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MICROFINANCE, HIV, AND WOMEN'S EMPOWERMENT

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INTRODUCTION

The following technical brief offers HIV field staff and program managers essential information on approaches to economic development—collectively known as economic empowerment or economic strengthening. The paper provides a brief review of general terminology, followed by a more detailed discussion of integrative microfinance and gender empowerment activities. (For purposes of this paper, the term “gender empowerment” is limited to women’s empowerment, defined as attaining gender equality and equality in rights, power, and resources.) Also, a number of gender-based programmatic and monitoring and evaluation (M&E) implications are outlined, as well as strategies for future programming. The paper concludes with a guide to pertinent resources. More than 50 topic-specific reports published in the last five years were reviewed for this brief, as well as conference abstracts and abstracts from U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) implementer meetings. Direct contact was also made with key organizations.

Out of the approximately one billion people in the world who have household incomes of less than US\$1 per day, 70 percent are women who work longer hours and perform a greater proportion of work while earning only up to 50 to 75 percent of men’s earnings (Dinkelman, Lam, and Leibbrandt 2007). They are often denied property rights or access to credit, and are employed outside the formal sector in jobs characterized by income insecurity and poor working conditions (U.N. Development Fund for Women [UNIFEM] 2000). This, coupled with recent challenges in microbicides and vaccines, has led to an increased focus on addressing the deeper structural and economic realities that limit the scope and impact of current prevention strategies (Kim et al. 2008). A decade’s worth of research strongly indicates that investing in women is the most effective way to increase

family expenditures on health and education, improve nutrition and food security, and ultimately protect against HIV-related emergencies (Kim et al. 2008).

Although the relationship between poverty and HIV transmission is complex, there is evidence from sub-Saharan Africa, Latin America, and Asia that greater national-level income inequality is associated with higher HIV prevalence rates (Gillespie, Kadiyala, and Greener 2007; Piot, Greener, and Russell 2007). Several studies have documented that the type and amount of resources women have at their disposal determine the extent to which female-headed households can cope with the consequences of the disease, as well as leverage life-saving HIV treatment and care (Mayoux 2006; Joint U.N. Programme on HIV/AIDS [UNAIDS] 2007). When faced with the costs associated with HIV, these households typically cope by depleting meager savings, borrowing money from relatives, taking on debt with high interest rates, and/or resorting to alternative means of procuring income such as disposing of assets (whether productive or nonproductive) or participating in transactional sex (Byron, Hamazakaza, and Gillespie 2006; Luke 2005). A quantitative study in Cape Town, South Africa, the Cape Area Panel Study (2002–2005), found that surveyed girls aged 14 to 22 years living in households that have experienced a recent economic shock (e.g., death or job loss) were more likely to have multiple partnerships and earlier sexual debut (Dinkelman, Lam, and Leibbrandt 2007).

The situation is further exacerbated by the fact that HIV itself contributes to worsening preexisting gender inequalities and social relations. Female-headed households and younger women tend to be the ones in greatest need (Kanyamurwa and Ampek 2007), and yet increasing workloads to offset the loss of income or of an income-earner often means that girls are pulled out of school to help in the home, thereby denying them access to an education. A sys-

temic review from sub-Saharan Africa demonstrates that since 1996 there has been a reduced relative risk of HIV among those who are more educated, particularly for young women who have obtained a secondary education (Hargreaves et al. 2008). A majority of studies since that time have shown education to reduce risk of infection, enhance self-esteem, and provide alternatives for earning a livelihood (International Planned Parenthood Federation [IPPF] and U.N. Population Fund [UNFPA]/Young Positives 2007; Masanjala 2007). Gender-based violence—most notably intimate partner violence—has also been identified as having an adverse effect on women’s health as well as being an important risk factor for HIV infection. According to several well-documented qualitative research studies, younger women and women who live in poverty are particularly affected by intimate partner violence (Jewkes 2010; Kim et al. 2008). A 2008 systematic review identified 41 sites in low- and middle-income countries and found higher education and household assets both to be indicators of lower intimate partner violence (Vyas and Watts 2009).

While gender, poverty, and gender-based violence alone do not define risk, they increase women’s vulnerability by, for example, limiting their knowledge of sexual risks, economic empowerment strategies, or bargaining power, thereby making them more dependent on their male partners (Lakwo 2006). In such economically and socially dependent relationships, a woman’s ability to leave a high-risk sexual relationship and/or negotiate safer sex with a non-monogamous partner is compromised, leaving her more vulnerable to HIV (Gupta 2002; Hallman 2004; Jewkes 2010; Luke 2006).

In short, economic empowerment activities provide critical assistance to women, enabling them to generate income, increase bargaining power, transform that bargaining power into desired actions and outcomes,

build a savings base for emergencies, and avoid selling assets that may affect their future livelihood (Alsop and Heinshohn 2005). To that end, gender-responsive economic empowerment/strengthening activities give women access to and control over vital economic resources (including their right to property and inheritance), which ultimately enhances their ability not only to mitigate the impact of HIV, but also to be less vulnerable to HIV (Kakwani and Son 2006; Pronyk et al. 2006).

INTEGRATIVE MICROFINANCE, HIV, AND WOMEN’S EMPOWERMENT

Twenty-five years into the epidemic, *economic empowerment* activities are not one of the main drivers of the current response to HIV. In the case of women, this must change. The term economic empowerment encompasses a myriad of definitions and practices designed to increase or protect income and assets among various groups (see Appendix 1). For women, these activities are specifically tailored to help prevent or minimize the impact of adverse livelihood shocks, such as illness or death of a key income-earner, so that individual or family survival is not compromised (Masanjala 2002). The literature detailing these microenterprise development (MED) and economic strengthening activities has identified three types of interventions—social assistance, assets

Food insecurity and livelihood vulnerability threatened to undermine CARE Rwanda’s HIV/AIDS program, where 70 percent of program beneficiaries are women. The program incorporated microfinance projects in 2006 to avoid this threat.

growth and protection, and income growth—each with adjoining activities. The following represent the most relevant as they relate to this topic. “Livelihood” is a means of living and the capabilities, assets (including human capital), financial, social, physical, and natural capital and activities required to sustain these assets. A livelihood encompasses income, as well as social institutions, gender relations, property rights, and access to state-controlled education, health, and other infrastructure services. A sustainable livelihood can cope with and recover from stress and shocks, while not undermining the livelihoods of future generations (IPPF and UNFPA/Young Positives 2007). MED is a poverty eradication strategy that involves providing or creating access to financial services, technology, or markets to help very small businesses and/or farms stabilize and grow. MED activities are also often targeted toward low-income women (84.2 percent in 2006) (Watson and Dunford 2006; Small Enterprise Education and Promotion [SEEP] Network 2008b). *Economic strengthening* refers to the portfolio of strategies and interventions that supply, protect, and/or grow physical, natural, financial, human, and social assets of households. Economic strengthening is generally targeted at the very poor and orphans and vulnerable children (OVC). In addition to some types of MED, economic strengthening also tends to include cash transfers, vocational training, workforce development, and legal services (SEEP Network 2008a).

Although all of those strategies have proven to be effective in certain instances, microfinance has proven to be particularly effective in improving women’s self-esteem, self-image, decision making, social empowerment, and in some cases improvements in public speaking. The achievements in these areas are often gained by combining traditional microfinance activities (e.g. microcredit and savings and loans) with health promotion campaigns, empowerment activities, and skills building, creating what is

termed *integrative microfinance activities*. Because this approach has been successful in addressing health, empowerment, and economic issues simultaneously (Jewkes 2010), it is particularly well-suited for addressing the interrelationships between HIV and women’s economic empowerment. Therefore, this paper will focus specifically on the ways that integrative microfinance activities empower women and thereby reduce their risk of contracting HIV.

Microfinance

Microfinance refers to a range of financial services for low-income people, including credit, savings, insurance, and money transfers (Odell 2010). Microfinance grew out of the need in the late 1990s to increase microcredit services such as savings and loans to poor clients (Watson and Dunford 2006). Made popular by the success of the Grameen Bank, microcredit programs have created an industry of lending to the poor with increasing sophistication and tools (United Nations Development Programme [UNDP] 2006). Microfinance institutions (MFIs) are any type of institution offering microfinance services, including informal institutions such as community-based financial institutions, banks, nonprofit organizations, and credit cooperatives. According to the Microcredit Summit Campaign, over the past few decades microfinance has grown to over 3,550 institutions of various types offering microfinance services to more than 100 million clients, 83 percent of whom are women (Daley-Harris 2009). A 2005 study by Women Advancing Microfinance (WAM) found that Asia had the highest percentage of women clients (86 percent), followed closely by sub-Saharan Africa (83 percent) and Latin America (80 percent) (Daley-Harris 2005). Although generally poor or vulnerable, these clients nonetheless are economically active individuals who do not have access to finance through formal financial institutions, such as banks (Cheston 2007; Kim et al. 2008). The most common mechanism that MFIs use is group-based lending, where borrowers form

groups to mutually guarantee one another's loans. Microfinance clients manage their own cash flow and apply it to whatever household priority they judge most important for their own welfare (Watson and Dunford 2006). While MFIs often charge high interest rates (higher than western standards) to cover operational costs, delinquency management, and the cost of capital, evidence demonstrates that the interest charged on loans is always significantly lower than the rate charged by other credit sources for poor women, such as loan sharks and moneylenders (Goss and Mitten 2007; Watson and Dunford 2006). Over the past two decades, microcredit has been growing at a rate of 30 percent annually, generally targeting women just at or above the poverty level (75 percent to 100 percent, depending on the country) (Mayoux 2007; United Nations Department of Public Information [UNDPI] 2005). Microcredit groups, particularly women's groups, tend to reduce reliance on moneylenders and promote asset growth, consumption smoothing, and occupational mobility (Odell 2010).

In terms of female clients, research indicates that poorer women tend to be more risk averse and to work in low-profit industrial sector activities such as retail, garment manufacturing, and the hotel and restaurant industries (Mayoux 2001; McCarter 2006; Mutalima 2006). Women may at times lack business skills and training to grow their businesses (Mutalima 2006). Female client reimbursement rates tend to be higher than those of males, and female beneficiaries often report increased decision making roles (Mutalima 2006; Watson and Dunford 2006). Female microfinance clients tend to spend money more on consumption, such as children's school fees and their children's health, rather than production, such as purchase of land and livestock (Cheston 2007; Cheston and Kuhn 2002). Women are also more likely to run their businesses as partnerships with family members or other associates. When they receive microfinance loans, female ben-

eficiaries have reported an increased role in household decision making, improved self-esteem and self-confidence, and expanded social networks. For example, 68 percent of microfinance participants evaluated in a Women's Empowerment Program in Nepal in 2002 experienced an increase in their decision making roles in areas traditionally dominated by men (Cheston and Kuhn 2002; McCarter 2006; Watson and Dunford 2006). The provision of saving services, particularly for women, has been seen as an important component of microfinance (Odell 2010).

Impact of Microfinance

Since the 1990s, as development agencies have shown an interest in using microfinance projects as a way to reduce poverty while at the same time empowering women, microcredit has been growing at a rate of 30 percent annually, generally targeting women just at or above the poverty level (75 percent to 100 percent, depending on the country) (Mayoux 2007; UNDP 2005). A 14-year study by the World Bank (WB) of three MFIs in Bangladesh found that 40 percent of the entire reduction of poverty in rural Bangladesh was directly attributable to microfinance (Watson and Dunford 2006). While there are many published studies of microfinance that focus on scope, scale, geography, and approach (i.e., formal or informal), there is a dearth of solid statistical evidence on its impact (Roodman and Murdoch 2009). For the first 20 years, the literature on the impact of microcredit relied almost exclusively on non-experimental methods and until recently on randomized trials (three randomized controlled trials of microfinance are underway or in development in Mexico, Morocco, and Peru) (Roodman and Murdoch 2009). Although the positive findings in published studies outweigh the negative or inconclusive ones (McCarter 2006), there are varying opinions regarding the impact of microfinance, particularly as it relates to poverty reduction. Indeed, the Center for Global

Development microfinance expert, David Roodman, sees the microfinance movement as being “split by dissent” (Roodman 2009).

Ultimately, it is very difficult to answer the question of the impact of microfinance, as microfinance is not a single tool but rather a collection of tools that serve different types of clients around the world. The positive effects of microfinance, particularly integrative microfinance, appear in stages. Business investment is often initially detected, within the first 15 to 18 months, followed by an increase in overall expenditures, with social changes occurring last (Odell 2010). Despite these difficulties of measuring the impact on social changes, some studies have demonstrated impact on health and gender empowerment (Jewkes et al. 2010).

Impact of Integrative Microfinance

Integrative microfinance, sometimes referred to as “microfinance plus,” is defined as microfinance projects that focus on finance and other development issues such as linking credit with skills building and education (Dunford 2001). Integrative microfinance is not a new concept and has been operating in several microfinance institutions for years. With more than 3,550 microfinance institutions servicing over 100 million poor clients worldwide (83 percent of whom are women) and operating in settings where poverty, gender inequalities, and HIV converge, integrative microfinance has the ability to cover HIV and women’s health on a massive scale. In 2000, a survey conducted of 22 microfinance institutions in 14 African countries found that 43 percent provided health information to clients (Parker 2000). In late 2004 and early 2005, Freedom from Hunger and the Microcredit Summit Campaign offered three- and five-day workshops on the integration of health education with microfinance services to over 160 institutions in eight countries across Asia and Africa. Following the training, 46 institutions began offering combined

services to close to half a million clients, affecting 2.3 family members per household.

In addition to health education, activities can be combined with other services and interventions such as empowerment activities, legislation, and reform policy to support small businesses and women’s rights. The sole use of microcredit programs has proven to be ineffective in an unstable macro-environment (such as Zimbabwe), as most of the projects prove to be impossible to sustain and to move beyond the pilot phase. In these circumstances, some of the most effective microcredit programs targeting women combine credit lending with activities at the micro level (e.g., shielding assets from depletion through wills, succession planning, and life insurance) and the macro level (e.g., addressing health issues, gender-based violence, and promotion of women’s human rights).

Empowerment is a process, and failure to address power relations within households and communities may further decrease access of women in households to some of the benefits of microfinance. Findings from a recent evaluation of micro-credit and HIV-related negotiation among partnered Dominican women clearly states that HIV-related negotiation is statistically significantly associated with control of one’s own money rather than the simple act of receiving a loan (Ashburn, Kerrigan, and Sweat 2008).

The IMAGE project based in South Africa, discussed in detail in the project examples section, has demonstrated that combining activities provides significant improvements for clients. In a 2006 evaluation, IMAGE clients compared to the control group demonstrated significant improvements: increased assets; increased income; greater perceived economic well-being; increased membership and savings through informal savings groups (stokvels) and burial societies; access to basic goods such as fuel, clothing, and other house-

hold items; improved housing (1.7 times more likely than control group to have made improvements in the homestead); and increased likelihood to pay for health services and school uniforms (Simanowitz 2008b). A 2001 review carried out by the International Center for Research on Women (ICRW) on nine programs in Africa, Asia, and Latin America linking youth reproductive health and livelihoods concludes that providing microfinance and job training coupled with education and advocacy around intimate partner violence leads to increased awareness and improved coping (Gupta and Selvaggio 2007).

Regarding the impact on health, there is also strong evidence that families with access to microfinance have better health practices, better nutrition, and get sick less often than comparison families (Watson and Dunford 2006). It has been well documented that one of the first changes to take place among microfinance clients, especially among the poorest women, is increased self-confidence and better health practices, including preventive health care and improved nutrition. When microfinance is combined with health education, these results are greatly enhanced (Ashburn, Kerrigan, and Sweat 2008; Kim et al. 2008; Watson and Dunford 2006). For example, a 2001 study demonstrated that subsequent to health education, 32 percent of clients of FOCCAS, an MFI in Uganda, had tried at least one HIV prevention practice, compared to 18 percent of non-clients (Watson and Dunford 2006). Microfinance activities have been best documented in terms of offering proven results in the area of economic empowerment and HIV prevention. A recent study in the Dominican Republic demonstrates that microfinance is more likely to affect empowerment specific to HIV-related behavior than directly affect HIV risk reduction. Having received a loan and the level of women's group participation was not statistically significantly associated with HIV-related negotiation. This study concluded that to affect empowerment specific to

risk reduction, microfinance projects must emphasize HIV-related relationships directly and provide direct support on creating greater gender household equality (Ashburn, Kerrigan, and Sweat 2008). Other economic interventions, such as rotating savings and credit associations, microcredit, and food aid and livelihood strategies, while on the increase, are still in a nascent stage compared to the microfinance sector (Kim et al. 2008).

To meet the HIV and health education and training needs of all microfinance clients, collaboration and partnership are key to the success of integrative microfinance activities. However, due to the competitive market and specialized skills sets, MFIs cannot and should not be expected to address issues such as gender inequalities and high rates of HIV alone, but rather they must remain focused on providing sustainable financial services and form partnerships and collaborations with other organizations that specialize in providing training around issues such as gender and HIV. The organizations should aim to create separate but parallel operations that are integrated within existing microfinance projects. By developing parallel services, with the MFI employing or subcontracting individualized trainers for HIV health services and gender empowerment training, there will be no drain on the financial sustainability of the existing MFI. Clear terms of reference must be developed between the partners, focusing on expectations, roles, responsibilities, and intended outcomes and problem resolution. Additionally, projects can be shared across U.S. Agency for International Development (USAID) offices and programs to increase multi-sectorial input. In Kenya, for example, a PEPFAR-funded economic strengthening project for OVC reports to an economic growth-cognizant technical officer with extensive microfinance expertise to receive technical input and monitoring (Academy for Educational Development [AED], Save the Children, and USAID 2008). A clear mapping

exercise to identify MFIs and organizations that have a solid reputation and the community's confidence must be carried out prior to any merge. U.S.-based organizations such as Freedom from Hunger and Development Alternatives, Inc. (DAI) have been at the forefront of this integrative approach for years (Watson and Dunford 2006).

Limitations of Microfinance

Although MFIs are a burgeoning industry, some limitations have been documented that warrant discussion. There continues to remain a scarcity of experimental evaluations of these programs and it is often cost-prohibitive to implement randomized control trials (Kim et al. 2008). Contextual constraints still create a gap in equal access for financial services, increasing or controlling income, or challenging subordination. The "very poor" and "chronically poor" face difficulties accessing microfinance services, as they are viewed as a credit risk by MFIs and community members (Carter and Ikegami 2007). Most MFIs still do not offer savings services and tend to focus on urban areas, thus failing to reach the rural poor. Moreover, although microfinance seeks to minimize the erosion of household assets, at best it can be seen as "income smoothing" and as decreasing a woman's vulnerability to crisis. Several microfinance projects noted only marginal net gains, or in some cases, an increased gain for only a limited time, with lower income levels following the close-out of the project (Mayoux 2006).

There are also some contradictory results of microfinance in relation to gender-based violence and HIV risk reduction. Proving that microfinance activities lead to reduction in HIV risk is still in its nascent stages, as there is still no direct linear relationship between economic independence and control over sexual health (IPPF and UNFPA/Young Positives 2007). While some studies and interventions, for example the South African Intervention with Microfinance for AIDS and

Gender Equity (IMAGE)/Rural AIDS and Development Action Research (RADAR), relate participation in a microfinance project with a reduction in intimate partner violence, still others discuss the negative consequences of involvement (Pronyk et al. 2008), such as an increase in workload, divorce rates, or domestic violence, as well as instances where women serve only as conduits of loans to their husbands (Bott, Morrison, and Ellsberg 2005; IPPF and UNFPA/Young Positives 2007; Mayoux 2006). According to a recent report, many of these studies have noted "methodological limitations, including predominantly retrospective designs, the absence of control groups, and the lack of pre-specified or clearly defined indicators of empowerment and violence" (Kim et al. 2008, p. s62). During the 1990s, it was well documented in Bangladesh that although women received the loans, less than 50 percent actually controlled loan use (Cheston 2007). A few years ago, of the 120 women clients surveyed from the Grameen Bank in Bangladesh, 70 percent noted an increase in aggression and violence from their spouses, an increase seemingly tied to their connection with microfinance (Cheston 2007; Schuler, Hashemi, and Badal 1998).

Younger women and adolescents (commonly defined as between the ages of 15 to 24 years) have been mostly excluded from MFIs due to age restrictions and the failure to adequately reach this community (IPPF and UNFPA/Young Positives 2007). A 2007 extensive literature review and case study analysis that primarily examined microfinance and livelihood programs in sub-Saharan Africa outlined several lessons learned. One of the case studies examining Shaping Health of Adolescents in Zimbabwe found mentorship to be difficult with this age group due to exploitation by mentors. Also, peer mentors were inaccessible due to infighting and competition for scarce market resources. A project evaluation concluded that mentorship by older women has proven to be more effective (IPPF and UNFPA/

Young Positives 2007). The paper also discussed that vocational training may improve livelihoods of younger women (15 to 19 years of age), particularly those without schooling, more so than microcredit and business skills training (IPPF and UNFPA/Young Positives 2007). A review by the ICRW that surveyed nine programs in Africa, Asia, and Latin America that link youth reproductive health and livelihoods concluded that these programs, due to a variety of factors, are only achieving marginal effectiveness in meeting both the reproductive health and livelihood needs of young people (ICRW 2001). However, microfinance programs that target older women with a specific gender and HIV training focus, such as one of the case studies discussed below, may be effective vehicles for HIV reduction as older women may serve as “cultural gatekeepers,” shifting norms around gender, gender-based violence, and discussion surrounding HIV. Furthermore, the increased income may allow younger women to stay in school longer. These indirect effects may outweigh some of the challenges discussed above (IPPF and UNFPA/Young Positives 2007).

Despite these challenges, integrative microfinance continues to be a viable option for addressing gender inequalities and HIV risk reduction. With a vast array of clients in poverty (100 million worldwide), over 83 percent of whom are women, integrative microfinance has the ability to cover HIV and women’s health on a massive scale.

PROJECT EXAMPLES

Interventions directed toward social environments and populations, known as “structural interventions,” are increasingly recognized as an important tool in the arsenal of HIV prevention methods (Blankenship et al. 2006). As previously mentioned, microfinance projects providing evaluative and pro-

grammatic data on the intersection of economic empowerment and HIV continue to be among the most well documented. The following examples illustrate integrative microfinance projects that have successfully focused on gender equality and health education, including HIV prevention and reproductive health. In addition to using an integrative method, these projects have been peer reviewed and/or received donor-led evaluations, and continue to be highlighted as success stories by a wide range of practitioners and donors.

The Intervention with Microfinance for AIDS and Gender Equity (IMAGE) Program

This program combines participatory training on gender, HIV, and community mobilization with microfinance. IMAGE is a collaborative alliance between the Small Enterprise Foundation (SEF), a solidarity group MFI that targets the poorest and most vulnerable women, and the RADAR Programme, based at the School of Public Health at the University of the Witwatersrand in Johannesburg, South Africa. Since 2001, SEF and RADAR, in partnership with the London School of Hygiene and Tropical Medicine, have been implementing the IMAGE project in South Africa’s Limpopo province. The project was initially developed as a scientific experiment, using a cluster randomized trial methodology to compare the experiences of 430 women from four villages with women from matched control villages. Following completion of the pilot phase (2001–2004), a scale-up phase (2005–2007) expanded the intervention to 79 additional villages. By 2007, the project was being implemented in more than 80 villages, reaching more than 4,500 clients (Simanowitz 2008b).

The first step of IMAGE is to use participatory wealth ranking to identify the poorest women (minimum of 18 years of age and a median age of 42) in a community and to actively motivate these women to join the organization. Credit is then provided through solidarity groups of five women for the pur-

pose of developing income-generating projects. As women's immediate financial needs were addressed and they were provided with important incentives for continued participation, their interest increased in the HIV education and gender empowerment activities that were integrated into microfinance programs. The gender and HIV training program is delivered bimonthly in combination with loan repayment meetings. The participatory learning program consists of 10 one-hour training sessions on topics such as gender roles, communication, domestic violence, and HIV. As a follow-up to this training, community mobilization interventions were added to encourage the participation of youth and men. The training programs were well received and did not compromise uptake or delivery of the microfinance intervention—loan repayments remained at a high of 99.7 percent (Kim et al. 2007).

A 2007 evaluation of IMAGE found a 55 percent drop in domestic violence in the project communities. Moreover, women's levels of economic well-being had improved: they were more confident, had greater influence in household decisions, and were challenging traditional gender norms. The women experienced an increased membership in informal savings groups and burial societies; an increased access to basic goods such as fuel, clothing, and other household items; improved housing; and an increased likelihood to pay for health services in the event of illnesses. Within a subsample of younger clients, a 60 percent increase in the proportion of people accessing voluntary counseling and testing for HIV and a 24 percent reduction in levels of unprotected sex among intervention participants were detected (Simanowitz 2008b). Indirect impacts on 14- to 35-year-old men and women living within IMAGE households and villages included significant improvements in openness and communication about sex and HIV, although not in changes in sexual behavior (Pronyk et al. 2008). The project demonstrates that increasing access to credit and savings can

lower risk factors, such as domestic violence, and for younger women leads to behavior change that reduces their HIV risk.

Pro Mujer Bolivia

A flagship MFI, Pro Mujer Bolivia's mission is to help poor and vulnerable women achieve personal, family, and community sustainability through integrative financial and health services. Established in 1990, Pro Mujer now consists of member organizations in Argentina, Peru, and Nicaragua. In Bolivia, the project works with impoverished women in eight of the country's nine regions. As of June 2008, Pro Mujer was offering its integrated microfinance, health, and business development services to more than 102,000 clients—most of whom are women—in 39 focal centers, with a loan portfolio of \$22,929,000. Pro Mujer organizes women in communal associations of 18 to 28 clients, provides them with working capital loans of US\$50 to \$1,500 carrying a four- to six-month term, and teaches them how to organize and manage a community bank. Each communal association is then composed of solidarity groups of four to seven women who mutually guarantee each another's loans and borrow and save together. Pro Mujer Bolivia also offers loans for short-term credit needs, education and health care, and larger loans for "graduated clients" who have already paid back previous loans, can offer collateral, or no longer need or wish to participate in the solidarity groups (Velasco and Chiba 2006).¹

Pro Mujer Bolivia offers health care and financial services from neighborhood/focal centers in highly populated areas that clients visit regularly to make loan payments, attend workshops, and get advice from their peers. Its physicians, nurses, and trainers provide basic health education during times set aside before and after repayment meetings to discuss nutrition, hy-

¹For more information, see www.mixmarket.org/mfi/promujer-bol.

giene, pre- and postnatal care, sexually transmitted infections (STIs) including HIV, family planning, and other reproductive health topics. As of 2004, clients paid a fixed fee for training and in-house health services, which ran as little as US\$2 to \$9 per year, depending on the country and services provided. The overall cost coverage for Pro Mujer Bolivia during this period, including direct and indirect income and donations, reached 100 percent (Velasco and Chiba 2006).

Pro Mujer also offers empowerment training. Women are engaged on topics of domestic violence, communication skills, and women's rights, using the workshops and group discussions to raise their awareness about leadership, gender issues, and self-esteem. The women are moreover linked with other organizations for counseling, legal assistance, and education and vocational training programs. In 2005, Pro Mujer Bolivia initiated village bank loans for self-employed teenagers and youth. In 2006, a micro-insurance scheme (Plan Tranquilidad), which covers the outstanding debt of a borrower in the case of her death, was introduced to the range of services (Imp-Act Consortium 2006).

A comparative impact evaluation carried out in 2003 by an independent evaluator, FINRURAL, analyzed the effect of the integrated services on the poverty level of clients with more than two years of membership and compared it to a similar group without exposure to Pro Mujer's services. The evaluators concluded that Pro Mujer's services decreased poverty, with only 20 percent of program participant households considered poor compared to 40 percent of non-participant households (FINRURAL 2003). This same study found 29 percent of Pro Mujer clients estimating an increase in income during the previous 12 months versus 18 percent of the non-client group. Fifty-two percent of Pro Mujer Bolivia clients reported making decisions regarding use of income compared with 44 percent of the control group, and only 4 percent claimed no de-

cision making power versus 10 percent of the control group (FINRURAL 2003).

In 2005, Pro Mujer Bolivia, Peru, and Nicaragua participated in a comparative study promoted by SEEP Network and USAID. The study compared evaluative data, services rendered, and financial data among the three MFIs, with a total of 126 clients and the directors and sample staff from all three units participating in focus groups. The study found that offering multiple services leverages Pro Mujer's existing infrastructure, improves client loyalty, and strengthens its competitive position in financial service markets. Significant institutional capacity was required, however, to meet the differing management requirements. In this study, while there were no substantial differences found for access to medical care among adults, there were significant improvements for access to certain preventative services—59 percent of long-term clients reported a Papanicolaou smear control at least once, versus 46 percent of the newer customers. The 2005 assessment demonstrated that Pro Mujer clients reported changes in knowledge, practices and attitudes, self-esteem, family planning, maternal-child health, and women's health particularly related to risk in pregnancy and abortion, prevention of cervical cancer, domestic violence, STIs, menopause, and overall hygiene. According to the 2005 evaluation, cost recovery was directly affected by size and age of the institution with those projects with more clients faring better than those with fewer. The evaluation concluded that long-term relationships with clients, service delivery via regional centers (known as "focal centers"), rural outreach, grouping of large numbers of clients to reach scale, management commitment, institutional demand, and the operating environment all determine the replicability and success of implementation. Finally, the study found that regular cost allocation of direct and indirect expenses benefits an institution's strategic and operational decision making, as well as its ability to communicate effectively with investors (Junkin, Berry, and Perez 2006).

Pro Mujer has received several awards and recognition from peer-based implementers and donors. In 2006, Pro Mujer International was awarded a US\$3.1 million grant from the Bill and Melinda Gates Foundation (one of the first MFIs to receive funding from this foundation) to develop new loan products to serve youth, rural populations, and other underserved groups in Latin America. In 2006, Pro Mujer Bolivia was awarded the Grameen Foundation's Pioneer in Microfinance Award, and the Inter-American Development Bank highlighted its sustainability level well above the average of MFI's worldwide. In 2007, Pro Mujer Peru was awarded the Inter-American Development Bank's Award for Excellence in Microfinance and outreach to the poor, and was named in Forbes' first-ever list of the World's Top 50 Microfinance Institutions. In 2006, it was rated number one in the world for portfolio quality by Microfinance Information Exchange.

STRATEGIES FOR FUTURE PROGRAMMING: GENDER-BASED PROGRAMMATIC IMPLICATIONS

When developing appropriate integrative microfinance projects, specific population, geography, gender, age, socioeconomic and vulnerability status, laws, and social/community support systems are all variables that must be assessed. It is well known that what works for a 40-year-old sex worker may not necessarily be applicable to a 20-year-old rural housewife. The following strategies are based on an extensive literature review and incorporate the valuable lessons learned from the field experience of other programs. These critical success factors should be considered when developing integrative microfinance programs so as to economically empower women to mitigate the impact of HIV and reduce its spread. Integrative microfinance activities must employ the strategies under each category.

BENEFICIARIES

- **Rely on community/group targeting for membership, with specialized targeting for vulnerable young women.** Some of the most effectively targeted microfinance programs for women, such as IMAGE and Pro Mujer, rely on self-selection and/or on members of the community identifying beneficiaries (AED, Save the Children, and USAID 2008). In World Learning's Ethiopia school-based OVC support project, community members determine the OVC that will receive benefits based on certain criteria (e.g., poverty status, double or single orphans, existing support systems, etc.). This creates transparency, balance, and group accountability around agreed-on criteria. To avoid participation of ineligible community members that exert pressure, an understanding of power dynamics within the community, participant screening, and a mentorship/probationary period are critical.

Using preexisting channels such as health groups and community-based organizations may produce mixed results—if the groups are meeting for other purposes, they will not necessarily work well together for microfinance activities (AED, Save the Children, and USAID 2008). Most microfinance-based professionals hold the belief that targeting can change the evolution of markets and overall economic development in a community, and that diversifying services assists with risk mitigation as some groups may be riskier than others in terms of repayment (AED, Save the Children, and USAID 2008).

Any women-targeted programming should be considered with attention to the needs of mothers with small children (such as ensuring that children are safe when mothers are engaged in business or group meetings). Additionally, stigma must be considered, as marginalization of female-headed house-

holds continues to be an obstacle to microfinance activities. Stigma also weakens involvement in social networks, as people are fearful of being labeled. A 2007 study in rural Uganda notes that targeting women living with HIV and widows for MED activities may actually increase stigma (AED, Save the Children, and USAID 2008).

Recent research from southern Africa demonstrates that targeting exclusively younger women to reduce HIV may not always offer positive results (Kim et al. 2007). Younger women should be targeted separately based on their needs. Vulnerable young women, such as trafficked child domestic and sex workers, often need specialized targeting intervention, as they are not commonly visible within the communities.²

Establishing self-help groups (SHGs) to implement income growth activities may also be successful, particularly among young women (see Box I). The groups serve to reduce isolation, provide peer mentoring on issues of sexual/reproductive

²The following represent three examples of such projects:

Sonagachi, Calcutta, India: Launched in 1992 by the All India Institute of Hygiene and Public Health, the Sonagachi Project began as a small health promotion project to inform sex workers in Kolkata (Calcutta), India, about HIV as well as to promote condom use and STI testing in this community. The mobilization effort, conducted in the Sonagachi red light district, has evolved into a multifaceted community effort to empower sex workers—60,000 (particularly women) in ways that go beyond HIV prevention.

Sanghamitra, Mumbai, India: Formed in 2005 with support from PSI, Sanghamitra has been working in Mumbai with over 6,500 female sex workers, their husbands, and clients to form a sex workers collective devoted to advocacy and savings programs.

Danaya So, Mali: A sex worker association working in HIV prevention, voluntary counseling and testing, peer education, medical resources, health, income generation, capacity building, and legal protection, Danaya So is currently working in 157 out of 201 registered brothels.

BOX I. PROJECT CONCERN INTERNATIONAL (PCI)

PCI has formed hundreds of SHGs, with 98 percent female membership. Members participate in business skills and savings and loan training, and engage in dialogue on common social, economic, and rights issues. The SHGs save and lend their own resources and develop and implement action plans to address community concerns. According to PCI, this creates a sustainable system to empower women socially and economically. Data from another project also demonstrated that longer involvement in these groups brought a more remarkable shift to women's independent decision making.

health, and increase awareness of gender-based violence, provided the groups are monitored and supported over time (Swain 2007). Leadership training must be instituted to ensure group sustainability, particularly in the absence of credit and program officers.

Implementation

- **Create separate but parallel operations integrated within existing MFIs with built-in start-up costs.** Direct financial resources toward integrative MFIs that already provide financial services along with other services such as education, health, business training, and literacy, and that focus on the poorest and most vulnerable in a community. Measuring financial sustainability of these MFIs is essential, including whether the MFI has an existing delinquency management strategy in an already competitive market. Additionally, provide training to MFIs on how to mitigate the internal and external risk of operating in an HIV environment (Goss and Mitten 2007). In order

to create a successful pairing of organizations, it is imperative to conduct a clear mapping exercise to identify MFIs with a solid reputation and community confidence. Start-up funds must also be allocated toward this integration. An independent evaluation following a Microcredit Summit Campaign and Freedom from Hunger workshop on the integration of health education with microfinance, carried out in eight countries across Asia and Africa with more than 160 participants, unanimously identified the need for more funding to support start-up costs of training and materials on the integration of health and microfinance (Watson and Dunford 2006). Successful collaboration may benefit from south-to-south capacity building by tapping into organizations and projects, such as the IMAGE/RADAR project, Freedom from Hunger, DAI, Pro Mujer, Bangladesh Rural Advancement Committee, and Grameen Bank in Bangladesh, which already offers integrative services, to provide technical assistance for newer projects and collaborations.

- **Conduct market analysis, cost per participant, climate constraints, and positive impacts for women.** Dedicate resources for MFIs to conduct thorough market analysis, including market participants, size of markets, accessibility of markets, quality and quantity of products, packaging, pricing, marketing, regulations and institutions in the market, measuring informal sector competition, and seasonal production. There should be a clear link between the proposed activities, market analysis, cost per participant, and positive impacts for women. Additionally, activities should be appropriate for the capacity, context, and culture of the possible target population (AED, Save the Children, and USAID 2008). Considering that access to land, electricity, and transportation, as well as obtaining necessary licenses, have been identified as common invest-

ment climate constraints for women and microfinance, build additional funding to address these constraints into program budgets.

- **Create modified products/programs for women.** In order to provide effective services, some of the programs and products may need to be tailored to meet the needs of women. Because women experience more time constraints due to their other household and caregiving duties, time spent arriving to and in group meetings, in the field, or at the point of service, should be minimized. Pro Mujer Bolivia offers integrated services in 41 focal centers that are located in geographically strategic locations so that most clients do not need to travel more than half an hour to arrive at the center where both the health and business staff are co-located. Crédito con Educación Rural, the largest group-based lender in Bolivia, brings integrated services to clients in the field (Watson and Dunford 2006). Additionally, because of the potential for increased tension and domestic violence discussed earlier, lending institutions need to be sensitive to confidentiality by not mandating a husband's signature on loan agreements and savings products. Finally, providing resources for local travel to enable access to HIV life-saving treatments for either the participant or family members may increase the client's ability to continuously participate in the project (AED, Save the Children, and USAID 2008).

In several countries, women lack property rights and cannot show legal ownership of assets. Women must be designated on all life and health insurance policies, and payouts should be made directly to a woman's account. Although several of the smaller microfinance activities do not require proof of ownership, larger group loans still require proof of collateral, thus preventing women from accessing more sophisticated financial products

(Guerin and Palier 2007). A gender audit carried out by the Humanist Institute for Cooperation with Developing Countries (HIVOS), a Dutch aid organization, and Promotion of Rural Initiatives and Development Enterprises, an MFI in Zambia, found that the collateral requirement was most disadvantageous for women (Mutalima 2006). All collateral and guarantor requirements must be removed. Some microfinance providers, such as Graameen, have mandated that a woman's name be on a property title in order to receive a loan. Alternatively, loan requirements could include transfer of assets to the woman's and/or both partners' names. Loans that reinforce and strengthen male responsibilities for household well-being (e.g., loans to finance a daughter's education or to purchase a productive asset for unmarried girls) may also be instituted. Loan repayment schedules and interest rates should reflect life cycle needs (e.g., school fees) and should allow for small deposits over a fixed period of time (Guerin and Palier 2007).

- **Create a gender-sensitive organizational culture.** Women expect their interactions with development staff to be more relational than transactional. They tend to gather facts and consult others, and may take more time to make decisions. They also tend to be more loyal and bring all of their own business contacts to any transactions or new businesses. Staff and loan officer attitudes, as well as the personal networks of decisionmakers, are all important to women. Gender awareness should be a criterion for staff recruitment. A gender-sensitive organizational working culture must be instituted, and customer care must be an expected core competency (Ashburn, Kerrigan, and Sweat 2008). A number of checklists are available to incorporate gender into MFIs and economic empowerment projects (see Resources).

It is also now understood that microfinance and economic empowerment activities are complex and may have adverse reactions if not reliant on an empowerment model that encourages women's equality in all aspects including level of projects (Ashburn, Kerrigan, and Sweat 2008). Microfinance projects may unwittingly cluster women in lower-return businesses with smaller loan sizes and less access to larger loans. Poor women are often relegated to a lower level of credit that fails to elevate them above the poverty line in any sustainable way. Activities must aim to move women beyond micro-businesses to "upper micro" profit centers or small and medium enterprise³ by providing skills training on market opportunities and threats. Opportunities for educational and professional advancement, financial literacy, and mechanisms for decision making should be part of all credit programs, as well as establishing longer-term borrower/customer relationships over a one-time loan.

- **Rely on female labor and increase female resource availability.** When female program participants are involved in program implementation, such as carrying out a market analysis and needs assessments, the program viability increases. Women's leadership and mentorship can be integral to success. Experience demonstrates that the way in which microfinance is delivered matters as much as whether or not people have access to financial services (Simanowitz 2008a). Women must be recruited, as program implementers and as beneficiaries, into the ranks of management, senior

³"The definition of 'micro' versus 'SME' varies by country and is usually defined by loan size, number of employees, and business turnover as indicators. As one example, the European Commission has defined microenterprises in Europe as having 0–9 employees and less than 10 million Euro annual turnover; requiring loan sizes of no more than 25,000 Euros, whereas small enterprises have 10–49 employees and less than 10 million Euro annual turnover" (McCarter 2006, p. 9).

governance, and peer mentorship of MFIs aimed at lending to women. A 2005 study looking at MFIs, conducted by WAM, found that women on boards ranged from a high of 40 percent in sub-Saharan Africa to a low of 27 percent (Cheston 2007). Donors may need to create incentives to encourage recruiting of female staff and mentors, as well as provide skills development in finance, accounting, gender policy, and impact analysis for female applicants. Additionally, needs assessments should explicitly look at gender issues of access and control, female prospective beneficiaries' level of risk-taking empowerment impacts, and gender-specific areas of vulnerability in order to increase the probability that the microfinance programs will lead to the empowerment of women. Loan conditions for all products must be revised to ensure that there is no gender discrimination.

- **Allow for group-based microfinance.** Several experts in the field espouse that group-based microfinance—projects that rely on groups to mutually guarantee one another's loans—allow for opportunities to address HIV and other health issues in a group setting. Microfinance activities such as the group meeting bring women together regularly over months and years to repay loans and deposit savings. Pro Mujer and IMAGE demonstrate that these meetings can be integrated with HIV education and gender equality discussions (including domestic violence) over long periods to gain confidence and develop trust. Results from the IMAGE evaluation show a positive relationship between an integrated package of HIV training and microfinance and HIV risk-reduction (Pronyk et al. 2008). Additionally, Pro Mujer documents cost efficiencies to the project as the administrative and program structure was only to be paid once, allowing the marginal costs of the education to be covered with revenue generated from microfinance. In early 2006, Pro Mujer participated in a cost allocation ex-

ercise with SEEP Network and found that “sustainability levels in financial service delivery improved by an average of 20 percent after cost allocation, while even after allocation, health services covered up to 142 percent of their costs with earned income and donations and up to 70 percent with earned income alone” (Watson and Dunford 2006, p. 20).

Monitoring and Evaluation

- **Utilize comprehensive assessments and measurements.** Funds must be dedicated to operations research and M&E activities measuring overall impact and detection of anomalies. A thorough situational analysis and baseline survey is essential and must include a full assessment of the gendered social, cultural, economic, and political contexts. For example, women may lack access to markets if mobility is constrained due to social norms, or younger unmarried women may experience different opportunities and constraints compared to older widowed or divorced women. Due to these constraints, women may respond differently to programs, reinforcing and/or causing unintended negative impacts (Johnson 2007). Shaping the Health of Adolescents in Zimbabwe is a case in point. Initiated in 2001, the outcomes and validity of this youth-focused microcredit program were reassessed two years later due to the perceived failure of the microcredit component. Finding microcredit too far removed from the realities of the young women, and in some cases the cause of increased sexual violence against them, phase two of the project replaced microfinance and microloans with vocational training for the targeted age group (16 to 22 years old) of out-of-school, economically impoverished girls. Respected local institutions for youth training programs were identified as partners, social support was integrated (including enhanced involvement of family members and guardians, career counseling, peer networking, and the provision

of safe social spaces for adolescents), while the life skills education component was expanded. To date, a follow-up evaluation has not been conducted measuring the effectiveness of these changes (Urdang 2008).

Based on M&E findings, additional resources should be provided by donors to integrative microfinance projects to implement course corrections as needed, such as when IMAGE realized that adding activities into existing microfinance staff activities was not as effective as having parallel but cohesive programming.

Microfinance programs must go beyond quantitative measures, such as financial profitability/input accounting, and include more qualitative measures, such as operational quality of groups and women's

control of resources. As discussed in the 2008 Dominican Study, having received a loan is not significantly associated with HIV-related negotiation but rather, control of one's own money has the greater impact. Empowerment impact assessments should be routine in financial, client satisfaction, and sustainability areas. They must move beyond the one-level unit of analysis of impacts toward short- and long-term empowerment assessments from a beneficiary perspective (i.e., using the sustainable livelihood approach, which measures gender inequalities from gender discrimination and the social/gender/power struggles rather than gender gaps). Many MFIs have found a gender self-assessment and/or a gender action plan to be useful in ensuring gender equity and promoting women's empowerment. In some cases, gender audits may be necessary.

BOX 2. GAUGING LEVELS OF VULNERABILITY

Useful indicators for women's empowerment were effectively adapted and used by the IMAGE/RADAR project in their research and training program. The program sought to understand the impact of a microfinance-based intervention on women's empowerment and the reduction of intimate partner violence in Limpopo Province, South Africa. The indicators were based on three categories of power: "power within," "power to," and "power with." These categories formed the basis for measuring change, with a set of indicators referring to each:

Power within:

- Self-confidence
- Financial confidence
- Challenging of gender norms

Power to:

- Autonomy in decision making
- Perceived contribution to household (by partner/others in household)
- Partnership relationship (degree of independence/respect)

Power with:

- Social group membership
- Collective action

- **Institute gender-sensitive poverty targeting.** Randomized trials that can measure multiple changes should be a basis for measuring impact on poverty reduction whenever possible. Standard poverty assessment tools do not always identify inequalities within a household, as some women living in households above the poverty line may nonetheless be eligible due to their high levels of vulnerability within the household and lack of control of household incomes. A scale to gauge the level of vulnerability (such as the one discussed in Box 2) of the household should be used, and data collection must take into account gender relations and gender inequalities, particularly as they relate to a woman's access to information about different household members' income and savings. Contextualized measurable indicators must be gender-sensitive in design and implementation. Gender-disaggregated statistics focusing only on numbers of borrowers and savers, numbers and size of loans, and repayment cannot be used as indicators of actual access, and even less as proxy indicators of empowerment (Johnson 2007). Female-specific indicators (e.g., particular type and number of items of female clothing, household goods, ability to buy fuel, or a gender-specific weighted poverty formula) may prove to be significant and useful proxy indicators of poverty (Mayoux 2004). Note that in segregated societies, household surveys should be conducted by women.

Close-Out of Project

- **Develop a clear exit strategy.** To avoid depreciation in household incomes following the close out of microfinance-based activities, the exit strategy must focus on assisting clients to continue income-generating activities following withdrawal of projects, articulating close-out plans clearly to participants, and ensuring that sustainable market opportunities are in place prior to close-out.

CONCLUSION

Bold action must be taken to combine microfinance with HIV education and empowerment training as the cornerstone of economic empowerment efforts to reduce a woman's risk of HIV and to assist with the economic stressors of HIV. There must be a focus on gender norms and relations and the construction of gender identities to counteract the underlying ideas of masculinity that are often the basis of gender inequity and contribute to a woman's risk of contracting HIV.

Because there is still no statistically significant data that microfinance reduces poverty (Roodman and Murdoch 2009), a critical success factor will be to focus on developing an economic empowerment model that encourages gender equality in control of one's money, empowerment training, and HIV prevention, as well as increasing access to loans and savings (Mayoux 2006). Donors should fund economic empowerment models that incorporate gender, equality, empowerment training, and HIV prevention, as well as increase a woman's access to and control over loans and savings.

RESOURCES

This section includes important resources for program managers in the field of microfinance and gender.

For important resource documents on **microfinance, economic strengthening, and HIV/AIDS** see the following:

- Microcredit Summit Campaign:
www.microcreditsummit.org
- Financing Healthier Lives: Empowering Women Through Integration of Microfinance and Health Education:
www.unfpa.org/public/publications/pid/2091

- The SEEP Network Guidelines for Microenterprise Development in HIV & AIDS-Impacted Communities: www.seepnetwork.org
- SEEP HIV & AIDS and Microenterprise Development Working Group: www.hamed.seepnetwork.org
- FIELD Report No. 2, Economic Strengthening for Vulnerable Children: Principles of Program Design and Technical Recommendations for Effective Field Interventions (2008): www.microlinks.org/ev_en.php?ID=21730_201&ID2=DO_TOPIC

For general information on **economic empowerment and HIV** see the following:

- microLINKS: www.microlinks.org/fs/hiv-aids
- MicroSave: www.microsave.org
- Microfinance Gateway: www.microfinancegateway.org

For **gender-specific information** on economic empowerment see the following:

- Sustainable Micro-finance for Women's Empowerment: www.genfinance.info
- WAM: www.waminternational.org
- GenderNet, WB: www.worldbank.org/gender
- Self-Employed Women's Association: www.sewa.org

A number of organizations have developed **manuals for women's financial literacy**. Examples from the joint initiative developed by Microfinance Opportunities and Freedom from Hunger can be found at:

- Microfinance Opportunities: www.microfinanceopportunities.org

- Foundation for a New Humanity: www.ffh.org
- Womankind Worldwide: www.womankind.org.uk/
- Siembra: www.genfinance.info/Chennai/Case%20Studies/SiembraManual_Chapter%203.pdf
- For a diagram-based methodology, Participatory Action Learning System: www.lindaswebs.org.uk/Page3_Orglearning/PALS/PALSIntro.htm

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APPENDIX I

TABLE I. MICROENTERPRISE, ECONOMIC STRENGTHENING, AND LIVELIHOOD ACTIVITIES	
<i>Interventions</i>	<i>Activities</i>
Social Assistance	Assets Transfer. The provision of productive goods—livestock, seeds, tools, cash—to people to help them re-establish their livelihood.
	Food Aid. The provision of food aid and support for food security, price, and related subsidies.
	Social Pension. Noncontributory transfer in the form of pensions.
	Public Works. Noncontributory transfer in the form of public works.
Asset Growth and Protection	Microfinance. The provision of financial services adapted to the needs of low-income persons, or persons otherwise systematically excluded from financial services, especially small savings deposits, insurance, remittances, and payment services.
	Rotating Savings and Credit Associations. Informal groups in which fixed sums are made to a common savings fund lent in succession to all group members based on preexisting distribution rules.
	Accumulated Savings and Credit Associations. Informal savings groups where all members regularly save the same fixed amount, while some participants borrow from the group. The group pools funds to use for business loans, savings, and mutual support, and members cross-guarantee individual loans.
	Insurance. The provision of insurance products to beneficiaries (life, disability, health, loan, weather).
	Legal Protection. The provision of legal services for asset protection.
Income Growth	Microfinance/Microcredit. A subsegment of microfinance that focuses on giving small loans to low-income people to enable them to earn additional income by investing in, establishing, or expanding microenterprises.
	Skills Training. The purposeful activity of transferring skills and knowledge to be used to secure a livelihood or pursue an occupation.
	Income-Generating Activities. Any legal activity that can boost household income and living standards, including agricultural/livestock production, horticulture, microenterprises, handicrafts, etc.
	Business Loans. Collaboration with, or establishment of, a lending institution to provide group or individual loans to start/grow a business.
	Job Creation. Development of jobs to earn income through paid employment.
	Market Linkages. A portfolio of interventions designed to increase the returns to caregiver-managed enterprises by understanding and taking account of the full market system in which they operate (AED, Save the Children, and USAID 2008; SEEP 2008b).