



**USAID**  
FROM THE AMERICAN PEOPLE

**HEALTH POLICY  
INITIATIVE**



# **REDUCING ADOLESCENT GIRLS' VULNERABILITY TO HIV INFECTION:**

## **EXAMINING MICROFINANCE AND SUSTAINABLE LIVELIHOOD APPROACHES**

### **A LITERATURE AND PROGRAM REVIEW**

**JULY 2008**

This publication was produced for review by the U.S. Agency for International Development (USAID). It was prepared by Terri Lukas of Constella Futures for the Health Policy Initiative, Task Order I.

The USAID | Health Policy Initiative, Task Order 1, is funded by the U.S. Agency for International Development under Contract No. GPO-I-01-05-00040-00, beginning September 30, 2005. HIV-related activities of the initiative are supported by the President's Emergency Plan for AIDS Relief. Task Order 1 is implemented by Constella Futures, in collaboration with the Centre for Development and Population Activities (CEDPA), White Ribbon Alliance for Safe Motherhood (WRA), Futures Institute, and Religions for Peace.

# **REDUCING ADOLESCENT GIRLS' VULNERABILITY TO HIV INFECTION:**

## **EXAMINING MICROFINANCE AND SUSTAINABLE LIVELIHOOD APPROACHES**

### **A LITERATURE AND PROGRAM REVIEW**

JULY 2008

The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

The author gratefully acknowledges Rajashree Panicker for compiling the organizational profile data that appears in the appendix and Emily Byron for assisting with editing and formatting this review.



# TABLE OF CONTENTS

Preface.....	v
Executive Summary .....	vii
Abbreviations .....	ix
Introduction.....	1
Methodology .....	1
<b>Part 1: Youth-Centered Programs and Preventing HIV Infection among Vulnerable Female Adolescents .....</b>	<b>1</b>
The Adolescent Period of Life and Female Adolescents’ Susceptibility to HIV Infection .....	2
Programs Targeting Adolescents and Their Impact on Adolescent Vulnerabilities to HIV Infection	5
Evidence of the Role Microfinance Can Play in Addressing Adolescents’ Vulnerability to HIV Infection .....	7
Applying Lessons from Current Youth Programs and the Microfinance Experience to Develop Sustainable Livelihood Programs Targeted at the Most Vulnerable Adolescent Girls.....	9
The Way Forward: Critical Issues to Address to Adapt Sustainable Livelihood Programs to the Needs of Adolescent Girls .....	11
<b>Part 2: Applicability of Microfinance Programs in Preventing HIV Infection among the Oldest Adolescents and Young Women .....</b>	<b>12</b>
Microfinance Programs Defined .....	12
Microfinance and HIV Prevention .....	14
The Impact of Microfinance on Poverty Alleviation .....	15
The Link between Microfinance and Specific Benefits for Women .....	16
The Link between Microfinance and the Effective Delivery of HIV Prevention and Other Social Welfare Services .....	17
Conclusion .....	19
Appendix A: Organizational Profiles.....	20
References.....	45
Additional Resources.....	52



## PREFACE

Increasing women’s access to income and productive resources is one of the five priority gender strategies of the President’s Emergency Plan for AIDS Relief (Emergency Plan) (PL 108-25). In late 2007, the Gender Technical Working Group (GTWG) of the Office of the U.S. Global AIDS Coordinator met with staff of the USAID | Health Policy Initiative, Task Order 1, to discuss ways to advance this strategy in Emergency Plan country programs in sub-Saharan Africa. In particular, the GTWG’s wanted to examine the applicability of microfinance programs in preventing HIV infection among adolescent girls, ages 10–19 years old. The discussions resulted in a scope of work that included the following deliverables: (1) a literature and program review of microfinance programs and an assessment of their contribution to reducing adolescent girls’ susceptibility to HIV infection; (2) based on the review findings, the development of a framework or informal reference tool to assist U.S. government (USG) country teams with identifying what kind of USG investment is warranted in microfinance projects and related economic strengthening efforts—to help prevent HIV infection within the target group; (3) a pilot assessment of the framework with implementing partners in two African countries; and (4) a final framework or tool for use by all USG country teams and implementing partners, as warranted.





## EXECUTIVE SUMMARY

Part 1 of this literature and program review focuses on youth-centered programs to prevent HIV infection among vulnerable female adolescents—including microfinance (MF) and sustainable livelihood programs. Part 2 analyzes the relationship between microfinance and HIV prevention in the general population, with a focus on women and the oldest adolescents in the target group. Adapting the traditional microfinance model to meet the needs of this sub-group could prove to benefit not only these adolescents but also the microfinance industry. The following are selected key findings of the review.

### Part I: Youth-Centered Programs and Preventing HIV Infection among Vulnerable Female Adolescents

- The literature underscores the urgency of devising effective program strategies to prevent HIV infection among highly vulnerable groups of female adolescents in sub-Saharan Africa. Current strategies and programs are not reaching this population because they are operating on untested assumptions about the population itself and the nature of the risk of HIV infection. Many assume that information and services can reach vulnerable female adolescents through urban, school, or youth-centered programs, yet evidence indicates that they are not being reached. Mainstream HIV prevention messages have little relevance to the lives of highly vulnerable female adolescents because they assume that these adolescents exert some control over the timing and frequency of sexual encounters, use of condoms, and HIV status of their partners, when they do not.
- Traditional microfinance programs can address some but not all of the structural risk factors for HIV vulnerability among subgroups of the target population. For example, they can be adapted to suit the oldest adolescents. As noted in Part 2 of this document, experimenting with adaptations to microfinance programs to meet the special needs of older adolescents could prove to be an important way for microfinance institutions (MFIs) to attract and recruit a new generation of clients. If donors attempt to undertake such experimentation, they should do so with the full cooperation of operating MFIs through a properly applied mix of financial incentives, an underwriting of risks to the financial sustainability of the MFIs, and funding for the required research.
- For younger adolescents, traditional microfinance programs are not suitable. Available well-documented evaluations of microfinance trials with adolescents suggest that opportunities to save and have regular access to those savings, in addition to safe social groups and non-judgmental mentors, are more relevant to their lives than credit for business formation.
- New or “second-generation” program strategies to reach these vulnerable adolescents can be built on current adolescent programs if countries and donors make a comprehensive commitment to do so. Such a commitment would involve challenging conventional programming wisdom, as some of the described adolescent programs have done, and investing resources to build an evidence base that tracks progress in reducing this target population’s HIV risk factors. Building such an evidence base should start with collecting and organizing data on adolescents by key risk factors and by country.
- Youth-centered sustainable livelihood programs offer a promising template through which HIV prevention strategies can be integrated to address a range of risk factors for adolescent girls, including child marriage, social isolation, low socioeconomic status, being out of school or unskilled, and being pressured to provide productive labor and income. These livelihood programs share with microfinance programs a link to local communities and markets and an aim

to improve adolescents' economic status and prospects. Yet, livelihood programs seem more adaptable to the circumstances of different adolescent subgroups than are microfinance programs alone. Hence, from a number of perspectives, sustainable livelihood programs for adolescent girls are suitable for testing as "second-generation" interventions to target and reduce HIV risk factors.

## Part 2: Applicability of Microfinance Programs in Preventing HIV Infection among the Oldest Adolescents and Young Women

- There are strong advocates for using microfinance as a vehicle to prevent HIV transmission and mitigate its effects on households. Microfinance programs focus on poverty alleviation, the empowerment of women, and the drive to extend coverage using internally generated financial resources, which are all critical assets in the fight against HIV.
- However, microfinance is not a panacea to prevent HIV infection. One should be cautious in thinking that microfinance can even be a primary force in preventing or mitigating the epidemic. Microfinance's clear and tested role in the face of the epidemic is to provide still productive adults an opportunity to strengthen their economic base, overcome present shocks, and build their future lives. Excessive loading of additional, non-financial objectives on MFIs should be avoided.
- The principal challenge advocates face in making their case for combining HIV prevention activities and microfinance activities is a lack of compelling evidence demonstrating a positive health impact that does not diminish microfinance's purpose of economic strengthening. Randomized controlled field trials of selected interventions are needed to judge the merits of alternative operational approaches and longitudinal studies to track the effect of desired behavior change interventions over time. For example, health education to prevent infection is probably the most common intervention adopted by MFIs. Yet, evidence from a (rare) researched case study reveals that education should be paired with community mobilization and other activities to empower women and men to change behaviors that reduce risk. In other words, health education alone, while affordable to MFIs, may have a marginal impact on prevention.
- Finally, the literature review suggests that international HIV/AIDS donors interested in finding out what role microfinance can play in prevention should reconsider how they use their funds to answer the important outstanding questions. Donors should build funding flexibility into the ways they approach this topic. For example, they could actively and systematically enlist MFIs in trials to add HIV prevention activities to their operations. If properly applied, a mix of financial incentives, underwriting risks to the financial sustainability of the MFIs, and funding for the required research could produce needed answers to the questions being raised.

## ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
AIMS	Assessing the Impact of Microenterprise Services (Project)
BRAC	Bangladesh Rural Advancement Committee
Camfed	Campaign for Female Education (International)
CCT	conditional cash transfer
CEDPA	Centre for Development and Population Activities
CGAP	Consultative Group to Assist the Poor
DHS	Demographic and Health Survey
Emergency Plan	President's Emergency Plan for AIDS Relief (United States)
FA	Families in Action
FFH	Freedom from Hunger
FINCA	Foundation for International Community Assistance
FOCCAS	Foundation for Credit and Community Assistance (Uganda)
GDP	Gross Domestic Product
GOB	Government of Bangladesh
GTWG	Gender Technical Working Group
HIV	human immunodeficiency virus
ICRW	International Center for Research on Women
IGVGD	Income Generation for Vulnerable Groups Development (Bangladesh)
IMAGE	Intervention with Microfinance for AIDS and Gender Equity (South Africa)
IPV	interpersonal violence
KDA	K-Rep Development Agency (Kenya)
MF	microfinance
M&E	monitoring and evaluation
MFI	microfinance institution
NGO	nongovernmental organization
OVC	orphans and vulnerable children
PATH	Program of Advancement through Health and Education (Jamaica)
PDA	Population and Community Development Association
PPP	Positive Partnerships Program (Thailand)
PRAF	Family Allowance Program (Honduras)
PROGRESA	Education, Health, and Nutrition Program (Mexico)
RH	reproductive health
ROI	return on investment
ROSCA	revolving savings and credit association
RPS	Social Safety Net Program (Nicaragua)
SEF	Small Enterprise Foundation
SFL	Sisters for Life
SHAZ	Shaping the Health of Adolescents in Zimbabwe
SKI	Street Kids International (Zambia)
TRY	Tap and Reposition Youth (Kenya)
USAID	United States Agency for International Development
USG	United States Government
UNAIDS	United Nations Program on HIV/AIDS
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	vocational training center
WFP	World Food Program



## INTRODUCTION

This literature and program review focused on the current and future role of microfinance and sustainable livelihood strategies in reducing adolescent girls' vulnerability to HIV infection in developing countries, particularly in sub-Saharan Africa. The key findings are summarized in two parts:

1. Youth-centered programs, including microfinance and sustainable livelihood programs, and, in particular, those aimed at preventing HIV infection among vulnerable female adolescents.
2. The relationship between microfinance and HIV prevention in the general population, with a focus on women and the oldest adolescents in the target group.

## METHODOLOGY

The literature and program search first centered on identifying documents that addressed the combined subjects of microfinance and HIV from the 1990s and onward. The identified documents were then screened to cull those related to the adolescent target group—females ages 10–19 years old—and gender-based programming. A search on adolescents and youth-friendly services, as well as youth livelihood programs was also conducted. The databases searched include those of international donors, consortia, the Joint United Nations Program on HIV/AIDS (UNAIDS), the United Nations Children's Fund, the World Bank, international consulting firms and research institutions, international public health and medical journals, and U.S.-based private voluntary associations.

These processes yielded few examples of economic-strengthening programs and projects targeted exclusively at youth, fewer in the age group of interest (ages 10–19), and still fewer that used robust research methods to evaluate the effects of their interventions. The reviewers identified five programs and projects that targeted benefits to adolescents (girls and boys)—either directly or through parents and guardians (TRY, SHAZ, CAMFED International, The Rainbow Model, and Street Kids' International: Youth Skills Enterprise Initiative Project). Only two of these programs, TRY and SHAZ, were evaluated using control groups that could allow for any generalizable results. Appendix A includes descriptions of those programs and projects that fit at least in part the screens of the objective (economic strengthening), target group (female adolescents), and evidence of effectiveness. The programs and projects are ordered alphabetically by name and are described according to the range of parameters examined to identify possible sources of influence on the target group's behavior. The chief parameters included the type of economic strengthening activity, program inputs and processes, performance indicators, program outcomes and follow-up, and the availability of cost or cost-effectiveness analyses. References are also noted to facilitate the readers' access to more detailed analyses.

## PART I: YOUTH-CENTERED PROGRAMS AND PREVENTING HIV INFECTION AMONG VULNERABLE FEMALE ADOLESCENTS

The review of sources focused on female adolescents ages 10–19 years old (who are particularly vulnerable to HIV infection) helped to answer the following questions:

- What do we know about the adolescent period of life and female adolescents' vulnerability to HIV infection in sub-Saharan Africa?
- What kinds of programs are targeted at this population group, and how well do they address adolescents' vulnerabilities to HIV infection?
- What evidence is there about the role that microfinance might play in addressing these vulnerabilities?

- What lessons can be learned from current youth programs and the microfinance experience to develop sustainable livelihood programs targeted at the most vulnerable adolescent girls?
- What issues must be addressed to adapt sustainable livelihood programs to the needs of adolescent girls?

## The Adolescent Period of Life and Female Adolescents' Susceptibility to HIV Infection

The literature on adolescence in developing countries, and in sub-Saharan Africa in particular, tells us that it is necessary to treat this period of life differently from childhood and adulthood.<sup>1</sup> Adolescence is a highly transitory period of life; the number and type of changes that adolescents experience in family structure, livelihoods, schooling, community bases, and identities are unparalleled in any other period. To cope with the multiple and rapid changes that occur in their lives, adolescents have specific needs for new types of decisionmaking powers. Adolescents need “safe places” to meet with peers and mentors, as well as resources to find alternatives to pressures to leave school, engage in illegal or unsafe work, abuse substances, marry early, have unsafe sex, and exchange sex for gifts or money (Bruce and Joyce, 2006).

Because of their highly transitory nature, the adolescent years are a time when boys' and girls' susceptibilities to HIV infection are particularly acute. In many parts of sub-Saharan Africa, it is characterized as a juncture of life in which traditional debilitating gender norms that are linked to increased risk of HIV infection take hold (Urdang, 2007). For example, in societies where girls are valued less than boys are, parents exert excessive protection over their girls, restricting their mobility in public in order to preserve their value as a commodity of marriage (i.e., their virginity) and under-invest in their education. When they lack secondary or even a primary education, girls' choices are limited to early marriage and child bearing, and they experience lower earnings throughout their lifetimes than if they had stayed in school (Summers, 1994). Girls living without parents might seek their own form of protection in relationships with older men, heightening their risk of infection and interpersonal violence (see below for a further discussion of the gender issues associated with the HIV epidemic). Adolescent boys, on the other hand, are encouraged to assume a masculine identity, which prizes risk taking and aggressive and dominating behaviors that are threatening to themselves, girls, and women. Such traditional patterns of male behavior fuel the HIV infection rate because males lack the same prohibitions on extramarital relationships that girls face and, in polygamous cultures, are encouraged to have multiple wives (Urdang, 2007).

Globally, the 15–24-year-old age group accounts for half of all new cases of HIV infection (UNAIDS, 2004).<sup>2</sup> Almost two-thirds of all young people living with HIV in the world (6.2 million) live in sub-Saharan Africa. Three-quarters of HIV infections in this age group are borne by adolescent girls and young women (Hallman, 2005; UNAIDS, 2004). In 19 African countries, at least 5 percent of females ages 15–24 are infected with HIV (UNAIDS, 2002).

As with the adult population, particular subgroups of adolescents are more vulnerable to infection than others. The literature that identifies and probes the heterogeneity of adolescents as it relates to vulnerability to HIV infection outlined the following characteristics as critical for attention by HIV programmers (Bruce and Joyce, 2006):

---

<sup>1</sup> This section on adolescent girls' risks for HIV infection in sub-Saharan Africa largely draws on the considerable amount of policy research done by the Population Council since the early 1990s on adolescents, particularly girls. This work has been designed to reveal social and economic determinants of adolescents' lives as well as their sexual, reproductive, and behavioral health. In particular, refer to the Transitions to Adulthood research: [www.popcouncil.org/ta/index.html](http://www.popcouncil.org/ta/index.html).

<sup>2</sup> Nearly 30 percent of the population of developing countries—approximately 1.5 billion people—are young people (between 10–24 years old). Roughly 325 million of young people are growing up on less than \$1 a day (Population Council, 2005).

- *Gender*—males’ and females’ behaviors change in different ways during adolescence, thereby subjecting the sexes to different risks.
- *Age*—very young adolescents, ages 10 to about 14, are different from older adolescents, and age grouping (even in five-year increments) masks important changes in vulnerability of infection.
- *Marital status*—married girls, unlike boys or young men, are often isolated from their peers and society in general and engage in high levels of unprotected sex with their older spouses;
- *Living arrangements and school status*—adolescents living with their parents and attending school have a low risk of infection compared with those living on their own and not in school.
- *Residential location*—adolescents living in urban areas generally face higher risks of HIV infection than those living in rural areas based on differential life challenges and opportunities.

In summary, girls in one or more of the following life situations are judged to be the most vulnerable to HIV infection: out-of-school, especially very young adolescents (ages 10–14); girls living apart from their families, particularly those newly migrated to cities and in domestic service; girls acting as heads of households and pressured to earn income; and married adolescents (under 18 years old) (Bruce, 2007). What is it about their life situations that make these girls particularly susceptible to HIV infection? In sub-Saharan Africa, a number of studies have identified the following “structural factors” of risk for HIV infection among adolescent girls.

**Child marriage.** According to analyses of Demographic Health Surveys (DHS) done by the Population Council in 49 developing countries, 38 percent of women ages 20–24 were married before the age of 18 (Bruce, 2006a). If present patterns continue, more than 100 million girls will be married by the next decade (Bruce, 2007). Marriage dramatically increases sexual frequency for adolescent girls, even compared with their sexually active unmarried counterparts (Blanc and Way, 1998). Compared with those who are unmarried, married adolescents have more unprotected sex, and their partners are typically older and more sexually experienced and thus more likely to be infected. A study in Kenya found that 31 percent of partners of married adolescent girls were HIV positive, compared with 12 percent of partners of unmarried adolescents; in Zambia, the rates were 32 percent and 14 percent, respectively (Clark, 2004). In addition to facing the health risks of bearing children when their bodies are not fully developed, married adolescents have higher HIV infection rates than unmarried sexually active adolescents. This difference has been attributed to married adolescents’ inability to negotiate condom use (Clark et al., 2006). Other characteristics of married adolescents include social isolation from their peers, restricted mobility, little education and no schooling options, and limited access to modern media and health messages. Child marriage mainly affects girls, not boys, and happens in regions of countries, even as the national rates of age at marriage are rising. Risk factors for child marriage include low socioeconomic status, single-parent or mother-only family status, no schooling or late entry to school, grade repetition, and leaving school before the end of secondary school (Bruce and Joyce, 2006; Blanc and Way, 1998; Clark et al., 2006).

**Social isolation.** Girls tend to have fewer friends than boys, and increased social isolation is correlated with increased sexual coercion. Already socially isolated from their peers, the majority of girls 10–14 years old in the urban areas of many sub-Saharan countries live with one or no parent (Chong et al., 2006). Even across income groups, girls have smaller and less reliable friendship networks than boys and fewer safe and supportive spaces in which to meet friends. Lack of safe spaces for girls is not only isolating emotionally, it also denies them platforms for program interventions (Bruce, 2007). As noted above, married adolescents are more socially isolated than their unmarried peers. In South Africa, the most socially isolated girls are six times more likely to have been physically forced to have sex than the most socially connected girls (Bruce and Chong, 2006). At the same ages, the most socially isolated boys are still less isolated than the least socially isolated girls (Bruce, 2006b).

**Absence from school during adolescence.** A global review of school enrollment reveals that currently enrolled unmarried girls, ages 15–17, are far *less likely* than girls of the same age who are not enrolled in school to have had sexual relations, sexually transmitted diseases, or be pregnant (Lloyd, 2005). The Interagency Task Team on Education reports on research that shows that educating girls “dramatically” reduces their vulnerability to HIV (UNESCO, 2008). Out-of-school girls in urban areas have no assets or skills and are prey to labor and sexual exploitation, especially if newly migrated to the city and employed in domestic service. In 18 sub-Saharan countries, where the DHS was conducted since 2000, more than 8 percent of urban girls are living apart from their parents and are out of school; in Burkina Faso, this proportion is 18 percent, and in Mali it is 21 percent (Bruce, 2007).

**Pressure to provide productive labor and income.** Often, poor families expect their girls to drop out of school after their primary years to provide economic support. They might act as heads of their households and/or take care of households where there is an HIV-infected person. Most-at-risk adolescent girls lack the economic and financial life skills needed to secure employment that is not degrading, isolating, unpaid in the home, or exploitative in return for sex. Such skills include basic principles of money management, building and safeguarding assets, learning how to access opportunities, planning for predictable events, and dealing with special challenges (Bruce and Joyce, 2006).

**Socioeconomic disadvantage.** A common theme or condition underlying all these risk factors is that HIV is most threatening to those adolescent girls with limited social and economic assets. In particular, poverty, orphanhood, and social isolation are associated with high HIV and pregnancy risk behaviors. For example, half of the poorest girls ages 14–19 in the Durban metro areas of KwaZulu-Natal, South Africa, report that their first sexual encounter was coerced (Hallman, 2005).

Intergenerational sex, also known as “age mixing,” is primarily experienced by unmarried adolescent girls who fall into one or more of the “highly vulnerable” groups described—socially isolated, not attending school, required to work and produce income, and socio-economically disadvantaged. According to the literature, economic transactions are key features of these relationships and frequently assumed to be the prime motivation for adolescents to be involved with older men. Because men have higher rates of infection than boys, the adolescent girl partner makes an implicit tradeoff for gifts, favors, money, or the promise of these things for an unknown elevation in the risk of HIV infection (Luke, 2003; Nkosana and Rosenthal, 2007; Hope, 2007a and 2007b). However, studies also reveal that economic transactions are not always the prime motivators of these sexual behaviors (Luke, 2003; Weissman et al., 2006a). Rather, girls engage in economic transactions within these relationships for a variety of motivations—from seeking emotional security, to seeking economic goods, to ensuring economic and physical survival, to being physically coerced (Luke, 2003; Luke and Kurtz, 2002). Thus, studies point out that some adolescent girls rationally enter into relationships with older men as a strategy to improve their security or status or to obtain material possessions in response to peer pressure; still others claim to do it out of genuine feelings of attraction (Hope, 2007b; Bagnol and Chamo, 2004; Weissman et al., 2006b).

Regardless of motivation, other analysts of the phenomenon of intergenerational sex point out that adolescents are neither likely to understand the health risks they assume when they enter into relationships with older men nor how to negotiate condom use when they do understand the risks (Hope, 2007a). In addition, because of their culturally and economically inferior positions vis-à-vis males, adolescent girls in many parts of sub-Saharan Africa have limited lifestyle choices available to them. If these choices were broader, the levels of intergenerational sex would probably be lower than the levels observed today (Hope, 2007a).



## Programs Targeting Adolescents and Their Impact on Adolescent Vulnerabilities to HIV Infection

Development programs targeted at adolescents as a group in developing countries started about two decades ago in response to the growing adolescent population, increasing rates of pregnancies out of wedlock, and youth unemployment (Bruce and Joyce, 2006). Popular program strategies to reach young people today include working through youth centers, peer education, family life education, and youth-friendly health services. The HIV epidemic is a critical reason for supporting and expanding these programs. Mainstream HIV programs often explicitly exclude unmarried adolescents from prevention efforts—out of denial that they are sexually active—and exclude married adolescents because programs (erroneously) consider them to be in a low-risk living situation (Bruce and Joyce, 2006). In addition, mainstream HIV prevention messages (promoting abstinence, lower sexual frequency and number of partners, condom use, knowing one's partner's HIV status, and avoiding sexual relations with infected partners) have little relevance to the lives of married or unmarried adolescent girls (Kim and Watts, 2005).

A variety of HIV-related services—such as counseling, education, healthcare treatment, and condom distribution—use these programs as platforms for reaching youth (Bruce and Joyce, 2006). However, these programs are not reaching the most-at-risk adolescent populations, particularly girls but also at-risk boys (Bruce, 2007). These programs usually assume that all adolescents can be lumped together and treated as a group, disregarding the internal diversity of adolescents as noted in the foregoing section. Instead of effectively targeting programs to meet the needs of the most vulnerable youth in specific settings, a western construct of the stages of young peoples' lives has been used instead (Bruce and Joyce, 2006). Among other things, this construct assumes that marriage takes place after adolescence and that most adolescents attend school and live with both parents. Such assumptions made implicitly or otherwise about adolescents' school attendance, residence, family resources, girls' safety, and comfort in public spaces have gone untested until very recently. As a result, youth program designs have tended to be replicated without reference to reliable information on who is and is not being covered by the services offered (Mensch et al., 1998).

The following summarizes key aspects of the performance of selected major youth programs in Africa in targeting the groups most vulnerable to HIV infection (as described above).

**Youth centers** are common features of adolescent programs worldwide. They are intended to provide young people with a place to interact with peers outside of home and school, recreational opportunities, access to health or reproductive services, and mentoring. An assessment of youth centers in Ghana, Kenya, South Africa, and Zimbabwe found a contrast between what youth centers are supposed to do and what actually happens, especially for girls (Arnold, 2003; Bruce and Joyce, 2006):

- Coverage of youth by these centers is low. Within the catchment areas of centers in Kenya, only 11 percent of boys and 6 percent of girls were aware of the centers. In South Africa, 29 percent of boys and girls in the catchment areas had ever visited a center.
- Youth centers are stigmatized by association with family planning organizations. Girls in particular feel that the community will identify them as sexually active if they are associated with family planning programs.
- Youth centers are dominated by boys. In Kenya and Zimbabwe, the assessment found that twice as many boys as girls used youth centers. In Kenya, girls who used the centers were harassed by the boys.
- Individuals visiting youth centers tend to be older youth or even adults. In Ghana, the average age of visitors to the youth centers was 18; in Zimbabwe, it was 21 years and in Kenya it was 24 years.

- At centers where the delivery of reproductive healthcare (RH) is integrated with recreation, clients come for recreation, not to access RH services. The percentage of visitors who came to youth centers for RH services was 4 percent in Zimbabwe and 12 percent in Ghana. Many centers are meant to provide HIV counseling and services to young people, but in South Africa, only 2 percent of consultations included condom provision.
- Counselors working in youth centers are often judgmental, and youth do not trust them to be confidential. In Ghana, 95 percent of the youth counseled reported that the counselor would guard confidentiality compared with 62 percent in Zimbabwe and 41 percent in Kenya.

Another series of evaluations of youth organizations in Ethiopia in 2005 revealed that only half of one percent of all programs for youth in Addis Ababa were reaching very young adolescent girls, even though 30 percent of very young adolescent girls in the city are living with no parent. Only 3 percent of girls contacted by these organizations were married even though the majority of Ethiopian girls are married during adolescence (Bruce, 2007; Bruce and Joyce, 2006; Erulkar and Mekbib, 2007).

**Peer education** programs are also undergoing evaluations to determine who they benefit, existence of gender biases, and their effectiveness. Available information suggests that these programs reach fewer girls than boys and offer girls and boys different information and services (Bruce and Joyce, 2006). For example, peer educators in South Africa were more likely to talk to boys about sexually transmitted infections and HIV than to girls (Bruce and Joyce, 2006). Other research in South Africa and Kenya points out that girls' concerns about confidentiality are different from boys' and that girls might be more receptive to talk to older females rather than peers about RH issues (Erulkar et al., 2001). An evaluation of peer education programs in Ghana found that secondary school students benefited the most and out-of-school youth not at all (Brieger et al., 2001). Lastly, peer education programs are not offered to married adolescents. As noted, in most countries, married female adolescents are the most sexually active and least well informed of all adolescents about HIV (Bruce and Joyce, 2006).

**Family life education** programs offer skill-based information and education about physiological changes, gender relations, sexuality, and life skills to adolescents, usually in schools (UNICEF, 2000). An evaluation of such programs by YouthNet in 2005 concluded that they had a positive impact on behavior across urban and rural groups, income ranges, institutional settings, gender, racial and ethnic groups, different ages, and both those sexually experienced and not. However, the achieved impact was modest, meaning that such education should be a component of larger programs rather than stand alone (Kirby et al., 2005). In addition, most of the programs evaluated were in schools, leaving open the question of effectiveness among youth not attending school and married adolescents.

**Youth-friendly health services** connect adolescents with health services by sponsoring special sessions for young people only or by setting aside a space within an established service-providing facility for adolescents only. Such adolescents-only spaces usually have different hours, lower or no fees, and youth participation as peer counselors compared with the general facility. In some places, providers are especially trained to be nonjudgmental (FOCUS on Young Adults, 2001; Family Health International, 2006). In turn, youth-friendly services can be targeted specifically to girls and young women by offering RH care or more generally by offering prevention and counseling. In particular, married adolescents are attracted by youth-friendly clinic services (FOCUS on Young Adults, 2001). Females are the heaviest users of youth-friendly services. The services are not reaching males or females from groups outside of the mainstream and at highest risk for infection, such as those who are not attending school; living on the streets; in foster care; using drugs; victims of sexual abuse; or gay, lesbian, bisexual, or transgender (Senderowitz, 1999). Similar patterns of mis-targeted youth programs for girls in Burkina Faso, Ethiopia (partially cited above), and Mauritania are also documented (Bruce and Joyce, 2006; Bruce, 2006a).

## Evidence of the Role Microfinance Can Play in Addressing Adolescents' Vulnerability to HIV Infection

As noted in Part 2, the microfinance movement has produced especially creative and practical solutions for poor women (and men) in India and Bangladesh and is expanding into Africa (Amin, 2007). Understandably, adolescent programmers are interested in adapting these solutions to improve the life conditions of socially and economically disadvantaged adolescents. Because poverty is a primary factor that increases adolescents' vulnerability to HIV, there would seem to be a natural link between microfinance and prevention of HIV infection among adolescents. Unfortunately, this review finds the link to be weaker than expected.

The literature and program experience reviewed tells us that economic objectives do not drive the behavior of adolescents as they do adults. In adolescents' lives, social objectives rank as high in importance as economic objectives, and on a macro scale, other forces (i.e., lack of access to formal schooling or low-quality schools) reduce adolescents' ability to make good use of the economic opportunities that might be available (Erulkar and Chong, 2005). From the perspective of a microfinance institution, repayment rates are still the most commonly used indicator of performance. Thus, these institutions do not voluntarily seek out adolescents, especially adolescent girls, as clients because they have little enterprise experience and frequently migrate for school, employment, or marriage (Pronyk et al., 2005).

Nonetheless, there is much to be learned from programs that tried to target microfinance options to vulnerable youth—even if their initial efforts did not work as intended. Two such programs that did this are described below. It is because these programs included large evaluation and research efforts that we are able to learn important lessons about the activities and their impact. The first program is the Tap and Reposition Youth (TRY) Program, launched in 2001 in Nairobi, Kenya.

**TRY in Nairobi.** The intent of TRY was to adapt lessons learned from microfinance programs aimed at adults and transfer them to an HIV vulnerable group of school girls ages 16–22 living in Nairobi's slums.<sup>3</sup> Important lessons were gleaned from the project because the implementing organization, K-Rep Development Agency (KDA), a research and evaluation arm of an established group-lending microfinance institution (MFI), collected service statistics and partnered with researchers to analyze those statistics and conduct a longitudinal study of participants matched to controls to assess changes (Erulkar and Chong, 2005; Erulkar et al., 2006). This review comments later on the value of conducting such research.

The TRY components included savings and credit, training in business and life skills, information on reproductive health, and mentoring. The objective of TRY was to test the hypothesis that these adolescents' involvement in group lending would change their attitudes about gender, increase their RH and HIV knowledge, and improve their negotiation skills related to sex while increasing their income and savings.

The girls were organized like adults into registered self-help groups with savings accounts, which they were required to contribute to regularly in order to establish collateral for loans. Small groups met regularly with KDA credit officers to be trained in loan policies and procedures, to collect savings, and to be trained in basic business management techniques, including such things as record keeping, marketing, pricing, budgeting, business plan development, and customer relationships. Mentors trained in HIV prevention, reproductive health, and life skills met regularly with the girls—sometimes outside of the

---

<sup>3</sup> After the pilot phase from 1998–2001, the project was evaluated by a microfinance expert and the model was adjusted and scaled up. Boys were included in some components of the project, but those are not reported on here (Hall et al., 2006).

scheduled group meetings. After eight weeks of training, two girls in each small group were given a loan, and after they made weekly loan repayments, more girls were given loans. As with adults, this is a core practice intended to reinforce group solidarity and responsibility.

After four years, the TRY participants exhibited stronger financial outcomes compared with the control group—they had higher incomes, assets, and savings, and they kept their savings in a safer place (in a bank, rather than at home). Their gender attitudes became more liberal as a result of their participation: TRY girls were more than twice as likely to believe that a wife should be able to refuse her husband sex than the girls in the control group. All these findings are tempered by the project's high drop-out rate (nearly two-thirds of the original participants). Unfortunately, TRY girls did not exhibit greater RH knowledge than those in the control group.

Unexpected problems encountered during the project also yielded important findings about what worked best for the youngest adolescents. These girls became dissatisfied with being required to save regularly and yet be denied access to their savings, being pressured to attend complicated business plan development classes that they felt were irrelevant, and taking out loans. The project adjusted to these complaints and formed “young savers clubs” for those disaffected adolescents. These clubs enabled these girls to keep their money in a safe place and retain the opportunity to gather with peers for socializing and mentors for support and advice. This innovation in the project resulted in a doubling of savings by young adolescents over what they had been before (Hall et al., 2006; Erulkar et al., 2006).

**SHAZ! in Zimbabwe.** A second program of interest is Shaping the Health of Adolescents in Zimbabwe (SHAZ!). The SHAZ! Program targeted 16–19-year-old poor, out-of-school, orphaned girls living on the outskirts of Harare, Zimbabwe. The objective was to break the cycle of poverty and AIDS in Zimbabwe by increasing these girls' knowledge and control over economic resources and thus, over the long term, reduce HIV infection through improving their abilities to negotiate safe sex. The program began in 2004 with a nine-month pilot phase that combined microcredit with HIV education and behavior change interventions. This pilot resulted in increased knowledge, relationship power, and condom use over previously-tested levels, as well as low repayment rates on loans and successful businesses. However, it was later concluded that the girls lacked necessary social support from mentors within the program and from families outside of the program to make good use of the credit. Zimbabwe's collapsed economy also shut off most opportunities for economic gain. This pilot project ended with the finding that livelihood activities would be more appropriate for adolescent girls than microcredit (SHAZ! Program, 2007).

The second phase of SHAZ! that began in 2006 applied these lessons and substituted vocational training for microcredit to improve livelihoods; expanded life skills education; and increased social support, career counseling, peer networking, and the provision of safe social spaces for the adolescents. This phase is being evaluated using a randomized controlled design and measuring its effects in terms of livelihoods and career development; sexual risk behavior and relationship negotiation; and biological outcomes such as HIV, other sexually transmitted infections, and unintended pregnancy (Bruce and Joyce, 2006; Urdang, 2007).

With respect to microfinance and targeting adolescents vulnerable to HIV, the TRY and SHAZ! experiences demonstrate the following (Hall et al., 2006; Urdang, 2007):

- Vulnerable adolescent girls will only be reached by interventions that include diagnostic research and tailored interventions.
- Social supports (from families, friends, etc.) are necessary inputs to strengthen adolescent girls' individual sense of economic empowerment.

- Older adolescents are a distinct MFI market. However, as opposed to adults, these adolescents might prefer business training versus business plan development, smaller loans of shorter duration, and access to their savings.
- Adolescents of all ages are eager to save if they can do so voluntarily and have flexible and safe access to their money.
- The group-based lending model<sup>4</sup> of collateral based on using social pressure is not well suited to vulnerable adolescents because this group is variously mobile, uprooted from their natal homes, and has weak social links.
- Overall macroeconomic conditions limit whatever efforts are made to strengthen adolescents' (or other groups') economic empowerment.

## **Applying Lessons from Current Youth Programs and the Microfinance Experience to Develop Sustainable Livelihood Programs Targeted at the Most Vulnerable Adolescent Girls**

The above program experiences, from traditional youth programs to those experimenting with microfinance components<sup>5</sup> to reach the most vulnerable adolescent girls, make it clear that a change in adolescent programming to prevent HIV is overdue. Such a change should depart from past patterns of uncritical duplication of programs and embrace the flexibility and experimentation of alternative approaches to determine what works and what does not (Bruce and Joyce, 2006; Family Health International, 2006). The attraction of microfinance is its focus on eradicating poverty as a key HIV risk factor for vulnerable adolescents. However, the experiences of TRY and SHAZ! show that mainstream microfinance programs employ approaches that are too narrow to apply directly to most adolescents, particularly the very young.

**The Sustainable Livelihoods Approach.** This approach shares with microfinance a focus on eradicating poverty, a “bottom-up” foundation in communities, a client base to which it is responsive, and a link to private markets. A youth-centered livelihoods approach treats adolescents differently from adults and girls differently from boys.<sup>6</sup> Applied in developing countries, this approach acknowledges that family and work demands dominate much of adolescents’ lives, and work is often a means of fulfilling family obligations. Because formal education is acknowledged as important but is not always possible, opportunities to develop workplace skills through informal means are also sought (Population Council and ICRW, 2000).

While the primary focus of microfinance programs is on credit, a sustainable livelihoods approach employs a broader strategy to find safe, productive employment for youth through building capabilities, resources, and opportunities to enable young people to define and pursue their goals.<sup>7</sup> Capabilities include skills, self confidence, and good health; resources can be financial (e.g., microfinance or savings), physical (e.g., housing), or social (e.g., networks). Opportunities include self employment, wage employment, and home-based work (Population Council, 2005; Population Council and ICRW, 2000). Advocates of this approach consider synergy among building capabilities, resources, and opportunities to be important, but not every program response needs to include all three domains (Population Council and ICRW, 2000).

---

<sup>4</sup> Refer to the discussion in Part 2 about the Grameen Bank, which popularized the group-based lending model.

<sup>5</sup> See Appendix A for descriptions of microfinance programs targeting adolescent girls and young women.

<sup>6</sup> The sustainable livelihoods for youth approach referenced here is adapted from the sustainable livelihoods framework defined by CARE, the United Kingdom’s Department of International Development, the Institute for Development Studies, and the World Bank (Population Council and ICRW, 2000).

<sup>7</sup> The working definition of livelihoods that encompasses capabilities, resources, and opportunities evolved from one developed by Robert Chambers and Gordon Conway in 1992 (Chambers and Conway, 1992).

The applicability of the sustainable livelihoods approach to reducing adolescent girls' vulnerability to HIV can be gauged by the extent to which it decreases child marriage and social isolation among married and unmarried girls, increases girls' school attendance or participation in skills-building programs, decreases pressure on girls to provide productive labor and income, improves their socioeconomic status or any mix of the foregoing. However, most livelihood programs are not directed at youth, and those that are, bypass younger, female, more rural and indigenous poor youth (Bruce and Joyce, 2006; Bruce, 2006b). Thus, for any particular adolescent age group, it is not known with certainty what mix of changes in structural risk factors will be most effective to prevent HIV infection or even what mix of activities will be most effective to bring about changes in particular risk factors. Because of these uncertainties, adolescent researchers strongly recommend that program planners experiment with various interventions from different sectors to target specific adolescent age groups and then monitor program inputs and outputs and evaluate the results (Urdang, 2007; Bruce and Joyce, 2006; Barnes, 2005).

Developing effective programming guidance to progress in addressing the livelihood issues of vulnerable adolescents depends on investments made to build such an evidence base. Yet researchers also tell us that ways can be found to build the evidence base while addressing an epidemic that disproportionately affects female adolescents and young women (Bruce and Joyce, 2006). Existing youth programs account for substantial assets that could be redeployed relatively rapidly and practically to expand the participation of vulnerable adolescent girls—participatory program tools are available to do this. Enough is known today to identify underserved vulnerable populations in specific catchment areas and redesign programs to include them (Bruce and Joyce, 2006; Bruce, 2006a). In this way, what is called a “new generation” of youth-centered programs could emerge by developing new strategies to reach currently excluded groups of vulnerable adolescents from existing youth initiatives (Population Council, 2005; Bruce, 2006b).

The following examples include both new and “re-engineered” youth programs with particularly innovative features.

**Married girls' clubs.** The First Time Parents Project in Gujarat and West Bengal states, India, organized groups of newly married adolescent girls and first-time mothers to address their social vulnerabilities and isolation. The objective of the project was to develop and test a package of social and health interventions that would improve married adolescent girls' reproductive and sexual health knowledge and practices and increase their ability to act in their own interest. The groups increased married girls' contact with peers and mentors, exposure to new ideas, knowledge about the legal system, access to pregnancy and postpartum care services, and acquisition of vocational skills. In addition, the groups increased girls' familiarity with government programs for women, public amenities, gender dynamics, relationship issues and nutrition (Population Council, 2005; Bruce, 2006b; Urdang, 2007).

**Reproductive Health “Plus.”** The Better Life Options Project targeted poor girls and young women ages 12–20 in India in the slums of New Delhi and the rural areas of Madhya Pradesh and Gujarat (CEDPA, 2001). This project aimed to improve the target group's mobility and decision making abilities by combining RH care with literacy training, family life education, and vocational skills training. A post-intervention comparison with control groups concluded that the girls' mobility and decision making abilities about such things as spending money and the timing of marriage had increased.

**Integrating sustainable livelihood program components into an RH project.** In the slums of Allahabad, India, a 10-month pilot project was started in 2001 to expand the decisionmaking power of young women by expanding their social networks and developing their financial and income-generating capacities (Grant et al., 2007). A livelihood project for girls ages 14–19 was integrated into a pre-existing project that was providing RH care for women, ages 20–49, and RH education for adolescent boys and girls, ages 10–19. The new project set up experimental and control areas where sessions on reproductive health were held. In addition, the group in the experimental area received vocational counseling, savings

account information, and follow-up support from a peer educator. Baseline and end-line surveys were conducted to measure differences in behavior and attitudes of the adolescents in the two areas. The surveys found that those girls in the experimental area had higher social skills and self esteem, were more informed about reproductive health, had more knowledge about safe places to gather with other girls, and were more likely to think of themselves as members of a group.<sup>8</sup>

**Family Life Education.** From 2005–2007, in Kwa-Zulu Natal, in the Durban metro area, the Pinetown Highway Child and Family Welfare Society collaborated with the Population Council to pilot a program for male and female adolescents and young adults, ages 14–24, to enhance their life options. Provision of safe spaces and social networks, financial management training, and awareness about HIV/AIDS were the components of the pilot. The curriculum to transfer the knowledge and skills included modules on life skills, financial literacy, and family life education; and was taught in community centers as well as in schools. For in-school youth, the program was offered after school hours in the school buildings. For out-of-school youth, the program was delivered in community centers. Preliminary findings show that participants in the pilot improved their attitudes and behavior regarding self-esteem, financial matters, and protection from HIV infection. Compared with non-intervention groups, they increased their discussions of topics after the training, had more exposure to messages in the media, and improved financial behaviors. Young women participants reported increased autonomy in spending their own money and (along with the young men) improved abilities to manage their lives (Hallman et al., 2007).

**A sustainable livelihood program to build adolescent girls’ “social capital.”** The Ishraq Program in Egypt is a collaborative effort among international nongovernmental organizations (NGOs) and the ministries of youth, education, and health to create a gender and age-safe program for out-of-school girls, ages 13–15. Ishraq uses youth centers and local schools to deliver an integrated curriculum of literacy, life skills, and sports; and as meeting places for these girls to socialize and build confidence and ownership over their bodies. Group formation was central to the program’s success in building “social capital” (i.e., strong cohesive groups of about 25 girls each). In groups, girls became motivated to learn and build networks. Ishraq was initially so popular with girls, their families, and communities that there are plans to expand it to 120 new villages (Population Council, 2005; Bruce, 2006b).

## **The Way Forward: Critical Issues to Address to Adapt Sustainable Livelihood Programs to the Needs of Adolescent Girls**

The Population Council convened a workshop in 2004 to review sustainable livelihood programming and research experience for adolescents from around the world (Population Council, 2005). A consensus was achieved about the way forward for a new generation of such programs—to help adolescents to “envision a future different from what they might have expected” ... “to open their eyes to the opportunities that occur.” Getting from here to there is the challenge for the present. The workshop concluded with an enumeration of critical issues to address:

- Adapting the content, training approaches, choice of savings and/or credit components of livelihoods programs to apply to specific age groups of the adolescent target group.
- Staging the interventions to correspond to consecutive periods of adolescence; entry-level activities for the youngest adolescents should merge into second-stage activities for the older ones.

---

<sup>8</sup> When the project ended, most girls were still using their acquired vocational skills, but few were still adding to their savings accounts. The pilot was too short to effect changes in the girls’ income-earning opportunities or alter deeply held gender stereotypes in the area that limited girls’ choices. Nonetheless, because care was taken in the study design and evaluation, the pilot makes an important contribution to the evidence base for developing effective adolescent programming.

- Experimenting with the program content of different livelihoods programs to encourage sustained participation, especially by adolescent girls.
- Experimenting with the mix of factors, including content, that interact to increase adolescents' participation, skills acquisition, and use of skills.
- Establishing professional consensus on the evaluation benchmarks for sustainable livelihood programs for adolescents; for example, what defines “success”? Thus, while long-term outcomes are being sought—such as asset building, establishing good savings behaviors, and assuming more gender equitable work roles—these are not feasible indicators to capture achievements for time-bound programs. Intermediate outcomes have to be established, which are more easily measured.

## PART 2: APPLICABILITY OF MICROFINANCE PROGRAMS IN PREVENTING HIV INFECTION AMONG THE OLDEST ADOLESCENTS AND YOUNG WOMEN

As noted in Part 1, adolescent girls, particularly the youngest, are not well suited to the requirements of traditional microfinance programs and are not sought out as clients by these programs. This does not mean that there is no value in encouraging MFIs to experiment with ways to link their programs with older adolescents and young women just leaving their adolescent years. The TRY Project demonstrated that the “adolescent girl” group consists of more than one market segment. The older adolescents had greater success with their businesses and loans than the younger ones who dropped out with higher rates (Hall et al., 2006). For MFIs who might be interested in or persuaded—through donor provided incentives—to target older adolescent girls as a new or niche market, TRY and other reviewed projects, offer lessons in how to do this (Hall et al., 2006).

There are MFIs that attempt and succeed in reaching populations otherwise ill-suited to the conventional credit and savings programs; the Grameen Bank is such an example. In 2005, Grameen initiated a “struggling” beggar members program. The beggars are not required to form a micro-credit group or attend weekly meetings. Regular group members act as mentors to the struggling members to provide guidance and support in selecting a loan size and a repayment rate, which are collateral and interest free (Bruce and Joyce, 2006). The aim is to orient these new members socially and financially, with the expectation that some of them will one day become regular members. Experts suggest that socially minded MFIs could apply this same aim to a segment of the female adolescent population because the MFI industry has something to offer this target group in the fight against HIV. Thus, it is important to understand the basic dynamics of MFIs, how they could be enlisted in preventing HIV among older adolescents, and what their limitations are. In this regard, Part 2 includes a discussion of selected microfinance and HIV prevention topics, answering the following questions:

- What are microfinance programs?
- What is the connection between microfinance programs and HIV prevention?
- What is known about the impact of microfinance programs on poverty alleviation?
- What is known about the benefits to women of microfinance programs?
- What is known about delivering HIV prevention plus other social services through microfinance programs?

### Microfinance Programs Defined

The primary objective of MF programs is poverty alleviation through allowing poor to access financial services otherwise unavailable in the regular commercial sector. In and of itself, microfinance is not a



panacea for poverty alleviation, but rather a tool to help people manage their financial affairs to take advantage of economic opportunities (Clark, 1999). In 1995, the Consultative Group to Assist the Poor (CGAP) was established by 29 bilateral and multilateral donor agencies to professionalize the MF industry, among other things. Key MF principles, endorsed by CGAP in 2004, formed the basis for CGAP's Good Practice Guidelines for Funders of MF in 2006 and feature financial sustainability as the bedrock of MF expansion, meaning no subsidies and no interest rate caps—with an eye toward becoming a permanent part of a country's financial system.

The amount of literature on microfinance and MF projects is extensive and increasing, reflecting the growing coverage of households with these services. The Microcredit Summit Campaign<sup>9</sup> estimated that in 2006, MF programs worldwide were serving about 85 million very poor people (Sample, 2006). The campaign periodically re-establishes its goals for expansion. In 2007, these goals were to serve 875 million people by 2015 and to help 100 million of the world's poorest families move above the \$1/day threshold by 2015 (affecting 500 million family members) (Daley-Harris, 2007).

According to the experience of the Grameen Bank in Bangladesh, the first microcredit organization to achieve major growth, the majority of MFI clients are living around countries' poverty lines, rather than in absolute poverty (Hashemi, 2000; Navajas et al., 2000). Successful MFI operations screen out possible high-risk clients (i.e., those without steady or multiple sources of income and some assets) (Hashemi, 2000). The worry is that truly destitute households would either consume the loan or the income that results from it and would be unable to make regular repayments from activities that do not generate immediate incomes. Women have been and still constitute the majority of MF clients and target groups. This is based on their reliable loan payback history and demonstrated linkages between increases in women's income and increases in child health and household welfare (Summers, 1994; Goldberg, 2005).

MFIs are a diverse group:<sup>10</sup>

- Among the kinds of institutions that provide MF services are time-limited credit projects, specialized NGOs, multi-sector NGOs, community savings and loan associations, revolving savings and credit associations (ROSCAs), cooperatives, government development banks, non-bank financial intermediaries, specially licenses finance companies, and banks (Clark, 1999).
- MFIs are becoming commercialized—as encouraged by CGAP—and regulated as banks, serving the wealthiest segments of the poor with individual loans. Different kinds of commercializing trends are happening, such as socially conscious investment houses offering certificates of deposit and large banks moving “downscale” to become micro-lenders. This is common in Latin America [e.g., Foundation for International Community Assistance (FINCA) branches and ACCION and Bank Rakyat, Indonesia, whose clientele are 80 percent male] (Sample, 2006; Anderson et al., 2002).
- One of the best known MFIs worldwide is Grameen Bank, Bangladesh, which popularized the group-lending model—the preferred platform for making non-financial services available to MF clients. In contrast to lending to an individual, based on the routine commercial practice of using an individual's assets as collateral, group lending substitutes social pressure and support for physical collateral for poor people lacking adequate collateral. Groups meet periodically to make

---

<sup>9</sup> The first Microcredit Summit was convened in 1997 by the Results Educational Fund. More than 2,900 delegates from 137 countries attended and launched a nine-year campaign to reach 100 million of the world's poorest families, especially women, with credit for self-employment and other financial and business services by the end of 2005. See: [www.microcreditsummit.org](http://www.microcreditsummit.org).

<sup>10</sup> Microfinance organizations differ in their lending methodologies and financing on such factors as client numbers and base, average loan size and length of loan, repayment schedule and incentives, interest rates and fees, group-lending requirements, collateral requirements, savings requirements, financial and non-financial products and training, and reliance on external funding (Anderson et al., 2002).

regular payments of principal, interest, and savings; and impart business and money management skills (Donahue, 2000; Parker et al., 2000; Anderson et al., 2002). Grameen serves more than 2 million borrowers today, mostly women (Sample, 2006).

- In Latin America, subsidized village banks, through NGOs, are popular. The FINCA model (Foundation for International Community Assistance) is particularly successful and is operating in Africa. It is a “generic” version of the Grameen Bank, with a more decentralized management structure adapted to dispersed populations, unlike those in Bangladesh. Typically village banks have 20–40 members, all women (Sample, 2006; Morduch, 1999).

## Microfinance and HIV Prevention

The literature reveals convincing arguments for enlisting MFIs in the fight against the HIV epidemic, especially in sub-Saharan Africa. First, as noted, microfinance programs focus on poverty alleviation, and poverty is a principal structural factor in countries fighting against HIV. Poverty is said to fuel HIV transmission just as the incidence of HIV deepens poverty (Pronyk et al., 2005). Globally, 90 percent of new HIV infections occur in poor countries and two-thirds of them in sub-Saharan Africa. By seeking to alleviate poverty, microfinance programs have the potential to stabilize the economic situation of vulnerable individuals and households and thereby reduce behaviors that are associated with poverty and increase the risks of HIV infection (Pronyk et al., 2005).

Microfinance is also considered to be a hopeful response to redressing, in addition to preventing, the resulting income effects of an individual’s positive sero-status within a household. That is, by providing access to financial services, MFIs enable clients to mitigate negative income and wealth effects and in doing so, preserve household assets, stores of wealth, and/or income streams (McDonagh, 2000; Parker 2000).<sup>11</sup>

Second, as Kofi Annan stated in an address given at Columbia University in New York in 2002, “AIDS has a woman’s face.” Women account for nearly half of the 40 million people living with HIV worldwide. In sub-Saharan Africa, 57 percent of adults living with HIV are women, and young women ages 15–24 are more than three times as likely to be infected as young men (UNAIDS, 2004). Research shows that along with tackling poverty, tackling gender inequality is central to controlling HIV in Africa (Kim and Watts, 2005). For women, the promise of microfinance is that it can broaden economic choices and strengthen their economic position in the household. Program studies show that such changes in status increase women’s decision making power, confidence, and self esteem—and thus their ability to avoid behaviors that make them vulnerable to HIV (Kim and Watts, 2005).

Third, arguments for enlisting MFIs in the fight against HIV include MFIs’ drive to scale up, reaching larger and larger numbers of poor clients, as an opportunity to integrate HIV prevention interventions, such as education and behavior change methodologies (McDonagh, 2000). And while access to microfinance can make an important contribution to stabilizing a particular number of HIV-affected households, as noted above, experts point out that it is most useful to households and individuals before they are affected by HIV (Parker et al., 2000; Donahue, 2000).

---

<sup>11</sup> Conditional cash transfers (CCTs) are mentioned as potential mechanisms to alleviate poverty as a factor contributing to the HIV/AIDS epidemic. CCTs have proved effective in providing incentives to poor families to send their children to school and use preventive health services, such as immunization, while helping to reduce poverty (DeJanvry et al., 2006); but they have not been applied to prevent HIV infection among this target group until recently. The World Bank is experimenting with CCTs for this purpose in Malawi and Tanzania. In Malawi, a CCT is linked to school attendance for young girls and a study is measuring the causal link of income on HIV risk directly and through school attendance indirectly. This pilot is ongoing (World Bank, No Date). In Tanzania, another pilot program is planning to pay Tanzanians between 15 and 30 years of age for having safe sex. This payment will be linked to counseling, in order to encourage people to consider the long term consequences of their behaviors (von Bothmer, 2008).

In summary, it appears that combining microfinance programming and HIV prevention efforts, particularly for women, should yield optimal results. But what evidence from program experience indicates that this combination will indeed yield positive results?

## The Impact of Microfinance on Poverty Alleviation

In reality, it is difficult to identify direct effects of microfinance on individual or household welfare (Anderson et al., 2002). It is conceptually difficult to evaluate the impact of microfinance on poverty alleviation for the following reasons:

- It is an open question the extent to which MFIs attract clients who by nature are entrepreneurial and thus inclined to succeed in business where other potential borrowers are not. To answer this question, randomized trials with control groups are necessary but rarely done because they are difficult and expensive to conduct.
- Income is brought into households from various sources, making it difficult to attribute the independent contribution of credit to household income.
- It is complicated to compare MFIs across studies because MFIs use different indicators and measures of outcome.
- Microfinance affects different clients differently based on their income levels.

Two studies of clusters of MFIs attempted to answer the question of whether microfinance reduces poverty (Anderson et al., 2002); they found that

- The loan effect on household income is positively correlated to the financial health of the borrower (Mosely and Hulme, 1998)—so MFIs choose between giving loans to poorer households, for a small income effect, or to the less poor, for a larger income effect; and
- MFIs are generally best at reaching those nearest the poverty line, rather than the very destitute; and these clients are best reached by group rather than individual loans (Navajas et al., 2000).

U.S. NGOs working internationally became concerned about preserving donor funding for MFIs that target the poor and thus successfully lobbied for passage of the Micro-enterprise Results and Accountability Act of 2004. This legislation guarantees that a significant portion of USAID funding for micro-enterprise development goes to MFIs that reach the very poor.<sup>12</sup>

A different kind of story can be told about how a committed microfinance program in Bangladesh was able to deepen its reach to a truly destitute population of rural women (Hashemi, 2000; Hashemi et al., 1996). This effort aimed to raise the women's incomes to a level that qualified them to join a regular microfinance program. The Bangladesh Rural Advancement Committee (BRAC), Bangladesh's largest NGO (with 3.5 million members), did this by teaming up with an existing safety net program of the Government of Bangladesh (GOB) and the World Food Program (WFP) to identify an "entry point" to engage the truly destitute in its activities. The resulting program, the Income Generation for Vulnerable Groups Development (IGVGD), began in 1985 as a pilot. Over a 10-year period, IGVGD provided food grain assistance, skills training, and savings and credit services to nearly 1 million women. As a result of their participation in IGVGD, two-thirds of these women permanently "graduated" from absolute poverty and became regular microfinance clients.

These impressive results were produced through careful (and expensive) monitoring and continual innovation within the program. The GOB and WFP were responsible for program monitoring, including

---

<sup>12</sup> To measure compliance with the terms of this Act, USAID supported the IRIS Center, University of Maryland, to design a set of country-specific poverty measurement tools in 2006 and 2007 (Daley-Harris, 2005).

spot-check field visits; funds for training and credit were supplied by donors and audited by WFP accountants. BRAC's internal research and evaluation department also conducted research studies. In addition, a longitudinal survey of a representative sample of IGVGD members was paid for and undertaken by WFP to assess the impact on the incomes of program participants.

The lessons of IGVGD are important in the following ways and will be revisited later in the report:

- External subsidies were absolutely essential to achieving this outcome.
- BRAC's careful cost accounting revealed the size of these subsidies per woman successfully lifted out of absolute poverty; and in this case, these subsidies were considered to be extremely cost-effective.
- BRAC did not allow the added services or food products to reduce its efficiency or lower its sustainability as an MFI. The NGO did this by functionally separating the financial and non-financial services.

## The Link between Microfinance and Specific Benefits for Women

As noted, women are a high priority target group for MFIs, but research conducted to identify the specific benefits that microfinance has brought to women has had contradictory results. A study in Bangladesh of the extent to which poor, rural women's participation in BRAC and Grameen Bank programs fostered their sense of empowerment found positive results, especially when the lending allowed women to control their loans exclusively (Hashemi et al., 1996). However, in another study, also concerning the Grameen Bank, women's involvement in a microfinance program worsened their situation in their households. Researchers found that the pressure of loan repayment led to increased violence toward women and increased debt through a process known as "debt recycling." This is a process whereby new loans are used to pay off existing loans, heightening financial insecurity of a household and friction among members within it (Rahman, 1999; Mayoux, 1997). Thus, conventional microfinance indicators such as the take-up of financial services by women or their repayment rates cannot be taken as evidence that women are being empowered or otherwise benefiting from microfinance programs (Mayoux, 1997).

Is it possible to identify the factors that led to positive outcomes for women in one context but not in another? No systematic, cross-cultural comparative study of ways in which microfinance programs contribute to women's empowerment was found. Analysts suggest that these different outcomes stem from the gender-based obstacles that existed within the particular microfinance project from its beginning but were not identified. To avoid negative outcomes, such as those noted above, experts advise the "engendering" of microfinance projects by approaching them with a "gender-aware" mindset, which involves more than merely targeting women (Johnson, no date). Nonetheless, doing this is difficult, owing to the organizational resistance that arises from the conflicting priorities of men and women in society (Johnson, no date; Mayoux, 1998).

To preserve the expected benefits for women, microfinance project planners should bring a strategic gender perspective into all stages of the project cycle—from information gathering, planning, and setting objectives to implementation and monitoring and evaluation. The literature also notes that the composition of staff involved in all phases of project development, implementation, and evaluation is critical to the engendering process. In particular, it is important that men are involved in the process to reduce perceived threats to their status (Johnson, no date). To be effective, such strategies should aim to overcome the various obstacles that women face in achieving their financial objectives. For instance, a project can be configured to address women's personal obstacles of illiteracy, educational achievement, or money management skills. It could also reach into the household by affecting women's interactions with their husbands (e.g., arising from traditional behaviors regarding division of labor, control of cash income, and violence). However, microfinance projects alone cannot affect the gender obstacles women face as a result of national or cultural enabling environment factors such as land ownership and property

rights, low pay, limited choice of careers, constraints on physical movement, and lack of independent access to financial services (Mayoux, 1997; Johnson, no date). Thus, it is clear that the empowerment of young women in particular "...requires fundamental change in the macro-level development agenda while at the same time ensuring support for young women to challenge gender subordination at the micro-level" (Urdang, 2007, p. 30).

## The Link between Microfinance and the Effective Delivery of HIV Prevention and Other Social Welfare Services

The literature and program review addressing MFIs and HIV describes both what MFIs are doing to stabilize their organizations and finances in the face of rising illness and death among members and their families and how they are trying to prevent HIV by offering new products and services. More program information is available on mitigation as compared with prevention efforts because mitigation represents the best efforts of MFIs to financially survive the epidemic (Donahue, 2000; McDonagh, 2000). Moreover, most MFIs consider engaging in HIV prevention programming to be both outside their mandate and threatening to it (Pronyk et al., 2005). Thus, MFIs' mitigation efforts are of interest to this review because to operate in sub-Saharan Africa where the epidemic shows scant signs of abating, the vast majority of MFIs will be obliged to make mitigation efforts part and parcel of their normal operating procedures.

It is no surprise that MFIs in countries experiencing severe epidemics appear to be the most innovative in offering their members different kinds of financial and non-financial products. A survey of 22 MFIs in 14 African countries found that the epidemic had reduced loan performance and increased staff costs (Parker et al., 2000). To mitigate these effects, MFIs established a range of different strategies, including workplace HIV/AIDS policies, early warning systems to monitor loan performance, new insurance products to reduce the risk of loan default, mandatory savings, health and funeral insurance, and centralized referrals to healthcare and legal services (Parker et al., 2000; McDonagh, 2000; Anderson et al., 2002; Donahue, 2000; Pronyk et al., 2005).

MFIs seeking to engage in HIV prevention activities often base their programs on those of MFIs already involved in delivering non-financial services to their members. These so called "credit plus" programs deliver a range of services, notably education, basic healthcare, health education, and behavior change messages and materials to encourage immunizations and the use of contraceptives (Sample, 2006). As noted previously, the group-lending feature of MFIs serving the poor, a key innovation of Grameen Bank, provides the essential, and some say natural way, to tie the routine financial operations of these institutions to the delivery of non-financial services to the membership.

Advocates of building on MFIs' group-lending platform and regular meetings to change behavior and prevent HIV point to several microfinance programs for scale-up (Dunford, 2001). Aside from the substance of the non-financial interventions themselves, the way in which the financial and non-financial services are delivered, assigned costs, and ultimately paid for is critically important for long-term operational sustainability. Most MFIs deliver financial services and non-financial services in one of three ways (Dunford, 2001):

- The unified approach—two sets of services (e.g., education and financial) are delivered to one client group by the same staff, and the costs of the two services are self financed by the MFI. A prime example of the unified approach is the Freedom from Hunger's Credit with Education Model, first developed in 1989–90 to improve household food security and child nutrition (Dunford and Denman, 2001). The business of these institutions is often referred to as "self-sustaining poverty lending." Advantages of this approach are lower overall costs, sustainability, and the potential for synergizing agendas. Challenges include developing staff capabilities in two

competencies while maintaining the quality of services and sustaining overall operations if costs cannot be controlled.

- The parallel approach—one organization creates two distinct programs for the same clients: one delivering microfinance services and the other delivering one or more social services. Each program has specialized staff who share the same organizational name and perhaps the same space and administration. In these cases, the quality of the programs is maintained by the one organization, but the cost centers are separated. The advantages of this approach are that disciplinary expertise can be maintained and financial risk to the MFI from the non-financial services is minimal. The challenges are moving to scale and preventing the dual institutional cultures and priorities from clashing and threatening the sustainability of the approach overall. The Grameen Family of Companies is a good example of the parallel approach of service delivery.
- The linked approach—services are provided by two independent organizations strategically aligned with one another, operating in the same area and serving the same clients. Quality of services, staff, and cost centers are maintained separately by each linked organization. Thus, there is no financial risk to either organization. The challenges are mitigating the possible minimal motivation for clients to take advantage of the non-financial services, moving to scale, and taking advantage of program synergies. The previously described IGVGD Program is an example of the linked approach (and one which overcame most of the associated challenges).

Examples of microfinance programs adopting the unified and parallel approaches are described below, along with available evidence regarding output or impact.

Freedom from Hunger (FFH) is one of the strongest advocates for the *unified approach*. In its original design, the education component aimed to improve health and nutrition of children under 5 years old as well as the income and assets of their families. Multi-year studies with the same research design and controls were conducted of microfinance programs in Ghana and Bolivia (MkNelly and Dunford, 1998 and 1999). The microfinance services demonstrated increased levels of livelihood security among clients, more regular earnings, growth in assets, and consumption smoothing. The education services demonstrated positive changes in health knowledge and self-reported practices of recommended health behaviors (e.g., exclusive breastfeeding immediately after birth and completed immunizations). Other effects measured included increases in women’s sense of empowerment, improvements in children’s diet, and nutritional status. Regarding the synergistic effects of combining microfinance with health education, the authors could only conclude that the addition of extra education did not diminish the microfinance results and vice versa.

The Intervention with Microfinance for AIDS and Gender Equity (IMAGE) Project operated a *parallel approach* for two years in a dense rural area of Limpopo Province, South Africa. IMAGE integrated a particular curriculum of gender awareness, HIV education, and community mobilization, which was developed and delivered by a university-based research and training program within an established MFI. The premise of the non-financial interventions was that to reduce vulnerability to HIV, women need to gain both knowledge about HIV and the skills and confidence to make changes in their lives that expose them to interpersonal violence (IPV) (Pronyk et al., 2006). Thus, in addition to developing business skills and experience and increasing assets and expenditures, women received gender-focused training to bring about empowerment benefits while controlling the risks of gender-related conflict within the household (Epstein and Kim, 2007; Kim et al., 2007; Microfinance, 2006). The university research and training program partner designed the study (cluster-randomized with controls) and conducted the impact evaluation, concluding that after two years, the intervention had reduced IPV levels by more than half in the intervention group (Pronyk et al., 2006). In addition, participation in the intervention resulted in greater self-confidence and financial confidence, more progressive attitudes about gender norms, and higher levels of participation in social groups and collective action. Unfortunately, the researchers

measured no effect on HIV incidence (Kim et al., 2007). An economic study of the costs of the training and workshops is ongoing.<sup>13</sup>

Other MFIs in Africa—such as in Kenya, South Africa, Tanzania, Togo, Zambia, and Zimbabwe—have been or are forming “strategic alliances” or “informal partnerships” with health organizations to deliver health education or other HIV prevention services to their membership.<sup>14</sup>

## CONCLUSION

In summary, tackling poverty and gender inequality is central to controlling the spread of HIV in sub-Saharan Africa, where more than half of those infected are female adolescents and young women. Theoretically, MFIs can do both, as well as scale up their client base using their internally generated resources.

Microfinance programs can mitigate poverty as a risk factor for HIV if efforts are explicitly made to recruit the poor as participants and retain them as clients. This effort is likely to require granting external subsidies to MFIs to operate, but such subsidies can be made efficiently, as shown by BRAC in the IGVGD Project. Similarly, microfinance programs can be “engendered” internally to yield specific benefits for young women if special attention is paid to analyzing and addressing gender obstacles that are within the reach of the programs to affect. Innovative approaches are being tested to deliver a variety of financial and non-financial services, information, and behavior change messages to women to enable them to avoid HIV infection. Countries and donors are beginning to recognize that gender obstacles also affect the external environment within which microfinance programs operate and if not addressed, will limit the theoretical benefits that could accrue to women. A major international effort is needed to build an evidence base of best practices from which microfinance programs can be developed to reduce the HIV infection rate of young females and their families.

---

<sup>13</sup> Young women who were family members of IMAGE participants benefited indirectly from the project through improved cross-generational communication. Study data demonstrated encouraging changes in knowledge, openness, access to voluntary counseling and testing, and collective action among these young women because of their interactions with IMAGE participants (Urdang, 2007).

<sup>14</sup> In 2000, UNAIDS and USAID supported 21 interviews of African MFIs about their activities to address HIV. Of these, 10 reported HIV prevention activities focused on health education: FOCCAS, Uganda; World Relief affiliates in Mozambique and Rwanda; Faulu, Kenya; PRIDE, Tanzania; ACOMB, Togo; MEDA, Tanzania; Christian Enterprise Trust, Zambia; Zambuko Trust, Zimbabwe; Small Enterprise Foundation, South Africa. Current information about the HIV prevention activities of these MFIs is not available (Parker et al., 2000).

## APPENDIX A: ORGANIZATIONAL PROFILES

<b>Program/Project Name</b>	Cama Seed Money Scheme (formed in 1998 by Camfed Alumni)
<b>Countries</b>	Zimbabwe (15 districts), Zambia (3 districts in 2005)
<b>MFI or NGO</b>	NGO (Cambridge, UK-based, founded 1993)
<b>Type of economic strengthening<sup>15</sup></b>	<ul style="list-style-type: none"> <li>• F: given micro grants and loans to start up and expand businesses</li> <li>• T: business training and mentoring for secondary school and vocational school leavers</li> </ul>
<b>Other Partners</b>	The Campaign for Female Education International (Camfed) supports, mentors, and pays costs of girls staying in school through the secondary level or attending a vocational training center; afterward, Cama support is available to them
<b>Population</b>	Zimbabwe: 836 young women and girls since 2000 Zambia: 180 young women and girls in 2005 Ghana: 308 young women and girls in 2004
<b>Inclusion criteria</b>	<ul style="list-style-type: none"> <li>• Young women and older adolescents in rural areas, primarily secondary school leavers</li> <li>• Most disadvantaged community members</li> </ul>
<b>Process</b>	<ul style="list-style-type: none"> <li>• Seed Money Scheme: small grants given to school leavers to initiate businesses, regular training and mentoring for business development, access to microloans to expand if businesses prove to be viable</li> <li>• Mentors, businessmen/women, community leaders engage with young women throughout the process</li> <li>• Beneficiaries become activists in own communities after succeeding in businesses to repeat the cycle and for quality-of-life improvements, gender rights, etc.</li> </ul>
<b>Inputs<sup>16</sup></b>	<ul style="list-style-type: none"> <li>• Introductory workshops for interested young women</li> <li>• Grants to start businesses</li> <li>• Ongoing training and mentoring</li> <li>• Monitoring of new businesses by community</li> <li>• Loans given for expansion</li> <li>• National/district awards given to high-performing entrepreneurs</li> <li>• Community support given to young entrepreneurs to succeed</li> <li>• Beneficiaries become activists in own communities</li> </ul>
<b>Special features</b>	<ul style="list-style-type: none"> <li>• Development cycle approach to make young women confident and provide the skills needed to make their businesses succeed</li> <li>• Beneficiaries become community activists to improve the lives of the least advantaged in their communities, esp. HIV-affected persons/households and children</li> <li>• Designed and managed by young women from rural areas who have started rural enterprises themselves</li> <li>• Given an initial non-repayable grant to set up business, after which a microloan is given when principles of managing the business are achieved</li> </ul>
<b>Indicators<sup>17</sup></b>	Number of business start-ups, women trained by previous trainees, children

<sup>15</sup> F = financial; T = training.

<sup>16</sup> Activities undertaken to prepare clients for participation in the program.

<sup>17</sup> Used to measure program accomplishments.



	supported to go to school, persons employed by assisted businesses, families provided with food and medical care by Cama scheme participants, Cama scheme beneficiaries working as activities in own communities, advocacy campaigns waged, Cama scheme participants who supported their own educational achievement; and health information disseminated by Cama scheme participant (This is a sampling of indicators; complete listing not found.)
<b>Outcomes</b>	Number of rural women supported to be economically independent; change in unemployment in communities; number/type of laws/practices changed in communities resulting from advocacy campaigns waged (List of outcomes is incomplete; no quantitative data found to verify claims of outcomes)
<b>Follow-up period/sustainability</b>	The Cama scheme is intended to be sustainable at community levels and is a long-term effort. All Cama programs are still operating
<b>Best practices</b>	Practices that empower young women to become economically independent and activists for change in their communities
<b>Cost</b>	N/A
<b>Lessons learned</b>	Unspecified, but acknowledged to have allowed the project to expand from Zimbabwe to Zambia to Ghana
<b>Reference</b>	<ul style="list-style-type: none"> <li>• Camfed International. 2004. "Camfed International: An Overview." Media Information, November 11. Cambridge, United Kingdom: Camfed International.</li> <li>• Camfed International. 2006. "Building the Capacity of Young Rural Women: The Cama Seed Money Scheme." Cambridge, United Kingdom: Camfed International.</li> </ul>

<b>Program/Project Name</b>	FINCA Uganda (affiliate of FINCA International, Inc. )
<b>Country</b>	Uganda (29 of 56 districts covered in 2000)
<b>MFI or NGO</b>	MFI that has partnered with some local hospitals and institutions to provide healthcare services and pilot an insurance program since 1999 for clients directly or indirectly affected by the AIDS epidemic
<b>Type of economic strengthening</b>	F: microfinance through group lending
<b>Other Partners</b>	USAID, through the BASIS-CRSP Program and World Council of Credit Unions Health insurance pilot done in collaboration with the United Kingdom's Department for International Development and Nsambya Hospital (Kampala) and Nsambya Hospital Health Partners
<b>Population</b>	37,000 clients, organized into 1,400 village bank groups
<b>Inclusion criteria</b>	<ul style="list-style-type: none"> <li>• Rural population</li> <li>• Rural women who already have a viable income-generating business</li> <li>• Specifically, very poor women—90 percent of clients live on less than \$1 a day</li> </ul>
<b>Inputs</b>	<ul style="list-style-type: none"> <li>• Village banking techniques, which include training in bookkeeping, accounting, loan administration</li> <li>• Direct provision: working capital loans, safe savings, access to group health insurance</li> <li>• Services provided through partnerships: credit insurance, accidental life insurance, healthcare, and health education—all for no additional fee</li> <li>• Constant training of all staff due to increased funding</li> </ul>
<b>Process</b>	<ul style="list-style-type: none"> <li>• Clients trained to manage loan and repayment</li> <li>• Clients save an amount equal to 10 percent of their loan as collateral, which is returned once repayment of the loan is made</li> <li>• Repayment cycle: 16 weeks</li> <li>• Interest: 4 percent per month</li> <li>• Businesses include grocery stores, retail shops, restaurants, kiosks, tailoring, trade in food products, and handicrafts</li> </ul>
<b>Special features</b>	<ul style="list-style-type: none"> <li>• Village banking lending</li> <li>• Credit and life insurance included in 4 percent/month interest on loans</li> <li>• Service provided at clients' doorstep</li> <li>• Children of clients enrolled in schools</li> <li>• Optional health insurance in certain areas (not for antiretroviral treatment provision), savings plan, and AIDS education seminars for 75–80 percent of clients directly or indirectly affected by HIV</li> </ul>
<b>Indicators</b>	<ul style="list-style-type: none"> <li>• Track per client per annum</li> <li>• Income generation</li> <li>• Savings mobilization (compulsory)</li> <li>• Contribution to local economy</li> <li>• Contribution to program sustainability</li> <li>• Social impact—education, training, etc.</li> </ul>
<b>Outcomes</b>	<p>For clients:</p> <ul style="list-style-type: none"> <li>• Increase in income generation, savings generation, contribution to local economy</li> <li>• Program sustainability through interest paid by clients</li> <li>• Social impact: 70 percent of clients' children are enrolled in school</li> </ul>

	<ul style="list-style-type: none"> <li>Platform provided for social interaction among clients, used to build group solidarity, socialization, etc.</li> </ul>
<b>Follow up period/ sustainability</b>	FINCA International attained operational and financial self-sufficiency eight years after inception
<b>Best practices</b>	FINCA holds that providing low-income families with working capital loans and savings is the best way to help clients cope with HIV
<b>Cost</b>	“Expensive” to sell loans door to door, raising operating costs
<b>Lessons learned</b>	<ul style="list-style-type: none"> <li>Donors need to assist with developing region-specific microenterprise responses and not assume that replication of successful models can work</li> <li>Sustainability of microenterprises is important</li> <li>Building staff capacity is important; capacity has been a bottleneck in FINCA</li> <li>Microfinance must be targeted to specific audiences</li> <li>Conducive legal and political environment for microfinance</li> <li>Donors should phase out their roles to link MFIs to commercial markets</li> <li>MFIs must reach greater numbers of clients to obtain scale, reduce costs, become sustainable, reach operational sustainability, control cost</li> <li>Challenges faced: illiteracy among most women, political interference, above-average client drop-out, men taking money from women</li> </ul>
<b>References</b>	<ul style="list-style-type: none"> <li>Kasi, Fabian. 2005. <i>Gender Targeting of Rural Financial Services: Is this Appropriate? Case study on FINCA Uganda</i>. FINCA Uganda.</li> <li>Parker, Joan, Ira Singh, and Kelly Hattel. 2000. <i>UNAIDS Background Paper: The Role of Microfinance in the Fight Against HIV/AIDS</i>. Bethesda, MD: Development Alternatives, Inc.</li> <li>Winship, Guy, and Earne, Julie. 2000. “FINCA, Uganda: Helping Microentrepreneurs Cope with AIDS.” Bethesda, MD: Microenterprise Best Practices Project, Development Alternatives Inc.</li> </ul>

<b>Program/Project Name</b>	FOCCAS (Foundation for Credit and Community Assistance)
<b>Country</b>	Uganda
<b>MFI or NGO</b>	MFI (founded 1996)
<b>Type of economic strengthening</b>	F: credit and savings T: non-formal education (Food for the Hungry Credit & Education Model)
<b>Other Partners</b>	<ul style="list-style-type: none"> <li>• Food for the Hungry, U.S-based private voluntary organization</li> </ul>
<b>Population</b>	13,000 clients
<b>Inclusion criteria</b>	Rural and peri-urban women
<b>Inputs</b>	<ul style="list-style-type: none"> <li>• Village banking model, solidarity groups</li> <li>• Financial service: credit and savings</li> <li>• Non-financial service: non-formal adult education on health, nutrition, family planning, HIV prevention, and business management</li> </ul>
<b>Process</b>	<ul style="list-style-type: none"> <li>• Traditional village banking methodology: <ul style="list-style-type: none"> <li>• Staff facilitate formation of banks</li> <li>• Five weekly training sessions</li> <li>• Management committee elected</li> <li>• Loan applied for and broken into smaller loans for individuals</li> <li>• Weekly meetings to deposit savings, make payments, and conduct health education; both done by loan officers</li> </ul> </li> </ul>
<b>Special features</b>	<ul style="list-style-type: none"> <li>• Increased flexibility in loan sizes, repayment period, and disbursement mechanism</li> <li>• Progress tracking system for field officers to respond to client needs</li> <li>• Work closely with local credit associations and regular bidirectional information exchange regarding clients</li> <li>• Return on investment (ROI): 16 percent</li> </ul>
<b>Indicators</b>	N/A
<b>Outcomes</b>	Household food security and better health and nutrition (in theory). No data to indicate impact of HIV/AIDS education
<b>Follow up period/ sustainability</b>	If the microfinance becomes sustainable, the education is sustainable
<b>Best practices</b>	HIV prevention education
<b>Cost</b>	Cost of integrated microfinance with health education is the same as microfinance alone, but reaching sustainability might take longer
<b>Lessons learned</b>	Adaptation of basic FFH model to local circumstances is essential
<b>Reference</b>	<ul style="list-style-type: none"> <li>• FOCCAS Uganda. 2000. <i>Integrated Microfinance and HIV/AIDS Education</i>. A Case Study for the Microenterprise Best Practices Project. Bethesda, MD: Microenterprise Best Practices Project. Development Alternatives, Inc.</li> <li>• FOCCAS Uganda and Imp-Act Program. No Date. "FOCCAS, Uganda—Summary Sheet." Mbale: FOCCAS Uganda. Accessed at <a href="http://www.worldbank.org/sief">www.worldbank.org/sief</a> on July 7, 2008.</li> </ul>

<b>Program/Project Name</b>	IMAGE (Intervention with Microfinance for AIDS and Gender Equity) Project
<b>Country</b>	South Africa
<b>MFI or NGO</b>	MFI associated with a university-based HIV/AIDS research and training program
<b>Type of economic strengthening</b>	<ul style="list-style-type: none"> <li>• F: microcredit</li> <li>• T: business management training and health education</li> </ul>
<b>Other Partners</b>	Small Enterprise Foundation (SEF)
<b>Population</b>	More than 40,000 active participants
<b>Inclusion criteria</b>	<ul style="list-style-type: none"> <li>• 18 years old and over (two-thirds were ages 35 years and over)</li> <li>• Limpopo Province in South Africa</li> <li>• SEF uses participatory wealth-ranking methods to target clients</li> <li>• SEF recruits most economically disadvantaged members in target area</li> </ul>
<b>Inputs</b>	<ul style="list-style-type: none"> <li>• A 12–15 month training curriculum, a continuous activity with the microfinance program, 1-hour sessions each</li> <li>• Sisters for Life (SFL) <ul style="list-style-type: none"> <li>○ Phase 1: gender-focused participatory learning program integrated into loan center meetings; includes 10-hour training sessions aimed to educate women in various topics</li> <li>○ Phase 2: involving men and boys for greater community mobilization and developing leadership skills; SFL approach; exclusive gender awareness and HIV training component, health education within established microfinance program</li> </ul> </li> </ul>
<b>Process</b>	<ul style="list-style-type: none"> <li>• Group lending based on the Grameen model</li> <li>• Repayment rate is greater than 99 percent</li> <li>• Group meetings bimonthly</li> <li>• Monitoring and evaluation (M&amp;E) at the individual, household, and community levels</li> <li>• Qualitative and quantitative data collected</li> </ul>
<b>Special features</b>	<ul style="list-style-type: none"> <li>• Nine quantitative indicators to measure empowerment: self confidence, financial confidence, challenging gender norms, autonomy in decisionmaking, perceived contribution to the household, communication within the household, relationship with partner, social group membership, and participation in collective action</li> <li>• Gender focus: gender roles, inequality, cultural beliefs, relationships, communication, and domestic violence</li> <li>• Intervention designed to involve the wider community through group-based learning (fostered solidarity) and collective action (community mobilization to engage youth and men)</li> </ul>
<b>Indicators</b>	<ul style="list-style-type: none"> <li>• Economic well-being and nine empowerment indicators at the individual, household, and community levels</li> <li>• Three IPV indicators; RH and HIV information among 14–35 year-old “highest risk” group</li> </ul>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• All nine indicators for measuring empowerment increased</li> <li>• Physical and sexual violence reduced by more than 50 percent</li> <li>• Reduced controlling behavior from intimate partners</li> <li>• Increased awareness about IPV</li> <li>• Study saw 99.7 percent repayment rate</li> </ul>

	<ul style="list-style-type: none"> <li>• Drop-out rate among IMAGE clients enrolled is less than drop-out initially experienced by the MFI alone</li> <li>• Higher savings, lower portfolio risk, and higher attendance at meetings</li> </ul>
<b>Follow up period/ sustainability</b>	<ul style="list-style-type: none"> <li>• After two years, IPV consistently decreased, greater communication and collective action within household and community observed, especially around sexuality and HIV</li> </ul>
<b>Best practices</b>	<ul style="list-style-type: none"> <li>• Not explicit: IMAGE is a collaboration between an MFI and an HIV/AIDS-focused organization</li> <li>• Though separate organizations, they provide unified service delivery</li> <li>• Gender-focused approach</li> <li>• SFL approach</li> <li>• Participants talked to daughters of co-participants about sexual practices rather than own daughters—caused intergenerational communication to improve</li> </ul>
<b>Cost</b>	N/A
<b>Lessons learned</b>	<ul style="list-style-type: none"> <li>• During center meetings, HIV training sessions should be held before loan repayment activities to encourage participation in training sessions</li> <li>• Unified delivery of services encouraged to promote the concept</li> <li>• Training should go beyond basic technical inputs on HIV prevention to address deep cultural and social beliefs and practices</li> <li>• Sometimes adolescents can be reached indirectly by targeting credit and gender-awareness training to older women in households</li> </ul>
<b>References</b>	<ul style="list-style-type: none"> <li>• Kim, Julia C., Charlotte H. Watts, James R. Hargreaves, Luceth X. Ndhlovu, Godfrey Phetla, Linda A. Morison, Joanna Busza, John D.H. Porter, and Paul Pronyk. 2007. “Understanding the Impact of a Microfinance-Based Intervention on Women’s Empowerment and the Reduction of Intimate Partner Violence in South Africa.” <i>American Journal of Public Health</i> 97(10): 1794–1802.</li> <li>• Pronyk, P.M., J.C. Kim, J.R. Hargreaves, M.B. Makhubele, L.A. Morison, C. Watts, and J.D.H. Porter. 2005. “Microfinance and HIV Prevention: Emerging Lessons from Rural South Africa.” <i>Small Enterprise Development</i> 16 (3): 26–38.</li> <li>• Hargreaves, James, Tesmer Atsbeha, John Gear, Julia Kim, Benjamin Mzamani Makhubele, Kalipe Mashaba, Linda Morison, Mmatshilo Motsei, Chris Peters, John Porter, Paul Pronyk, and Charlotte Watts. 2002. “Social Interventions for HIV/AIDS: Intervention with Microfinance for AIDS and Gender Equity.” <i>IMAGE Study, Evaluation Monograph No.1</i>.</li> <li>• Urdang, Stephanie. 2007. <i>Change, Choice and Power: Young Women, Livelihoods, and HIV Prevention</i>. New York: International Planned Parenthood Federation, United Nations Population Fund, and Young Positives.</li> </ul>

<b>Program/Project Name</b>	Positive Partnerships Program (PPP)
<b>Country</b>	Thailand
<b>MFI or NGO</b>	NGO: Population and Community Development Association (PDA)
<b>Type of economic strengthening</b>	<ul style="list-style-type: none"> <li>• F: microcredit</li> <li>• T: business training to partnership businesses (between HIV-positive and -negative people)</li> </ul>
<b>Other Partners</b>	Pfizer Thailand Foundation
<b>Population</b>	422 partnerships and 844 clients (between 2004 and 2006)
<b>Inclusion criteria</b>	<ul style="list-style-type: none"> <li>• 50 percent of clients are HIV positive</li> <li>• Age: early 20s to 50s</li> <li>• Men and women, as men account for two-thirds of those infected in Thailand</li> <li>• Women were majority of participants</li> </ul>
<b>Inputs</b>	<ul style="list-style-type: none"> <li>• Train PDA staff</li> <li>• Collaborate with local government and health agencies, public and private</li> <li>• Train community volunteers, review applications, select clients based on pre-determined criteria, and agree on loan amounts</li> <li>• Conduct baselines, arrange trainings, establish local clubs (support groups)</li> <li>• Provide loans and monitor each stage of the project (interest rates near or at the bottom of market rates)</li> </ul>
<b>Process</b>	<ul style="list-style-type: none"> <li>• Selection committee for loan applications: PDA staff, health officials, local government officials, and school teachers</li> <li>• Criteria: regular attendance in meetings, clarity and quality of business plan, willingness to be open about HIV status, economic need (but no means testing)</li> <li>• Business partners were usually related—family, friends, colleagues, etc.</li> <li>• Flexibility in repayment schedules early on in partnership, and additional training if needed</li> </ul>
<b>Special features</b>	<ul style="list-style-type: none"> <li>• Skills training: general microentrepreneurship, management, and business skills</li> <li>• All participants establish ongoing links to healthcare services, including check-ups and access to antiretrovirals</li> <li>• \$600 loan for one year to be split equally between both partners</li> <li>• M&amp;E: Bamboo Ladder is a 10-point scale to measure clients' perceptions, concerns, aspirations before during and after PPP's implementation</li> </ul>
<b>Indicators</b>	<ul style="list-style-type: none"> <li>• Five key areas looked at for improvement during M&amp;E: physical health, mental health, social condition, economic condition, quality of life</li> </ul>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• Repayment rate: 91 percent</li> <li>• Increase in self-esteem of clients</li> <li>• Self-esteem: tolerance to discrimination, assuming of leadership roles</li> <li>• Increased acceptance by HIV-negative persons to work/associate closely with HIV-positive individuals (20–90 percent increase between 2004–2006)</li> <li>• Increased understanding of the disease by HIV-negative individuals</li> </ul>
<b>Follow-up period/sustainability</b>	No studies yet: period of this project is January 2004–October 2007

<b>Best practices</b>	<ul style="list-style-type: none"> <li>• This experience has much to offer donors and civil society about how to improve the health and economic well-being of people affected by the disease</li> <li>• Study included in UNAIDS best practices</li> </ul>
<b>Cost</b>	<p>External donor (Pfizer): total loan used: \$477,000; max 12.5 percent per annum of loan fund used for administrative expenses</p> <ul style="list-style-type: none"> <li>• Costs include salaries, workshops/training seminars, meetings with partnerships, transportation and communication, project M&amp;E</li> </ul>
<b>Lessons learned</b>	<ul style="list-style-type: none"> <li>• Comprehensive strategies for the AIDS epidemic most successful, not those narrowly directed at health</li> <li>• Openness and direct interaction between HIV-positive and -negative people improves HIV awareness and prevention efforts</li> <li>• Decrease in stigma and poverty through this partnership</li> <li>• Business training is needed before loans made</li> <li>• Positive HIV status does not imply bad credit risks</li> <li>• Business success lies in the improvement in health of participants and better linkage to health facilities</li> <li>• Ultimate goal: help clients graduate to formal banking by building credit history and collateral</li> <li>• Involvement of an established civil society organization is important for success</li> </ul>
<b>Reference</b>	<p>UNAIDS. 2007. <i>The Positive Partnerships Program in Thailand: Empowering People Living with HIV/AIDS</i>. Geneva: UNAIDS.</p>



<b>Program/Project Name</b>	Pro Mujer
<b>Countries</b>	Bolivia, Nicaragua, and Peru <sup>18</sup>
<b>MFI or NGO</b>	MFI providing unified service based on provision model
<b>Type of economic strengthening</b>	<ul style="list-style-type: none"> <li>• F: microfinance, a variation on the village banking model (solidarity groups of 5–7 members).</li> <li>• T: <ul style="list-style-type: none"> <li>– Health and personal care training and PHC consultations, pre- and post-natal monitoring and vaccinations, family planning</li> <li>– Training in business development</li> </ul> </li> </ul>
<b>Other Partners</b>	<ul style="list-style-type: none"> <li>• USAID in Bolivia, Nicaragua, and Peru</li> <li>• USAID Microenterprise Development Office</li> </ul>
<b>Population</b>	<p>In 2004:</p> <ul style="list-style-type: none"> <li>• Bolivia: 63,547 financial and 48,500 health</li> <li>• Nicaragua: 17,413 financial and 17,413 health</li> <li>• Peru: 24,863 financial and 22,871 health</li> </ul>
<b>Inclusion criteria</b>	Women+++
<b>Inputs</b>	<ul style="list-style-type: none"> <li>• Financial: working capital loans, village banking and individual methodologies, educational loans (only in Peru), pre-credit training, savings</li> <li>• Health: maternal and child health, sexual and reproductive health, health training, and continual women’s empowerment training</li> <li>• Business development: continual business education, specialized technical training, personal consulting (only in Peru)</li> <li>• Other: computer center, information on civil and legal rights</li> </ul>
<b>Process</b>	<ul style="list-style-type: none"> <li>• Service delivery through focal centers, outreach, or community associations</li> <li>• Health training was a mandatory part of the loan repayment meetings</li> <li>• In Bolivia, clients paid a fixed monthly fee of \$0.50 for training and health services</li> <li>• In Nicaragua, there was a reduced fee-for-service basis and family planning fee</li> <li>• In Peru, clients were not charged additional fees</li> <li>• Volunteers from the community would generate ownership of health services</li> <li>• Provision of direct healthcare and agreement with allied providers</li> <li>• Loan repayment, medical care, and health education all received at focal centers, monthly or bimonthly, along with health and business training</li> <li>• Staff were trained to provide basic health training, and health promoters were certified by doctor and elected by community</li> </ul>
<b>Special features</b>	<ul style="list-style-type: none"> <li>• Adapting intervention strategies to local conditions</li> <li>• Integrated service delivery of finance and healthcare through a linked model</li> <li>• Decentralized operating style—created space for developing strategies based on local context and the client market</li> </ul>
<b>Indicators</b>	<ul style="list-style-type: none"> <li>• Health benefits: health knowledge, change in preventive practices, willingness to seek preventive and medical care</li> </ul>

<sup>18</sup> Pro Mujer in Peru is a small MFI and therefore provides health and other ancillary services through a third party to limit cost.

	<ul style="list-style-type: none"> <li>• Service quality: safety and security of clients, number of service providers, accessibility of health services</li> <li>• Financial and health services: clients served, average gross portfolio, cost per service, cost per client, percentage of total costs, operational self-sufficiency, health costs covered by income, and donations</li> <li>• Sustainability: services offered, fees charged, number of clients paying fees, ability of the implementing institution to raise funds</li> </ul>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• Health outcomes: clients value both healthcare and training services offered by and through Pro Mujer. Increase in family planning practices, better nutrition, and overall pregnancy care. Greater willingness to visit a doctor and more proactive in health matters. Improved communication with husbands, decreased family violence, and increased self-confidence</li> <li>• Service quality: convenient access to services through linkages and permanent staff at focal centers, lower transaction costs</li> <li>• Epidemiological impact of health services unknown</li> </ul>
<b>Follow-up period/sustainability</b>	<ul style="list-style-type: none"> <li>• The Bolivia project was started in 1989, the Nicaragua project in 1996, and the Peru project in 2000; all projects developed a cost accounting methodology to better allocate costs and increase efficiency—to date, only Bolivia has achieved sustainability</li> </ul>
<b>Best practices</b>	<ul style="list-style-type: none"> <li>• Long-term relationship with clients</li> <li>• Service delivery through focal centers—one-stop access to a range of services, improved convenience of health services, lowered transaction costs, security for women</li> <li>• Rural outreach</li> <li>• Grouping of large numbers of clients to reach scale</li> </ul>
<b>Cost</b>	Cost allocation/activity based on a costing study; health services were cross-subsidized or offered at low prices; the full cost of providing healthcare services was calculated as US\$2–9 per client per year (Junkin et al., 2006)
<b>Lessons learned</b>	<ul style="list-style-type: none"> <li>• Commitment of top management to a holistic approach of financial and health services delivery is necessary</li> <li>• Cost accounting of financial and non-financial services necessary for long-term sustainability.</li> <li>• Upper management skills required to manage a multi-service institution</li> <li>• Capable medical staff and providers must be available at an affordable cost to maintain this kind of finance plus health system program</li> <li>• To be successful, clients should not have competing sources of health services available to them</li> <li>• Clients are willing to pay for education and health services, but this demand may have to be built up over time</li> <li>• Legal and regulatory system must allow for the integration of financial and healthcare delivery provision</li> <li>• Detailed comparison: strengths and weaknesses of all three MFIs detailed in the study</li> </ul>
<b>Reference</b>	Junkin, Ruth, John Berry, and Maria Elena Perez. 2006. “Healthy Women, Healthy Business: A Comparative Study of Pro Mujer’s Integration of Microfinance and Health Services.” New York: Pro Mujer.

<b>Organization name/affiliation</b>	Rainbow Model of Care for Children
<b>Country</b>	Zambia
<b>MFI or NGO</b>	MFI
<b>Type of economic strengthening</b>	<ul style="list-style-type: none"> <li>• F: microcredit groups</li> <li>• H: nutrition centers, first-aid shelter for street kids</li> <li>• T: educational support</li> </ul>
<b>Other Partners.</b>	N/A
<b>Population</b>	In 2004, 18,161 people, including 14,110 children
<b>Inclusion criteria</b>	Under 17 years of age and having lost at least one parent to HIV
<b>Inputs</b>	<ul style="list-style-type: none"> <li>• First aid and shelter for street kids</li> <li>• Education support</li> <li>• Nutrition centers</li> <li>• Micro-credit groups</li> </ul>
<b>Process</b>	<p>Twin tracks: to balance the short-term needs of families with long-term self-sustainability</p> <ul style="list-style-type: none"> <li>• Track 1: family chooses a small business activity, attends two-week training, submits budget proposal, and receives soft loan given at zero percent interest for three months</li> <li>• Track 2: MFI provides assistance for food and education for three months</li> </ul>
<b>Special features</b>	<ul style="list-style-type: none"> <li>• Awareness groups formed: 20 families with children orphaned by AIDS act as participatory support groups</li> <li>• Twin track approach to microcredit</li> </ul>
<b>Indicators</b>	Self-sustainability for families graduated from the microcredit program: number of meals per day and number of children in school
<b>Outcomes</b>	Repayment rate: 65.25–86.27 percent
<b>Follow-up period/sustainability</b>	N/A
<b>Best practices</b>	Microcredit as a way to break the cycle of poverty and ill health
<b>Cost</b>	N/A
<b>Lessons learned</b>	N/A
<b>Reference</b>	Strobbe, Francisco. 2005. "The Role of Microfinance in Addressing the HIV/AIDS Pandemic in Africa: The Rainbow Model Provides a Future for AIDS orphans." <i>Microfinance Matters</i> (11). UN Capital Development Fund.

<b>Program/Project Name</b>	Sinapi Aba Trust (SAT) and Opportunity International S&L in Ghana (OI-SASL)
<b>Country</b>	Ghana (10 regions)
<b>MFI or NGO</b>	MFI (OI-SASL) and NGO (SAT)
<b>Type of economic strengthening</b>	<ul style="list-style-type: none"> <li>• F: microfinance—savings, credit, insurance</li> <li>• T: business training, mentoring, financial planning, leadership development</li> </ul>
<b>Other Partners</b>	Opportunity International, USAID
<b>Population</b>	SAT: 32,000; OI-SASL: 28,500 clients
<b>Inclusion criteria</b>	Those in small-scale trading and service businesses
<b>Inputs</b>	<p>SAT:</p> <ul style="list-style-type: none"> <li>• Financial products: mandatory loan insurance, mandatory death benefit insurance, emergency loans, and education trusts for minors</li> <li>• Non-financial products: HIV prevention programs, legal services</li> </ul>
<b>Process</b>	<p>SAT:</p> <ul style="list-style-type: none"> <li>• Trust groups: After eight training sessions, each group elects its own president and a treasurer to collect loan payments and savings; each member gets an \$80 loan to start, and after the group repays, they can take bigger loans (the group has 4–6 months to repay. RoI is similar to the commercial rates)</li> <li>• Businesses included selling food, sewing, and beauty shops</li> </ul>
<b>Special features</b>	<p>SAT:</p> <ul style="list-style-type: none"> <li>• Poverty pyramid: different levels of loans for people at various stages of poverty (ultra poor, laboring, self-employed, entrepreneurial)</li> <li>• Trust groups (group lending)—after “graduating,” members can borrow bigger, individual loans with longer repayment periods</li> </ul>
<b>Indicators</b>	<ul style="list-style-type: none"> <li>• Social and economic performance at individual, household, community, and society levels; percent of loans to women</li> <li>• Financial performance—e.g., outstanding portfolio (\$), average loan size; portfolio at risk (more than 30 days); operational and financial sustainability, loan activity, cost per loan (efficiency), jobs created</li> </ul>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• Increased business income</li> <li>• Increased personal income</li> <li>• Increase spending on children’s education, family illnesses, housing, nutrition</li> <li>• Provision of cushion for future financial shocks</li> <li>• Precise nature and amount of above impacts unclear</li> </ul>
<b>Follow up period/sustainability</b>	SAT: 114 percent operational sustainability; OI-SASL: 104 percent operational sustainability (as reported, unsure of definition)
<b>Best practices</b>	N/A
<b>Cost</b>	Cost per loan for worldwide Opportunity International Network: \$53.00 for average loan size, \$294.00 (across 27 countries)
<b>Lessons learned</b>	SAT: Field interviews with clients yielded positive impacts; survey data provided unclear results because there are no standardized measures of success from MF industry overall and research methods for non-financial impacts are still being developed
<b>References</b>	<ul style="list-style-type: none"> <li>• Opportunity International. No Date. “Building the Leading Microfinance</li> </ul>

	<p>Provider in Ghana: USAID Leverage and Impact Case Study #2: Opportunity International in Ghana.” Oak Brook, Illinois: Opportunity International.</p> <ul style="list-style-type: none"><li>• Lightbourne-Coley, Raquel (ed.). 2006. “First Quarter Report 2006.” <i>Quarterly Summary Report</i> 7(2): 1–4. Oak Brook, Illinois: Opportunity International Network.</li></ul>
--	--

<b>Program/Project Name</b>	Street Kids International (SKI) Project's Youth Skills Enterprise Initiative
<b>Country</b>	Zambia
<b>MFI or NGO</b>	NGO
<b>Type of economic strengthening</b>	<ul style="list-style-type: none"> <li>• Training and counseling in small business set-up</li> <li>• Business management</li> <li>• Access to credit</li> </ul>
<b>Partners</b>	Young Women's Christian Association, Zambia Red Cross
<b>Population</b>	N/A
<b>Inclusion criteria</b>	<ul style="list-style-type: none"> <li>• Youth 14–22 years old</li> <li>• Out-of-school or street kids with no previous work experience</li> </ul>
<b>Inputs</b>	<ul style="list-style-type: none"> <li>• Credit</li> <li>• Peer group mentoring for business development</li> <li>• Life skills, decisionmaking skills training</li> <li>• Networking with public/private sector (to reach beyond SKI's resources)</li> </ul>
<b>Process</b>	<ul style="list-style-type: none"> <li>• Community outreach and needs assessment</li> <li>• Recruitment and selection, skills training, loan approval and disbursement (three months to this point) peer support network and individual counseling (peer support and counseling takes about one year)</li> <li>• Treasurer assigned for each team to collect payments</li> <li>• More detailed and relevant training forthcoming as number of loans increases</li> </ul>
<b>Special features</b>	<ul style="list-style-type: none"> <li>• Peer-based approach to learning and collateral</li> <li>• Combination of individual and group-based learning and counseling methodologies</li> <li>• 15 percent interest</li> <li>• First loan: US\$45, second loan: US\$80, and third loan (maximum): US\$60, except when credit has been established</li> <li>• Loan repayment period: three months</li> <li>• Loan disbursement: within five days of loan approval</li> <li>• Participants required to save 10 percent of loan in group savings account</li> <li>• Group picnics organized; certificates of success awarded for loan repayment</li> </ul>
<b>Indicators</b>	N/A
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• Economic empowerment</li> <li>• Impact on participants: greater financial resources for food, clothes, household activities; ability to identify goals and run business; reduced high-risk behavior; increased awareness about HIV transmission and prevention; friendship and support from peers; sense of pride and purpose; improved relationship with family</li> <li>• Impact on families: additional resources for food and siblings' education</li> <li>• Impact on communities: community-living replaces living on the streets, peers are positive role models, more products accessible, often on credit</li> </ul>
<b>Follow-up period/sustainability</b>	<ul style="list-style-type: none"> <li>• Repayment rate is average 60 percent</li> <li>• Aim is to achieve at least an 80–90 percent repayment rate</li> </ul>
<b>Best practices</b>	Start small; employ self-directed and peer-based approaches to learning; use peer teams instead of collateral for loans; involve parents, guardians, community

<b>Cost</b>	N/A
<b>Lessons learned</b>	<ul style="list-style-type: none"> <li>• Optimal group size is 12–15 youth</li> <li>• Co-facilitation of groups by staff recommended</li> <li>• Five training sessions of 2–3 hours each required for receiving a second loan</li> <li>• Training is tailored to specific needs of the youth participating</li> <li>• A treasurer is named for each group to collect weekly contributions</li> <li>• Additional support/guidance needed during the first 2–3 weeks of the loan repayment period</li> </ul>
<b>Reference</b>	Street Kids International. 2002. <i>Youth Skills Enterprise Initiative: A Zambian Case Study of Micro-Enterprise and Microcredit Support for Street-Based Youth</i> . Toronto: SKI.

<b>Program/Project Name</b>	TRY (Tap and Reposition Youth) Program, K-Rep Development Agency
<b>Country</b>	Kenya
<b>MFI or NGO</b>	MFI
<b>Type of economic strengthening</b>	<ul style="list-style-type: none"> <li>• F: microsavings and credit, individual savings option</li> <li>• T: business management training, mentoring</li> </ul>
<b>Other Partners</b>	K-Rep Development Agency Population Council
<b>Population</b>	Participants in the TRY Project: 326 girls
<b>Inclusion criteria</b>	<ul style="list-style-type: none"> <li>• Urban slums</li> <li>• 16–22 years old</li> <li>• Out-of-school adolescents</li> </ul>
<b>Inputs</b>	<ul style="list-style-type: none"> <li>• Group savings account served as collateral for microloans and microcredit</li> <li>• Six days of training covering business and life skills, planning skills, entrepreneurial skills, gender roles, and RH education</li> <li>• Mentoring by adults</li> <li>• Young Savers Club and passbook system; treasurer appointed; ROI 15 percent</li> </ul>
<b>Process</b>	<ul style="list-style-type: none"> <li>• Modified group-based (Grameen) model</li> <li>• Group takes accountability of the loan. Participant makes a business plan, which the group reviews and approves. Two girls receive a loan at a time and the others can apply when their counterparts have established credibility through regular repayments.</li> <li>• Weekly group meetings and repayments—girls make continuing contributions to a group savings account, starting immediately after training, with a starting minimum of US\$0.65 each week; after eight weeks of savings, the first loan is given out to each group for US\$130, with an ROI of 15 percent</li> <li>• Businesses typically include hair salons, food stands, and petty trade</li> </ul>
<b>Special features</b>	<ul style="list-style-type: none"> <li>• Livelihood approach, social support group, mentoring, and phased program implementation—with regular improvements based on feedback obtained through a built-in performance evaluation mechanism</li> <li>• Do not report cost evaluation</li> <li>• Mentors organized informational seminars and invited guest speakers to talk about HIV, domestic and gender-based violence, women’s rights, drug and alcohol abuse, male-female relationships, and family planning</li> </ul>
<b>Indicators</b>	<ul style="list-style-type: none"> <li>• Financial/economic performance: increase in individual earnings, number of household assets, savings, girls who have savings, number of girls who keep savings in a “safe place” (bank)</li> <li>• Social performance: increased liberal attitudes on gender issues</li> <li>• Increased knowledge of HIV and sexual negotiation: RH knowledge, increased condom use, increased negotiation on high-risk sexual behavior</li> </ul>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• Clients showed higher income levels than non-clients; program was more effective for women above 20 years old, who had an interest in setting up their own businesses</li> <li>• Younger girls concentrated on savings and keeping their finances in a safe place</li> </ul>



	<ul style="list-style-type: none"> <li>• Older girls did better with financial and social performance, but the program successfully increased all participants' knowledge of reproductive health and high-risk behaviors</li> </ul>
<b>Follow up period/ sustainability</b>	<ul style="list-style-type: none"> <li>• Drop-out rate: 66 percent</li> <li>• Only 54 percent borrowed microloans after training, savings, and mentoring was provided</li> </ul>
<b>Best practices</b>	<ul style="list-style-type: none"> <li>• Linkages with a full service MFI are key for the success of such programs</li> <li>• Innovations needed</li> <li>• Savings club</li> </ul>
<b>Cost</b>	N/A
<b>Lessons learned</b>	<ul style="list-style-type: none"> <li>• Most adolescent girls value individual savings and low-risk income-generating opportunities</li> <li>• Segmenting youth markets is important to accommodate for the diversity among needs and backgrounds</li> <li>• It is important to “stage” programs to respond to needs and develop financial and other skills</li> <li>• Training and support varies in complexity with stages</li> <li>• Combining financial and non-financial services is necessary</li> <li>• For young entrepreneurs, “ideas” are key and then “capital”; but youth tend to focus on the latter. They prefer to borrow from friends, ROSCAs, and others—for informal finance and savings—and regard these as key sources of capital rather than MFIs (Dr. Geetha Nagarajan, Research Director, Chemonics International, USAID learning conference)</li> </ul>
<b>References</b>	<p>In addition to program report:</p> <ul style="list-style-type: none"> <li>• Erulkar, Annabel S., and Erica Chong. 2005. <i>Evaluation of a Savings and Microcredit Program for Vulnerable Young Women in Nairobi</i>. New York: Population Council.</li> <li>• Erulkar, Annabel, Judith Bruce, Aleke Dondo, Jennefer Sebstad, James Matheka, Arjmand Banu Khan, and Anne Gathuku. 2006. “Tap and Reposition Youth (TRY): Providing Social Support, Savings, and Microcredit Opportunities for Young Women in Areas with High HIV Prevalence.” <i>Promoting Healthy, Safe, and Productive Transitions to Adulthood</i>, Brief 15.</li> </ul>

<b>Program/Project Name</b>	Various: PROGRESA (Education, Health, and Nutrition Program), Mexico PATH (Program of Advancement through Health and Education), Jamaica RPS (Social Safety Net Program), Nicaragua Bolsa Familia (consolidated previously formed CCTs, namely Bolsa Alimentacao, Bolsa Escola, and PETI (Program for the Eradication of Child Labor), Brazil FA (Families in Action): Colombia PRAF (Family Allowance Program): Honduras
<b>Region</b>	Latin America and the Caribbean (Mexico, Jamaica, Honduras, Nicaragua, Colombia, Chile, Brazil)
<b>MFI or NGO</b>	Neither: CCTs
<b>Type of economic strengthening</b>	<ul style="list-style-type: none"> <li>• Long-term human capital accumulation objectives to break the poverty cycle</li> <li>• Becoming cornerstone of countries' national welfare strategies</li> <li>• Most have education and health/nutrition components</li> </ul>
<b>Other Partners</b>	Mostly public sector suppliers of education and health services International lenders
<b>Population</b>	PROGRESA: 5 million families (2005) Bolsa Familia: 2–5 million households (2004) FA: 362,000 households (2001) PRAF: 30,000 households (2000) RPS: 30,000 households (2004) PATH: 180,000 households (2005)
<b>Inclusion criteria</b>	<ul style="list-style-type: none"> <li>• Poor households with children, selected through defined per capita income levels, assets, or scoring formulas</li> <li>• Infants, children, up to 15 years old for health visits</li> <li>• Pregnant women, who fall within income levels and within families</li> </ul>
<b>Inputs</b>	<ul style="list-style-type: none"> <li>• Monthly cash grants given directly to families (e.g., to educate their children/adolescents and use specific health and nutrition services)</li> <li>• Targeting mechanisms to identify poor households</li> <li>• Monitoring of conditionality requirements for compliance</li> </ul>
<b>Process</b>	<ul style="list-style-type: none"> <li>• Administered by central government, by specially created entities (not line-ministries)</li> <li>• CCTs include a variety of conditionalities in health and education, aiming at increasing beneficiaries' use of specified services</li> <li>• Health conditionality: regular healthcare visits to centers, vaccinations, prenatal/postpartum care for women, health education, enrollment and regular attendance at schools, etc.</li> </ul>
<b>Special features</b>	<ul style="list-style-type: none"> <li>• Mexico is including the most rigorous evaluations of health interventions, meaning other countries are paying less attention to health in evaluations</li> </ul>
<b>Indicators</b>	Various, depending on the program: <ul style="list-style-type: none"> <li>• Education: school enrollment and attendance rates, for PROGRESA (additional)=average test scores, percent teachers trained, percent schools with basic teaching material</li> <li>• Health and nutrition: child growth rate and development monitoring, diarrhea incidence, vaccination coverage, malnutrition rates, maternal health service utilization rate, and satisfaction rate with pre/post care</li> </ul>

	<ul style="list-style-type: none"> <li>• Overall: change in health and education spending/poverty headcount/poverty gap/child participation in labor force</li> <li>• Evaluations of CCTs are relatively rigorous in non-health areas; these are supported by policymakers and used to plan and guide program operations/expansion</li> </ul>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• Positive school enrollment rates of both boys and girls (Mexico, Colombia, Nicaragua)</li> <li>• Reduced child labor (Mexico, Brazil)</li> <li>• Significant improvement in nutrition monitoring and immunization rates (Mexico, Colombia, Nicaragua)</li> <li>• Consumption levels: mean expenditure on food increased among the household (Mexico, Colombia, Nicaragua)</li> <li>• Effective and efficient means to transfer income to the poor and for promoting human capital accumulation by poor households</li> </ul>
<b>Follow-up period/sustainability</b>	<ul style="list-style-type: none"> <li>• Concerns about CCTs bypassing need to improve supply-side quality/quantity of services</li> <li>• CCTs might undermine autonomy of local governments through excessive centralization</li> <li>• Need incentives built into programs to graduate beneficiaries from programs (e.g., job creation)</li> <li>• CCTs funded from tax revenues and international lending; do CCTs break the poverty cycle? (No clear answers)</li> </ul>
<b>Best practices</b>	<ul style="list-style-type: none"> <li>• Between short-term poverty alleviation and long-term human capital accumulation, the latter is considered by some to be the most valuable</li> <li>• Debate about keeping income-generation activities separate from income-transfer and investment activities; some CCTs are combining them, others are not</li> </ul>
<b>Cost</b>	<p>Overall level of expenditures, gross domestic product (GDP):</p> <ul style="list-style-type: none"> <li>• Colombia: 0.12 percent GDP; Jamaica: 0.32 percent GDP; Mexico: 0.32 percent GDP</li> </ul>
<b>Lessons learned</b>	<ul style="list-style-type: none"> <li>• Effective CCT programs depend on having a good supply of healthcare and education services for the target group, as CCT mandates use of these services</li> <li>• Effective CCT programs assess if assumptions about use of services by poor are correct before starting income transfers with this condition</li> <li>• Only some CCT programs give grants to increase/improve supply (e.g., Nicaragua: teachers eligible for bonuses; Mexico: grants given to ensure adequate supplies of equipment, medicine, etc.)</li> <li>• Some amount of people being paid to use services that they would anyway and/or using services that they do not need</li> <li>• Target the extreme poor</li> <li>• A more rigorous evaluation of health effects is recommended</li> </ul>
<b>References</b>	<ul style="list-style-type: none"> <li>• Rawlings, Laura, and Gloria Rubio. 2003. "Evaluating the Impact of Conditional Cash Transfer Programs: Lessons from Latin America." <i>World Bank Policy Research Working Paper</i> No. 3119.</li> <li>• Rawlings, Laura. 2004. <i>A New Approach to Social Assistance: Latin America's Experience with Conditional Cash Transfer Programs</i>. Washington, DC: Social Protection Unit, Human Development Network, World Bank.</li> <li>• Glassman, A., J. Todd, and M. Gaarder. 2007. "Performance-Based Incentives for Health: CCT Programs in Latin America and the</li> </ul>

	<p>Caribbean. Center for Global Development.” <i>Working Paper</i> No. 120.</p> <ul style="list-style-type: none"><li>• Lagarde, Mylene, Andy Haines, and Natasha Palmer. 2007. “Conditional Cash Transfers for Improving Uptake of Health Interventions in Low- and Middle-Income Countries.” <i>Journal for the American Medical Association</i> 298(16): 1900–1910.</li></ul>
--	--

<b>Program/Project Name:</b>	WORTH
<b>Countries</b>	Ethiopia, Kenya, Tanzania, Uganda, Zambia (2004–2009)
<b>MFI or NGO</b>	Local NGO partners identified and supported to sustain activities
<b>Type of Economic Strengthening</b>	F: savings/credit via community controlled village banking; includes dividend distribution T: literacy and numeracy training
<b>Other Partners</b>	<ul style="list-style-type: none"> <li>• Various: currently, five-year USAID grant (recent past: USAID’s Assessing the Impact of Microenterprise Services (AIMS) Project)</li> <li>• Pact, U.S.-based private voluntary association</li> </ul>
<b>Population</b>	69,000 women in these five countries by 2009 (poor and very poor)
<b>Inclusion Criteria</b>	Rural women
<b>Inputs</b>	<ul style="list-style-type: none"> <li>• Curriculum and materials development and publishing</li> <li>• External technical assistance</li> <li>• Local literacy volunteers</li> <li>• Networking among groups to provide support and mentoring and troubleshoot issues</li> </ul>
<b>Operational Processes</b>	Follows “WORTH Implementation Cycle”: <ul style="list-style-type: none"> <li>• Selects and equips NGO partner with simple admin/financial systems</li> <li>• NGO partner mobilizes community</li> <li>• Groups self-train and start village banks</li> <li>• Groups build community linkages</li> <li>• Direct support from Pact ceases, and Pact exits from the location</li> </ul>
<b>Special Features</b>	<ul style="list-style-type: none"> <li>• Dividends distributed (from interest on loans made)</li> <li>• Appreciative Planning and Action Approach used to enable women to meet the challenges of caring for orphans and vulnerable children (OVC); emphasis on saving vs. lending</li> <li>• Clients decide their own savings and interest rates</li> <li>• WORTH groups create dynamic networks for social action after formation, such as care for OVC</li> </ul>
<b>Indicators</b>	<ul style="list-style-type: none"> <li>• Among clients: change in literacy rate, level of savings; number of women entrepreneurs, change in business income, number of grassroots campaigns sponsored, changes in household decisionmaking roles</li> <li>• Overall: numbers of borrowers, gross loan portfolio, average loan balance, number of savers, total savings</li> </ul>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• WORTH groups graduate to full independence</li> <li>• WORTH groups’ social action seek economic security for OVC and their caregivers and raise community awareness about HIV</li> </ul>
<b>Follow-up Period/Sustainability</b>	12–24 months
<b>Best Practices</b>	Training in literacy and numeracy before starting the village bank; groups learn about HIV and other gender-related issues; groups raise awareness of others in community, network, and help launch other groups
<b>Cost</b>	Pact pays local NGOs monthly fee for each 10 groups recruited, trained, supported in addition to the cost of inputs noted above
<b>Lessons Learned</b>	This savings-led, client-controlled model (which is also promoted by other U.S. private voluntary organizations, such as CARE, Save the Children)

	empowers rural women to craft their own responses to development challenges (traditional MFIs do not work with poor rural women, but this model does)
<b>Reference</b>	Odell, M., M. Pickens, and E. Tubbs. 2004. "Pact's WORTH Model: A Savings-led Approach to Economic Security and Combating HIV/AIDS." Prepared for the Microenterprise Solutions for the World's Poorest symposium on December 9, 2004.

<b>Program/Project Name:</b>	Zambuko Trust
<b>Country</b>	Zimbabwe
<b>MFI or NGO</b>	MFI
<b>Type of economic strengthening</b>	<ul style="list-style-type: none"> <li>• F: individual loans, group loans, and Trust Bank (group-lending village banking model)</li> <li>• T: business management training</li> </ul>
<b>Other Partners</b>	<ul style="list-style-type: none"> <li>• Associated with Opportunity International Network since 1992</li> <li>• USAID through the AIMS Project</li> </ul>
<b>Population</b>	<ul style="list-style-type: none"> <li>• Urban and rural areas</li> <li>• Very poor women</li> </ul>
<b>Inclusion criteria</b>	<ul style="list-style-type: none"> <li>• Marginalized, unemployed, microentrepreneur</li> <li>• Very poor who need training in business management</li> </ul>
<b>Inputs</b>	<ul style="list-style-type: none"> <li>• Individual loans: clients go through half-day orientation to learn about loan requirements and good business practices</li> <li>• Trust Bank program: clients go through one-hour training sessions for eight weeks before receiving their first loan</li> <li>• One-time training only</li> <li>• No special gender-focused initiatives mentioned</li> </ul>
<b>Operational processes</b>	<ul style="list-style-type: none"> <li>• Monthly repayment collected</li> <li>• Group meetings held among self-selected groups of clients</li> <li>• Businesses included mainly manufacturing (50 percent) and trading (&gt;40 percent), and the rest were agriculture or food preparation</li> <li>• No mention of training provided</li> </ul>
<b>Special features</b>	<ul style="list-style-type: none"> <li>• ROI during period of study: 32 percent in 1997 and 52 percent in 1999, due to high inflation in Zimbabwe at that time</li> <li>• Management of financial portfolio: MFI charges a mandatory insurance fee of 1 percent to cover the outstanding loan of deceased clients</li> <li>• Only gives loans to economically active microentrepreneurs</li> </ul>
<b>Indicators</b>	<ul style="list-style-type: none"> <li>• Generation of profits from use of loans</li> <li>• Better management of finances</li> <li>• Resources</li> </ul>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• Empirical evidence: matched participants and conducted a longitudinal study over a two-year period</li> <li>• Household level 1: increase in household assets and funeral-related assistance, and affected clients had a greater number of income sources</li> <li>• Household level 2: significantly greater percentage of male clients (6–16 years old) attending school compared with non-clients; no effect observed among female clients</li> <li>• Household level 3: increased frequency of consumption of nutritious food and diversification of income sources</li> <li>• Enterprise level: not much change due to high inflation between 1997 and 1999</li> <li>• Individual level: better financial management and increased savings</li> </ul>
<b>Follow-up period/ sustainability</b>	<ul style="list-style-type: none"> <li>• Conducted baseline study in 1997 and follow-up in 1999; the study asked clients to list reasons for drop-out</li> <li>• See “lessons learned” below</li> </ul>
<b>Best practices</b>	N/A

<b>Cost</b>	N/A
<b>Lessons learned</b>	<ul style="list-style-type: none"> <li>• Influence of the macro-environment: high inflation affects interest and repayment rates and financial stability of MFI</li> <li>• Unmet need for business management training</li> <li>• Drop-out due to inability to repay loans</li> <li>• Relocation outside program catchment area, or personal financial crisis</li> <li>• Simpler to account for program's ability to increase a particular source of income, rather than the overall household income</li> <li>• Poverty status of the household had a significant relation to intake of a member due to death or illness, but it did not seem to change its poverty status, indicating the new member might join as an economically productive member</li> <li>• Household size and structure, not the microfinance program, were found to be the key determinants of moving the household out of poverty</li> </ul>
<b>Reference</b>	Barnes, Carolyn, and Erica Keogh. 2002. <i>Microfinance and Mitigation of the Impacts of HIV/AIDS: An Exploratory Study from Zimbabwe</i> . Washington, DC: AIMS Project, Management Systems International.



## REFERENCES

- Amin, Sajeda. 2007. "Adolescent Livelihood Programs in South Asia." Presented at the Youth Microenterprise Conference in Washington, D.C.
- Anderson, C. Leigh, Mary Kay Gugerty, Ruth O. Levine, and Marcia Weaver. 2002. *Microfinance and HIV/AIDS: Five Key Questions on Program Impact*. Seattle, WA: The University of Washington, Synergy Project.
- Arnold, Emily. 2003. "Adolescent and Youth Sexual and Reproductive Health: Charting Directions for a Second Generation of Programming." New York: Population Council and United Nations Population Fund.
- Bagnol, Brigitte, and Ernesto Chamo. 2004. "Intergenerational relationships in Mozambique: What is Driving Young Women and Older men?" *Sexual Health* 3–4.
- Barnes, Carolyn. 2005. *Economic Strengthening Activities Benefiting Orphans and Vulnerable Children in Africa: Mapping of Field Programs*. Washington, DC: Academy for Educational Development.
- Barnes, Carolyn, and Erica Keogh. 2002. *Microfinance and Mitigation of the Impacts of HIV/AIDS: An Exploratory Study from Zimbabwe. Assessing the Impact of Microenterprise services (AIMS) paper*. Washington, DC: Management Systems International.
- Blanc, A., and A. Way. 1998. "Sexual behavior and Contraceptive Knowledge and Use Among Adolescents in Developing Countries." *Studies in Family Planning* 29(2): 106–16.
- Brieger, William, Grace Delano, Catherine Lane, Oladimeji Oladepo, and Rola Oyediran. 2001. "West African Youth Initiative: Outcome of a Reproductive Health Education Program." *Journal of Adolescent Health* 29(6): 436–446.
- Bruce, Judith. 2007. "Girls Left Behind: Redirecting HIV Interventions toward the Most Vulnerable." *Promoting Healthy, Safe, and Productive Transitions to Adulthood* Brief No. 23.
- Bruce, Judith. 2006a. *How to Conduct a Coverage Exercise: A Rapid Assessment Tool for Programs and Services*. New York: Population Council.
- Bruce, Judith. 2006b. *A Note on the Social and Economic Development and Reproductive Health of Vulnerable Adolescent Girls*. Florence, Italy: UNICEF Innocenti Research Center.
- Bruce, Judith, and Amy Joyce, eds. 2006. "The Girls Left Behind: The Failed Reach of Current Schooling, Child Health, Youth-serving, and Livelihoods Programs for Girls Living in the Path of HIV." New York: Population Council.
- Bruce, Judith and Erica Chong. 2006. *Investing in the Diverse Universe of Adolescents: A Note on Research, Program and Policy Priorities*. New York: Millennium Project.
- Camfed International. 2006. "Building the Capacity of Young Rural Women: The Cama Seed Money Scheme." Cambridge, United Kingdom: Camfed International.

- Camfed International. 2004. "Camfed International: An Overview." Media Information, November 11. Cambridge, United Kingdom: Camfed International.
- Centre for Development and Population Activities (CEDPA). 2001. "Adolescent Girls in India Choose a Better Future: An Impact Assessment." Washington DC: CEDPA.
- Chambers, Robert, and Gordon R. Conway. 1992. "Sustainable Rural Livelihoods: Practical Concepts for the 21<sup>st</sup> century." *Discussion Paper* No. 296. Sussex, United Kingdom: Institute of Development Studies.
- Chong, Erica, Kelly Hallman, and Martha Brady. 2006. *Investing When It Counts: Generating the evidence base for policies and programmes for very young adolescents. Guide and toolkit*. New York: UNFPA and Population Council.
- Clark, Heather. 1999. "Some Issues for Consideration for the Workshop on Microfinance and HIV/AIDS." Paper prepared for the UNAIDS Workshop, New York.
- Clark, Shelley. 2004. "Early Marriage and HIV Risks in Sub-Saharan Africa." *Studies in Family Planning* 35(3): 149–160.
- Clark, Shelley, Judith Bruce, and Annie Dude. 2006. "Protecting Girls from HIV/AIDS: The Case Against Child and Adolescent Marriage." *International Family Planning Perspectives* 32(2): 79–88.
- Daley-Harris, Sam. 2007. *State of the Microcredit Summit Campaign Report 2007*. Washington, DC: Microcredit Summit Campaign.
- Daley-Harris, Sam. 2005. *State of the Microcredit Summit Campaign Report 2005*. Washington, DC: Microcredit Summit Campaign.
- De Janvry, Alain, Elisabeth Sadoulet, Pantelis Solomon, and Renos Vakis. 2006. "Uninsured Risk and Asset Protection: Can Conditional Cash Transfer Programs Serve as Safety Nets?" *Social Protection Discussion Paper* No. 0604. Washington, DC: World Bank.
- Donahue, Jill. 2000. *Microfinance and HIV/AIDS: It's Time to Talk*. Washington, DC: Displaced Children and Orphans Fund & War Victims Fund, USAID.
- Dunford, Christopher. 2001. *Building Better Lives: Sustainable Integration of Microfinance with Education in Child Survival, Reproductive Health, and HIV/AIDS Prevention for the Poorest Entrepreneurs*. Washington, DC: Microcredit Summit Campaigning.
- Dunford, Christopher, and Vicki Denman. 2001. "Credit with Education: A Promising Title II Microfinance Strategy: Supporting Integrated Food Security and Nutrition Programs to Improve Health and Well-Being of Women and Children." Washington, DC: Academy for Educational Development, Food and Nutrition Technical Assistance Project.
- Epstein, Helen, and Julia Kim. 2007. "AIDS and the Power of Women." *The New York Review of Books* 54(2): 39–41.
- Erulkar, Annabel S., Mags Bensinksa, and Queen Cebekhulu. 2001. *An Assessment of Youth Centers in South Africa*. Nairobi: Population Council Frontiers Program.

Erulkar, Annabel, Judith Bruce, Aleke Dondo, Jennefer Sebstad, James Matheka, Arjmand Banu Khan, and Anne Gathuku. 2006. "Tap and Reposition Youth (TRY): Providing Social Support, Savings, and Microcredit Opportunities for Young Women in Areas with High HIV Prevalence." *SEEDS Publication Series* No. 23. New York: Population Council.

Erulkar, Annabel S. and Erica Chong. 2005. *Evaluation of a Savings and Microcredit Program for Vulnerable Young Women in Nairobi*. New York: Population Council.

Erulkar, Annabel S., and Tekle Ab Mekbib. 2007. "Reaching Disadvantaged Rural Girls, Creating Social Support, and Discouraging Child Marriage in Amhara, Ethiopia." *Promoting Healthy, Safe, and Productive Transitions to Adulthood* Brief 20.

Family Health International. 2006. YouthNet End of Program Report—Taking Action: Recommendations and Resources. Arlington, VA: YouthNet, Family Health International.

FOCCAS Uganda. 2000. *Integrated Microfinance and HIV/AIDS Education*. A Case Study for the Microenterprise Best Practices Project. Bethesda, MD: Microenterprise Best Practices Project. Development Alternatives, Inc.

FOCCAS Uganda and Imp-Act Program. No Date. "FOCCAS, Uganda—Summary Sheet." Mbale: FOCCAS Uganda. Accessed at [www.worldbank.org/sief](http://www.worldbank.org/sief) on July 7, 2008.

FOCUS on Young Adults. 2001. *Advancing Young Adult Reproductive Health: Actions for the Next Decade: End of Program Report*. Washington, DC: Pathfinder International.

Glassman, A., J. Todd, M. Gaarder. 2007. "Performance-Based Incentives for Health: CCT Programs in Latin America and the Caribbean. Center for Global Development." *Working Paper* No. 120.

Goldberg, N. 2005. *Measuring the Impact of Microfinance: Taking Stock of What we Know*. Washington, DC: Grameen Foundation.

Grant, Monica J., Barbara S. Mensch, and Mary P. Sebastian. 2007. "Introducing Adolescent Livelihoods Training in the Slums of Allahabad, India." *Promoting Healthy, Safe, and Productive Transitions to Adulthood* Brief No. 2.

Hall, Joan, Aleke Dondo, and Jennefer Sebstad. 2006. *Microfinance Brief: Tap and Reposition Youth (TRY): Providing Social Support, Savings, and Microcredit Opportunities for Young Women in Areas with High HIV Prevalence*. New York: Population Council.

Hallman, Kelly. 2005. "Gendered Socioeconomic Conditions and HIV Risk Behaviors Among Young People in South Africa." *African Journal of AIDS Research* 4(1): 37–50.

Hallman, Kelly, Kasthuri Govender, Eva Roca, Rob Pattman, Emmanuel Mbatha, and Deevia Bhana. 2007. "Enhancing Financial Literacy, HIV/AIDS Skills, and Safe Social Spaces among Vulnerable South African youth." *Promoting Healthy, Safe, and Productive Transitions to Adulthood* Brief No. 4.

Hargreaves, James, Tesmer Atsbeha, John Gear, Julia Kim, Benjamin Mzamani Makhubele, Kalipe Mashaba, Linda Morison, Mmatshilo Motsei, Chris Peters, John Porter, Paul Pronyk, and Charlotte Watts. 2002. "Social Interventions for HIV/AIDS: Intervention with Microfinance for AIDS and Gender Equity." *IMAGE Study, Evaluation Monograph* No.1.

- Hashemi, Syed. 2000. "Linking Microfinance and Safety Net Programs to Include the Poorest: The Case of IGVGD in Bangladesh." *Focus Note 21*. Washington, DC: Consultative Group to Assist the Poor.
- Hashemi, S.M., S.R. Schuler, and A.P. Riley. 1996. "Rural Credit Programs and Women's Empowerment in Bangladesh." *World Development* 24: 635–653.
- Hope, Ruth. 2007a. *Addressing Cross-Generational Sex: A Desk Review of Research and Programs*. Washington, DC: Population Reference Bureau.
- Hope, Ruth. 2007b. *Gender Equality and the HIV Pandemic*. Fairfax, VA: MIDEGO, Inc.
- Johnson, Susan. No date. *Gender and Microfinance: Guidelines for Good Practice*. Bath: University of Bath, Centre for Development Studies. Accessed on July 8, 2008, at [www.gdrc.org/icm/wind/gendersjonson.html](http://www.gdrc.org/icm/wind/gendersjonson.html).
- Junkin, Ruth, John Berry, and Maria Elena Perez. 2006. "Healthy Women, Healthy Business: A Comparative Study of Pro Mujer's Integration of Microfinance and Health Services." New York: Pro Mujer.
- Kasi, Fabian. 2005. *Gender Targeting of Rural Financial Services: Is this Appropriate? Case study of FINCA Uganda*. Kampala: FINCA Uganda.
- Kim, Julia C., and Charlotte H. Watts. 2005. "Gaining a Foothold: Tackling Poverty, Gender, Inequality, and HIV in Africa." *British Medical Journal* 331: 769–772.
- Kim, Julia C., Charlotte H. Watts, James R. Hargreaves, Luceth X. Ndhlovu, Godfrey Phetla, Linda A. Morison, Joanna Busza, John D.H. Porter, and Paul Pronyk. 2007. "Understanding the Impact of a Microfinance-Based Intervention on Women's Empowerment and the Reduction of Intimate Partner Violence in South Africa." *American Journal of Public Health* 97(10): 1794–1802.
- Kirby, Douglas, B.A. Laris, and Lori Roller. 2005. "Impact of Sex and HIV Education Programs on Sexual Behaviors of Youth in Developing and Developed Countries." *Youth Research Working Paper* No. 2. Washington, DC: Family Health International.
- Lagarde, Mylene, Andy Haines, and Natasha Palmer. 2007. "Conditional Cash Transfers for Improving Uptake of Health Interventions in Low- and Middle-Income Countries." *Journal for the American Medical Association* 298(16): 1900–1910.
- Larson, David. 2004. "Technical Briefs: Frequently Asked Questions on Basic Microfinance Concepts." Bethesda, MD: Microenterprise Best Practices Project, Development Alternatives, Inc.
- Lightbourne-Coley, Raquel (ed.). 2006. "First Quarter Report 2006." *Quarterly Summary Report* 7(2): 1–4. Oak Brook, Illinois: Opportunity International Network.
- Lloyd, Cynthia B. (ed). 2005. "Schooling and Adolescent Reproductive Behavior in Developing Countries." In *Growing up Global: The Changing Transitions to Adulthood in Developing Countries*. Washington, DC: The National Academies Press.
- Luke, Nancy. 2003. "Age and Economic Asymmetries in the Sexual Relationships of Adolescent Girls in sub-Saharan Africa." *Studies in Family Planning* 34(2): 67–86.

- Luke, N., and K. Kurtz. 2002. *Cross-generational and Transactional Sexual Relations in sub-Saharan Africa: Prevalence of Behavior and Implications for Negotiating Safer Sexual Practices*. Washington, DC: Population Services International and International Center for Research on Women, A Mother's Promise Campaign.
- Mayoux, Linda. 1997. *The Magic Ingredient? Microfinance and Women's Empowerment*. Paper prepared for Micro Credit Summit, Washington, D.C.
- McDonagh, Amy. 2000. "Microfinance Strategies for HIV/AIDS Mitigation and Prevention in sub-Saharan Africa." *Working Paper* No. 25.
- Mensch, Barbara S., Judith Bruce, and Margaret E. Greene. 1998. *The Uncharted Passage: Girls' Adolescence in the Developing World*. New York: Population Council.
- "Microfinance, Intimate-partner Violence, and HIV." Editorial. 2006. *The Lancet* 368(9511): 1937.
- MkNelly, Barbara, and Christopher Danford. 1999. "Impact of Credit with Education on Mothers and their Young Children's Nutrition: CRECER Credit with Education Program in Bolivia." *Freedom from Hunger Resource Paper* No. 5. Davis, CA: Freedom from Hunger.
- MkNelly, Barbara, and Christopher Danford. 1998. "Impact of Credit with Education on Mothers and their Young Children's Nutrition: Lower Pra Rural Bank Credit with Education Program in Ghana." *Freedom from Hunger Resource Paper* No. 4. Davis, CA: Freedom from Hunger.
- Morduch, J. 1999. "The Microfinance Promise." *Journal of Economic Literature* 35: 1569–1614.
- Mosley, P., and D. Hulme. 1998. "Microenterprise Finance: Is There a Conflict between Growth and Poverty Alleviation?" *World Development* 26(5): 783–790.
- Navajas, S., M. Schreiner, R.L. Meyer, C. Gonzales-Vega, and J. Rodriguez-Meza. 2000. "Microcredit and the Poorest of the Poor: Theory and Evidence from Bolivia." *World Development* 28(2): 333–346.
- Nkosana, Josephine, and Doreen Rosenthal. 2007. "The Dynamics of Intergenerational Sexual Relationships: The Experience of Schoolgirls in Botswana." *Sexual Health* 4(3): 181–187.
- Odell, Marcia, Mark Pickens, and Erica Tubbs. 2004. "Pact's WORTH Model: A Savings-led Approach to Economic Security and Combating HIV/AIDS." Prepared for the Microenterprise Solutions for the World's Poorest symposium on December 9, 2004.
- Opportunity International. No date. "Building the Leading Microfinance Provider in Ghana: USAID Leverage and Impact Case Study #2": Opportunity International in Ghana." Oak Brook, Illinois: Opportunity International.
- Parker, Joan. 2000. *Discussion Paper: Microfinance and HIV/AIDS*. Bethesda, MD: Microenterprise Best Practices Project, Development Alternatives, Inc.
- Parker, Joan, Ira Singh, and Kelly Hattel. 2000. *UNAIDS Background Paper: The Role of Microfinance in the Fight Against HIV/AIDS*. Bethesda, MD: Development Alternatives, Inc.
- Plan Benin. 2006. *Youth Empowerment: Young People in Benin Take Charge of their Sexual Health*. Surrey, United Kingdom: Plan International.

Population Council. 2005. *Building Assets for Safe, Productive Lives: A Report on a Workshop on Adolescent Girls' Livelihoods*. New York: Population Council.

Population Council and International Center for Research on Women (ICRW). 2000. *Adolescent Girls' Livelihoods, Essential Questions, Essential Tools: A Report on a Workshop*. New York: Population Council and ICRW.

Pronyk, Paul M., James R. Hargreaves, Julia C. Kim, Linda A. Morison, Godfrey Phetla, Charlotte Watts, Joanna Busza, and John D. H. Porter. 2006. "Effect of a Structural Intervention for the Prevention of Intimate-Partner Violence and HIV in Rural South Africa: A Cluster Randomised Trial." *The Lancet* 378: 1973–1983.

Pronyk, P.M., J.C. Kim, J.R. Hargreaves, M.B. Makhubele, L.A. Morison, C. Watts, and J.D.H. Porter. 2005. "Microfinance and HIV Prevention: Emerging Lessons from Rural South Africa." *Small Enterprise Development* 16(3): 26–38.

Rahman, A. 1999. "Microcredit Initiatives for Equitable and Sustainable Development: Who Pays?" *World Development* 27(1): 67–82.

Rawlings, Laura. 2004. *A New Approach to Social Assistance: Latin America's Experience with Conditional Cash Transfer Programs*. Washington, DC: Social Protection Unit, Human Development Network, World Bank.

Rawlings, Laura, and Gloria Rubio. 2003. "Evaluating the Impact of Conditional Cash Transfer Programs: Lessons from Latin America." *World Bank Policy Research Working Paper* No. 3119. Available at: <http://ssrn.com/abstract=636482>.

Sample, Bob. 2006. "How RESULTS Activists Collaborated With Microcredit Leaders and High Government Officials to Build the Microfinance Movement." Paper prepared for the Global Microcredit Summit 2006 in Halifax, Canada.

Senderowitz, J. 1999. *Making Reproductive Health Services Youth Friendly*. Washington, DC: FOCUS on Young Adults, Pathfinder International.

SHAZ! Program. 2007. "SHAZ! Pfavira Ngoma Usiku Urefu." Contact Dr. Susan Laver, PhD., [slaver@unicef.org](mailto:slaver@unicef.org).

Street Kids International (SKI). 2002. *Youth Skills Enterprise Initiative: A Zambian Case Study of Micro-Enterprise and Microcredit Support for Street-Based Youth*. Toronto: SKI.

Strobbe, Francisco. 2005. "The Role of Microfinance in Addressing the HIV/AIDS Pandemic in Africa: The Rainbow Model Provides a Future for AIDS orphans." *Microfinance Matters* (11). UN Capital Development Fund.

Summers, Lawrence H. 1994. "Investing in all the People: Educating Women in Developing Countries." *EDI Seminar Paper*. Washington, DC: World Bank.

UNAIDS. 2007. *The Positive Partnerships Program in Thailand: Empowering People Living with HIV/AIDS*. Geneva: UNAIDS.

UNAIDS. 2004 Report on the Global HIV/AIDS Epidemic: 4<sup>th</sup> Global Report. Geneva: UNAIDS.

UNAIDS. 2002 Report on the Global HIV/AIDS Epidemic. Geneva: UNAIDS.

UNESCO. 2008 “Girls’ Education and HIV Prevention: Advocacy Briefing Note.” Paris: Inter-Agency Task Team on Education, UNESCO.

UNICEF. 2000. *Skills-Based Health Education to Prevent HIV/AIDS*. New York: UNICEF.

Urdang, Stephanie. 2007. *Change, Choice and Power: Young Women, Livelihoods, and HIV Prevention*. New York: International Planned Parenthood Federation, United Nations Population Fund, and Young Positives.

von Bothmer, Eleonore. 2008. “Safe Sex Subsidy.” *D+C Development and Cooperation* 49(6): 262. Frankfurt: InWent (Capacity Building International). Accessed at [www.inwent.org/ez/magazines/200806/index.en.shtml](http://www.inwent.org/ez/magazines/200806/index.en.shtml) on July 8, 2008.

Weissman, Amy, Janine Cocker, Lisa Sherburne, Mary Beth Powers, Ronnie Lovich, and Mary Mukaka. 2006a. “Cross-Generational Relationships: Using a ‘Continuum of Volition’ in HIV prevention work among Young People.” *Gender and Development* 14(1): 81–94.

Weissman, Amy, Janice Cocker, Lisa Sherburne, Mary Beth Powers, Ronnie Lovich, and Mary Mukaka. 2006b. “Reframing and Addressing Cross-generational Relationships in Malawi.” *Exchange on HIV/AIDS, Sexuality, and Gender* 1.

Winship, Guy, and Earne, Julie. 2000. “FINCA, Uganda: Helping Microentrepreneurs Cope with AIDS.” Bethesda, MD: Microenterprise Best Practices Project, Development Alternatives Inc.

World Bank. No Date. “HIV/AIDS Prevention.” Washington, DC: World Bank, Spanish Trust Fund for Impact Evaluation and Results-based Management in Human Development Sectors. Accessed at [www.worldbank.org/sief](http://www.worldbank.org/sief) on July 8, 2008.

## ADDITIONAL RESOURCES

Askew, Ian, Jane Chege, and Carolyne Njue. 2004. *A Multi-Sectoral Approach to Providing Reproductive Health Information and Services to Young People in Western Kenya: Kenya Adolescent Reproductive Health Project*. Nairobi: Frontiers in Reproductive Health (Population Council), Program for Appropriate Technology in Health (PATH), Government of Kenya.

Bingeneheimer, Jeffrey. 2007. "Wealth, Wealth Indices and HIV Risk in East Africa." *Viewpoint* 33 (2): 83–84.

Brady, Martha, Lydia Saloucou, and Erica Chong. 2007. *Girls' Adolescence in Burkina Faso: A Pivot Point for Social Change*. New York: Population Council.

Consultative Group to Assist the Poorest (CGAP). 2002. *Helping to Improve Donor Effectiveness in Microfinance*. Microfinance Donor Projects: 12 Questions about Sound Practice. Washington, DC: CGAP.

Erulkar, Annabel S., and Mairo Bello. 2007. *The Experience of Married Adolescent Girls in Northern Nigeria*. New York: Population Council.

Frankenberger, Timothy R., Michael Drinkwater, and Daniel Maxwell. 2000. *Operationalizing Household Livelihood Security: A Holistic Approach for Addressing Poverty and Vulnerability*. Atlanta: CARE.

Fraser, Frances, Colleen Green, and Mary Miller. 2004. *Microfinance and HIV/AIDS: Tools for Making Institutional Changes in Response to HIV/AIDS*. Bethesda, MD: Development Alternatives, Inc.

Goss, Salah, and Lauren Mitten. 2007. *Microfinance and HIV/AIDS Note: Achieving a Common Understanding: What AIDS Service Organizations and Microfinance Institutions Need to Know About Working in HIV/AIDS Prevalent Communities*. Washington DC: Development Alternatives, Inc.

Green, Colleen, Mary Miller, Laurie Liskin, and Joan Parker. 2001. *Microfinance and HIV/AIDS: Defining Options for Strategic and Operational Change*. Bethesda, MD: Microenterprise Best Practices Project, Development Alternatives, Inc.

Halford, Stuart, Anthea Lawson, Nicola Sharp and Simon Heap. 2004. *I'm a Teenager. What Happened to my Rights?* Surrey, United Kingdom: Plan.

Jones, Nicola, Rosana Vargas, and Eliana Villar. 2007. "Conditional Cash Transfers in Peru: Tackling the Multi-dimensionality of Childhood Poverty and Vulnerability." Chapter in Alberto Minujin et al. (ed.) *Social Protection Initiatives for Families, Women and Children: An Analysis of Recent Experiences*. New York: New School and UNICEF.

Moya, Cecelia. 2002. *Life Skills Approaches to Improving Youth's Sexual and Reproductive Health*. Washington, DC: Advocates for Youth.

Pettifor, Audrey E., Diana M. Measham, Helen V. Rees, and Nancy S. Padian. 2004. "Sexual Power and HIV Risk, South Africa." *Emerging Infectious Diseases* 10(11): 1996–2004.



Population Council. 2006. "Adolescent Girls' Social Support and Livelihoods Program Design Workshop: Summary." Nairobi, Kenya, March 22–23.

Rhyne, Elisabeth, and María Otero. 2006. *Microfinance through the Next Decade: Visioning the Who, What, Where, When and How*. Boston: ACCION International.

Van Der Gaag, Nikki. 2007. *Because I am a Girl: The State of the World's Girls 2007*. London: Plan.

Wright, GAN. 2000. *Microfinance Systems: Designing Quality Financial Services for the Poor*. New York: Zed Books, Ltd.



Health Policy Initiative, Task Order I  
Constella Futures  
One Thomas Circle, NW, Suite 200  
Washington, DC 20005 USA  
Tel: (202) 775-9680  
Fax: (202) 775-9694  
Email: [policyinfo@healthpolicyinitiative.com](mailto:policyinfo@healthpolicyinitiative.com)  
<http://ghiqc.usaid.gov>  
<http://www.healthpolicyinitiative.com>