ	
• ແມ່ຍິງມີຄວາມເຊື່ອມັ່ນໃນການດູແລສຸຂະພາບຂອງໂຕເອງ	
• ການຕັ້ງຄັນແລະການເກີດລູກທີ່ປອດໄພ	
• ເດັກແດງມີສຸຂະພາບແຂ້ງແຮງ	
• ຄ່າໃຊ້ຈ່າຍຄົວເຮືອນທີ່ລົດລົງທີ່ບໍ່ຕ້ອງປິ່ນປົວພະຍາດ ແລະຊຸກຊ້ອນຈາກການຕັ້ງຄັນແລະການເກີດລູກທີ່ບໍ່ປອດໄພ	
• ລະບົບການກຳກັບດູແລງານຜະດຸງຄັນແລະການເຜີກຜະດຸງຄັນໃນລະດັບຊາດທີ່ດີຂຶ້ນ	

### ຕອນທີ 3 ການປະເມີນຄວາມຕັ້ງໃຈໃນການຈ່າຍເງິນ (Willingness to Pay: WTP)

3.1 ກະລຸນາລຽງລຳດັບຄວາມສຳຄັນຂອງສິ່ງຂອງຕໍ່ໄປນີ້

ຫວຍທີ່ຖືກເລກທ້າຍ 3 ໂຕ  
ລົດຍົນ 4 ປະຕູ
ທີ່ດິນຕິດກັບແຮງຊົນລະປະທານ 10 ໄລ່  
ອາຫານຜີ 3 ມື້ອຊົວຊີວິດ
ເຮືອນ 2 ຊັ້ນພ້ອມທີ່ດິນ  
ທຶນການສຶກສາສຳລັບລູກຫຼານ

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3.2 ກະລຸນາລະບຸຈຳນວນເງິນສຳລັບສິ່ງຂອງໃນຂໍ້ 3.1 ໂດຍຈຳກັດເພດານທີ່ 20.000.000 ກີບ

ສິ່ງຂອງໃນຂໍ້ 3.1 (ລຽງຕາມລຳດັບຄວາມສຳຄັນ)	ຈຳນວນເງິນ
1.	
2.	
3.	
4.	
5.	
6.	

3.3 ລະບຸຈຳນວນເງິນສຳລັບຜົນຕອບແທນຕໍ່ໄປນີ້ຈາກໂຄງການພັດທະນາສັກກະຍະພາບຄູເຝິກຜະດຸງຄົ້ນ

ຜົນຕອບແທນ	ຈຳນວນເງິນ
• ຄູເຝິກຜະດຸງຄົ້ນມີຄວາມຮູ້ເລື່ອງຜະດຸງຄົ້ນແລະການສອນຜະດຸງຄົ້ນຫຼາຍຂຶ້ນ	
• ຄູເຝິກຜະດຸງຄົ້ນມີຄວາມເຊື່ອມັ່ນໃນວິຊາຊີບແລະຄວາມສາມາດໃນການເຮັດວຽກທີ່ໂຮງໝໍ ວິທະຍາໄລ ແລະໂຮງຮຽນເຝິກຜະດຸງຄົ້ນ	
• ຄູເຝິກຜະດຸງຄົ້ນມີຄວາມຄິດເຊິ່ງບວກແລະຄວາມເຊື່ອມັ່ນໃນໂຕເອງ	
• ຜູ້ບໍລິຫານສາມາດ ບໍລິຫານການຮຽນການສອນຜະດຸງຄົ້ນຢ່າງມີປະສິດທິພາບ	
• ຜະດຸງຄົ້ນມີຄວາມຮູ້ແລະຄວາມສາມາດຫຼາຍຂຶ້ນ	
• ຜະດຸງຄົ້ນມີຄວາມຄິດເຊິ່ງບວກແລະຄວາມເຊື່ອມັ່ນໃນໂຕເອງ	
• ແມ່ຍິງມີຄວາມເຊື່ອມັ່ນໃນການດູແລສຸຂະພາບຂອງໂຕເອງ	
• ເດັກແດງມີສຸຂະພາບແຂ້ງແຮງ	
• ລະບົບການກຳກັບດູແລງານຜະດຸງຄົ້ນແລະການເຝິກຜະດຸງຄົ້ນໃນລະດັບຊາດທີ່ດີຂຶ້ນ	

ຕອນທີ 4 ສະຖານະການບໍ່ມີໂຄງການພັດທະນາສັກກະຍະພາບຄູເຝິກຜະດຸງຄົ້ນ

ຖ້າບໍ່ມີໂຄງການພັດທະນາສັກກະຍະພາບຄູເຝິກຜະດຸງຄົ້ນ ຜົນຕອບແທນຕ່າງ ໆ ຈະເປັນຢ່າງໃດ

ຜົນຕອບແທນ	ຜົນຕອບແທນ ຈະມີຈຳກັດ	ຜົນຕອບແທນ ຈະເທົ່າກັບ ຕອນມີໂຄງການ	ຜົນຕອບແທນ ຈະຫຼາຍຂຶ້ນ
• ຄູເຝິກຜະດຸງຄົ້ນມີຄວາມຮູ້ເລື່ອງຜະດຸງຄົ້ນແລະການສອນ ຜະດຸງຄົ້ນຫຼາຍຂຶ້ນ			
• ຄູເຝິກຜະດຸງຄົ້ນມີຄວາມເຊື່ອມັ່ນໃນວິຊາຊີບແລະ ຄວາມສາມາດໃນການເຮັດວຽກທີ່ໂຮງໝໍ ວິທະຍາໄລ ແລະ ໂຮງຮຽນເຝິກຜະດຸງຄົ້ນ			
• ຄູເຝິກຜະດຸງຄົ້ນມີຄວາມຄິດເຊິ່ງບວກແລະຄວາມເຊື່ອມັ່ນ ໃນໂຕເອງ			
• ຜູ້ບໍລິຫານສາມາດ ບໍລິຫານການຮຽນການສອນຜະດຸງຄົ້ນ ຢ່າງມີປະສິດທິພາບ			
• ຜະດຸງຄົ້ນມີຄວາມຮູ້ແລະຄວາມສາມາດຫຼາຍຂຶ້ນ			
• ຜະດຸງຄົ້ນມີຄວາມຄິດເຊິ່ງບວກແລະຄວາມເຊື່ອມັ່ນໃນ ໂຕເອງ			
• ແມ່ຍິງມີຄວາມເຊື່ອມັ່ນໃນການດູແລສຸຂະພາບຂອງໂຕເອງ			
• ການຕັ້ງຄັນແລະການເກີດລູກທີ່ປອດໄພ			
• ເດັກແດງມີສຸຂະພາບແຂ້ງແຮງ			
• ຄ່າໃຊ້ຈ່າຍຄົວເຮືອນທີ່ຄົດລົງທີ່ບໍ່ຕ້ອງປິ່ນປົວພະຍາດ ແຊກຊ້ອນຈາກການຕັ້ງຄັນແລະການເກີດລູກທີ່ບໍ່ປອດໄພ			
• ລະບົບການກຳກັບດູແລງານຜະດຸງຄົ້ນແລະ ການເຝິກຜະດຸງຄົ້ນໃນລະດັບຊາດທີ່ດີຂຶ້ນ			

ຕອນທີ 5 ໂຄງການແລະແຜນງານອື່ນທີ່ອາດສົ່ງຜົນຕອບແທນຄ້າຍຄືກັບໂຄງການພັດທະນາສັກກະຍະພາບ ຄູເຝິກຜະດຸງຄົ້ນ

5.1 ລະບຸຊື່ໂຄງການແລະແຜນງານທີ່ຄ້າຍຄືກັບໂຄງການພັດທະນາສັກກະຍະພາບຄູເຝິກຜະດຸງຄົ້ນ

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5.2 ເຈົ້າຄິດວ່າໂຄງການແລະແຜນງານຕ່າງ ໆ ໃນຊັ້ນ 4.1 ທີ່ເຈົ້າລະບຸມາມີອິທິພົນຕໍ່ປະເດັນຕໍ່ໄປນີ້ບໍ່ ກະລຸນາຂຽນເຄື່ອງໝາຍ ຖືກຕ້ອງ (✓) ໃນຊ່ອງທີ່ເໝາະສົມ

ຜົນຕອບແທນ	ອິທິພົນ
• ຄູ່ເຜົ່າຜະດຸງຄັນມີຄວາມຮູ້ເລື່ອງຜະດຸງຄັນແລະການສອນຜະດຸງຄັນຫຼາຍຂຶ້ນ	<input type="checkbox"/> ມີອິທິພົນ <input type="checkbox"/> ບໍ່ມີອິທິພົນ
• ຄູ່ເຜົ່າຜະດຸງຄັນມີຄວາມເຊື່ອມັ່ນໃນວິຊາຊີບແລະຄວາມສາມາດໃນການເຮັດວຽກທີ່ໂຮງໝໍ ວິທະຍາໄລ ແລະໂຮງຮຽນເຜົ່າຜະດຸງຄັນ	<input type="checkbox"/> ມີອິທິພົນ <input type="checkbox"/> ບໍ່ມີອິທິພົນ
• ຄູ່ເຜົ່າຜະດຸງຄັນມີຄວາມຄິດເຊິ່ງບວກແລະຄວາມເຊື່ອມັ່ນໃນໂຕເອງ	<input type="checkbox"/> ມີອິທິພົນ <input type="checkbox"/> ບໍ່ມີອິທິພົນ
• ຜູ້ບໍລິຫານສາມາດ ບໍລິຫານການຮຽນການສອນຜະດຸງຄັນຢ່າງມີປະສິດທິພາບ	<input type="checkbox"/> ມີອິທິພົນ <input type="checkbox"/> ບໍ່ມີອິທິພົນ
• ຜະດຸງຄັນມີຄວາມຮູ້ແລະຄວາມສາມາດຫຼາຍຂຶ້ນ	<input type="checkbox"/> ມີອິທິພົນ <input type="checkbox"/> ບໍ່ມີອິທິພົນ
• ຜະດຸງຄັນມີຄວາມຄິດເຊິ່ງບວກແລະຄວາມເຊື່ອມັ່ນໃນໂຕເອງ	<input type="checkbox"/> ມີອິທິພົນ <input type="checkbox"/> ບໍ່ມີອິທິພົນ
• ແມ່ຍິງມີຄວາມເຊື່ອມັ່ນໃນການດູແລສຸຂະພາບຂອງໂຕເອງ	<input type="checkbox"/> ມີອິທິພົນ <input type="checkbox"/> ບໍ່ມີອິທິພົນ
• ການຕັ້ງຄັນແລະການເກີດລູກທີ່ປອດໄພ	<input type="checkbox"/> ມີອິທິພົນ <input type="checkbox"/> ບໍ່ມີອິທິພົນ
• ເດັກແດງມີສຸຂະພາບແຂ້ງແຮງ	<input type="checkbox"/> ມີອິທິພົນ <input type="checkbox"/> ບໍ່ມີອິທິພົນ
• ຄ່າໃຊ້ຈ່າຍຄົວເຮືອນທີ່ລົດລົງທີ່ບໍ່ຕ້ອງປິ່ນປົວພະຍາດ ແລະກຸ້ອນຈາກການຕັ້ງຄັນແລະ ການເກີດລູກທີ່ບໍ່ປອດໄພ	<input type="checkbox"/> ມີອິທິພົນ <input type="checkbox"/> ບໍ່ມີອິທິພົນ
• ລະບົບການກຳກັບດູແລງານຜະດຸງຄັນແລະການເຜົ່າຜະດຸງຄັນໃນລະດັບຊາດທີ່ດີຂຶ້ນ	<input type="checkbox"/> ມີອິທິພົນ <input type="checkbox"/> ບໍ່ມີອິທິພົນ

**ຕອນທີ 6 ຂໍ້ສະເໜີແນະໃຫ້ກັບ UNFPA Thailand Country Office ແລະ TICA**

6.1 ຂໍ້ສະເໜີແນະເລື່ອງຫຼັກສູດເຜີກອົບຮົມ

6.2 ຂໍ້ສະເໜີແນະໃຫ້ກັບ TICA

**ຖ້າພື້ນທີ່ບໍ່ພໍ ກະລຸນາຂຽນຂໍ້ສະເໜີເພີ່ມຕື່ມບົນເຈ້ຍເປົ່າ ຂໍຂອບໃຈ**

**Appendix VI**  
**Social Return on Investment (SROI) Survey**  
**“Midwifery Capacity Development” Project**  
**Under the UNFPA South-South and Triangular Cooperation**

**Part 1 General Information**

1.1 Indicate your role in this project by placing ✓ in the appropriate box

- Midwife
- Midwife teacher
- Midwifery education administrator
- Citizen

1.2 If you are midwife teacher or midwifery education administrator, indicate when (year) you attended the training course at Khon Kaen University .....

1.3 Currently, you work at.....  
 City.....Province.....

**Part 2 Duration of the Project Outcomes**

In your view, indicate the direction of each outcome (A maximum of 5 years)

Outcome (s)	Duration (year)
1. Midwifery educators’ enhanced competency and knowledge on midwifery education	
2. Participants’ enhanced motivation and integration of expertise with their employment within the nursing and midwifery schools and hospitals	
3. Positive feeling and improved self-confidence and self-esteem	
4. Effective administration of midwifery education	
5. Midwives’ enhanced competency and knowledge on midwifery	
6. Positive feeling and improved self-confidence and self-esteem	
7. Women’s increased confidence in taking care of their health	
8. Safe pregnancy and delivery	
9. Healthier babies	
10. Decreased financial loss from pregnancy- and delivery-related complications	
11. Enhanced national capacity and competency in midwifery education	

**Part 3 Willingness to Pay (WTP)**

3.1 Arrange the following commodities in order of importance

- |                 |                          |                           |
|-----------------|--------------------------|---------------------------|
| Winning lottery | Irrigated land           | A double-storey house     |
| A car           | Free meal for a lifetime | Scholarships for children |

3.2 Indicate the monetary value of each commodity from Step 1 (A maximum of 20,000,000 Kip)

Commodity (-ies)	Value (Baht)
1.	
2.	
3.	
4.	
5.	
6.	

3.3 Indicate the monetary value of each project outcome (A maximum of 50,000 Baht)

Outcome (s)	Duration (year)
1. Midwifery educators' enhanced competency and knowledge on midwifery education	
2. Participants' enhanced motivation and integration of expertise with their employment within the nursing and midwifery schools and hospitals	
3. Positive feeling and improved self-confidence and self-esteem	
4. Effective administration of midwifery education	
5. Midwives' enhanced competency and knowledge on midwifery	
6. Positive feeling and improved self-confidence and self-esteem	
7. Women's increased confidence in taking care of their health	
8. Healthier babies	
9. Enhanced national capacity and competency in midwifery education	

#### Part 4 Deadweight Evaluation

If there were no midwifery capacity development project, how would the following outcomes change?

Outcome (s)	Limited Change	Remained the Same	Improved
1. Midwifery educators' enhanced competency and knowledge on midwifery education			
2. Participants' enhanced motivation and integration of expertise with their employment within the nursing and midwifery schools and hospitals			
3. Positive feeling and improved self-confidence and self-esteem			
4. Effective administration of midwifery education			
5. Midwives' enhanced competency and knowledge on midwifery			
6. Positive feeling and improved self-confidence and self-esteem			
7. Women's increased confidence in taking care of their health			
8. Safe pregnancy and delivery			
9. Healthier babies			
10. Decreased financial loss from pregnancy- and delivery-related complications			
11. Enhanced national capacity and competency in midwifery education			

#### Part 5 Deadweight Evaluation

5.1 Indicate the programs/projects with similar objectives and activities as the "Midwifery Capacity Development" project.

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5.2 Indicate whether the programs/projects in 4.1 have affected the following outcome (s)

Outcome (s)	Impact of other programs/projects on the outcome
1. Pregnant women and adolescent mothers' confidence in taking care of their health and their babies'	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Safe pregnancy and delivery	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Healthier babies	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Decreased financial loss from pregnancy- and delivery-related complications	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Decreased financial loss from COVID-19 infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Avoided COVID-19 deaths	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Avoided unintended pregnancies	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Teens' confidence and ability to make informed choices about their reproductive health	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Decreased workload due to healthier mothers and newborns	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Increased confidence in providing RMNCH services	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Increased confidence in using modern medical knowledge to assist childbirth in the local circumstances	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Part 6 Other recommendations for UNFPA Thailand Country Office and TICA**

6.1 Recommendations on training curriculum

6.2 Recommendations for TICA



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