FORWARD-LOOKING REVIEW:
WORLD VISION'S APPROACHES TO INTEGRATING MICROENTERPRISE DEVELOPMENT AND HIV/AIDS RESPONSE

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ACRONYMS

ADP	Area Development Program
AIC	AIDS Information Center
AIDS	Acquired Immuno Deficiency Syndrome
ARV(s)	Anti-Retro Viral(s)
ASCA	Accumulating Savings and Credit Association
ASOs	AIDS Support Organizations
BDS	Business Development Services
CA(s)	Correspondence Analyst(s)
CBOs	Community Based Organizations
CCC	Community Care Coalition
CDF(s)	Community Development Facilitator(s)
C&EO(s)	Credit and Education Officer(s)
CETT(s)	Care and Education Training Team(s)
CHARMS	Core HIV/AIDS Response Monitoring System
CO(s)	Credit Officer(s)
CwE	Credit with Education
DBSP	Dynamic Business Start-up Program
FBO(s)	Faith Based Organization(s)
FFH	Freedom from Hunger
FGD(s)	Focus Group Discussion(s)
FINCA	Foundation
FITSE	Finance Trust for the Self-Employed
HBC	Home Based Care
HH	Household
HIV	Human Immuno-deficiency Virus
LC	Local Council
LOE	Level of Effort
MED	Microenterprise Development
MEDHA	Microenterprise and HIV/AIDS
MED-Net	Micro Enterprise Development Network
MFI	Micro Finance Institution
MS	MicroSave
NGOs	Non-Governmental Organizations
OVC	Orphans and Vulnerable Children
PAR	Portfolio at Risk (standard microfinance industry financial performance ratio)
PRA	Participatory Rapid Analysis
PLWHA	People (or Person) Living with HIV and AIDS
PTMCT	Prevention of Mother to Child Transmission
RoSCA	Rotating Savings and Credit Association
SARO	Southern Africa Regional Office
TDCSP	Thukela District Child Survival Project
TOR	Terms of Reference
UDP	UWESO Development Program
UWESO	Ugandan Women's Efforts to Save Orphans
VCT	Voluntary Counseling and Testing
VSL	Village Savings and Lending
WV	World Vision
WVM	World Vision Malawi

EXECUTIVE SUMMARY

Purpose of the Review

World Vision (WV) and WV-affiliated microfinance institutions (MFIs) recognize that poverty and HIV/AIDS are inextricably linked and mutually exacerbating. Based on this recognition, World Vision and several WV-affiliated MFIs implemented pilot projects to test different approaches to integrating MED and HIV/AIDS response.

Each of these pilots has undergone an individual assessment or evaluation. World Vision and WV-affiliated MFIs felt it timely to conduct a review of the findings of all these assessments/ evaluations and to consider relevant state-of-the-art findings by other organizations.

The purpose of the review is to identify the best way(s) forward for the work of WV and its MFI affiliates in the integration of MED and HIV/AIDS response, in preparation for scaling up approaches that have proven effective and efficient. This will inform and guide future efforts by WV MFI and other MED-focused staff, HIV/AIDS-focused staff, national directors, regional staff, support office staff, and partnership office staff to develop high quality programming integrating MED and HIV/AIDS response. In light of World Vision's commitment as a child-focused organization, particular attention was given to how integration can benefit children (in particular children orphaned and otherwise made vulnerable by HIV/AIDS), their families and communities.

Impact of HIV/AIDS on Children, their Families and Communities

There is widespread and well-founded concern about the impacts of HIV/AIDS on children and families. HIV/AIDS puts enormous economic stress on households and the slide from relative comfort to destitution can be frighteningly quick. Among the many impacts of HIV/AIDS on children, loss of educational opportunities, reduced capacity of mothers and female guardians to provide adequate care for the children under their care and stigmatization are of particular concern.

Interventions by World Vision and WV-affiliated MFIs will have significant, sustainable impacts on children's vulnerability and well-being when programs strengthen ongoing capacities of affected families and communities to protect and care for vulnerable children. A key time to intervene for most microenterprise interventions is before a household has become severely vulnerable, when an appropriate microenterprise intervention can strengthen its capacity to weather crisis and can prevent or slow economic erosion. Microenterprise interventions can help households bounce back from a crisis also; however, the effectiveness of such an intervention will depend greatly on how deeply a given crisis has affected the household.

A fundamental challenge is to develop multi-sectoral responses that are long term and occur at a scale that matches the magnitude of the HIV/AIDS pandemic. These responses should also enable households to:

- Keep children in school
- Improve and maintain income flows
- Maintain or accumulate assets
- Participate in and benefit from community safety nets

Summary Description of Integrated HIV/MED Pilots

Pundutso in Zimbabwe: Accumulating Credit and Savings Associations (ASCA)— ASCA methodology aims to reach a clientele whose very low incomes make them either ineligible or too risk-averse to access credit via a microfinance institution. The pilot aimed to provide a model for ADPs where microfinance is not viable or where only limited funding is available. With the ASCA approach, loans are provided solely from members' savings. Members self-select to form savings groups and agree on a monthly contribution per member toward a group fund. By combining their savings, groups create an internal loan fund. Members borrow money from the internal fund at an agreed interest rate and the fund continues to grow through monthly contributions and revenue from interest rates charged on the internal loans.

The WV-affiliated MFI in Zimbabwe, Pundutso, promotes the model among communities rather than directly providing the financial service. Since the group manages the fund, Pundutso's costs are limited to the training process that builds group capacity to manage their funds. Pundutso uses its staffing structure to second employees to the project and provides logistical support.

Finance Trust for the Self-Employed (FITSE) in Malawi: Unified Integrated Approach to Credit with Education—FITSE, the WV-affiliated MFI in Malawi, uses a credit methodology called Credit with Education (CwE) developed by Freedom from Hunger (FFH). CwE combines village banking with low-cost, informal education that capacitates women and their families in HIV/AIDS prevention and care. FITSE uses a "unified" approach for CwE. In this approach, FITSE's loan officers manage a portfolio of loan client groups and provide training in HIV/AIDS education to their clients during their routine repayment meetings. FITSE refers to them as Credit and Education Officers (C&EO).

Micro Enterprise Development Network(MED-Net) in Uganda: Parallel Integrated Approach to Credit with Education—The MEDHA project of MED-Net, the WV-affiliated MFI in Uganda, also uses CwE. However, it uses a "parallel" approach to integrate the HIV/AIDS education within MED-Net's community banking groups. In this approach, MED-Net hires separate HIV/AIDS-focused staff—called peer educators—to work alongside the loan officers. Each specializes in their respective roles; the loan officer manages her/his loan portfolio and the HIV/AIDS-focused staff provides the HIV/AIDS education. The peer educators also support the formulation of Care and Education Training Teams (CETTs) among the community bank group members.

Thukela District Child Survival Program (TDCSP) in South Africa: HIV/MED Intersectoral Project— TDCSP was a multi-sectoral program to mitigate the impact of HIV/AIDS. It featured a variety of partnerships made with government, non-governmental organizations and community groups. TDCSP integrated business management training, home based care, catalyzing community response to orphans, and building awareness about the impact of HIV/AIDS. To address the economic impacts of HIV/AIDS, the HIV/MED Intersectoral Project was added in December 1999 through an amendment to the overall grant and ran through the end of July 2003. The MED component of TDCSP was comprised mainly of partnering with Dynamic Business Start-up Program (DBSP), which offered business management training lasting roughly 3 weeks and conducted follow up visits over the subsequent 12 months.

Standard MFI Operations in Areas Heavily Affected by HIV/AIDS— The main difference between ASCA-type methodologies[1] and MFIs is the way group members access credit. In an MFI, it is the institution that provides external loan capital. In the ASCA method, the loan capital comes from an internal group fund made up of members' savings. In terms of outreach,

[1] An ASCA-type methodology refers to programs focused on building capacity of community self-managed savings and lending where loan capital is internally generated from members savings as opposed to externally funded by donor granted or soft loan capital.

both can reach large numbers of vulnerable households, but the ASCA tends to reach households further down the poverty scale.

In either case, it can be argued that access to credit alone is an HIV/AIDS response that mitigates the economic impacts of the pandemic. A cross section of any self-selected solidarity group served by an MFI or belonging to a self-managed ASCA savings group would probably reflect the HIV prevalence in the general population. In high prevalence areas, solidarity groups are likely to include people who are living with HIV/AIDS or people who are caring for orphans, are widowed, are single heads of household, or are supporting someone in their family living with AIDS and related illnesses. For example, Kenya's WV-affiliated MFI, KADET; found that 45% of interviewed clients care for orphans. In Uganda, MED-Net found that its 20,485 clients care for 12,069 children under the age of 18; of these, 46% are not the household head's own children. Of these non-biological children, 75% have lost one or both parents. The same clients support a further 4,208 children under the age of 18 living outside the household; most of whom (82%) have lost one or both parents.

Key Lessons Learned

HIV/AIDS education and MFIs—According to clients, HIV/AIDS education not only enhanced their financial capacity individually and as a solidarity group, but also afforded access to information and services that reduced the burden of HIV/AIDS-related crises. Unfortunately, because none of the pilots' yielded conclusive data about the impact of integrating MED and HIV responses on clients, it is impossible to attribute objectively clients' perception to the integrated pilots with confidence.

Effectiveness of HIV/AIDS information is strongest when passed between peers who trust each other and/or where peers are respected members of the community. MFI solidarity groups are built on trust and respect. As such, they can be an effective platform for disseminating HIV/AIDS information and creating awareness, particularly when addressing stigma and discrimination.

However, in terms of mobilizing community response to the pandemic's impact on children and their families or in providing technical expertise regarding care and support to the wider community, the MFI does not have a comparative advantage.

Collaboration between ADP and MFI staff made HIV/AIDS training and linkages to HIV/AIDS service providers easier, but the MED-ADP partnership was not smooth. This was in part because of insufficient effort to ensure communication and collaboration between WV and MFI staff at all levels.

Parallel versus unified approaches to integrating credit with HIV/AIDS education (CwE)—MEDHA in Uganda used parallel integration of CwE where separate staff was hired to manage loan portfolios and HIV/AIDS training respectively. FITSE in Malawi used a unified approach where both roles (loan portfolio management and HIV/AIDS education) were fused within the loan officer's job description.

The advantage of the parallel approach appears to be that each person can achieve in-depth specialization and is more effective as a result. However, the disadvantage appears to be that developing partnerships with specialized staff can be frustrating and take time. The advantage of the unified approach is that an MFI can control all aspects and doesn't have to wait for another organization or staff person. However, the disadvantage is that this overloads the loan officer and reduces quality of both training and loan delivery/recovery.

The ACSA approach—This methodology reaches more deeply into the survival economy than does institutional lending. Since this approach does not entail dispersing and recovering external loan capital or handling clients' savings deposits, it is less risky to the implementing organization. It also has promise of reaching significant numbers of people at an affordable cost. The community ASCA institution becomes sustainable, though the service provided by the supporting organization is not fee-based.

Recommendations

A. Optimizing effective integration of MED and HIV/AIDS response

In areas where MFIs and WV programs are co-located

- *Capitalize on the comparative advantages of ADP and MFI programming*. The MFI should focus on the efficient delivery of sustainable financial services to the working poor, including the integration of basic awareness raising training regarding HIV/AIDS. World Vision should focus on catalyzing sustainable community-owned response to the impact of HIV/AIDS, particularly as it relates to children.
- *WV should promote the parallel approach to CwE.* Having separate staff specialize in loan portfolio management and HIV/AIDS education respectively enables the necessary technical expertise to develop. Close partnership with ADP or other World Vision programming in HIV/AIDS response may afford opportunities to share the cost of additional staff.
- *Refocus HIV/AIDS training offered to MFI clients*. MFIs should limit HIV/AIDS training to information and linkages for the direct benefit of its client base and their children. When going beyond this to mobilization of the wider community, or to initiate HBC or OVC related activities, MFIs must join in partnership with WV programs.
- *Working relationships between WV and MFI staff*. World Vision national offices and MFI senior management must provide leadership for integration strategies from the design stages to implementation of integrated programs. There should also be joint meetings at ADP and branch levels to plan for, implement and manage integration (e.g. quarterly ADP meetings, weekly loan officer meetings, etc.)

In areas with WV programs only and no MFIs

- *Build WV capacity to implement and manage the ASCA approach.* WV should create a separate project for this within the ADP, using ADP or supplemental resources. Adding this duty to MFI operations would overburden even a mature MFI, let alone one still dealing with its own early institutional development. Moreover, ASCA management is structurally different than that of a MFI.
- Given the benefits that MFI clients perceived in HIV/AIDS education, ASCAs should also integrate HIV/AIDS education into their groups' capacity building process. Each ASCA group should be linked to HIV/AIDS education providers – either ADP HIV/AIDS-focused staff or other HIV/AIDS-focused trainers available in the area.

In areas with MFIs only and no WV programs

- *HIV/AIDS training for MFI clients.* MFIs should integrate information about HIV/AIDS in their credit delivery system. However, they should avoid encouraging clients to mobilize the community or to initiate separate HBC and OVC programs and instead foster connections with existing community care initiatives. MFIs will need input from specialist HIV/AIDS support organizations to maintain quality of the HIV/AIDS training.
- *Parallel versus unified approach.* While the parallel approach appears to be more conducive to technical excellence in both credit and HIV/AIDS expertise than is the unified approach, it may not be feasible for an MFI to absorb the additional cost of separate staff in the absence of a WV partner that can share costs. Whichever approach is used, though, MFI

senior management must be vigilant in controlling the quality of the HIV/AIDS education component.

B. Cross-Cutting Recommendations

- *Harmonizing goals, objectives and indicators with baseline study design.* Baseline information must be streamlined and limited to what the project will track over time. It must also be tightly linked to the indicators the project chooses to demonstrate results. The M&E system then needs to flow and build on baseline information gathered
- *Assisting integrated programs with an action research agenda; including M&E systems.* WV's staff focused on HIV/AIDS-related research should assist countries with the next phases of their pilots in developing a solid action research agenda. Areas of particular importance are: 1) general template for a framework of sample goals, objectives and indicators, 2) coordinating with WV's Core HIV/AIDS Monitoring System (CHARMS), 3) assist MFIs to measure social performance and making it a routine function within operations.
- *Strengthening use of performance indicators.* MFIs need to pay even closer attention to performance indicators so they can serve as an "early warning system." Examples of such indicators would be portfolio at risk (PAR>30), the loan loss reserve or default fund, client attendance at meeting and client retention or drop out rates.
- *Analyzing MFI cost effectiveness and managing costs of integration*. WV will need to calculate the costs of providing HIV/AIDS training, linking to service providers and developing partnerships between ADP and MFIs. However, WV must go beyond simply tallying up operational costs and dividing by the number of clients served. It may be less costly to have a loan officer also deliver HIV/AIDS training, but it isn't if portfolio quality suffers as a result. Similarly, if hiring two people results in enhanced loan portfolio performance, the extra cost may be justified.

I. Background and Purpose of Review

A. Background

World Vision (WV) and WV-affiliated microfinance institutions (MFIs) recognize that poverty and HIV/AIDS are inextricably linked and mutually exacerbating. In areas with high HIV prevalence or at high risk, it is essential to integrate HIV/AIDS responses and microenterprise development (MED) strategically, in order to maximize reduction of poverty and reduction of the transmission and impacts of HIV/AIDS.

Based on this recognition, World Vision and several WV-affiliated MFIs implemented several pilot projects to test different approaches to integrating MED and HIV/AIDS response. Each pilot has been evaluated individually. In addition, data have recently been collected on the extent to which the standard operations of several WV-affiliated MFIs reach orphans and vulnerable children in HIV/AIDS-affected areas. The time has come to conduct a review of the findings of all these efforts, also considering relevant state-of-the-art findings by other organizations.

B. Purpose

The purpose of this review is to identify the best way(s) forward for the work of WV and its MFI affiliates in the integration of MED and HIV/AIDS response, in preparation for scaling up approaches that have proven effective and efficient.

Further, the review will allow MFI Directors and leaders and HIV/AIDS and MED technical staff in WV national, regional, and support offices and the WV partnership office to better fund and develop high quality HIV/AIDS and MED programming that benefits children (in particular children orphaned and otherwise made vulnerable by HIV/AIDS, or OVC), their families and communities.

This is in recognition of microfinance's critical role and comparative advantage in strengthening the safety net of those upon whom OVC and people living with HIV/AIDS (PLWHA) rely. At some point, most PLWHA won't be able to provide for themselves or their family and children any longer. If a spouse or extended family member's economic resources are too weak or have been eroded too far, then they will be unable to care not only for the PLWHA, but also the surviving children or other dependent household members. This situation perpetuates vulnerability to poverty and to the further transmission of HIV/AIDS. It also undermines the community safety net as those who are unable to care for themselves or for their family and children will overburden it—leading to despair, hopelessness and apathy—an environment in which HIV/AIDS thrives.

II. Impact of HIV/AIDS on Children, their Families and Communities

A. Overview

There is widespread and well-founded concern about the impacts of HIV/AIDS on children and families. Most major documents that discuss the effects of the pandemic share many of the same conclusions:

- The HIV/AIDS pandemic is an evolving disaster—the scale of the social and economic impacts of the HIV/AIDS pandemic is large and getting larger.
- AIDS is not only a health issue, but also a development crisis.
- The pandemic is unraveling years of hard-won gains in economic and social development.
- AIDS' economic toll is exacted at the household and community levels. It starts with eroding the resources of the person living with AIDS, depletes the resources of the

immediate and extended family, and threatens to overwhelm the capacity of communities to act as a safety net.

- Agencies and donors pay too little attention to the massive scale of impact and reach only a small fraction of individuals, families and communities affected by HIV/AIDS.
- The fundamental challenge is to develop coordinated, multi-sectoral interventions that make a difference over the long term at a scale that approaches the magnitude of the HIV/AIDS pandemic.

When HIV/AIDS strikes a household, the stress of illness, death, and uncertainty about the future can be overwhelming. HIV/AIDS puts enormous economic stress on households as they care for sick family members, experience the loss of productive adults, or take in orphans. The slide from relative comfort to destitution can be frighteningly quick. Families and communities coping with AIDS–related illness and death shoulder a heavy burden; the greatest economic impact of HIV/AIDS on them comes from the high costs of treatment and the need to assist surviving family members.

There are many dimensions to the impacts of HIV/AIDS on children and families. Loss of educational opportunities for many AIDS-affected children is of particular concern. Children may be needed at home to help care for sick family members or to work in the fields. Children also drop out of school if their families can no longer afford school expenses due to reduced household income. Some children may opt out of school because they are too worried about a parent's condition or because they feel stigmatized by the nature of a parent's illness.

The economic impacts of HIV/AIDS on children also manifest themselves through the reduced capacity of their mothers and female guardians to care for them. In most societies, it is primarily a woman's duty to care for sick family members or relatives and for children. This obligation forces many women to neglect subsistence crop production, activities that generate income for the household, and the direct care of their children. After a husband's death, his widow and children may lose household assets and/or their home due to "property grabbing" by his relatives. In addition, in many countries, widowed grandmothers take on the burden of caring for their grandchildren and experience severe economic stress as a result.

In the end, the economic decline experienced by caregivers is not much different from that experienced by the person with AIDS. In fact, the economic care-giving burden continues after the person with AIDS dies in the form of their orphaned children and unpaid debts or outstanding hospital bills.

B. Interrelationship of Households and Communities

The capacity of households to provide for children depends on maintaining or stabilizing livelihoods. Wages from formal or self-employment, physical assets, and savings provide a *household safety net.* However, these resources erode quickly as parents become caregivers for sick family members, become sick themselves, or take in additional dependents.

When the household safety net fails them, households look to relatives, neighbors, or the wider community for relief. Individuals concerned for their friends, neighbors, and families often organize to provide moral support and material relief to households affected by HIV/AIDS. This is the foundation of a *community safety net.*

Household and community safety nets are inherently inter-related. The extent to which each can provide an economic buffer to the impact of HIV/AIDS depends on how successfully they interact to support one another. It also depends on how well a household is able to "piece

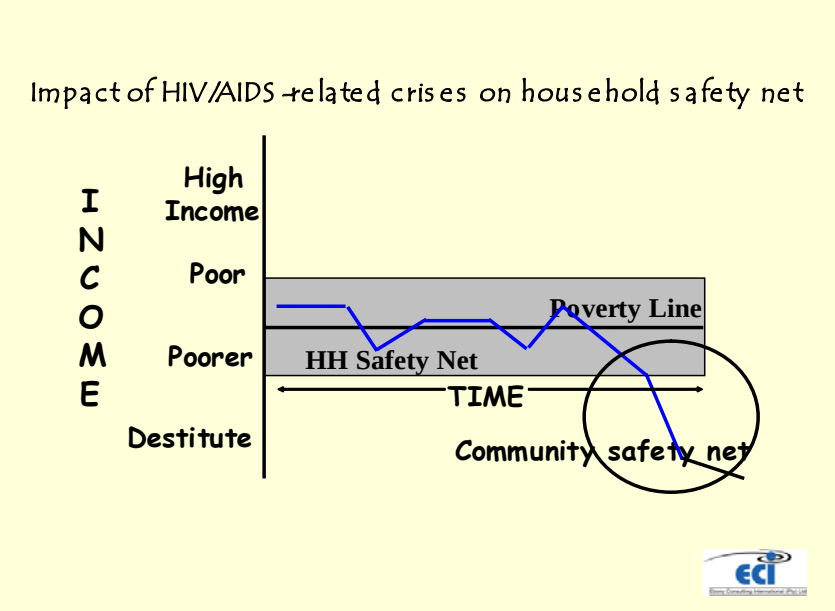
together" social and financial coping mechanisms so that they can deal with HIV/AIDS crises over an extended period.

Strong household safety nets help families maintain their assets and remain economically productive. In addition, this capacity allows them to be part of a community safety net for those in crisis, both extended family members and other community members. However, if too many households are unable to support themselves, their needs rapidly overwhelm community safety nets. Minimizing the number of families in need of relief increases the chances that the community can maintain a safety net for its most vulnerable members (Donahue, 1998 and 2002). Interventions by World Vision and WV-affiliated MFIs will have significant, sustainable impacts on children's vulnerability and well-being when programs strengthen ongoing capacities of affected families and communities to protect and care for vulnerable children.

C. Strengthening Household and Community Capacities

The above section illustrates the importance of catalyzing community response to supplement the household safety net. HIV/AIDS-related crises can push households inexorably into poverty. AIDS marches on indiscriminately, wiping out the economic resources of people who never thought they would be poor as well as those who were already worried about their next meal. This is of great concern, since households play multiple roles in support of children and can serve as the backbone of a community safety net. If household economic capacity is not strengthened, then household members will need increasing external support and they will not be able to care adequately for their children or support their neighbors. This is the larger context within which MED fits.

Throughout discussions the consultant has had with World Vision and the staff of other working to integrate HIV and MED projects, there is frequent reference to "the most vulnerable"; e.g., widows and other guardians of OVC, older OVC themselves, PLWHA, etc. However, as illustrated in the figure below, HIV/AIDS is a moving target.



A household may have been stable at the onset of HIV/AIDS-related crises. However, when a household experiences multiple crises, its safety net is depleted, and it can slide into destitution. The circle in the figure illustrates the tendency of HIV/AIDS program staff to bring in MED support when households, PLWA and orphans are already at their most vulnerable. Solutions that lead such households back to economic independence are expensive and time

consuming. Waiting until a household or individual is at this point before intervening with MED is not optimal.

A key time to intervene for most microenterprise interventions intended to mitigate the impacts of HIV/AIDS is before a household has become severely vulnerable, when an appropriate microenterprise intervention can strengthen its capacity to cope with crisis and can prevent or slow economic erosion. This is when the deepest and most sustained impact can be achieved at lowest cost. At the same time, a microenterprise intervention can help households to bounce back after a crisis; but the effectiveness of the intervention will depend on how deeply a household has been affected, and how resilient its safety net was before it was affected by a given crisis.

In addition, as stated at the beginning of this document, making a difference **over the long term at a scale that approaches the magnitude of the HIV/AIDS pandemic** must be a fundamental aim of coordinated, multi-sectoral interventions. In addition, when designing integrated MED and HIV/AIDS response initiatives, World Vision should enable households to:

- **Keep children in school**; including ensuring that children have enough food so they can perform at school and that the psycho-social condition of children does not prevent them from focusing on their school work.
- **Improve and maintain income flows** to the household; enhancing the profitability of economic activities or enabling household members to diversify their economic activities are examples of how to improve income flows.
- **Maintain or accumulate assets**; selling productive assets undermines future income earning capacity and reduces the positive options a household has when confronted with a crisis for which they need an unexpected lump sum of cash.
- **Participate in and benefit from community safety nets**. A strong community safety net depends on the participation of the wider community; at the same time, communal activities to look after vulnerable children can reduce the burden of a HIV/AIDS-related crisis so that caregivers are not overwhelmed.

III. Summary of World Vision Pilot Projects to Integrate MED and HIV/AIDS Response

A. Accumulating Credit and Savings Associations—Pundutso in Zimbabwe

i) Background

In Zimbabwe, where more than 70% of the population is estimated to be facing food shortages and HIV/AIDS prevalence rate is estimated at 33.7%, World Vision staff identified the need to integrate microfinance with ADP activities to develop effective responses to HIV/AIDS. Therefore, Pundutso, a Microfinance Institution (MFI) affiliate of World Vision Zimbabwe, launched a pilot initiative based on ASCA methodology in April 2003. The pilot covers the informal settlements of Hatcliffe Extension, Porta Farm and Casa Banana, which are also covered by ADPs.

ASCA methodology aims to reach a clientele whose very low incomes make them either ineligible or too risk-averse to access credit via a microfinance institution. The pilot was intended also to serve as a model for ADPs to start financial services in areas where microfinance institutions are not viable or where only limited funding is available.

Two informal mechanisms, among many used by poor people to pool savings, are the **RoSCA** (**Ro**tating **S**avings and **C**redit **A**ssociations) and the **ASCA** (**A**ccumulating **S**avings and **C**redit **A**ssociations). Members of a RoSCA put in equal amounts of money that is pooled and rotated equally in turn to each person. The ASCA is similar to the RoSCA except that the pooled savings are not automatically rotated. Members choose whether to take the pooled money out as a loan or not. A loan is paid back with interest, which allows the pooled funds to accumulate.

The ASCA strategy is based on CARE's Village Savings and Loan (VSL) methodology, originally developed in Niger and now operating in Mali, Tanzania, Uganda, South Africa, Mozambique and Ethiopia. The characteristic of VSL methodology that distinguish it from an MFI is the way group members access credit. In an MFI, it is the institution which provides external loan capital. In the VSL (and ASCA) method, the loan capital comes from an internal group fund made up of members' savings. Members borrow money from the internal fund at an agreed interest rate and the fund continues to grow through monthly contributions and revenue from interest rates charged on the internal loans.

As an MFI, Pundutso promotes the ASCA model among communities rather than directly providing the financial service. Since the group manages the fund, there is very little to no administration cost to Pundtuso related to managing the groups' funds; costs are limited to the training infrastructure that builds group capacity to manage their funds.

Pundutso uses its staffing structure to second employees to the project and provides logistical support in procuring a vehicle, motorcycles and other office equipment. Personnel that provide 100% level of effort (LOE) for the ASCA pilot are a s**upervisor** who oversees field activities of the Promoters, six **promoters** who are directly responsible for training and monitoring ASCA groups and an R&D/MIS assistant. Other staff that provide partial LOE to the ASCA pilot as staff of Pundutso are the **Project Director** (the current Executive Director of Pundutso at 30% LOE), an **Operations Manager** (80% LOE), a **Project Accountant** (the current Finance Manager at 40% LOE), and a **Bookkeeper** (50% LOE).

Impact Assessment—The consultant was part of a World Vision team that conducted a one-week assessment of the impact of the Pundutso pilot with the ASCA concept in April 2004. The pilot had been operating for less than a year, so the team looked at emerging trends that could guide the development of the approach for the remainder of the project life. The following are the hypotheses about impacts and success criteria that were developed before the field research was undertaken:

- The savings element in the ASCA approach is felt as an important advantage to other microfinance services
- Participating in an ASCA group means no stigma for a client, taking into account her/ his HIV infection status and allows the client, to conduct a normal, un-stigmatized business life.
- The ASCA concept can provide additional important services to clients such as business development training (BDS), promoting knowledge and messages on HIV, referring clients to health institutions
- When providing services, the ASCA project does not distinguish between those affected by HIV/AIDS and those who are poor
- Strong social bonds develop within the ASCA groups
- ASCA rules allow savings withdrawals and cash- outs for all types of typical slum emergencies; i.e., illnesses, fire, educational needs, food price hikes, funerals, etc.
- Pundutso ASCA program provides for long- term business viability and the potential for clients to graduate to Pundutso loan services
- Pundutso ASCA project will be self-sustainable after two years and will provide fee based services in order to contribute to its own budget

The team used qualitative methods to gain the ASCA members' perspective regarding the impact of HIV/AIDS and other emergency related shocks on their wellbeing. Focus group discussions (FGDs) and individual interviews centred on:

- Ranking crises and determining how they affected clients
- Examining the coping strategies used by ASCA members to counter the above crises
- The role of ASCAs in strengthening coping strategies and mitigating the shocks experienced as a result of crises.

ii) Pundutso's goals and objectives

Goal 1: To reduce economic vulnerability and improve livelihood security for 1,680 families in Beitbridge, Hatcliffe, and Pota Farm.

Goal 2: To test and adapt a savings and credit model appropriate to the Zimbabwean context and determine the quantitative and qualitative benefits derived by the poor through participation in the pilot initiative

Summary Table of Objectives and Indicators

Specific Objectives / Intermediate Results		Indicators
SO1—Access to and use of savings product serves as improved financial risk management mechanism for target households		**% of HH reporting sale of assets to cover emergency or life cycle payments** **% of HH reporting use of savings to cover emergency or life cycle payments**
IR 1.1	Increase in year-round liquidity evenness for target HHs through participation in ASCA groups	mean number of months HHs report depletion of cash reserves
IR 1.2	Increase in target HHs' cash reserves through participation in ASCA groups	average monthly savings balance (per member, per group, all groups)
IR 1.3	Increase use of savings to improve family well-being	% of HHs reporting cash-out expenditures on agricultural inputs, school, or medical items
SO2—Target HH have increased opportunities to investment in productive activities		**% HHs with at least one family member engaged in productive activity** **% increase in average household income**
IR 2.1	ASCA groups on-lend savings to members for productive purposes	# of loans disbursed per savings cycle (per group/all groups) # of microenterprises financed through loans
IR 2.2	Linkages established between ASCA members ADP associations	# of meetings between ASCA members and ADP groups/associations per savings cycle (per group/all groups)
SO3—The Savings and Credit model is appropriate for the rural target population after testing and adaptation		**% of members leaving group during or after savings cycle** **% of groups that can self-regulate loans** **% of groups continue to operate independent of Pundutso support**
IR 3.1	Increased understanding and implementation of methodology features suitable for project participants	# of changes made to methodology based on data collection # of documented member problems and recommendations
IR 3.2	Increased documentation of quantitative and qualitative benefits derived by rural poor through participation in initiative	# and length of documents produced from data collection

iii) Major findings

Client perception of Puduntso ASCA's impact—Although this pilot had operated for less than a year at the time of the assessment, clients feel that it had been a major and timely coping strategy. The most significant factor about the ASCAs is that it afforded members with quick access to a lump sum of cash whenever they needed it—sometimes for the first time in their lives. Other comments were that the ASCA concept "opened our brains/eyes", "gave us zeal to work harder" and "encouraged us to set goals for ourselves". These perceptions are not unique to Pundutso's ASCA pilot; such results consistently emerge in many other countries where this methodology has been implemented.

In addition, the following list points to factors that are key mechanisms to mitigating the impact of HIV/AIDS-related crises:

- ASCA groups created an important social bond during a time when social values in the slums were on the decline. Some members experienced this social capital as "peace of mind". They felt confident now that if they fell sick, others in the group would assist them with food, medicine and looking after their family.
- ASCAs enabled interviewees to restart businesses or expand businesses in a crisis period, as it allowed easy access to capital. Some groups allowed existing members in good standing to use loans to respond to emergencies.
- The accumulated savings that were distributed as a lump sum at the end of a savings cycle enabled members to buy consumer items, fulfill social obligations, or increase their business level. Members used the lump sum to pay for: 1) assets, in particular kitchen utensils; 2) care of children, especially school fees; 3) health care needs, most often medicine; 4) business capital and 5) housing needs, usually rent or the purchase of building materials.

Impact on members' business—Over the last year in the ASCA pilot, level of business for most enterprises has increased approximately 200%, after adjusting for inflation. Most interviewees calculated their daily needs to be a minimum of the equivalent of $2 for a family of four. Profits, they reported, surpassed daily needs, with the top end entrepreneurs reporting sales of up to $16 and profits of $6.

Monitoring and evaluation of outputs and impact—Pundutso has a user-friendly log frame that is straightforward and relevant. However, the indicators chosen to judge whether the pilot has had impact on mitigating the impact of HIV/AIDS could be improved slightly. Currently, project staff chose indicators directly linked to group member's sero-status and whether orphans benefit directly as members. These indicators have not yielded satisfying or reliable information. In addition, the indicators might exacerbate stigma.

B. Unified Integrated Approach to Credit with Education—FITSE in Malawi

i) Background

FITSE uses a **"unified"** approach for the integration of Credit with HIV/AIDS Education. In this approach, the MFI's loan officers—Credit and Education Officers, or C&EOs—manage a portfolio of loan client groups and provide training in HIV/AIDS education to their clients during their routine repayment meetings.

According to official statistics available at the time of the March 2004 evaluation, the HIV/AIDS prevalence rate in Malawi is estimated at 17%. The pandemic is spreading rapidly in areas where there is migration and cross border trade. This is the case in the border towns of Karonga and Chitipa where Finance Trust for the Self-Employed (FITSE) began operations.

FITSE is an MFI affiliate of World Vision Malawi. Operational as of June 2000, the MFI has five branches and, as September 2003, reaches 1,211 active clients with a portfolio of US$111,013. Portfolio at Risk ratio stands at 6.12%.

FITSE uses a credit methodology called *Credit with Education* developed by Freedom from Hunger (FFH), which combines village banking with low-cost, informal education that capacitates women and their families in HIV/AIDS prevention and care. In 2002, FITSE contracted FFH to conduct a Training of Trainers (TOT) for Credit Officer in an HIV/AIDS module called "Facing AIDS Together"[2].

Mid Term Review—The consultant conducted a review of FITSE's Credit with Education methodology in the Karonga and Chitipa branches as part of a team in March 2004. The team included staff from a Malawian consulting firm. The purpose of the evaluation was to:

- assess progress towards October 2004 impact objectives;
- assess if interventions are sufficient to reach desired outcomes;
- identify barriers to achievement of objectives;
- provide recommended actions to guide the staff through 31 September 2004; and
- provide recommendations for adjustments in the pilot design including objectives, outputs and activities

An MIS expert engaged by the Malawian consulting firm managed the quantitative data analysis and supervised three data entry clerks. The evaluation team trained and supervised six research assistants to administer the survey questionnaire. The team also used qualitative methods based on MicroSave's Market Research for Microfinance tools to conduct focus group discussions among FITSE's client groups.

ii) FITSE's goal and objectives

Summary Table of FITSE Goal and Objectives

Goal	Objectives
To strengthen the capacity of vulnerable individuals, households and communities to respond to the economic, social and health impact of HIV/AIDS	**1.** To ensure at least 60% of the 3,500 clients engage in safe sex practices. **2.** To increase business incomes of at least 75% of 3,500 clients so that families or HBC givers that have OVC or family members who are seriously ill will have an improved financial situation and improved well being **3.** To increase knowledge level of at least 75% of 3,500 clients on HIV/AIDS prevention, care and condemnation of stigmatization **4.** To increase the ability of at least 60% women and youth (school Leavers) to provide financially for their households and decrease their risk behavior through involvement in MED-HIV/AIDS linked activities **5.** To increase awareness of and response to HIV/AIDS pandemic among civil society, local groups like Home Based care givers and Peer Educators through HIV/AIDS prevention & care education sessions and collaboration **6.** To ensure clients have access to available Voluntary Counseling and Testing (VCT) services **7.** To ensure sustainability and growth/expansion of the program, which will ensure that HIV/AIDS interventions can continue after funding has ended

iii) Major findings

Rigor of evaluation regarding impact—Although it was possible to make a general assessment of the FITSE pilot, the team was not able to introduce enough rigor to formally evaluate and draw strong conclusions about its impact on clients. Several factors contributed to this:

- There was no baseline data against which to measure progress towards achieving objectives or impact on clients, their children and families;

[2] FFH, in conjunction with World Relief, produced "Facing AIDS Together" specifically for Faith Based Organizations.

- Indicators measured output primarily and those that were designed to show impact as evidenced by a change of behavior[3] were not specific enough to provide good data;
- The sample size for the quantitative survey was too small; only 247 clients, 11% of the pilot's estimate of 2,300 active clients[4], were interviewed.
- The team was not able to conduct enough focus group discussions to provide strong triangulation of emerging trends. Of the 27 projected FGDs, only 10 took place.

Client perception of FITSE's impact —Clients felt they had increased their knowledge about HIV/AIDS and that this awareness contributed to changing their perceptions of and attitudes towards PLWHA. Client groups demonstrated this change in attitude by incorporating articles in their by-laws that forbids discrimination based on a person's sero-status. In addition, clients felt they were better able to care for PLWHA and orphans whose parents died from HIV/AIDS. Finally, the loans from FITSE enabled clients to improve their businesses. Business income enabled clients to respond to crises, to pay school fees for the children under their care and to cover food, medicine and hospital expenses when a family member is bedridden. Some clients said that "after caring for someone with an illness and then covering the funeral, the business can collapse. FITSE helped to resurrect the business."

Operational and loan product design issues—Various institutional issues relating to microfinance operations and loan product design made it difficult to analyze the effectiveness and impact of the HIV/AIDS training separately. The following summarizes these issues:

- FITSE's fee structure and loan products are complicated. The various fees, interest rate and the cost of forced savings result in a high effective interest rate. During FGDs on loan product attributes, client dissatisfaction with these factors overshadowed their satisfaction with HIV/AIDS training.
- C&EOs often use their own interpretation of fees, loans and procedures when explaining them to clients or when addressing repayment and group problems. There is need to streamline operations, standardize procedures, work on building capacity of C&EOs to harmonize understanding of loan package and institute a consistent approach to "trouble shooting" when faced with problems.
- Operating procedures for training and monitoring C&EOs on the HIV/AIDS sessions is neither standardized adequately, nor fully institutionalized into operations. There is no formal training for new loan officers; this is left to the "on-the-job" guidance from current C&EOs.

[3] i.e. "60% of 3,500 clients are able to negotiate for safer sex", "60% of women and youth clients decrease risk behavior"
[4] Estimated at time of March 2004 evaluation.

Summary Table—Progress towards Achieving Objectives

Objective	Indicators	Progress	Notes
1.	60% of 3,500 clients are able to negotiate for safer sex	86.8% of clients mentioned abstinence, 10.5% said faithfulness and 52.2% mentioned using a condom as ways of avoiding HIV.	The survey did not reveal whether the knowledge demonstrated by clients resulted in changed behavior
2.	o 75% of 3,500 clients increase business incomes o 75% of 3,500 client families are caregivers of PLWA and/or have orphans	o 61% of clients said they make more profit, 44% felt their business grew and 19% said they have more customers as a result of FITSE o 30% of clients are caring for orphans.	The FGDs confirmed that clients' perception is that FITSE has had an impact on their financial capacity. However, it is not possible to conclude whether this had a direct relationship to an increase in caring for orphans.
3.	75% of 3,500 clients are able to mention key learning outcomes of the HIV/AIDS training	o See results for Objective 1 for prevention knowledge. o 55% of clients show love, 43% said to provide moral support, 40% said PLWA should not be blamed and 55% mentioned nutritious food.	Since there is no baseline, it is possible that clients were aware of these issues before they joined FITSE, particularly in Karonga and Chitipa where USAID has "Corridors of Hope", an HIV/AIDS prevention and awareness program.
4.	60% of women and youth clients maintain/increase HH equity/ assets, business profits, increase savings and decrease risk behavior	o See Objective 2 for results relating to business profits o See objective 1 for results relating to risk behavior	Although there were questions about assets, household equity and savings in the survey questionnaire, this information was not analyzed for the final report.
5.	60% of 3,500 clients have increased awareness and have increased involvement in HIV/AIDS issues.	See results for Objective 1 for prevention knowledge.	There was no data tracked regarding involvement in HIV/AIDS issues. The FGDs did not reveal significant activity outside of increasing knowledge inside the clients' groups.
6.	25% of 3,500 clients have taken voluntary HIV tests	24% of clients have gone for an HIV test at a VCT center	This appears to be the most successful result of FITSE. However, the sample size of the survey needs to be increased in order to verify this trend.
7.	o 61% operational self sufficiency o PAR and drop out rate o Client satisfaction with CwE product	o At the time of the evaluation, up-to-date information on PAR, operational self sufficiency and drop out rate was not available. o During the FGDs, dissatisfaction with other attributes of FITSE's loan package overshadowed clients' appreciation of the HIV/AIDS sessions.	The Karonga branch was in flux at the time of the evaluation and financial records were only available in Mzuzu.

C. Parallel Integrated Approach to Credit with Education—MEDHA in Uganda

i) Background

Micro Enterprise Development Network (MED-Net) is a Microfinance Institution affiliate of World Vision Uganda. Operational as of June 1997, the MFI operates in 10 districts and, as of 30th April 2005, serves 20,485 clients with an outstanding loan portfolio of US$ 2,845,201.

MEDHA uses a **"parallel"** approach for the integration of Credit with HIV/AIDS Education. In this approach, the MFI hires separate HIV/AIDS-focused staff—a peer educator—to work alongside the loan officers. Each specializes in their respective roles; the loan officer manages her/his loan portfolio and the HIV/AIDS-focused staff provides the HIV/AIDS education.

MED-Net, in partnership with World Vision Uganda, launched the Microenterprise Development and HIV/AIDS (MEDHA) program in October 2003 in an effort to integrate the World Vision Hope Initiative[5] within microfinance operations. Integration of the MEDHA training occurred within MED-Net's community banking groups. Of MED-Net's total clientele, community bank clients constitute 39.96% while loans outstanding are 17.11% of the entire portfolio. MEDHA training reached 16% of the all of community bank clients and 6.3% of MED-Net's total clientele.

MED-Net hired three peer educators, whose role is to provide the MEDHA training to clients, support the formulation of Care and Education Training Teams (CETTs), help in identifying affected families and provide follow up assistance. Peer educators work hand in hand with the MED-Net credit officers and WV Uganda ADP staff where the two programs are co-located. In non ADP areas, peer educators link CETTs to other HIV/AIDS service providers.

End of Pilot Evaluation—The consultant led an end-of-pilot evaluation team of MEDHA and MED-Net staff in May 2005. The evaluation reviewed the performance of the MEDHA pilot, identified key lessons learned, and provided recommendations for the future efforts of World Vision and WV-affiliated MFIs to develop integrated HIV/AIDS responses. Questions addressed by the evaluation team include:

- Were the objectives of the program met?
- What unanticipated outcomes – positive and negative – emerged during program implementation?
- What impacts did the MEDHA program have in the lives of the children, families, and communities where it was implemented?
- Is the MEDHA program design and process financially and programmatically sustainable? If not, what improvements are necessary?

The evaluation team used qualitative focus group discussion (FGD) techniques based on *MicroSave's* Market Research for Microfinance PRA tools to gain insight about clients' perceived impact of the HIV/AIDS training. To provide some limited quantitative information, the team used MEDHA's monitoring system.

[5] World Vision's Hope Initiative is its global effort to expand and enhance response to HIV/AIDS in all the nearly 100 countries where WV operates.

ii) MEDHA's goal and objectives

.Goal	Objectives
To complement the process of social economic empowerment through the stimulation of appropriate responses to the impacts of HIV/AIDS upon low-income earners in Uganda	**1.** Provide economic support as well as build capacity within people and families infected and affected by HIV/AIDS in responding adequately to the epidemic through provision of financial services. **2.** To link up the HIV/AIDS infected clients to service providers for counselling, training, treatment and support as well as sensitising and training of affected families and orphans thereby reducing the impact of HIV/AIDS. **3.** To link up the activities of ADPs response to HIV/AIDS in the tracks of prevention, care and advocacy to micro enterprise development in extending care to orphans and other vulnerable children **4.** Contribute towards reducing the further spread of HIV/AIDS among clients, their families and the wide community **5.** Provide care and support for MED clients' families affected with HIV/AIDS and their children. **6.** Document and share sound best practices and lessons learned in the integration of Micro Enterprise Development (MED) on HIV/AIDS response with the entire WV partnership and WV-affiliated microfinance institutions.

iii) Major findings

Findings from output indicator monitoring reports— MEDHA exceeded most of the output targets established for the pilot's objectives. However, achieving the output targets does not equate to outright success since impact of an intervention cannot be verified from output indicators alone. Although MEDHA conducted a baseline survey, it did not gather data on indicators that could later shed light on impact. It is also likely that double counting has occurred between output indicators relating to referrals and linkages as well as homes visits for people living with HIV and AIDS (PLWHA) and orphans and vulnerable children (OVC).

Findings from FGDs on unexpected positive outcome—MED-Net credit officers and branch managers perceive that the MEDHA training has enhanced the cohesion within groups because the women are "no longer just about collecting money and repaying loans; the group members feel that, together, they are responsible for life." This cohesion might be reflected in slightly better portfolio quality; the PAR ratio for MEDHA-trained groups is 3.95% as compared to 5% for non-trained groups. In addition, credit officers are better able to approach a client they know or suspect is HIV positive, thereby avoiding repayment problems.

Findings from FGDs on unexpected negative outcome—Clients responded to care and support for PLWHA and orphans without first mobilizing the wider community to join them. Thus, CETTs and MED-Net clients became the "answer" to everyone's problems. Consequently, CETTs are turning to MED-Net for material and technical support. This goes well beyond MED-Net's comparative advantage as a provider of financial services and poses a threat to its focus on achieving sustainability.

Linkages between MED-Net, MEDHA and ADP staff—MED-Net, MEDHA and World Vision staff did not have an opportunity to appreciate fully the reasoning behind the introduction of MEDHA training and its purpose. As a result, implementation may have been slower than desired in the beginning. The mid-term evaluation conducted by senior staff from WV International facilitated interaction between ADP and MED-Net/MEDHA staff. This leadership served to catalyze team spirit and now the ADP staff is enthusiastic about the positive role of MEDHA.

Credit officer and peer educator—There is a symbiotic relationship between the credit officer and peer educators. On the one hand, it would be difficult for the peer educator to deliver the

MEDHA training without the credit officer preparing their way. On the other hand, the credit officer could not do justice to both training/counseling and managing credit delivery/ repayment. In the opinion of the credit officers and management, the knowledge and skills of a counselor conflicts with persistence necessary to follow up on repayments. The credit officer's performance targets are based on portfolio performance. Their focus is on maintaining healthy ratios. Diverting attention to providing MEDHA training, follow-up and counseling would undermine this role. The workload for both is too much.

Training process—Once clients started implementing what they had learned from MEHDA, their understanding of the significance of it deepened and they wanted to know more. Yet there was not a similar process set up for peer educators. As a result, despite the monthly visit each group receives from MEDHA staff, most clients still asked for refresher or additional training.

Limits of the role of an MFI in community mobilization — The MEDHA training appears to emphasize HIV/AIDS information, HBC and OVC program issues over community mobilization techniques. At the same time, community members appear to have high expectations for CETTs to provide them with material support. It would seem logical for MED-Net to build up this part of the training. However, the "culture" of an MFI centers on creating quality and efficient service delivery. This serves clients wanting access to sustainable financial services very well; but it fits in less well with community mobilization.

Summary Table of Progress towards Achieving Objectives

Objective	Performance Indicators (output)	Targets[6]	Actual	Variance	Notes
MFI performance	Value of loans Disbursed (In US $)	**$151,898**	272,055	**79%**	Repayment rate for MEDHA-trained client groups is not significantly better than for the non-trained. This may change once MEDHA is offered to more groups. The PAR ratio and loans disbursed to groups are significantly better. This might be due to how MEDHA chose groups to train. If they started with better groups, then loans disbursed is not due to MEDHA training.
	Outstanding Loan Portfolio (In US $)	**$98,734**	108,822	**10%**	
	# of active clients	**1,191**	1,277	**7%**	
	# of active credit client groups	**64**	69	**8%**	
	Repayment Rate	**97%**	98%		
	Portfolio at Risk >30 Days	**5%**	3.95%		
Purpose	# of staff trained in HIV/AIDS issues	**60**	31	**-48%**	Although MEDHA underperformed in this output, it did not hamper staff and CETT's outreach capacity.
	# of CETTS (prevention and care/support)	**90**	74	**-18%**	
1.	Total # of clients reached by end of project (with loans)	**1,191**	1,277	**7%**	FGD results indicated that the knowledge gained from the training and the linkages facilitated by the MEDHA peer educators allowed client to better "manage" the impact of HIV/AIDS, protecting their business and loans and enhancing clients' financial capacity.
2.	# of people receiving VCT	**179**	844	**372%**	Linkages and referrals between credit clients, other community members and providers for HBC, ARV treatment, VCT services also helped to reduce the burden of care and support of PLWHA and orphans.
	# of female clients receiving PMTCT	**214**	1,202	**462%**	
	# of referrals	**953**	1,126	**18%**	
3.	# of OVC reached via CCC		142		
	# of OVC identified		1,427		
4.	# of clients sensitized on HIV/AIDS issues	**1,191**	1,277	**7%**	FGD results show that people at the community level still have misconceptions about HIV/AIDS; but that MEDHA training has changed this. However, it is still difficult for women to negotiate safe sex with their husbands.
	# of community members sensitized by CETTs	**2,000**	5,918	**196%**	
5.	# of clients receiving care and support services	**715**	1,154	**42%**	CETTs have organized community fundraising events to benefit orphans and PLWHA and share their own resources with vulnerable households. Orphans are identified and linked to mat'l support and school fees.
	# of OVC cared for (via CETT initiative)		1,136		
	# of homes visited		1,071		
	# of PLWHA visited	**450**	1,594	**254%**	

[6] Targets listed here are for year one of the pilot. Technically, the targets for year two should be pro-rated and added in here since the project is 3 months into year two. In addition, some of the indicators were developed after the mid term evaluation (Sept 2004) and were not assigned targets.

D. HIV/MED Intersectoral Project—Thukela District Child Survival Program in South Africa

i) Background

In Okhahlamba Municipality where the Thukela District Child Survival Project (TDCSP) operates, 33.5 % of women attending antenatal clinics are HIV positive; 59.3% of children live in poor households and 60% of people over the age of 20 are unemployed. Previous studies in Okhahlamba Municipality indicate that stigma and poverty appear to be significant factors inhibiting individuals and households to successfully adapt economic strategies; reduce risky sexual behavior and respond positively to the impact of HIV/AIDS in the community.

One of the distinguishing features of **TDCSP** is the variety of partnerships made with government, non-governmental organizations and community groups. TDCSP integrated **business management training**, **home based care**, catalyzing **community response to orphans**, and **building awareness about the impact of HIV/AIDS**.

To address the economic aspect of the above situation, the HIV/MED Intersectoral Project was added in December 1999 through an amendment to the overall grant and ran through the end of July 2003. Overall, the project aimed to increase the capacity of vulnerable households to respond to the social, health, and economic impact of HIV/AIDS—particularly as it relates to the well being of children. The project also sought to transform despair and hopelessness that HIV/AIDS can bring into communities to legitimate hope and planning for the future.

The MED component of TDCSP comprised mainly of partnering with Dynamic Business Start-up Program (DBSP), which offered business management training lasting roughly 3 weeks and conducted follow up visits over subsequent 12 months. The training reached 387 clients by the end of the project. The following table summarizes the content of the DBSP training curriculum.

Summary of Module Content

Module	Topic
1	Identifying business opportunities
	How to generate business ideas
2	Defining business
	Examining business activities
3	Identifying trading opportunities
	How to market your product
	Coming up with 3 business ideas
4	Identifying service opportunities
	Records a business needs to keep
	Marketing research
5	Manufacturing
	Develop a marketing plan for 3 business ideas
6	Working out your profit
	Develop a financial plan for the 3 business ideas
7	Setting the selling price
	Managing yourself and your business
	Develop a management plan for the 3 business ideas
8	Developing a business plan
9	How to beat your competition
	Developing a record keeping plan
10	The 'Golden Rules of Business"

ii) HIV/MED Intersectoral Project goal and objectives

Goal	Objectives
Strengthen the capacity of vulnerable individuals, households and communities to respond to the economic, social and health impact of HIV/AIDS on their households.	**1**. Households with chronically ill family members or households that care for orphans, will maintain or improve their incomes through MED activities **2**. Increase in women's and youth's ability to provide financially for their households and decrease their risk behaviour, through involvement in MED linked activities **3**. Increased awareness of and response to the HIV/AIDS pandemic among civil society, local institutions/ groups and intervention target groups through activities such as labour saving, collaboration and networking within the community **4**. Households with acutely or chronically ill family members will have improved knowledge, skills and support to care for the chronically ill. **5**. Households and communities with orphans will have appropriate awareness and knowledge to care for the orphans. **6**. Project experiences / lessons for MED and care /support activities among vulnerable households and communities will be documented and shared with policy makers, practitioners and communities in KZN, SA and beyond. **7**. Ensure that effective program components can continue after project completion and be taken to scale

End of Project Evaluation—The consultant facilitated a multi faceted team to carry out the evaluation activities. Members included World Vision staff and colleagues from various institutions and implementing partners. The evaluation team used a combination of qualitative and quantitative methods to build on previous data collected and to further describe the the complex landscape in which World Vision's clients reside.

The team used qualitative tools to gain insight into how MED clients view the financial pressure they experience from HIV/AIDS-related crises, the coping mechanisms they employ (including the role their microenterprises play) and how these have changed over time.

iii) Major findings

Progress made towards achieving objectives—The project has made good progress towards most of its objectives; however, because the monitoring and evaluation system did not collect information in the same format as the indicators were articulated, it is difficult to gauge progress for many of the indicators; most notably for objectives one and two (see "Summary Table of Progress Made towards Achieving Objectives" on the following pages).

Evaluating impact —TDCSP had a very thorough and rigorous evaluation system in place for the HIV/AIDS component of the HIV/MED Intersectoral project. However, the quantitative measures for economic monitoring were not adequate. For example, the types of assets that communities find most helpful in times of crisis were not tracked and so it is not possible to determine whether the assets that were tracked mitigate the impact of HIV/AIDS. In addition, the amount of information demanded of MED clients was burdensome; clients that resented this became uncooperative.

Impact of business management training on clients—Of the 387 clients trained in business management, 70% of them live in vulnerable households[7], 74% are still in business and 66% of those still in business maintained or increased business profits. It is clear from the information gathered that MED clients view their businesses as key to responding to economic, social and health impact of HIV/AIDS. However, it was less clear what contributed to the enhanced performance of clients' businesses as many of them also accessed loans which were

[7] TDCSP considered a household vulnerable if they were taking care of someone who is ill, had experienced a death, and/or are taking care of orphaned and vulnerable children. Most of the 70% were caring from someone who was ill.

not part of the HIV/MED component. Which was responsible for performance— the training, or the loan, or both?

Targeting clients for MED based on HIV/AIDS criteria— MED clients in 10 of the DBSP training courses were initially identified by TDCSP for participation using criteria of vulnerability relating to HIV/AIDS. Of these TDCSP identified clients, 80% were from vulnerable households. MED clients in 12 additional DBSP courses initially self-selected for Ncedisizwe[8] loans and attended the DBSP course before acquiring their loans. Of these, 77% were from vulnerable households. The project attracted a majority of vulnerable households within their MED client group without specifically "targeting" them for services.

HIV and MED integration effect on improving awareness and reducing risky behaviour—Women know how HIV is transmitted and how to prevent transmission. In spite of this, women still feel at risk of getting HIV infected. In FGDs, it emerged that if women try and negotiate safe sex, their partners either threaten to, or do, stop their financial support; or they get violent. The survey and FGDs revealed that women who had been in business the longest and were not in a permanent relationship seemed freer to disengage from risky sexual behaviour.

Modes of HIV/AIDS message dissemination—Working with knowledge bearers and trusted informants in a community seems to be most effective in 'new' messages taking root. There are knowledge gaps, however even once knowledge is acquired, practice lags far behind. Incorporating messages as part of other activities, such as support group meetings, appears to be more effective than holding workshops solely for message dissemination about HIV/AIDS.

Emergence of hope—Many of those participating in the FGDs and individual interviews connected their feelings of hope to participation in HIV/MED activities. Participants defined hope as the belief that the future holds success and that faith makes success a self fulfilling prophecy. When there is hope, people want to talk to each other and share problems; communities unite, reach out and support each other. There is acceptance and love and one is sure that the future holds success. What brings hope is people listening, showing they care and having faith; all elements that come full circle to what happens when there is hope. Hope is a "virtuous cycle".

[8] Ncedisizwe is a WV MFI affiliate, but was not a formal, budgeted component of the HIV/MED Intersectoral project.

Summary Table—Progress towards Achieving Objectives

Indicators	Progress
Objectives 1 and 2—MED training	
50% of vulnerable households will: ❖ Maintain net household equity, meet their basic household needs and pay school fees for all primary school children in the household	*Positive trends emerged; however, results are inconclusive as the M&E system did not capture information in terms of % of vulnerable households meeting the objective's targets*
20% of vulnerable households report making a household improvement in the last 6 months.	
50% report having a savings account	
70% of MED clients (youth and women) will maintain or increase business profits.	*Target met*
50% report reducing their risky sexual behaviors.	*Results inconclusive, although the longer women are in business, the better able they seem to negotiate safer sex and the more likely they report condom use during their last encounter.*
Objective 3—Message Dissemination	
Three key prevention / response messages designed	*Target surpassed*
75% of MED clients will know messages, 50% will practice.	*Target not met—36% of MED clients elected to attend the messages workshops*
10 volunteer community counselors/ coaches will be trained in counseling and in the transfer of messages	*Target surpassed*
75% of households received support from one or more community networks	*Inconclusive, surveys did not take quantitative measures for this indicator.*
Objective 4—Home Based Care	
75% of primary caregivers practice universal body fluid precautions and state proper refuse disposal	*Target surpassed*
75% of primary caregivers state at least 3 methods of protecting the patient from further infection	*Target not met—30% could state three methods; 100% could state at least one method.*
At least 120 home based care givers trained	*Target not met (beyond project's control).*
A referral system in place	*Target met*
Objective 5—Care and Support of Orphan and Vulnerable Children	
# of independently organized meetings	*The 5 committees have had an average of 10 meetings since the project began.*
Action plans created & implemented	*4 of 5 committees have a vision statement; 3 have action plans.*
# of OVC with personal development plans	*Two of three committees have plans*
Committee invests time/resources	*Indicators are too new for conclusive data.*
Committee share and activities reflect message	
# of OVC supported by peers	

E. Standard MFI and ASCA Operations in Areas Heavily Affected by HIV/AIDS

The main difference between ASCA-type methodologies[9] and MFIs is the way group members access credit. In an MFI, it is the institution which provides external loan capital. In the ASCA method, the loan capital comes from an internal group fund made up of members' savings. In terms of outreach, both can reach large numbers of vulnerable households, but the ASCA tends to reach households further down the poverty scale.

In either case (MFI or ASCA), a cross section of any self-selected solidarity group served by an MFI or belonging to a self-managed ASCA savings group would probably reflect the HIV prevalence in the general population. In high prevalence areas, it is also likely to include people who are caring for orphans, are widowed, are single heads of household, or are supporting someone in their family suffering from AIDS and related illnesses. For example:

- In Uganda's World Vision-affiliated MFI, MED-Net's 20,485 clients care for 12,069 children under the age of 18; of these 46% are not the household head's own children. And of these non-biological children, 75% have lost one or both parents. The same clients support a further 4,208 children under the age of 18 living outside the household; of these, 82% have lost one or both parents.
- In Kenya, WV interviewed 6,667 clients in WV-affiliated MFI, KADET. They found that 45% of these clients are caring for orphans. The number of orphans in their households is 6,820. Clients support an additional 9,605 orphans living outside their households.

Therefore, it is important to review the impact that both these methodologies (standard MFI operations and ASCA-type methodology) have on such households and the degree to which access to microfinance services mitigates the impact of HIV/AIDS. On a general level, impact evaluations of both standard MFI services and ASCA type methodologies show that access to credit enables businesses to survive crises and households to smooth income and accumulate assets[10]. These are crucial elements in mitigating the economic impact of HIV/AIDS-related crises and preventing a household's decline into destitution.

A literature review and analysis conducted by Freedom from Hunger concludes: *…"poverty lending [microfinance] is unlikely to produce major economic gains for poor households. However, in relative terms, these modest gains seem likely to make very important contributions to household survival, such as income smoothing and insurance against emergencies. And these are precisely the types of livelihood strategies that, if strengthened, are most closely associated with increased household food security and nutritional status".*

An impact evaluation of a CRS microfinance program in Burkina (Adelski et al. 2001) observed that *"…both the quantitative and the qualitative evaluation-data show that the microfinance activity definitely has had a positive impact on women's lives[11]. Clients reported spending 2.5 times more on their children's education than trainees, having 6.5 times more savings than trainees, and spending 2.5 times more on health care than trainees. The clients stated that*

[9] An ASCA-type methodology refers to programs focused on building capacity of community self-managed savings and lending where loan capital is internally generated from members savings as opposed to externally funded by donor granted or soft loan capital.

[10] See also Cohen et al. *"Microfinance, Risk Management and Poverty"*, Management Systems International, for Assessing the Impact of Microenterprise Services (AIMS), USAID Washington, D.C. March 2000 and Wright et al. *"Vulnerability, Risks, Assets and Empowerment – The Impact Of Microfinance On Poverty Alleviation"*. World Development Report 2001, MicroSave-Africa & Uganda Women's Finance Trust, March 1999. For impact of ASCA-type methodology, see "CARE International's Village Savings & Lending Programme in Africa—Microfinance for the Rural Poor that Works", Hugh Allen, August 2002.

[11] Women who had three or more loans from the village banks are the impact group and referred to as "clients;" women who have had training but not yet obtained loans are the control group and referred to as "trainees."

most of their profits are spent on their children and other household expenses. These are proxy indicators for increased income, which is linked to improved food security".

And finally, consider the findings below from impact studies specifically on MFIs and HIV/AIDS:

- The NGO Uganda Women's Efforts to Save Orphans (UWESO) spun off its support to income generating activities to form a separate, but affiliated MFI, which serves primarily widows. This MFI found not only that two-thirds of its clients care for orphans[12], but also that clients cared for more orphans and had larger households than did non-client households. Client households experienced just as many, if not more, deaths and cases of chronic illnesses as did non-clients.
- The UWESO study also revealed that clients experienced better asset accumulation, higher levels of spending on food, medicine, clothes and school fees for children, and better quality of shelter (including sanitation) than did non-clients.
- In an exploratory study done by Horizons in Zimbabwe, Zambuko Trust clients have a higher average household size, have a higher dependency ratio than do non-clients and are more likely to be widows. Zambuko Trust clients are also more likely to have a savings account and to send children to school (mostly male children)[13]

As far as microfinance's mitigating effect on the impact of HIV/AIDS is concerned, consider the following excerpts from studies on the topic:

….. "These groups of widows and orphans have with time been transformed into economically productive entities that are able to not only sustain their livelihoods but demonstrate an ability to handle economically viable enterprises that go beyond mere survival to progress in housing, food and nutrition as well as general economic well being and education of the orphans, non-orphan children and the clients themselves." (UWESO Development Program in Uganda)

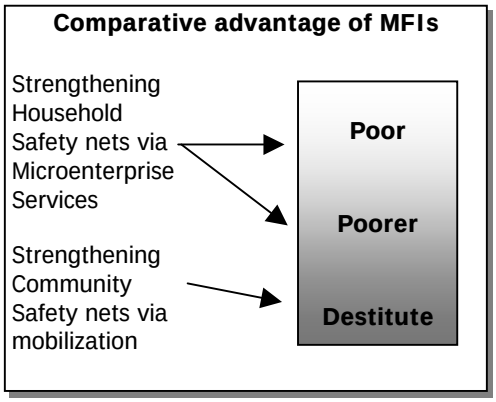
…… "A woman in Malawi who sold fried donuts received a loan from Save the Children's microcredit project (GGLS)[14]. The loan allowed her to move into the more lucrative fish trading business and, with the increased revenue, build up a bit of savings. However, her sister became ill and she had to take care of her. So, she went back to donut selling and used her savings to make ends meet. After her sister died, she was still able to go back to petty fish trading." (STEPS—previously COPE—program in Malawi)[15]

…. "Several members of a CARE microfinance institution (PULSE) in Zambia said they joined a credit group so that they could increase their business volume or diversify their activities. They were concerned because a family member was ill, and they anticipated that they would have to support his children in the future. The clients knew that their family expected them to take care of these children because they had a business activity. They also knew they needed to prepare themselves so they could absorb this new burden." (SCOPE/OVC in Zambia)

…. "The 17-year old daughter of a Kenya Women's Finance Trust (KWFT) client started taking over her mother's business as her health deteriorated. When the mother died, the group offered her place in their group to the daughter. Since she was under the legal age for entering into contracts, she couldn't be given a loan. So, they turned the mother's savings over to the daughter and allowed her to keep an honorary membership until she turned 18." (KWFT in Kenya)

[12] Joseph Tumushabe, "Quantitative Assessment of Impact of UWESO Development Program", April 2004. Uganda
[13] Caroline Barnes, et al, "Microfinance and Households Coping with HIV/AIDS in Zimbabwe: An Exploratory Study", September 2001.
[14] GGLS or Group Guaranteed Lending and Savings.
[15] Williamson, John, and Jill Donahue. 1996. *Developing Interventions to Benefit Children and Families Affected by HIV/AIDS: A Mid-Term Review of the COPE [Community-Based Options for Protection and Empowerment] Project*

The primary value of conventional microfinance in high prevalence areas is strengthening community safety nets as opposed to directly benefiting the most affected households. As stated at the beginning of this document, it helps households buffer the worst impact of HIV/AIDS by strengthening its economic resources, which in turns enables them to support other, more vulnerable, households (i.e. forming part of the community safety net).



Another comparative advantage of MFIs is its built-in mandate to scale up operations in order to achieve self-sufficiency. The microfinance industry expects its services to attain operational and financial sustainability to become permanent fixtures in the country's institutional landscape. Increasing client outreach to achieve economies of scale is one way that MFIs balance the cost of lending to poor people. The very mandate of the industry demands that an institution's coverage grow and that its services become a long-term establishment, not a transitory initiative. Both of these attributes are potent forces in designing approaches that will mitigate the impact of HIV/AIDS.

There is also the potential positive contribution that microfinance can make to promoting HIV prevention – by making community members (especially women) more economically independent and thus better able to avoid transactional sex or other economically-motivated behaviors that increase risk of HIV transmission.

Microfinance, though, is not a panacea for mitigating the economic impact of AIDS. For example, the preceding statement regarding MFI's potential for HIV prevention must be balanced with the possibility that increased access to economic resources can increase opportunity for risky behavior for some clients (especially males – e.g. fish traders have disposable income for alcohol, drugs, transactional sex, etc.) Or that increased independence of women can create conflict with their long term partners. In the South Africa WV program, FGDs with women clients revealed that enhanced economic standing of women already in marriages did not help them to negotiate safer sex with their husbands; in some cases it escalated domestic violence.

In the MicroSave study on microfinance and HIV/AIDS conducted by the consultant, the team found that a loan changes from boon to burden when increased pressure and competition for lump sums of cash occur just as a client experiences a dip in income flow—usually due to closing the business to undertake care giving responsibilities. Microfinance loans become a less preferred coping mechanism once an HIV/AIDS-related crisis begins eating into productive assets.

Survival of an MFI depends on clients paying back loans in full and on time. Thus, microfinance is not for households whose members have no productive capacity and have been the most negatively affected by HIV/AIDS. Such clients may need to leave the microfinance institution until they are back on their feet (Parker 2000).

Finally, strengthening client businesses via microfinance does not automatically result in improved child well-being; additional action may be needed to ensure this link (e.g. community sensitization and mobilization), but strengthening the economic resilience of a household is essential to sustainable improvements in children's safety and well-being.

IV. Comparison of Strengths and Weaknesses

Two matrices are provided here to summarize analysis of the various WV approaches. The first examines strengths and weaknesses of each approach in the following three operational contexts:

- *WV program only:* Area with an ADP or other WV HIV/AIDS response program, but no MFI
- *MFI only:* Area with a WV-affiliated MFI and no ADP/WV HIV/AIDS response program
- *WV program and MFI co-located:* Area where a World Vision-affiliated MFI and an ADP or other WV HIV/AIDS response program are both operating

The second matrix looks at the approaches in terms of responding to programming aspects that are fundamental in order to design projects effective at mitigating the economic impact of HIV/AIDS on children and their families. Those aspects include:

- Long term sustainability: as defined by cost effectiveness and scale of outreach[16]
- Performance and results: as defined by depth of outreach[17], sending and keeping children in school, increasing assets and improving participation in and access to community safety nets.

[16] Scale of outreach refers to how many clients financial services reach.
[17] Depth of outreach refers to how deeply into the survival economy financial services reach.

A. Strengths and Weaknesses within Program Context Matrix

Program Context	Zimbabwe (ASCA)		Malawi (Unified CwE)		Uganda (Parallel CwE)		South Africa (HIV/MED)	
	Strengths	*Weaknesses*	*Strengths*	*Weaknesses*	*Strengths*	*Weaknesses*	*Strengths*	*Weaknesses*
ADP only	- Methodology is simple to learn, less costly, has better potential scale and depth of outreach than an MFI. - Can be incorporated in ADP structure - Internal partnerships are easier to forge when programs are within the same overall mgt structure.	- Requires staff to specialize in and focus only on training & monitoring ASCA groups. - Learning curve for ADP staff is steep. - May be difficult to shift staff mentality to facilitating poor people's mobilization of internal resources.	None—WV has already concluded that loan delivery and collection must be separated from ADP structures and handled by a specialized institution.	Experience has shown that welfare and lending using external capital are not very successful when handled by the same entity.	Same as strengths for the unified CwE approach	Same as weaknesses for the unified CwE approach	HIV/AIDS training, HBC network and community mobilization was done well by specialist WV staff	There are few training models that have proven effective, ADP staff would not have skill set to develop one.
MFI only	An MFI could enhance access to external capital for those who experience exceptional growth.	- Managing groups inside an MFI's operations is likely to overwhelm capacity. - No specialist support for HIV/AIDS training. - Groups may feel entitled to external capital and be less cohesive as a result.	- MFI & loan officer have control and don't have to wait for partner or staff person. - Unified role has potential cost savings and thus greater affordability	- Lack of specialized staff may produce ineffective HIV training + overburden MFI staff, reducing their loan service efficacy	- Specialized staff may produce better results making up for cost of staff	- Building quality partnerships with other ASOs may be difficult or none may exist - Cost of spec. staff may be difficult for MFI to afford	None, unless MFI and training partnership shows marked impact on performance.	- TDCSP reached the fewest clients with MED. - Providing training alone for very poor clients does not recover costs or show better impact on businesses than providing loans in any context.
ADP and MFI co-located	- MFI can help explain economic aspects of ASCA and household economic dynamics to ADP staff, thus reducing their learning curve. - ADP adds value with HIV/AIDS awareness & community mobilization	- Same as weaknesses for MFI only. - MFI staff may have misconceptions about ASCA methodology and pass these on to ADP staff	- ADP adds value with HIV/AIDS awareness & community mobilization - MFI adds value in scale + economic strengthening	- MFI may not see need for , or have time to develop relationship with, ADP partner since loan officer has dual roles	- ADP adds value with HIV/AIDS awareness & community mobilization - MFI adds value in scale + economic strengthening	Organizational priorities may not mesh, making partnership frustrating	MF and training partnership with ADP adding value with HIV/AIDS training could enhance impact	

B. Comparison Matrix of MED and HIV Integrated Pilot Projects

Integrated Pilot	Long term sustainability		Performance and results—potential of positive impact on children			
	Cost effectiveness	*Scale of outreach*	*Depth of outreach*	*Children in school*	*Increased assets*	*Community safety nets*
ASCA methodology (Zimbabwe)	Although members do not pay for capacity building services, savings groups can sustain themselves after 6 to 8 months. Worldwide CARE estimates the cost for long term VSL programs at $18 to $30 / client.	Projected outreach for Pundutso ASCA after one year is **1,000** savings group members. After four years, CARE Zimbabwe reached **49,086** group members with the same methodology.	The ASCA methodology is well known to reach more deeply into the survival economy than do MFIs, reaching more vulnerable individuals and households than MFIs can	Sending children to school with accumulated savings of the ASCA was second only to buying assets. This is common in similar projects using ASCA methodology	Buying assets was the top priority purchase members made with their ASCAs' accumulated savings. This is also common in similar projects using ASCA methodology.	The pilot was too new to see whether this model would lead to improved participation in or access to safety nets. Though members said they are respected now in the community & feel confident they can get help when needed.
Unified integrated approach to CwE (Malawi)	Up-to-date costs were not available to the team, but using budget requirements from the FY04 CwE Concept paper for Malawi and project outreach, costs are roughly $153 / client	Projected outreach after +/- 4 years is **3,500** clients.	Target client is typical for MFIs; FITSE attracts the productive poor already engaged in economic activities, but not necessarily the poorest.	Clients stated they could pay for school fees because their businesses improved.	Inconclusive. Information gathered about asset accumulation was not included in the final report.	Clients reported that stigma reduced because of CwE, but there was no evidence of improved participation in or access to safety nets.
Parallel integrated approach to CwE (Uganda)	Information was not examined by consultant during evaluation.	After almost 8 years, outreach is **20,485** clients.	Community bank product reaches the poorest, but represents 39% of overall clientele.	Same as Malawi, except that CETTs also mobilized funds for orphans' school fees.	Information on assets was not tracked. Clients said they bought assets due to improved business.	Significant increase in client participation in and access to community safety nets.
HIV/MED Intersectoral Project (South Africa)	Client businesses benefited from the training, but paid a token fee to DBSP, which was not meant to cover costs.	**387** clients reached over the pilot (3 ½ years)	Analyzing how poor clients were was not part of the evaluation. Although literacy was a pre-requisite.	Same as above, except business improved because of training. Some accessed loans outside of TDCSP.	Assets increased, but attribution to the project is dubious. Assets tracked not those useful in crises.	Significant increase in access to various organizations' services. Unclear whether community safety nets improved.

V. Key Lessons Learned

- The majority of clients interviewed appreciated the value of HIV/AIDS education. In their opinion, it not only enhanced their financial capacity individually and as a solidarity group, but also afforded access to information and services that reduced the burden of HIV/AIDS-related crises. This is good for both clients and for the MFI as it improves risk management.

- It is not clear whether clients would be willing to pay for HIV/AIDS education if it increased the cost of lending to them. One client group mentioned that the administration fee was an important attribute of the loan product because it afforded them access to HIV/AIDS education and business training. Yet, experience in integrating education with microfinance services show that, over time when such services are institutionalized, clients can see the education as a "hoop" to jump through in order to get the loan.

- There is some indication that performance of groups under the CwE methodology is somewhat stronger in terms of repayment and portfolio at risk. This, however, has not been adequately studied over long enough periods to state with confidence.

- Effectiveness of HIV/AIDS information is strongest when passed between peers who trust each other and/or where peers are respected members of the community. MFI solidarity groups are built on trust and respect; as such, they are an effective platform for disseminating HIV/AIDS information and creating awareness; particularly when addressing stigma and discrimination.

- At the same time, effective responses to the impact that HIV/AIDS has on children and their families must go beyond peer to peer interaction, or individual changes in behavior and involve the whole community. This is particularly true where care and support is concerned. Yet an MFI or other MED-related organization does not have an institutional comparative advantage in mobilizing community response to the pandemic's impact on children and their families or in providing technical expertise regarding care and support.

- Effectiveness of HIV/AIDS information was most noticeable in TDCSP and MEDHA, where education and MED components were handled by specialist staff. The collaboration of ADP staff made the HIV/AIDS training and linkages to service providers easier, but the MED-ADP partnership was not smooth; in part, because staff was inadequately prepared, the world views of ADP and MED staff collided, or the collaboration was seen as an imposed burden rather than an advantage.

- In the parallel integrated CwE approach, the advantage appears to be that HIV/AIDS technical knowledge is brought in by specialized staff; the loan officer is not expected to be expert in two disciplines. However, the disadvantage appears to be that developing partnerships with specialized staff can be frustrating and might take time—even when the staff is all part of the WV "family". In addition to the time and frustration of developing a partnership, where there is no ADP there may be no partners or partners of quality with whom to engage.

- In the unified approach, an MFI can control all aspects and doesn't have to wait for another organization or staff person. The loan officer fully exploits her/his close relationship with clients. However, the disadvantage is that this might overload the loan officer and reduce quality of both training and loan delivery/recovery. In addition, the MFI probably doesn't have internal capacity to build loan officers' technical excellence vis a vis HIV/AIDS over the long term. This requires a very different skill set from that of microfinance.

- An MFI must have worked out its institutional "kinks" in order for HIV/AIDS education to be effective. Strong client dissatisfaction with the loan product overshadows their appreciation of HIV/AIDS education. And disjointed supervision of staff in loan or training delivery reduces its quality and by extension its impact.

- In areas heavily affected by HIV/AIDS, standard MFIs (no integration) seem to reach vulnerable households, however critics of microfinance often state that vulnerable households are forced to sell off productive assets or use school fee money to make loan payments. In addition, there is little evidence to support the common perception that economic improvement reduces risk behavior or women's ability to negotiate safe sex with husbands/long term partners. Finally, addressing discrimination and stigma must be deliberately addressed; changes don't occur simply because a community has access to loans.

- Yet, MFIs typically do not investigate whether credit leads to negative coping strategies. Neither MED-Net nor FITSE track drop out rates or interview clients who have dropped out to see whether loans became a burden to them. Similarly, MFIs in general do not investigate the extent to which stigma and discrimination regarding HIV/AIDS occur among their clients

- The ASCA model reaches more deeply into the survival economy than does institutional lending. Since this approach does not entail dispersing and recovering external loan capital or handling clients' savings deposits, it is less risky to the implementing organization. It also has promise of reaching significant numbers of people at an affordable cost. The community institution becomes sustainable, even though the service provide by the supporting organization is not fee-based. CARE Zimbabwe, who has more extensive experience with this methodology than does World Vision, finds that such programs cost $18 to $30 per client when costs are spread over the long term.

- It is a misconception that members of ACSA-like groups automatically need external capital as their businesses and capacity grow. The following are findings from other revolving loan fund and ASCA experiences when injecting external capital:
  - ✓ Long experience has shown that people are more vigilant when monitoring repayment of their own capital (hot money) than when it is externally supplied capital (cold money)
  - ✓ Groups may perform well initially when they are dealing with their own capital, however, they may begin to fall apart when external capital is injected
  - ✓ External capital distorts savings behavior, particularly if external capital is for matching or topping up what groups mobilize. Other organizations who have implemented self managed savings and credit associations found that groups who expect savings to be matched by external funds artificially inflate the amount they are capable of sustaining in order to increase the "match".
  - ✓ Unless group members understand very clearly the pros and cons of absorbing additional debt, they may take on more credit than they or their businesses can handle—turning credit into a burden, not an advantage.
  - ✓ Similar to the preceding point, many members of an ASCA group live in areas where there are easily saturated markets and weak purchasing power among consumers. Increasing amounts of credit do not deepen markets, or increase purchasing power. For example[18], it is easy to provide a 100% monthly return if a borrower has taken out $1 and trades in matches. If, however, a borrower takes out a loan of $100, very few

[18] The following example is taken from Hugh Allen's monograph of "CARE International's VS&L Program in Africa—Microfinance for the Rural Poor that Works."

investments can yield the same return because the demand for matches in a village is finite.

In summary, the journey to identify the best way forward has begun, but it is not over. For example:

- None of the pilots' monitoring and evaluation designs yielded conclusive data about the impact of integrating MED and HIV responses on clients, particularly in terms of whether clients' children are better off. Thus, it is impossible to attribute objectively clients' perception of improved capacity to mitigate the impact of HIV/AIDS to the integrated pilots.
- Cost of integrating HIV/AIDS training was not adequately addressed during evaluations
- The connection between integrating HIV/AIDS responses and stronger group performance has not been explored fully enough

VI. Recommendations for Future Integration of MED and HIV/AIDS

The following recommendations are divided into two sections:

a. Recommendations to optimize effective programming to integrate MED and HIV/AIDS response in contexts where there is: i) a WV program and an MFI co-located; ii) WV program locations that have no affiliated MFI partner; and iii) an MFI only.

b. Cross-cutting recommendations related to monitoring and evaluation, action research, and cost effectiveness

A. Optimizing Program Effectiveness

i) WV and MFI co-locations

Capitalize on the comparative advantages of ADP and MFI/MED programming.
Maximize impact by capitalizing on MFI and World Vision ADP comparative advantages:

- MFI should focus on its strength in the efficient delivery of sustainable financial services to the working poor; including the integration of basic awareness raising training regarding HIV/AIDS. This combination should aim at mitigating impact of HIV/AIDS at the *individual client and household* levels.
- World Vision ADP, on the other hand, should focus on its strength as a catalyst of sustainable community-owned response to the impact of HIV/AIDS, particularly as it relates to children. This is intended to mitigate impact of HIV/AIDS at the *community* level.

Parallel Approach to CwE[19]
WV should promote the MEDHA, or parallel approach, to CwE in ADPs and other programming areas where there is strong HIV/AIDS response underway. Having separate staff specialize in loan portfolio management and HIV/AIDS education respectively creates a better environment to develop training quality, technical expertise and subsequent impact. The added cost of hiring separate staff may well be justified by improved solidarity group performance, although this aspect warrants further monitoring and evaluation assuming this is a foregone conclusion. Close partnership with ADP or other World Vision programming in HIV/AIDS response may afford opportunities to share the additional cost between the ADP and MFI; thus reducing cost to both. The impact created by synergy of HIV/AIDS response and economic resilience may well add up to improved cost effectiveness.

[19] The recommendations on the parallel approach to CwE were included in the MEDHA evaluation and are repeated here for the benefit of other programs interested in taking up this approach.

Refocus HIV/AIDS training offered to MFI clients
MFIs should limit HIV/AIDS training to information and linkages for the direct benefit of its client base and their children. When going beyond this to mobilization of the wider community, or to initiate HBC or OVC related activities, MFIs must join in partnership with WV programs. In ADP and MFI co-locations, this would involve connecting with World Vision's Hope Initiative that aims to catalyze Community Care Coalitions (CCC): sustainable community-led initiatives to care for the most vulnerable members of the community.

Working relationships between WV and MFI staff
MFIs should strengthen working relationships with the ADPs:

- World Vision national offices and MFI senior management must provide leadership for integration strategies. Deliberate involvement of national and senior MFI management is necessary to develop strategies and guide the integration and mutual sensitization among staff regarding MFI and WV ADP approaches.
- Tailor orientation to integration of MED with HIV/AIDS programming according to type of staff; i.e. at national World Vision level, a strategic and policy focused content is ideal; for intermediate staff, strategic considerations and implications regarding the management of integration is appropriate. For field staff, training should be geared towards the type of work they are expected to do and how they will facilitate linkages and connections.
- Conduct joint meetings at ADP and branch levels to plan for, implement and manage integration (e.g., quarterly ADP meetings, weekly loan officer meetings)
- Prioritize and harmonize MFI expansion with ADP implementation of the CCC model

ii) WV program locations that have no affiliated MFI partner

Build WV capacity to implement and manage the ASCA approach
WV should build institutional capacity to launch the ASCA approach rather than develop a WV-affiliated MFI or wait for one to expand to their program location. WV could contract CARE staff to support staff training, but should not link this to WV-affiliated MFIs. It is recommended that WV create a separate project for this within the ADP and using ADP resources. Adding this duty to MFI operations would overburden even a mature MFI, let alone one still dealing with its own early institutional development. Moreover, ASCA management is structurally different than an MFI; an MFI deals in risk management of externally supplied capital and acts as financial intermediary between its clients and the capital. An MFI hopes to retain its clients as long as possible. The ASCA approach deals in building the capacity of a community institution; training and advising members in the creation of a self-managed group that becomes the financial intermediary between themselves and their own internally supplied capital. The ASCA approach entails "graduating" groups out of the program; only providing them with intensive technical assistance over a relatively limited time (6 to 10 months).

Create linkages between ASCA groups and ADP HIV/AIDS programming
Given the benefits that MFI clients' perceived in HIV/AIDS education, ASCAs should also integrate HIV/AIDS education into their group capacity building process. Each ASCA group should be linked to HIV/AIDS education providers – either ADP HIV/AIDS-focused staff or other HIV/AIDS-focused trainers available in the area. Linkages should serve to provide education and awareness about HIV/AIDS to ASCA group members and should inform ASCA members about community care efforts underway (including CCCs) and how the ASCA members can both benefit from and contribute to these. Similarly, ADP staff and CCC leaders should provide a basic overview of the ASCA approach to OVC and HBC home visitors, OVC guardians, older OVC, and PLWHA about the ASCA approach. Those who are interested may choose to form an ASCA group. ASCA group formation should be voluntary, based on perception of self-interest and mutual trust. Group formation should not be required by the ADP or any other external entity.

Injecting external capital

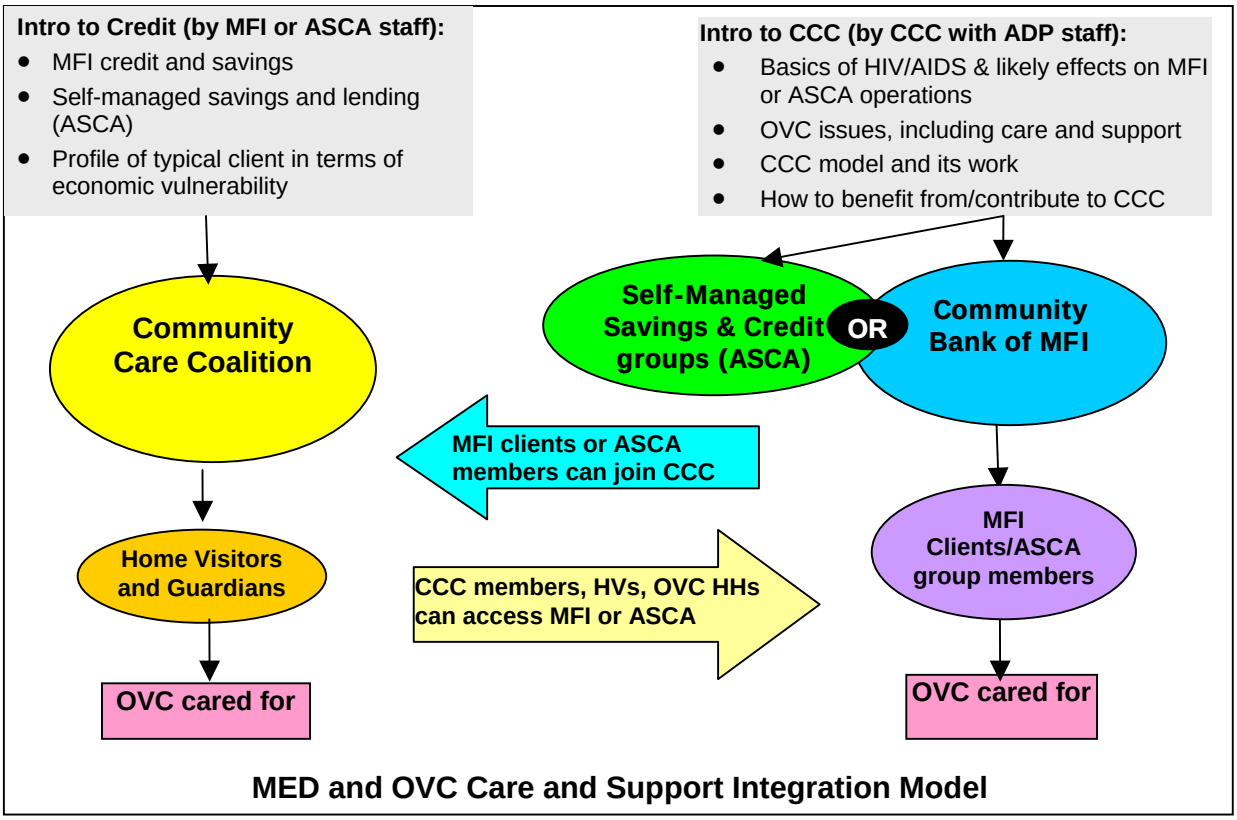
Offering external capital to ASCA groups is not recommended. As pointed out in the lessons learned section, injecting external capital elicits high and unrealistic expectations on the part of group membership, weakens the group solidarity, and distorts savings behavior.

Graduating ASCA members to MFI loans

The consultant recommends not having linkage of ASCA members to MFI loans as a goal at the outset, but rather allowing the model to evolve naturally and letting clients lead the way on whether their capital needs have been met. In addition, WV must look beyond its internal learnings and seek out what other organizations that have long experience in this model (i.e. CARE) have found.

Minimum approach to integrating HIV/AIDS response and MED in ADP areas

The diagram below illustrates a minimum approach to integrating HIV/AIDS and MED interventions (either MFIs or ASCA methodology) in ADPs with an MFI or ASCA groups, with a focus on strengthening OVC care and support.



This diagram was developed by Sammy Mwangi, Martha Newsome, and Peter Samuelsen, and subsequently modified by the consultant.

This approach entails two types of orientation sessions:

1. *An orientation session for MFI or ASCA groups to the community care coalition, conducted by CCC leadership with support from ADP HIV/AIDS-focused staff if necessary.* This orientation will introduce MFI clients or ASCA members to the basics of HIV/AIDS and to the work of the CCC, so that they and their households can benefit from and perhaps contribute to the CCC. There are a variety of ways that MFI clients/ASCA members can contribute to the work of the community to care for OVC its most vulnerable residents, including:

- Becoming part of CCC leadership
- Becoming a home visitor for OVC or PLWHA
- Making financial or material contributions to assist the OVC and PLWHA being cared for by the CCC.

2. *An orientation session to ways to access and productively use credit (microfinance or ASCAs) for CCC members, home visitors, OVC guardians, older OVC, and PLWHA, conducted by MFI staff or the ADP staff responsible for ASCAs.* This orientation introduces all these populations to the credit resources available within the community, through either MFIs or ASCAs. Individuals who are interested can then agree with others in the community either to form an ASCA or to apply to the MFI for capital.

   Managed well, involvement in MFI community banks or ASCA groups can enhance the capacity of CCC members and home visitors to care for the OVC and PLWHA to whom they are committed. Managed poorly, this involvement can undermine the community care effort by diverting CCCs' and home visitors' attention to economic activity rather than the broader community care effort. It is important that the ADP staff recognize this danger and work with CCCs and their home visitors to find an appropriate balance.

This approach should be considered as the absolute minimum in integration of MED and HIV/AIDS response within an ADP. The consultant strongly advises use of the other approaches recommended in sections i) and ii) above in addition to this minimal approach.

iii) MFI only locations

HIV/AIDS training for MFI clients

Given the benefits that MFI clients perceive, MFIs should be encouraged to integrate HIV/AIDS education in their credit delivery system. Similarly, if increased financial capacity and stronger cohesiveness among client groups leads to better repayment and fewer drop outs, this is cost saving to MFI—and well worth the investment.

However, as stated in the recommendation section for MFI and WV/ADP co-locations, MFIs should limit HIV/AIDS training to information and linkages for the direct benefit of its client base and their children, as opposed to encouraging clients to mobilize the community or to initiate separate HBC and OVC programs.

The consultant still maintains that the parallel approach is more conducive to technical excellence in both credit and HIV/AIDS expertise. However, it must be noted that there are advantages and disadvantages to both the unified and parallel approaches (as laid out in the matrices and lessons learned). In addition, it may not be feasible for an MFI to absorb the additional cost of separate staff in the absence of a WV partner with whom to share costs. Therefore, in such cases, an MFI may opt for the unified approach. Whichever approach is used, though, MFI senior management must be vigilant in controlling the quality of the HIV/AIDS education component. Developing partnerships with organizations specializing in HIV/AIDS education is an important aspect of maintaining quality.

Where integration is not occurring or not immediately possible, standard MFIs should track their client drop out rate to see whether the MFI is losing valuable clients and then, conduct a "drop out" study to determine why clients leave the program.

Developing partnerships with non-WV HIV/AIDS organizations
MFIs will need input from specialist HIV/AIDS support organizations in 1) maintaining quality of their HIV/AIDS training and 2) when intending to go beyond information to community mobilization, HBC and OVC activities.

When MFIs intend to get involved in mobilizing the wider community to respond to HIV/AIDS, it will be important to identify and partner with HIV/AIDS organizations that are committed to catalyzing a community response to mitigate the impact of the pandemic on children and their families, since this in keeping with World Vision's child centered nature.

Connecting to leadership, organizations or initiatives goes beyond creating linkages for material support. A connection must involve the development of a long term relationship with an organization in order to catalyze a community wide response to PLWHA and OVC.

Operational improvements to the unified and parallel CwE model.
When opting for the unified approach, MFIs must explore ways to create incentives to reward loan recovery and dispersal as well as social performance (HIV/AIDS education) with clients. This so-called "double bottom line" requires a dual incentive system for staff. Currently, WV's incentive systems account for loan portfolio performance only.

With either the parallel or unified integrated credit with education approach, the burden for operationalizing the double bottom line must rest with the institution, not the loan officer. Equal attention to social performance and loan recovery must reflect an institutional core value and be part of the MFI's overall strategy; it cannot be lip service. The budget must also reflect investment in achieving excellence in the social aspect as much as in the financial aspect.

MFIs need to improve the manner in which training in HIV/AIDS education is handled for new staff as well as planning for continuous skill development of trainers. Currently, there is not an adequately systematic approach to internalizing and institutionalizing staff development into routine MFI operations. Quality control should also be an integral part of the systematic approach.

B. Cross-Cutting Recommendations

This section provides recommendations cutting across all contexts and types of approaches to integration of MED and HIV/AIDS response. The recommendations address:

- Program design
- Monitoring & evaluation
- Action research and
- Cost effectiveness

Harmonizing goal, objectives and indicators with baseline study design
Baseline information must be streamlined and limited to what the project will track over time. It must also be tightly linked to the indicators the project chooses to demonstrate results. The M&E system then needs to flow and build on baseline information gathered. At the same time, staff should ensure that clients are not overburdened by too many or too long surveys. The consultant designed a baseline study approach, complete with suggested quantitative and qualitative tools for the MEDHA pilot's second phase. A set of suggested goals, objectives and indicators accompanied the baseline study design. This could be shared with other MED & HIV integration projects.

Assisting integrated programs with action research agenda; including M&E systems
None of the pilots yielded conclusive data about the impact of integrating MED and HIV responses on clients, particularly in terms of whether clients' children are better off. WV's staff focused on HIV/AIDS-related research should assist countries with the next phases of their pilots in developing a solid action research agenda. Some of the more important contributions would be to:

- Develop a general template for a conceptual framework offering examples of goals, objectives and indicators. This will ensure easier comparison across models and avoid trying to compare "apples to oranges".
- Coordinate the use of the Hope Initiative's Core HIV/AIDS Monitoring System (CHARMS) and advise country staff in its use. This could go a long way in standardizing monitoring and evaluation approaches.
- Assisting MFIs to measure social performance and making it a routine function within operations. The Imp-Act initiative for MFIs was launched for precisely this reason. WV could facilitate MFI participation in Imp-Act (see www.imp-act.org)
- Study connection between integration of HIV/AIDS responses and 1) the performance of MFI solidarity groups (repayment, drop out rate, PAR), 2) the impact on care for vulnerable children, 3) improved participation in and access to community safety nets and 4) the impact on MFI clients' business performance

Analyzing MFI cost effectiveness and managing costs of integration.
WV will need to calculate the costs of providing HIV/AIDS training linking to service providers and developing partnerships between ADP and MFIs or other non-WV organizations responding to the impact of HIV/AIDS. Cost effectiveness was not an aspect studied by the consultant when assessing the pilots in this document; yet it is an extremely important consideration when comparing the efficacy of the various models WV is piloting. In general, WV must go beyond simply tallying up operational costs and dividing by the number of clients served. For example:

- Senior management sees that it is less costly to have a loan officer also deliver HIV/AIDS training, but then finds out that portfolio quality suffers—perhaps because one person is playing two roles. Do the savings on staff costs justify the lower portfolio quality?
- Management decides to hire two people and discovers that group solidarity is enhanced such that repayment performance, attendance and drop out rates improve. Does the improved performance outweigh the cost of the extra staff person?

The MFI can also develop new products and services or flexible policies to serve client needs better, but this means additional costs. One response is to increase interest rates and/or fees. Some alternatives for keeping costs down while striving to innovate:

- Using participatory methods of wealth ranking with clients to ensure the institution is reaching deeply into the country's poorest economic strata[20]
- Encouraging internally financed and controlled emergency funds or informal RoSCAs that solidarity group members manage
- Inviting the participation of clients to propose product and methodology innovations via the use of MicroSave participatory market research tools

Similarly, MFIs need to pay even closer attention to performance indicators so they can serve as an "early warning system." Examples of such indicators would be portfolio at risk (PAR>30), the loan loss reserve or default fund, client attendance at meeting and client retention or drop out rates. Finally, MFIs may need to develop new strategies for staff development or benefits. An increase in staff mortality translates into higher re-training and recruitment costs.

[20] For instance, the CASHPOR House Index and SEF's Poverty Wealth Ranking. These tools are low-cost and can be a way of reaching new markets (e.g. poorer clients).