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# ECONOMIC STRENGTHENING PROGRAMS FOR HIV/AIDS AFFECTED COMMUNITIES:

## EVIDENCE OF IMPACT AND GOOD PRACTICE GUIDELINES

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This publication was produced for review by the United States Agency for International Development. It was prepared by Angela Stene, Taara Chandani, Aneesa Arur, Rebecca Patsika and Andrew Carmona for the Private Sector Partnerships-One project.



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### **DISCLAIMER**

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# ACRONYMS

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ART</b>	Antiretroviral Treatment
<b>ASCA</b>	Accumulating Savings and Credit Associations
<b>BMI</b>	Body Mass Index
<b>CGAP</b>	Consultative Group to Assist the Poorest
<b>CSA</b>	Child Savings Accounts
<b>COPE</b>	Community-based Orphan Child Protection and Empowerment Project
<b>DG</b>	Dependency Grant
<b>EMG</b>	Emerging Markets Group
<b>GDP</b>	Gross Domestic Product
<b>HH</b>	Household
<b>HIV</b>	Human Immunodeficiency Virus
<b>ILO</b>	International Labor Organization
<b>IMAGE</b>	Intervention for AIDS, Gender and Equity
<b>MFI</b>	Microfinance Institution
<b>NCHS</b>	National Center for Health Statistics
<b>NGO</b>	Nongovernmental Organization
<b>OAP</b>	Old Age Pension
<b>OVC</b>	Orphaned and Vulnerable Children
<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>PLWHA</b>	Persons Living with HIV/AIDS
<b>SD</b>	Standard Deviation
<b>STD</b>	Sexually Transmitted Disease
<b>TRY</b>	Tap and Reposition Youth
<b>USAID</b>	United States Agency for International Development
<b>VS&amp;L</b>	Village Savings and Loan
<b>WHO</b>	World Health Organization



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# EXECUTIVE SUMMARY

Donors and practitioners recognize the need to extend economic and livelihood support to individuals, families, and communities affected by HIV/AIDS. Increasingly, multisectoral programs that can integrate health, economic strengthening, educational and social protection services are being tested and implemented. Yet knowledge of what works, for whom and why, is still limited. There is little cross-fertilization of best practices and lessons across different sectors, including health, economic development, and social protection.

This report was commissioned by Office of HIV and AIDS of the United States Agency for International Development (USAID) to provide guidance to health practitioners as they decide to build or add on an economic strengthening component to their work. It centers on two questions:

- *To what extent are economic strengthening interventions improving the wellbeing of people living with and affected by HIV/AIDS?*
- *How can programs more effectively serve these communities and assess impact?*

The report discusses the evidence of impact that economic strengthening programs have on communities affected by HIV/AIDS and develops good practice guidelines and recommendations for health programmers.

It begins with a discussion on why economic strengthening programs are needed for HIV/AIDS-affected communities as they cope with the long-wave shock of the epidemic, and illustrates how economic support can be tailored for different vulnerable groups most affected by HIV/AIDS. The paper then describes the main functions of economic strengthening programs, from social assistance or safety-net programs (cash or food transfers), to asset-growth and protection services (savings and insurance) as well as income growth initiatives through market linkages and vocational training.

This discussion is followed by a short summary of the evidence of impact that economic strengthening programs have on the welfare of targeted individuals or households and their ability to mitigate risk among vulnerable groups. It also shares key gaps in the evidence base according to program type and offers recommendations for donors and practitioners.

## KEY FINDINGS

- Though a direct correlation between risk for HIV/AIDS and the economic strengthening programs cannot be established, several components of wellbeing among HIV/AIDS affected households (economic status, nutrition, self-reported health status, asset, and school material ownership) are positively affected by economic strengthening interventions. However, more research is needed to help inform program design and to understand the nuances of intrahousehold resource allocation, gender dynamics and the long term affects of economic strengthening programs.
- Cash transfers have been found to be quite effective in improving the wellbeing of HIV/AIDS affected households. Even small grants can have dramatic impacts on the nutritional status, cognitive growth,

and development of young children. Cash transfer programs have demonstrated a reduction in severity of destitution as measured by improvements in food consumption, a reduction in child labor and small increases in health expenditures (Schubert 2007; Devereux et al. 2007; Schubert 2005; Miller and Toska 2008). School enrollment impacts however were very small, though absenteeism of already enrolled students and ownership of school supplies and uniforms improved considerably. Taken together, these aggregate improvements in wellbeing may be seen as a way to reduce the poverty that often encourages high-risk behaviors (Kim et al. 2008).

- Savings services impact positively on household welfare and ability to cope (Allen 2002, CARE 2008). Where measured, successful saving among women and adolescent girls was generally correlated with increased confidence, participation in social networks, and overall attitudes about their ability to address HIV/AIDS related risks and challenges (Kabeer 2005, CARE 2008, Ssewamala et. al 2006). Savings schemes have produced dramatic self-reported nutritional gains, but less conclusive evidence of impact on health care expenditures (Allen 2002, CARE 2008). During crises, poor households first draw on their savings before selling their larger livestock or business capital assets (Donahue et al. 2001). Savings schemes were viewed by participants as less risky than microfinance schemes, which may induce stress, particularly for younger female clients (Kim et. al. 2008).
- Of the economic strengthening programs reviewed, microfinance has the most established correlative link with HIV/AIDS mitigation behaviors and attitudes, particularly among women (Kim et al.). Integrated health and microfinance programs have led to some positive behavior change outcomes and reduction of risk factors associated with HIV/AIDS (Pronk 2006). Microfinance initiatives are linked with improvements in women's self-confidence, household decision-making authority, bargaining power and participation in community leadership roles (Kim et al. 2008; Cheston and Kuhn 2002). These initiatives have also led to improved food consumption and increased utilization of healthcare services (Bronson 2008) especially among orphans and vulnerable children. Youth and children however may benefit more from mentorship and skill-building initiatives (Urdang 2006).

## **KEY RECOMMENDATIONS BY ECONOMIC APPROACH**

### **SOCIAL ASSISTANCE AND CASH TRANSFER SCHEMES**

- Practitioners and donors should work with local governments to integrate cash transfers with social protection frameworks to be instituted over the long term.
- Approach conditional obligations, such as vaccinations for children in exchange for cash relief with caution. Some programs try to induce health promotion by tying conditionalities to certain services. Conditionalities should be evaluated on an individual basis, according to the context, and the pros and cons of each should be considered from multiple perspectives. For example, health services that are not safe, clean, affordable, accessible, or continuously available should not be tied to cash transfers. Some locales may never be appropriate for conditionalities, even if a neighboring area has found successful ways to implement them. Any obligation tied to aid for the poorest of the poor should carefully consider the context before it is implemented.

## **INSURANCE**

- Encourage only institutions or groups that have the capacity to assess and manage risk to undertake insurance services.
- Ensure that insurers working in communities with a high prevalence of HIV and AIDS mitigate risk by expanding the size of risk pools.

## **SAVINGS**

- Consider savings as a first step for poor households to build their asset base and access a broader menu of financial services.
- Tailor savings products to the needs and capacities of the people the products seek to reach, as well as the capacity and reliability of the institutions administering the products.
- Ensure that participants in group-based savings self-select into schemes and are able to manage them independently.

## **INCOME GROWTH**

- Recognize that income growth and enterprise development are long-term business propositions.
- Focus on working through sustainable institutions that provide loans and ensure arms-length relationships with clients. To avoid confusion, loans and grants should not be accessed under the same roof.
- Conduct market research to understand the business needs of different target groups and the type of services and viable market opportunities to match their capacity and environment.
- Reserve business loans for people who are capable of engaging in income-generating activities.
- Vocational skills training can be an important complement to business loans, and appropriate for adolescents and other groups not ready to access a loan. Among adolescents, it can help, to build confidence; a factor which can reduce vulnerability to high risk behaviors (Hall 2006; Erulkar and Chong 2005; Kim et al. 2008).

## **CROSS-CUTTING RECOMMENDATIONS FOR ECONOMIC STRENGTHENING IMPLEMENTATION**

- More research is needed to assess the impact of economic strengthening programs on health and wellbeing of groups affected by HIV/AIDS. Key indicators addressed should include: nutritional uptake, education, income diversification, access and adherence to care and treatment of HIV/AIDS, and other health care needs of the household.<sup>1</sup>
- Ensure that implementing partners have the capacity to administer services regularly and reliably.
- Avoid targeting based on HIV/AIDS status. This raises concerns about stigma, equity and validity due to challenges in accurately identifying HIV/AIDS affected populations.

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<sup>1</sup>The evaluation of the Mchinji Social Cash Transfer scheme, conducted by the Boston University's Child Health Policy Research Institute, will be the first direct evaluation of these types of effects (Miller 2007). Further research should use this as a basis for further investigation of this topic.

- Assess intrahousehold dynamics to ensure optimal use of benefits.
- Link economic strengthening (particularly for the most vulnerable) to complementary services to ensure the effective use of resources.
- Consider tapping into the existing safety nets available to vulnerable groups. This includes both the informal safety nets that are indigenous to the communities, as well as formal government safety nets. Often, the locally generated safety net (such as a funeral or solidarity lending group) may be more long-lasting than a donor or government-funded program.
- Involve relevant specialists at the initial phase of designing multisectoral programs to define an approach that reflects best practices across different sectors.
- As appropriate, maximize the earning and growth potential of beneficiaries by instituting strategies for graduating clients between different types of economic strengthening programs.

# I. INTRODUCTION

## I.1 BACKGROUND

The pathways of poverty and HIV/AIDS are closely connected and create a vicious cycle of illness and impoverishment in low-income and high-risk communities. Destitution may lead to riskier behaviors such as transactional or concurrent sexual relationships. While there are many drivers of HIV/AIDS – gender inequalities, mobility, and the biology of the virus – poverty is key among these.

Over the past two decades, responses to the HIV/AIDS epidemic have largely addressed prevention, behavior change, and curative health interventions. However, economic challenges related to HIV/AIDS are coming to the fore, as millions of households deplete their household's limited resources in the struggle to afford treatment and care. Practitioners are increasingly aware of the need to integrate health and economic development interventions to more holistically respond to the HIV/AIDS crisis.

As a result, economic strengthening initiatives are now considered to be an important strategy in enabling HIV/AIDS-affected households to cope with the effects of the epidemic and preserve livelihoods that sustain basic needs such as food, water, shelter, health, education, and social protection (Conway and Chambers in Allen 2005). Country programs have begun to add economic strengthening components to HIV/AIDS support programs. While microfinance initiatives often try to incorporate HIV/AIDS prevention education into group meetings, most economic strengthening programs have not been rigorously evaluated for integration of HIV/AIDS prevention. In the absence of such research or evidence of impact, practitioners rely on assumptions as they make critical decisions about where to invest limited resources to mitigate the spread and effects of HIV/AIDS. This paper reviews the evidence of how economic strengthening program can affect wellbeing (nutrition, education, health, and coping mechanisms) and vulnerability to HIV/AIDS and offers recommendations for program design, implementation, and evaluation.

## I.2 STUDY SCOPE

This report was commissioned by the Office of HIV and AIDS at the United States Agency for International Development (USAID) to offer guidance to health sector practitioners who seek to add economic strengthening initiatives to their core health programming. It defines **economic strengthening initiatives** as the portfolio of strategies and interventions that supply, protect, and/or grow physical, natural, financial, human and social assets.

The report reviews the evidence on the impact of economic strengthening initiatives on communities affected by HIV/AIDS and highlights the gaps in existing knowledge by exploring:

- *To what extent are economic strengthening interventions improving the wellbeing (financial, nutritional, health status, school enrollment) of people living with and affected by HIV/AIDS?*
- *How can programs measure and assess impact of these interventions on households?*

The report offers recommendations to donors and health practitioners interested in designing or partnering with economic strengthening programs. It also highlights gaps in the evidence base and offers suggestions for further research. The programs and evidence discussed herein are primarily based in southern and eastern Africa, where HIV prevalence rates are highest and where there is the strongest concentration of economic strengthening programs among HIV/AIDS-affected households.

### **I.3 METHODOLOGY**

The research methodology comprised a desk-review of literature and interviews with key informants. The desk-review included literature published in peer-reviewed journals and “gray” material from donor agencies and implementers working in the respective sectors.

Studies analyzed in this paper explicitly measured impacts of economic strengthening approaches on key components of individual and/or household well-being of HIV/AIDS affected or high-risk groups. Only studies conducted in high HIV/AIDS prevalent countries, targeted by the President’s Emergency Program for AIDS Relief (PEPFAR) were included.<sup>2</sup> The authors defined components of wellbeing as: nutritional status or food consumption, utilization of necessary health services, educational enrollment and attendance, and proxy measures of self-esteem. Efforts focused on identifying and reviewing empirically-based impact evaluations that measured at least one dimension of well-being. Literature sources reviewed include: program reviews, impact evaluations, and published journal articles from the following thematic areas: HIV/AIDS, microfinance, enterprise development, social protection, youth development, gender studies, and monitoring and evaluation.

In addition to scanning empirical studies, the team reviewed existing practices, and policy recommendations for economic strengthening approaches were also reviewed through key online resource centers including the Small Enterprise Education and Promotion (SEEP) Network, the Microfinance Gateway supported by the Consultative Group to Assist the Poorest (CGAP), the AIDS Alliance, and the Children’s Rights Information Network. A list of additional online networks and Web sites is provided in Annex A.

Twenty-four phone interviews were held with representatives of the health and economic development fields. These interviewees worked in donor agencies, implementing organizations, consulting firms and academia. See Annex B for a complete list of people interviewed and their affiliations. The interviews were semi-structured and elicited informants’ views on the evidence of economic strengthening initiatives, identification of promising programs and practices and challenges related to monitoring and evaluation of multisectoral programs. The majority of interviews were held with informants at the head offices of donor and implementing agencies, though some interviews with field staff were also conducted.

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<sup>2</sup> <http://www.pepfar.gov/countries/index.htm> Countries included in the PEPFAR program include: Botswana, Cambodia, the Ivory Coast, Ethiopia, Guyana, Haiti, India, Kenya, Malawi, Mozambique, Namibia, Nigeria, Russia, Rwanda, South Africa, Tanzania, Uganda, Vietnam, Zambia and Zimbabwe.

## 2. WHY ECONOMIC STRENGTHENING FOR HIV/AIDS-AFFECTED HOUSEHOLDS?

### 2.1 POVERTY AND HIV/AIDS

When affected by HIV/AIDS, poor households face financial and social burdens associated with prolonged illness and medical expenses, loss of productive labor, death of family members, funeral expenses, and care for extended families and orphans. Within households, the impact is shouldered differently by key demographic groups. For example, orphans and vulnerable children face a unique set of struggles such as lack of psychosocial support, access to education, health services, and proper nutrition. Vulnerable children may be taken out of school, face stigma, be deprived of basic resources, or be forced to join the workforce prematurely – factors that hinder their longer-term cognitive and physical development. Adolescent girls are vulnerable to a whole host of unique challenges, if the household becomes destitute due to lost productivity of the household.

Women are likely to assume additional responsibilities as caregivers and must find ways to augment household income (Lartego-Lawson and Deshmukh 2008). In countries with high prevalence rates, the elderly are increasingly bearing the responsibility of care for orphans. In southern Africa, many orphans and other children live in a household headed by a grandparent or person over 65 (Booyson 2004). The elderly however also face unique challenges, as their health care needs and productive work capacity change in later years.

Table I illustrates how the varying economic needs of different groups most affected by HIV/AIDS can be met through economic support programs, recognizing that these will vary according to context and over time.

**TABLE I. HOW SUPPORT PROGRAMS MEET ECONOMIC NEEDS OF HIV/AIDS-AFFECTED GROUPS**

Target groups	Illustrative needs that can be met directly by economic support interventions
People living with HIV/AIDS	<ul style="list-style-type: none"> <li>• To access medical treatment, food supplements, and care</li> <li>• To support oneself and dependents while physically able</li> <li>• To ensure financial protection for nonproductive years</li> </ul>
Children/ Youth/ Adolescent girls	<ul style="list-style-type: none"> <li>• To have protection via social and financial safety nets and avoid engaging in high-risk behaviors</li> <li>• To avoid prematurely engaging in exploitative labor or leaving school to care for dependents</li> <li>• To access education and improve future human development prospects</li> </ul>
Women	<ul style="list-style-type: none"> <li>• To maintain stable income and assets and avoid high-risk behaviors</li> <li>• To avoid exploitative labor and relationships which may elevate risk to HIV/AIDS and other physical and mental stressors.</li> <li>• To have the means to support and care for extended families and children</li> </ul>
Elderly (caregivers)	<ul style="list-style-type: none"> <li>• To have the means to care for oneself and offer stability and care for OVC</li> </ul>

## 2.2 A CONTINUUM OF ECONOMIC STRENGTHENING ACTIVITIES

Economic strengthening activities include a broad array of approaches: social assistance programs, asset growth and protection, and income growth (James-Wilson et al. 2008). Table 2 depicts a continuum of economic strengthening activities by service, focus, and target group. It describes the types of financial assistance provided in each economic strengthening approach, as well as how the different approaches can be tailored to the productive capacity and level of household need.

Notably, social cash and food transfers are considered ‘targeted’ services, since they are appropriate for the most vulnerable groups. As households affected by HIV/AIDS often are extremely vulnerable due to constraints on productive labor capacity, it is often effective to target cash transfer programs toward both households that are both labor constrained and the ultra poor. In regions with high HIV/AIDS prevalence rates, this targeting method has proven to be highly effective in reaching HIV/AIDS affected households and orphans and vulnerable children, without raising concerns of stigma, and without making inclusion dependent on testing services, which may be scarce or inefficient.

Protective services, such as savings and insurance, are important for all families regardless of their degree of vulnerability while asset growth and income growth approaches may be seen as services more appropriate for less vulnerable populations that have productive labor capacity (Donahue 2005). Notably, household vulnerability may shift, particularly as the effects of HIV/AIDS change. Thus, the continuum is not intended to imply a strictly linear movement from social assistance to income growth programs. For a broader discussion of the efficacy of targeting please see Annex F below.

**TABLE 2: CONTINUUM OF ECONOMIC STRENGTHENING PROGRAMS**

<b>Approach</b>	<b>Social Assistance</b> <i>Supply relief assistance and support</i>	<b>Asset Growth &amp; Protection</b> <i>Restore or maintain economic resources</i>	<b>Income Growth</b> <i>Strengthen or increase economic resources</i>
<b>Services</b>	<ul style="list-style-type: none"> <li>• Asset and cash transfers</li> <li>• Food aid</li> <li>• Social pensions</li> <li>• Public works</li> </ul>	<ul style="list-style-type: none"> <li>• Group and individual savings</li> <li>• Insurance services</li> <li>• Legal services to protect vulnerable groups</li> </ul>	<ul style="list-style-type: none"> <li>• Business loans</li> <li>• Skills training</li> <li>• Income-generating activities</li> <li>• Market linkages</li> </ul>
<b>Focus</b>	<p>Most vulnerable*</p> <p><i>Unable to engage in economic activity</i></p>	<p>Very vulnerable</p> <p><i>In transition, needs assistance to achieve a more stable economic position</i></p>	<p>Somewhat vulnerable</p> <p><i>Stable but poor</i></p>

<b>Illustrative Target Group</b>	<ul style="list-style-type: none"> <li>• Elderly caregivers</li> <li>• Poor women or widows</li> <li>• PLWHA of all ages at the symptomatic stages</li> <li>• Child-headed households</li> </ul>	<ul style="list-style-type: none"> <li>• All caregivers (women, elderly and poor households)</li> <li>• Youth</li> <li>• PLWHA</li> </ul>	<ul style="list-style-type: none"> <li>• Caregivers with productive capacity</li> <li>• Youth</li> <li>• PLWHA with productive capacity.</li> </ul>
			

Sources: Adapted from Donahue (2005), James-Wilson et al. (2008).

\*The severity of vulnerability among Orphans and Vulnerable Children is closely tied to the vulnerability of their caregivers or support networks.

Poverty induced by HIV/AIDS fluctuates over time and is largely defined in terms of the household’s or individual’s ability to engage in productive work. Household labor constraint is therefore a key indicator of a household’s viability and is largely measured by the dependency ratio, or the number of people in a household that need looking after. Since HIV/AIDS often affects productive adults, and induces families to care for the chronically ill, or children orphaned by the disease, the dependency ratio of affected households is often much higher than the national average, thereby generating a good variable for prioritizing destitute households (Miller and Tsoka 2008).

The different types of economic strengthening initiatives are defined and elaborated below. Examples of each type of program, evidence of their impact, a discussion of the appropriateness by target group, and good practice guidelines will be presented in the following sections.

**2.2.1 SOCIAL ASSISTANCE**

Social assistance programs are intended to provide a first line of relief for households. They typically consist of asset transfers whereby governments and donors provide a safety net for the most vulnerable. **Cash transfer programs** are increasingly seen as an effective mechanism to offer basic subsistence for the most destitute households. Targeting and distribution, particularly in rural and remote areas, can be challenging and may require an approach that includes community buy-in and public payment points to ensure the most destitute households are reached.

Cash transfer schemes can be targeted toward the poorest households who are also unable to carry out productive work: the elderly or disabled, and households caring for OVCs. Cash transfers may be *conditional*, whereby beneficiaries are obligated to participate in training, education, or health services to qualify for the grant, or *unconditional*, where no obligations are put on the beneficiaries. Often however, the unconditional grants may be tied to voluntary, complementary services.

Evidence from Malawi, South Africa, and Zimbabwe suggests that cash transfer programs may be a child-centered and AIDS-mitigation approach, since many of the destitute families (labor constrained and ultra poor) are HIV/AIDS-affected households, and may also be caring for OVCs.

Because the poorest households often spend the bulk of their income on food - 60 percent among the poor, and 80 percent among the ultra poor - cash transfers often translate most immediately into

improved food consumption (Adato and Bassett 2007). Households also tend to invest some of the cash transfers in small income-generating activities (small livestock, informal crafts) and, to a lesser extent, on medical services and school fees, uniforms, and materials due to the small amount offered by many cash transfer schemes (\$10-\$13/month in Malawi and Zimbabwe). See Annex C for an example of the Mchinji Cash Transfer scheme in Malawi.

## 2.2.2 ASSET GROWTH AND PROTECTION

Asset growth and protection programs include savings, insurance, and legal protection, which are critical for families coping with unexpected crisis (drought, crop failure, illness, or loss of the household's breadwinner) while continuing to afford basic essential goods and services over the long term. Legal services for widows or children and other groups subjected to stigma or discrimination are also included in this category.

Savings and insurance services are appropriate and a necessary form of financial protection for **all poor households**. However, voluntary insurance is often not accessible to the chronically ill (who may be excluded from the schemes) or to those who are unable to make regular premium contributions.

Savings and loan services are available informally and formally; each mechanism has its pros and cons. Institutions offering these savings and loans programs may include formal deposit-taking financial institutions, nongovernmental organizations (NGOs), or community-based savings groups. Some require mandatory fixed deposits as collateral for loans; other programs include group savings schemes, which play a dominant role in many developing countries including Mexico, the Philippines, Uganda, and countries in West Africa (Deshpande 2006). Group savings can provide financial protection, strengthen community networks and social capital, and help families cope with HIV/AIDS by making resources available to the sick.

Examples of group schemes include the Accumulating Savings and Credit Associations (ASCAs), in which self-selected groups make regular contributions to a pool of funds that are either invested in a joint group enterprise or channeled for members' own use.

In some cases, individual savings products are being developed to meet the needs of vulnerable youth and those affected by HIV/AIDS. This includes Child Savings Accounts (CSAs), where children manage an account with an adult signatory, or matched savings schemes that offer incentives for vulnerable groups to save regularly.

**Microinsurance** is defined as insurance available to the poor to protect them from risk (ie. crop failure, natural disaster, or the death of a family member.) The key distinguishing factor between microinsurance and regular insurance is its focus on the poor. Microinsurance may include health, life, asset (eg. crop) protection (Churchill 2006). Like regular insurance, microinsurance allows households to pool and plan for risks; both can be effective at mitigating disasters (death or injury) that are unlikely to affect the whole community at one time.

Microinsurance is relatively new product that has been particularly useful in West and Central Africa. Also known as "community based insurance", microinsurance enables households to cover funeral costs, afford health coverage, and manage other emergencies. In high HIV prevalence contexts, such schemes

can be an important point of protection for affected and poor families, albeit for a limited scope of coverage.

Many insurers however view health insurance for PLWHA as an expensive and risky investment especially in high HIV/AIDS prevalence countries. Microinsurers, like regular insurers, must rely on sound actuarial models when designing their products, while complying with local laws about exclusions and coverage. In some cases, funeral or agricultural coverage has been found to be a more affordable way of preserving food security and wellbeing of HIV/AIDS-affected households (Roth et al. 2007; Chandani 2008).

Trends in donor funding, employer-based insurance, and public subsidies have enabled a few commercial and community-based insurers to extend antiretroviral treatment (ART) insurance coverage to low-income communities. Global donor funding for ART for example has reduced the cost of providing treatment to people living with HIV/AIDS (PLWHA), thereby making it more affordable to insure. While examples are still limited, case studies from Nigeria, Rwanda, and Uganda demonstrate successful examples of community and commercial insurance that includes ART by tapping public subsidies, donor funds, and cross-subsidization of employer-based insurance payments (Chandani 2008). Some life insurance schemes in South Africa, Uganda, and Zambia have dropped exclusions for PLWHA from their policies due to bad publicity, drops in sales of their insurance product, and difficulty of isolating HIV/AIDS as cause of death.

### 2.2.3 INCOME GROWTH

Income growth programs bolster the productive capacity of vulnerable households through financial services, job training, and market linkages. They are diverse in their objectives and approaches. Generally, these types of services require significant capacities, skills, and motivation by the individual or group accessing the service. They can build the economic resiliency of vulnerable families to cope with crises and potentially contribute to a reduction in risk behaviors. In particular, access to **business loans** can help households or individuals invest in an enterprise and diversify their income sources over time. Loans are generally intended for business purposes but are also commonly used for consumption (food, health care, and school fees) by poor families.

Community-based savings and loan groups (including ASCAs, described above) are a source of financing for the poor, as are regulated microfinance institutions (MFIs). MFIs generally serve low-income communities with the full package of financial services (including loans, savings facilities, remittances, and insurance) and use group or individual lending models. Many income growth programs provide **vocational** and **skills training** in a particular trade, such as agriculture or handicrafts, or offer generalized management and business training support. These services are commonly offered with loans.

Other programs may offer technical assistance in **income-generating activities** such as poultry rearing or a trading business. Recently, economic strengthening programs are realizing the importance of creating strong **market linkages**, whereby they conduct a full analysis of the demand and supply channels across a given product or industry to identify opportunities for adding value along the way. Programs that are able to find a new niche or link into regional and global markets are more likely to achieve growth and viability.

Increasingly, different types of income growth programs are being tailored for groups affected by HIV/AIDS, especially adolescents and women. These efforts have largely centered on the provision of business loans and vocational training and have tended to remain small in scale, such as the COPE project that is described in the case study in Annex D. Only a few initiatives have rigorously considered broader market linkages when designing programs for families or individuals affected by HIV/AIDS.

### 3. EVIDENCE OF THE IMPACT OF ECONOMIC STRENGTHENING PROGRAMS ON THE WELLBEING OF HIV/AIDS-AFFECTED HOUSEHOLDS

Like the relationship between poverty and HIV/AIDS, vulnerability to the virus is difficult to quantify since risk factors are multifaceted. While some determinants of risk are easy to measure - geographic prevalence, gender, and other demographic characteristics - others are not - self-confidence, social assets, locus of control, and empowerment.

The complex, multifaceted nature of the relationship between economic strengthening interventions and HIV/AIDS does not lend itself well to experimental design and attribution of causality. Economic strengthening interventions often target household units, whereas HIV/AIDS interventions typically target individuals.

In light of these constraints, this review limited its research to economic strengthening interventions, in high HIV/AIDS prevalent countries where the various impacts were disaggregated by six commonly cited variables of wellbeing: financial status, nutritional status, attitudes and knowledge about HIV/AIDS, health outcomes, health spending, and school enrollment/educational spending. Annex E reports evidence according to specific target groups.

Key findings by economic approach are discussed below.

#### 3.1 SOCIAL CASH TRANSFERS

**Though social cash transfer schemes appear to improve several components of wellbeing in HIV/AIDS-affected households, no schemes have directly evaluated their impact on HIV risk reduction.** The Boston University Child Policy Research Center's forthcoming evaluation of the Mchinji Social Cash Transfer scheme in Malawi will offer new insight on the correlative effects of cash transfer's impacts on households affected by HIV/AIDS, by target group. To date, however, evidence simply shows a reduction in severity of destitution mostly marked by improvements in food consumption [1,2,3,4,5,6], a small reduction in child labor [3], and small increases in health expenditures [1,3,4,5,6].<sup>3</sup> Combined, these improvements in wellbeing may reduce the poverty that often encourages high-risk behaviors (Kim et al. 2008).

**Indicators such as the household dependency ratio<sup>4</sup> is one way of targeting social cash transfers to households that are not only poor, but also labor constrained. In high HIV prevalence countries, this targeting mechanism often reaches high numbers of HIV/AIDS-affected households as well as high numbers of OVCs.<sup>5</sup>** Experts indicate that targeting households

<sup>3</sup>Throughout this paper, the citations in brackets refer to evaluations of economic strengthening approaches summarized in Annex E.

<sup>4</sup>The Mchinji cash transfer evaluation defines the dependency ratio as: (% of household members < age 19) + (% over 65)/(% of adults between 19-65) \* 100. In the Mchinji program, 40 percent of households had no working adults and 2.6 dependents. Of the remaining households that did have a productive, working adult, the dependency ratio was 333 percent (as compared to the national average of 110 percent) (Miller and Tsoka 2008).

<sup>5</sup>Cash transfer programs that seek to reach families affected by HIV/AIDS face challenges associated with stigma, equity, and low levels of testing and disclosure (Inter-Agency Task Team (IATT) on Children and HIV and AIDS Working Group on Social Protection 2007; Adato and Bassett 2007).

suffering from abject poverty, and lack of productive work capacity may be a preferable targeting method to reach households affected by HIV/AIDS without raising concerns of stigma, discrimination, equity, and accuracy of testing.

Finding that poverty was widespread in Zambia, the Kalomo Trust Cash Transfer Program further prioritized most in-need households by including not just labor constraint and poverty, but food deprivation (1400kcal/per person per day) as an inclusion criterion. A synthesis of seven cash transfer programs in Zambia, Malawi, and South Africa revealed that 50-80 percent of participating households were HIV/AIDS-affected, even though selection criteria centered around poverty and household labor capacity (Schubert 2007). Annex F details targeting criteria, while Annex G describes the assumptions made in the evaluation of the targeting of the ultra-poor and labor-constrained households in Malawi and Zambia.

**Cash transfers have the strongest impact on the poorest households with nutrition being the first component of wellbeing to improve.** Among the poorest households, which may spend up to 80 percent of their income on food, improved nutritional status is one of the first outcomes to respond to cash transfers. Number of meals consumed, and self-reported levels of satiation at meal time increased dramatically, with young children exhibiting some of the strongest, immediate effects (Adato and Bassett 2007).

**Even small grants (\$10-\$13/month for the Malawi and Zambian social cash transfer programs) can lead to dramatic impacts on young children's nutritional status and cognitive growth and development.** Cash transfers yield marked gains for households. Self-reported levels of satiation after meals improved from 42.6 percent to 65.2 percent<sup>6</sup> [1, 2, 3]. Children under 5 years experienced a 10.5 percentage point difference in being underweight, a 2.2 percentage point reduction in wasting and a 4.2 percentage point reduction in measured levels of stunting [2] as compared to control groups.<sup>7</sup>

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<sup>6</sup> The statistic of reported satiation levels is from the Kalomo Trust Cash Transfer Program in Zambia [1].

<sup>7</sup> World Health Organization (WHO) definitions for children under 5 who are underweight: Weight-for-age is < 2 standard deviations (SD) below of the National Center for Health Statistics (NCHS) or WHO reference median. Stunting: Height-for-Age <2 SD below the NCHS/WHO reference median. Wasting: <2 SD weight/height.

### **Nutritional Gains May Yield Great Results for the Ultra Poor, Particularly Among the Young Boys and Girls Under the Age of 5.**

It is believed that the ultra poor spend up to 80 percent of their income on food.\* The immediate impact that cash transfers have on reported satiation levels, consumption, and even growth status among young children are remarkable.\*\* The impact of improved nutrition is most dramatic for children under age 5 as evidenced by significant improvements in overall health, wellbeing, and cognitive development.

Children who receive the South African Child Support Grant for two of their first three years of life are expected to achieve more of their physical growth potential as an adult. Researchers estimate that children with early access to nutrition during their critical early years of development will grow one standard deviation (2.1 percent of their total adult height, or 3.5 cm). The physical impact is closely linked to the child's cognitive growth and income potential. Researchers estimate that the 3.5 cm increase in height may correlate to \$27 to \$42 of increases monthly wages for the entirety of that child's life from age 25-42 [5].

Though increased wages cannot be proven to reduce risk of contracting HIV/AIDS, alleviating destitution and promoting empowerment can diminish high-risk behaviors (Kim et al. 2008).

\* Engels Theory states that the most poor spend 60 percent of their household income on food. The ultra poor spend up to 80 percent of their household income on food (Streeten 1998).

\*\* Engels Theory (Streeten 1998).

### **Nutrition and HIV/AIDS**

Improved nutrition is vital for preventing and managing illness. Improved nutrition can prevent infections that leave women more vulnerable to HIV/AIDS infection. Nutrition is also vital to ART, as the drugs work less effectively on a malnourished individual (Gillespie and Kadiyala 2005). Studies have also found that ART adherence and nutrition counseling services – critical to ensuring compliance with the drug regimen – can complement cash transfer interventions that reach significant numbers of families affected by HIV and AIDS (Adato and Bassett 2007; Schubert 2007). Though targeting by HIV/AIDS status is not advised, adding complementary economic services to HIV/AIDS treatment programs is one way to discreetly reach PLWHA (Adato and Bassett 2007; Schubert 2007).

**Impacts on health status are inferred from self-reporting and from increased expenditures on health** [1, 3, 5, 6]. The Old Age Pension Scheme in South Africa has dramatic self-reported data on improvements in health status as measured on a five-point scale from very poor to excellent (Case 2001). Partial blindness was reduced by more than half, and may be due to affordability of transport to eye clinics (especially among the elderly [1]). Other significant health impacts, from the Mchinji cash transfer scheme in Malawi, include a 7.9 percent drop in reported illness per month among adults and 10.9 percent reduction among children [3].

**Cash transfers exhibit a modest effect on school enrollment, though there is some evidence suggesting cash transfers may have a larger effect on reducing absenteeism among already enrolled children.** The social cash transfer schemes in Malawi, South Africa, and Zambia all produced a small, 3-8 percent increase in school enrollment. However, absenteeism among enrolled students in Zambia was notably improved, based on reports from 2005 that absenteeism decreased from 40 to 24 percent [1]. The Mchinji Cash Transfer scheme also produced a 10 percent reduction in child labor outside the home, which may contribute to improved child wellbeing, and also signal reduced destitution [3]. In a cost modeling in seven sub-Saharan African countries conducted by the International Labor Organization (ILO), universal access to education would cost from 1.7 percent of gross domestic product (GDP) to 6.2 percent of GDP if scaled up between 2005 and 2034.<sup>8</sup> The child benefit (worth half the universal old age pension) paid to all children up to age 14 would require from 1.5 percent of GDP to 4.5 percent of GDP (Pal et al. 2005).

**Pilot social cash transfer programs have been large in scope, and may be amenable to national scale-up, and often integrated with public poverty reduction schemes.** The pilot Kalomo District (Zambia) and Mchinji (Malawi) cash transfer schemes targeted 1,000 and 3,000 households respectively. Based on the costs of the pilot schemes, crude estimates for national scale-up suggest that the Zambia model would cost \$21-26 million if scaled up to reach the country's 200,000 most destitute households (Devereux et al. 2005). The Mchinji plan would cost \$42 million if scaled up to reach 250,000 destitute households, and would benefit 1 million people including 650,000 OVC (Schubert 2007). South Africa's Child Support (\$90/month) reaches approximately 7 million beneficiaries although the operational costs were not evaluated. Researchers have concluded that South Africa's Old Age Pension Scheme, which as of 2002 paid \$110/month to 1.9 million beneficiaries, cost the country \$2 billion annually, or 1.4 percent of the country's GDP (Schubert 2007). An ILO costing study which analyzed seven sub-Saharan African cash transfer and healthcare programs projected that nationally-scaled, universal old age and disability pensions (worth a daily \$0.50 in purchasing power parity) would cost between 0.3 percent and 0.6 percent of GDP by 2034. Further, a basic universal health care package would cost these countries between 4 percent and 11 percent of GDP. Ethiopia was the exception, where 31 percent of GDP would be needed to provide a universal healthcare package. These models suggest that more research should be carried out to assess the cost of specific program components, country contexts, and projected impacts on poverty (Pal et al. 2005).

**Cash transfer programs that target ultra-poor and labor-constrained households often result in better wellbeing for children living in those households.** (Schubert 2007). Anecdotal evidence from the cash transfer programs in Zambia and Malawi show that women, elderly men and women, and even child-headed households spend assets wisely on child-oriented health, nutrition, and educational expenditures (Schubert 2007; Barrientos and DeJong 2004). The slogan of the Kalomo cash transfer scheme (Zambia), "The poor are not irresponsible," challenges the belief that the poor households will *not* optimally use resources to benefit the household's and children's wellbeing. This is a departure from many Latin American cash transfer programs initiated in the 1980s and 1990s, which required households to allocate resources for children's health and education, to ensure that assets were spent on children's wellbeing.

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<sup>8</sup> The ILO conducted a cost modeling of social protection packages (including an old age pension, national health insurance, children's education, and a child benefit) that run from 2005 to 2034 in seven sub-Saharan African countries (Burkina Faso, Cameroon, Ethiopia, Guinea, Kenya, Senegal and Tanzania). The evaluation concluded that many facets of protection could potentially be affordable if donors and governments prioritize them as a poverty reduction mechanism.

**Research about intra-household and gender dynamics and resource allocation however is lacking.** There is less available data on how men with ability to work spend resources, since cash transfer programs targeting households that are ultra poor and labor constrained are more often led by women and generation gap households (Schubert 2007; Schubert and Slater 2006). Some research suggests that empowerment of women, as manifested by negotiation power and ability to control household revenue, does have a significant impact on how household resources are allocated (Pfeiffer 2003). Another study of South Africa's pension scheme, counters the commonly held belief that women spend more on children's needs than men. The study found that elderly men spend on average approximately 5 percent more on education and food compared to their female counterparts. It also challenges the belief that male beneficiaries spend much of their cash transfers on items such as alcohol and tobacco. In fact, these expenses represented only 8 percent of the total household expenditure men (Schubert 2007) [6].

### **3.2 ASSET GROWTH AND PROTECTION (SAVINGS SCHEMES AND INSURANCE)**

**Evaluations of how savings and insurance schemes directly affect vulnerability to HIV/AIDS are rare or inconclusive.** One study showed that teenage girls in a group savings scheme who received RH knowledge were three times more likely than the control group to insist on condom use, and nearly two times more likely to be able to refuse sex. However, these indicators were only two among many, and they did not show significant differences between the control and experimental groups. Notably, girls in the control group were significantly more knowledgeable about the safety of oral contraception and the lack of cure for HIV/AIDS than girls in the intervention group [7].

**Where measured, having savings was generally correlated with increased confidence, participation in social networks, and overall attitudes about HIV/AIDS.** Studies on the impact of women's participation in group savings schemes in India showed that long-term members place a high value on the social networking benefits of the scheme (Kabeer 2005). Empirical evidence among younger girls in Zimbabwe revealed that the social networking was among the most valued aspect of this economic approach, according to the female participants [9]. Another program, which included an education and HIV/AIDS information component with a matched savings scheme for OVC, revealed improved attitudes about HIV/AIDS and their ability to control risk [8].

**Savings schemes have produced dramatic self-reported nutritional gains, but less conclusive evidence of gains in health care expenditures.** The CARE Village Savings & Loan (VS&L) Schemes in Zimbabwe reported a marked improvement (45 percent to 85 percent) of respondent households eating foods from all major food groups [9]. The same study also showed that two-thirds of households participating in the VS&L scheme reporting improved access to health services, though 11 percent reported reduction in access to health services [9].

**School enrollment among children in affected households showed a statistically significant, yet small (4 percent) increase in school enrollment** among boys living in households with a saving scheme [9]. OVC enrolled in an HIV/AIDS prevention education program with a matched savings fund for schooling reported more favorable outlooks about planning for their future schooling, and preventing HIV/AIDS [8].

**Scope and cost of savings programs that target HIV/AIDS affected families can vary greatly among interventions.** For example, the South Africa Child Development Savings Account [8] and the Tap and Reposition Youth (TRY) program [9] were small in scope, reaching 50 OVCs with the Africa Child Development Savings Account Program and 326 control and participating matched pairs in the TRY intervention. These programs provided more mentoring and individual attention to the participants and were smaller in scope. By contrast, CARE's vast experience of serving 1.9 million people with savings and loans schemes revealed that the cost to formally managed programs could range from \$500 to \$1000 per household to implement. However, informal, community-managed saving schemes in Zimbabwe realized significant savings in operational costs. The CARE VS&L schemes there were able to reach 50,000 people by mid-2004 at the average cost of \$60 per client. CARE attributes the operational cost savings to the simplicity of the community-managed model, and fewer inputs needed from paid CARE staff and logistical resources [9].

**Savings services appear to have a positive impact on household welfare and ability to cope.** Assessments of CARE's VS&L schemes in Zimbabwe and Mozambique showed that women's participation in the scheme resulted in increased ownership of household assets, consumption of major food groups, use of health services, and stability of their businesses. Families who cared for OVC also were better able to cope after participating in the scheme [9].

**There is high demand for safe, flexible savings and insurance products.** During crises, poor households first draw on their savings, before selling their productive assets such as larger livestock or business capital (Donahue et al. 2001). Savings schemes viewed by participants as less risky than microfinance schemes, which may induce stress, particularly for younger female clients [7] (Cohen and Sebstad 2005).

**Among insurance products, the poor have the highest demand for health and funeral insurance.** This is particularly important where the cost of funeral rights are expensive, but also a necessary social obligation to the deceased and to the community of mourners (Roth et al. 2007). Studies on insurance demand consistently reveal that the loss of a household income earner and sickness of a family member are the greatest concerns of the poor (Cohen and Sebstad 2005).

### **3.3 INCOME GROWTH (MICROLOANS, VOCATIONAL SKILLS BUILDING, MARKET LINKAGES, AND VALUE CHAIN PROGRAMS<sup>9</sup>)**

**Microfinance has the most established correlative link with HIV/AIDS mitigation behaviors and attitudes, particularly among women** (Kim et al.)<sup>10</sup> In one study, adult female microfinance participants reported a 24 percent reduction in unprotected sex, attributed to increased confidence in negotiating safer sex practices (Simanowitz 2008). In these women's households, other members reported increased communication about HIV/AIDS and a 60 percent increase in voluntary counseling and testing for HIV.

<sup>9</sup> A value chain is a sequence of activities carried out by multiple enterprises to produce and sell goods and services. As a raw material travels along this chain, each enterprise adds to the value of the good or service until the final product is delivered to the consumer.

<sup>10</sup> From 1995-2001, USAID supported a number of research and impact studies under its Assessing the Impact of Microenterprise Services (AIMS) Project that explored the impact of microfinance services on the poor, including on HIV-affected clients.

However, market linkage and value chain programs for youth and AIDS-affected communities have not been evaluated for reducing HIV/AIDS risk and vulnerability.

**Younger adolescents and children for whom microfinance may not be appropriate, can still benefit from skill building and mentorship.** Studies call into question the appropriateness of microfinance for younger girls due to the high drop-out rates under the social pressure of repayment [7, 11]. Youth and children may benefit more from mentorship and skill-building initiatives until they are more mature and able to graduate to microlending programs (Urdang 2006).

**Microfinance has also led to improved food consumption, especially among OVCs.** The Zambuko Trust program of Zimbabwe showed increases in food consumption among poor borrowers [10], while Project HOPE's Microloans for Business participants who could report eating four meals within the past two days increased from 24 percent at the study baseline to 58 percent at follow-up. OVC reported even greater food consumption increases: At the baseline, only 55 percent of OVC reported eating four meals within the past two days; at the one-year follow-up, 87 percent of OVC reported doing so. Food consumption among other children also increased as 72 percent of children were reported to have eaten six meals in the previous two days, up from 49 percent at the baseline [12].

**Health care utilization and knowledge about HIV/AIDS increased among microfinance participants.** Project HOPE conducted an evaluation of its large scale microfinance programs which improved the economic status and quality of life for families caring for 45,000 OVCs in Namibia and Mozambique. Based on self-reported data collected in northern Namibia among 86 children and 146 caregivers (at baseline and a one year follow-up), caregivers revealed an increase in always seeking needed medical care increased from 40% to 49%. Impacts on OVCs were even greater with those reporting using hospital services the last three times as needed, increasing from 39 percent to 94 percent. Children also reported greater HIV/AIDS prevention knowledge increasing from 51 percent to 70 percent. [12].

**Based on the limited evidence, increases in school enrollment among microfinance participants seem to remain low.** The Zambuko Trust revealed only a 4 percentage point difference in boys' enrollment as compared with a control group [10]. The Project HOPE microfinance schemes reported a 6 percent increase in school enrollment among participating OVC (from 93 percent to 99 percent) [12]. Though the latter indicator had little room for improvement, it is notable that OVC ownership of school supplies rose from 44 percent to 75 percent [12].

**Some microfinance programs that integrate health and education services in high-prevalence contexts have achieved significant scale.** Project Hope's microloans for business program in Namibia and Mozambique reached 45,000 OVC with improved economic status or quality of living [12]. The IMAGE program (Microfinance and Gender and Health Education) reached 40,000 women in South Africa [11]. Alternatively, CARE's village lending model realized significant cost savings by implementing informal, community operated lending programs as compared to more formal lending programs[9]. Exploring ways to combine microfinance with existing health programs is discussed in the recommendations section.

**There is considerable positive evidence about the effect of microfinance on women’s empowerment as measured by indicators of self-confidence, household decision-making authority, bargaining power, and participation in community leadership roles** (Kim et al. 2008; Cheston and Kuhn 2002). Despite the nuanced dynamic between HIV/AIDS and poverty, women who are economically dependent on their male partners may have less freedom to negotiate sexual conditions (including abstinence, condom use, and monogamy). Microfinance has been found by researchers to be a powerful instrument to empower women economically while shoring up self-confidence. Over the long term, this increased self-confidence may help reduce dependence on men and risky behaviors that increase vulnerability to HIV/AIDS. Also notable was one study’s marked improvements in nine indicators of women’s empowerment when paired with microfinance activities<sup>11</sup> [11]. In “Exploring the Role of Economic Empowerment on HIV/AIDS,” Kim et al. (2008) note the increased sense of empowerment may reduce women’s risk behaviors associated with HIV/AIDS transmission. Further, in a study among Kenyan commercial sex workers, vocational skills training led to a decreased dependence on sex work and reduction in the number of sexual partners [14].

Studies also have suggested a link between women’s increased earning potential and changing power imbalances in the household (Kim, J. et. al 2009). Some researchers have found instances where partner jealousies, conflict, and violence have been exacerbated if men view women’s economic empowerment as a challenge to traditional gender roles (Bott et al. 2005, Jewkes 2002). Because of the value of microfinance programs however in increasing women’s financial independence and visibility in the community, many practitioners recommend that microfinance programs continue. To minimize the potential for partner conflict, microfinance programs can integrate gender empowerment training and advocacy with men and the community at large into the traditional financial components of lending (Kim, J. et. al 2009, Bott et al. 2005). As an example, the Image microfinance project in South Africa incorporated empowerment and domestic violence training among borrowers. Among those receiving the training, reports of intimate partner violence declined from 10 percent to 4.5 percent among the 430 participants, as compared to their matched controls [11].

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<sup>11</sup> The indicators that showed statically significant improvements in the IMAGE study included: self- and financial confidence, autonomous decision making, perceived contributions to the household and society, partner relationships, and participation in social groups and collective action [11].

## 4. EVALUATING THE IMPACTS OF ECONOMIC STRENGTHENING PROGRAMS

Little research has been conducted to evaluate the impacts of economic strengthening programs on households and key target groups affected by HIV/AIDS (Anderson 2002; Gammage 2006; Maluccio and Flores 2004).<sup>12</sup> This clearly underscores the importance of building strong monitoring and evaluation plans into existing and future programs so practitioners can draw from empirical evidence on “what works for whom and why” going forward. There are considerable challenges to effectively monitor and evaluate these initiatives, which are outlined below. The challenges are followed by a review of current evaluation practices, and finally proposed indicators that could be used to evaluate the effects and impact of economic strengthening initiatives on wellbeing of households affected by HIV/AIDS (Tables 3 and 4). Recommended indicators draw heavily from the evaluation of the Mchinji cash transfer program<sup>13</sup> and Project HOPE’s impact evaluation on microfinance for OVC households.

**Challenges of evaluating the impact of economic strengthening programs on wellbeing of HIV/AIDS-affected households.** Challenges in impact evaluation include high attrition, ethical concerns about withholding the intervention to create a “control” group, hidden interhousehold dynamics, and difficulty comparing the diverse range of economic strengthening programs and their impact on health outcomes. Finally, sufficient resources must be allotted to carry out rigorous assessments of programmatic impact.

Isolating the effect of a single stream of money generated through savings, cash transfers, microfinance activities, or a combination thereof make causality difficult to establish. Certain variables associated with risk to HIV/AIDS (low self-confidence, hopelessness, autonomy in decision making) are difficult to quantify and measure, let alone attribute to an isolated economic intervention. When impact is assessed, it is often because a large-scale program has funds to outsource the evaluation to a research firm or university.

Eligibility requirements for certain programs may also affect the outcome or use of the services, further clouding the impact of the intervention. Clients who self-select into income growth or asset protection efforts may not be representative of their peers.

**Current practices in impact measurement.** In light of these challenges, economic strengthening programs often report on the donor-required financial and social output indicators (e.g. *number of beneficiaries trained* or *the volume of savings generated*) to track operational performance, without evaluating impacts (James-Wilson et al. 2008; Richter et al. 2004).<sup>14</sup>

<sup>12</sup> USAID is therefore supporting two studies (on the Mchinji Cash Transfer scheme and CARE VS&L) that are intended to shed more light on this relationship.

<sup>13</sup> See [www.childpolicyresearch.org](http://www.childpolicyresearch.org). An impact evaluation specifically of the impact of cash transfers on PLWHA and other target groups will be analyzed and published in Spring 2009.

<sup>14</sup> The interviews were largely focused on programs involved in income growth and asset protection services.

Meanwhile, true impacts, such as changes in *household productive assets* or *improvements in health status* are not assessed due to lack of capacity and resources for more sophisticated impact evaluation.

**Recommendations for evaluating impact of economic programs.** Tables 3 and 4 offer a menu of illustrative indicators to measure health and wellbeing effects and impacts of economic strengthening interventions.

Table 3 focuses on illustrative indicators of health and wellbeing. Indicators are not listed by target group (girls, women, etc.) but can apply to some or all of the key target groups of economic strengthening programs for the HIV-affected. They can be used to assess individual impacts, or to disaggregate impacts among target groups relevant to specific programs (e.g., to assess the impact of microfinance on girls' food consumption). The indicators presented in Table 3 may be applicable to social assistance, asset protection, or income growth programs. In contrast, Table 4 presents indicators that vary by type of economic strengthening program. They include immediate indicators of program functioning and impact indicators that are directly related to the core mandate of the program (for instance, in the case of insurance, to mitigate the effects of severe economic shock on consumption of essential goods and services).

#### **Empowering Beneficiaries for Timely, Continuous Monitoring and Evaluation: Learning from Project HOPE**

When new caregivers of OVC enroll in Project HOPE's Village Health Bank, key baseline indicators of the household's socioeconomic indicators are collected. Caregivers are given a simple child status index card that can be used to track the child's development and health status every six months according to six key variables:

- Nutrition and development – *Eaten foods from all 3 food groups in the last 2 days*
- Health – *No fever in the last two weeks*
- Shelter – *Sleeps under a mosquito net*
- Education – *Able to read and write (over 7 years old)*
- Parity with other children – *Does same work in the house as other children*
- Psycho-social – *Usually sleeps at night without crying.*

The use of illustrations does not require the user to be literate, as caregivers simply place checkmarks next to the scenarios depicted. This simple method allows Project HOPE to gather data every six months on a child's progress, in a cost-effective manner.

*(Interview: John Bronson, Project HOPE)*

Table 3 includes a non-exhaustive, but representative list of core illustrative indicators to measure health, nutrition, and wellbeing impact of economic strengthening programs on HIV/AIDS-affected households. These indicators can be used among all target groups (e.g., PLWHA, OVC) and the full range of economic strengthening programs.

Intrahousehold decision making and resource allocation dynamics affect household member's wellbeing. A variety of factors: e.g., profile of the aid recipient, household head, decision making and bargaining power, as well as the unique and specific needs of household members, affect how resources will be allocated within the household (Kingdon 2005). Intrahousehold dynamics are also particularly important among destitute households, as members may use the bulk of their revenue stream to care for the special needs of one member (e.g., a terminally sick individual). Therefore it may be important to measure impact at the individual level by characteristics that could influence the extent to which individual household members benefit from the additional resources available to the household unit, e.g. gender or age. Moreover, if a program has a specific goal to increase children's education, or ensure female child empowerment, the indicators below should be disaggregated by the appropriate target group to inform program design strategies.

Sources of information used to construct Table 3 include: evaluation of the Mchinji Social Cash Transfer scheme, Demographic and Health Surveys, and recommendations from the Project HOPE's monitoring and evaluation specialist. For more information on HIV/AIDS-related outcome and impact indicators, please refer to the most recent PEPFAR indicators, which will be made publicly available toward the middle of 2009.

**TABLE 3. ILLUSTRATIVE CORE INDICATORS TO MEASURE ECONOMIC STRENGTHENING IMPACT ON WELLBEING**

**Indicators for Illness, Nutrition, Wellbeing, Psychosocial, Coping Abilities to Absorb Economic Shocks**

**Health Status:**

**What is the health status of the individual (or household, if the interviewer is asking at the household level)?**

- % reporting health status as (fair, poor, good or excellent).
- % of individuals reporting illness in past 4 weeks.
- % of individuals reporting illness (cough, stomach pain, fever) in past 4 weeks who saw a health care provider (by type).
- % of individuals reporting illness that limits activities in the past 4 weeks.
- % of individuals reporting long term/chronic illness (more than 1 month in past year - arthritis, chest pain, TB, asthma, HIV/AIDS, or other chronic illness).

**Is the person's health sufficient to carry out productive work (or school attendance if the individual is of school age).**

- % who report having an illness stop normal activities in the past year (for 1 day, 7 days or another specified time).
- % of individual reporting illness in past year that required someone else to stop activities to provide care.
- % report having difficulty walking 5 km (unable, very difficult, somewhat difficult, no difficulty) currently or in past year.
- % report having difficulty sweeping the floor (unable, very difficult, somewhat difficult, no difficulty) currently or in past year.

**Can the individual afford to spend and sustain spending (if needed) on health care? In the past 6 months (or choose a 'significant day/event' to serve as a marker to aid recall):**

- % who sought care from (gov't/private hospital clinic, traditional healer, relative/friend, community health worker, herbalist, grocer, faith healer, other, none) for last illness.
- % who reported NOT seeking care at last illness due to the following factors: (illness not serious, or no time, no money, no transport, hospital/health center far away, did not want treatment, clinic is too crowded, no one can help, other).
- % of those who purchased medicine (antibiotic, over the counter pain killer, ART, Quinine/Fansidar for malaria, etc.) to treat the last reported illness in which medicines were needed.
- % of individuals who adhered to ARV regimen (or other necessary medicine, for instance) to sustain the person's health in the preceding 6 months.
- % reporting health expenditures (clinics, medicine, transport costs, pharmacy, etc.) in response to the last illness.

## Nutritional Status:

**Is nutrition being improved or sustained (assumes baseline survey was conducted)? Period of recall can be a month for the self-reported indicators.**

- % with anthropometric measurements that indicate that household members (and children in particular) are underweight.\*
- % stunted or wasted (most appropriate with children under the age of five).\*\*
- % having eaten (0, 1, 2, 3, 4) meals yesterday.
- % reporting insufficient food for (0, 1, 2, 3, 4, 5, 6, 7, 8, 9+) days during the past month.
- % reporting (too full, satisfied, somewhat hungry, hungry) generally after meals.
- % reporting eating (cereals/grains, roots, beans/nuts, vegetables, meats/fish, fruits, cooked food, milk products, sugar, beverages, spices).

\* These measurements are calculated through Body Mass Index (BMI). BMI = weight in Kg/height in meters<sup>2</sup>. Underweight < 18.5 Kg per meters<sup>2</sup>; normal weight = 18.5-24.9 Kg per meters<sup>2</sup>. Other options for calculating nutritional status include arm circumference and skin fold thickness.

\*\* WHO definitions for children under 5 who are Underweight: Weight-for-age is < 2 standard deviations (SD) below of the National Center for Health Statistics (NCHS) or WHO reference median. Stunting: Height-for-Age < 2 SD below the NCHS/WHO reference median. Wasting: < 2 SD weight/height.

**Mortality Indicators:** (Acknowledge that these questions may be difficult for the household to answer, allow option not to answer).

- % of households reporting that any child or adult has passed away during a specified period.
- If yes, tally the name and relationship to the head of household of the individual who died, as well as length of illness prior to the death (days, weeks or years). If possible probe for the cause of death: heart attack/stroke, cancer, HIV/AIDS, TB, pneumonia/other respiratory illness, stomach/diarrhea illness, malaria, meningitis, other, don't know.

**Psychosocial Indicators:** Psychosocial status is generally better assessed through qualitative research.

Even if researchers use a standardized scale (such as those listed below), qualitative formative research is critical to gather contextually relevant understanding of psychosocial dynamics.

Each sub-group will have very different responses, and they must be culturally appropriate. Emotional health can be expressed behaviorally, through physical health, self-perception/self-esteem, and overall functioning.

*Children's Proxy Indicators:* behavior, hygiene, cleanliness, nutritional status, functional status (do they function and behave and have cognition at age-appropriate levels?). Examples of standardized scales for assessing children's psychosocial state include the Child Behavior Checklist (Achenbach System of Empirical Assessment, <http://www.aseba.org/support/SAMPLES/PreschoolCBCLSample.pdf>). This checklist is referenced as an example only. Any psychosocial evaluative behavior checklist would require local and adaptation that is rigorously evaluated, pre-tested and translated for local context.

*Elderly and Adults:* General Health Questionnaire (12–60) (Global Health Questionnaire examples: [http://www.gl-assessment.co.uk/health\\_and\\_psychology/resources/general\\_health\\_questionnaire/general\\_health\\_questionnaire.asp?css=1](http://www.gl-assessment.co.uk/health_and_psychology/resources/general_health_questionnaire/general_health_questionnaire.asp?css=1)). Medical Outcomes Study, Short Form-36 (Rand Corporation, [http://www.wsib.on.ca/wsib/wsibobj.nsf/LookupFiles/POCMTBIRand/\\$File/MTBI\\_RAND.pdf](http://www.wsib.on.ca/wsib/wsibobj.nsf/LookupFiles/POCMTBIRand/$File/MTBI_RAND.pdf)).

## Wellbeing:

### What is the perceived wellbeing of the individual?

- % reporting (not hopeful, little hopeful, hopeful, don't know) that their situation will improve.
- % reporting satisfaction with life (very unsatisfied, unsatisfied, neither satisfied or unsatisfied, very satisfied).
- % reporting household consumption is (less than enough, enough, more than enough).
- % reporting housing is (less than adequate, neutral, adequate, more than adequate).

## Hygiene:

### What is the hygiene level of the household?

- % reporting frequency of having soap to bathe (never, 1-3X/week, 4-7X/week).
- % reporting frequency of brushing teeth (never, 1-3X/week, 4-7X/week).
- % reporting # of changes of clothes (0-1; 2-3; 4-5; 6+).
- Frequency of bathing (0, 1-3, 4-7X/week).

## Ability to Cope/Absorb Shocks:

- % reporting (lower crop yield, crop disease, livestock death/stolen, rise in food prices, illness/accident of household member, death of household member, damage to house) in the preceding two years.
- % reporting that economic shocks caused (loss of income, child to leave school for > 1 week, child to leave school permanently, prostitution, begging) in the preceding two years.

## Additional OVC, Specific Indicators:

### Does the household report caring for OVC?

- % reporting a child in the house that does not have a biological mother or father in the household due to (migration for work, divorced, desertion, sick, married, death of parent, remarried, do not know).
- % of caregivers reporting caring for a nonbiological child more than 4 days/week.

If yes:

- % with the orphan(s) or vulnerable child(ren) currently (or not) enrolled in school (if age 6-17).
- % reporting that children missed (1, 2, 3, 4, 5, 6, 7+) days of school in the past month.
- % reporting that children stopped attending school due to (still in school, no school fees, to care for sick family member, poor school performance, no interest, got married, graduated, pregnant/parenting, got a job, expelled, work at home, disabled, work outside the home).
- % with children completing grades (1-14 or university).
- % with children repeating a grade.
- % repeating a grade due to (school fees, cared for sick family member, poor grades, pregnant/parenting, married, illness, working in the home, working outside the home, not interested, not important to adults).
- % of household with children desiring to return to school.

#### **Additional PLWHA Specific Indicators:**

- Since many households may allocate much of the resources to the PLWHA, use the indicators about health status, in combination with the economic indicators to assess if the PLWHA is getting access to needed treatment, and also to assess if the rest of the household is getting adequate nutrition, health care, school enrollment (as appropriate).



<p><b>Asset Protection**</b> (Restore or maintain economic resources)</p> <p><i>Group and Individual Savings</i></p> <p><i>Insurance</i></p> <p><i>Legal Protective Services (to protect vulnerable groups)</i></p>	<ul style="list-style-type: none"> <li>- % of households reporting increase in asset ownership.</li> <li>- % of households reporting increased ability to cope with economic shocks (see these indicators listed above).</li> </ul> <p>Insurance services may include (life/funeral insurance, home damage, crop, health). <i>With all insurance schemes it is important to first determine if the household has experienced a shock, even beyond focus of intervention. Ideally, any form of insurance, should help the household cope with all sorts of shocks (illness, weather, livestock death).</i></p> <p><b>Illustrative impact indicators of successful insurance schemes:</b></p> <ul style="list-style-type: none"> <li>- Include the indicators about basic household consumption (use nutrition, health seeking behaviors, school enrollment indicators above) to determine if households are able to cope with shocks within the past 1 month (or another appropriate time frame).</li> <li>- % reporting that crop failure caused (loss of income, child to leave school for &gt; 1 week, child to leave school permanently) within the past 12 months.</li> <li>- % reporting receiving payments on claims made to the insurer, in the event that crop failure (or other insured event) occurred within the past 12 months.</li> <li>- % of households reporting that children have taken part in the following risk activities in past 12 months (or other appropriate time frame): begging, leaving school in order to work, prostitution, skipping meals, sent to live with another household for care and support.</li> <li>- Women: % reporting the following risk activities in the past 12 months: begging, prostitution, migration away from their families.</li> </ul> <p><i>Note: Nutritional indicators, health seeking behaviors (ability to access needed health care), hygiene, wellbeing, and psychosocial indicators apply to all target groups.</i></p> <p><b>Particularly relevant for divorced, separated, and widowed women, and also orphans.</b></p> <ul style="list-style-type: none"> <li>- % engaged in productive work.</li> <li>- % with access to credit, if they need it.</li> <li>- % with sufficient legal status to care for their children, be head of their household, own livestock, remain in their dwelling, and maintain their land.</li> <li>- % reporting they have received legal assistance if they need it.</li> <li>- % reporting requiring legal assistance to maintain (head of household, right to care for their children, right to own/rent land etc) but not being able to access it.</li> </ul>
<p>** Target audiences for asset growth and protection include very vulnerable households (those in transition) including caregivers of OVC, youth, and PLWHA.</p>	

<p><b>Asset Growth***</b></p> <p><i>Microfinance</i></p> <p><i>Skills Training</i></p> <p><i>Market Linkages</i></p>	<ul style="list-style-type: none"> <li>- <b>Business loans/Microfinance</b> <ul style="list-style-type: none"> <li>- % reporting sufficient loans to increase their business.</li> <li>- % reporting ability to repay.</li> <li>- % reporting increase in income (before and after), baseline is necessary.</li> </ul> </li> <li>- Note: programmatic best practices from field practitioners suggest that skills training should be complementary, but not mandatory to receiving economic strengthening assistance. <ul style="list-style-type: none"> <li>- % reporting increased knowledge, skills in the training program.</li> <li>- % reporting increased confidence to use the new skill for income-generating activities.</li> </ul> </li> <li>- <b>Market linkages</b> (baselines are important to determine the effect of the market linkage program). <ul style="list-style-type: none"> <li>- % reporting increased revenue due to application of the new skill (determine profit values and compare with the cost of inputs) over the last month, year, or since program inception.</li> <li>- % reporting increased clientele base, or increased market access as compared to before the program inception.</li> </ul> </li> <li>- <b>Income-generating activities</b> (baselines are important to determine the effect of the market linkage program). <ul style="list-style-type: none"> <li>- % reporting increased revenue due to application of the new skill (determine profit values and compare with the cost of inputs) over the last month, year, or since program inception.</li> </ul> </li> </ul>
<p>*** Business loans, skills, vocational and market linkages are best targeted toward those who are somewhat vulnerable but with productive capacity: caregivers, youth (though youth may respond better to mentorship and skill building, than to loans) and PLWHA who have productive capacity.</p>	

## 5. RECOMMENDATIONS FOR DONORS AND PRACTITIONERS BY PROGRAM TYPE

### 5.1 CHALLENGES TO THE EVIDENCE BASE ON POVERTY AND HIV/AIDS

While economic strengthening programs to prevent and mitigate the effects of HIV/AIDS are increasingly being utilized in the field, rigorous evaluations of these programs are limited. Greater economic and food security generally have been found to have protective effects against risk of transmission while shoring up households abilities to cope with economic shocks. But the complex relationship between HIV/AIDS and poverty calls for broader economic empowerment interventions than poverty or hunger alleviation alone (Kim et al. 2008).

Economic empowerment is multifaceted. It involves hard-to-evaluate concepts such as interhousehold dynamics, self-confidence, trust, respect, and access to capital and essential services that do not easily lend themselves to cross-sectoral experimental design. The multitude of factors that affect HIV/AIDS and poverty are also difficult to measure, making causality and attribution of program effects difficult to assign. In addition, there is a lack of common units for measuring poverty and HIV/AIDS interventions: Poverty and food assistance often target households while HIV/AIDS programs target key risk groups. These challenges have also constrained researchers' ability to systematically evaluate the dynamic relationship between HIV/AIDS, and economic strengthening programs.

Common definitions of wellbeing, and risk reduction are still being defined. For example, the USAID-funded Consultative Group to Assist the Poorest (CGAP) has designed a focused research agenda to investigate the **impact of linking economic programs with broader social protection services or other productive employment opportunities**. As this research is still nascent, it does not yet provide empirical evidence of how enterprise development and market linkage programs affect households. Forthcoming evaluations will assess how vocational training and enterprise development efforts impact different target groups.<sup>15</sup>

**Overall, there is a significant need for more research to assess the impact of economic strengthening programs on the health and wellbeing of groups affected by HIV/AIDS.** Nevertheless, while more robust research is needed on the impact of economic strengthening programs, some data are available from impact evaluations, published literature, and policy guidelines developed by practitioners and scholars that make it possible to make some preliminary recommendations for program design.

### 5.2 RECOMMENDATIONS

Recommendations based on formal evaluations are noted in brackets which correspond to the study number in Annex E. Recommendations from literature reviews, policy frameworks and guidelines are cited in parenthesis.

<sup>15</sup> See <http://www.cgap.org/p/site/c/>

## 5.2.1 SOCIAL ASSISTANCE AND CASH TRANSFER PROGRAMS

### Donors:

- **Work with governments to integrate cash transfers with social protection frameworks to be instituted over the long term.** Cash transfers should be complemented by social welfare services (including early children services), and productivity and employment-based schemes over the long term (Devereux et al. 2005).
- **If conditionalities are tied to participation in an economic strengthening program, ensure that adequate supplies of the service are available and accessible to beneficiaries.** Consider the participant's opportunity costs (e.g., time, transport costs, child care commitments) before applying conditionalities (Devereux et al. 2005).

### Practitioners:

- **Use transparent poverty criteria for targeting households and do not target based on HIV status.** Where appropriate, make eligibility criteria transparent, with clear cut-offs such as income, caloric consumption, labor constraints, and the presence of chronically ill, elderly, and orphaned children. Use a participatory approach and multiple layers of targeting to increase the most vulnerable households in a transparent manner [1, 3].

Notably, the Mchinji (Malawi) and Kalomo District (Zimbabwe) cash transfer programs demonstrate that when the most poor and labor-constrained and food-deprived households are targeted in high HIV/AIDS prevalence areas, 70 percent of the households selected for inclusion are deemed to be HIV/AIDS affected. See Annex G for the targeting evaluation methods.

## 5.2.2 INSURANCE AND SAVINGS

### Donors:

- **Invest in research to tailor insurance to meet the needs of HIV/AIDS-affected households.** While research points to a growing demand for insurance products to help the poor cope with economic crisis, there are few evaluations of microinsurance's effects on communities affected by HIV/AIDS (Cohen and Sebstad 2005; Sebstad et al. 2006).<sup>16</sup>
- **Consider savings as a first step for poor households to build their asset base and access a broader menu of financial services.** Savings may be more appropriate than loans for the very poor, particularly among young girls who may not yet have the coping skills to manage the social pressure of loans [7] and women who feel that using their own savings to start a new business venture is less risky and preferable to a loan (James-Wilson et al. 2008).
- **Encourage only institutions or groups that have the capacity to assess and manage risk to undertake insurance services.** Insurance is a highly specialized field. It also requires a high level of trust among consumers so they feel confident in giving their funds to an institution for an event that may not occur. To protect policyholders and ensure that schemes are viable, insurers

<sup>16</sup>The CGAP Working Group on Microinsurance launched a project in 2003 to document the experiences of microinsurance operations around the world and identify good and bad practices. The working group conducted 24 case studies, documenting the lessons of more than 40 organizations.

need to draw on actuarial input and maintain sound financing and investment policies around their core insurance business (Chandani 2008). Insurance programs are difficult to initiate in a region that has had no exposure to insurance. Education of the public is essential to making insurance schemes successful (James-Wilson et al. 2008).

### Practitioners:

- **Tailor savings products to the needs and capacities of those they seek to reach, as well as the capacities of the institutions administering the products.** A variety of individual savings (CSA, matched savings, contractual savings, mobile savings) and group savings schemes (ASCAs or community welfare funds) can be identified based on client demand, capacity, and institutional options. Products should be simple, safe, and flexible to ensure that families can draw on their funds to meet emergency or routine household needs (James-Wilson, 2008, Hall et al. 2006).

**Ensure that participants in group-based savings self-select into schemes and are able to manage them independently.** Encouraging groups that form for other purposes (such as home-based support) to create a savings group is not as successful as having groups self-select into group savings schemes. Savings groups should set clear criteria for membership and conditions for managing the fund to ensure transparency and efficiency in processing. While savings groups can offer members a valuable networking opportunity, groups also require a high level of trust, and individual commitment (James-Wilson et. al 2008).

**Vulnerable groups can be successful at managing group lending schemes outside of formal institutions.** Analysis of informal, self-managed group savings schemes (both Rotating and Accumulating Savings and Credit Associations) show that these can be very useful and appropriate to help HIV/AIDS affected households cope and prepare for economic shocks (James-Wilson 2008). These schemes can be appropriate stepping stone for more formal savings schemes for groups such as youth, children, or remote groups without prior experience with formal savings and microfinance institutions.

Best practices of the informal group savings and credit schemes include encouraging time-bound (eg. 6-12 months) savings periods, after which savings and interest are returned to participants for transparency (James-Wilson 2008). Other recommendations include allowing savings groups to design their own meeting frequency terms, contribution amounts, and determine how savings and loans will be managed and other bylaws. Strong training and operational manuals however should be in place to ensure that the appropriate management and tracking of the transactions. External borrowing or donations should be restricted and earnings from savings and loan schemes should stay within the savings group. Loans should be utilized for productive or consumptive purpose (Allen 2002) and transactions with the group savings schemes should be as simple as possible to maximize access and convenience for participants (James-Wilson 2008).

- **For long-term savings and lending programs, ensure that savings are placed in reliable – and ideally formally regulated – institutions.** These are able to provide long-term security to clients to accurately monitor balances over time. Such institutions can also provide loans or other financial services to clients after they have developed a savings base (James-Wilson et al. 2008).

- **Ensure that insurers working in communities with a high prevalence of HIV/AIDS mitigate risk** by expanding the size of risk pools and ensure a sufficient spread of risk, utilize accurate mortality and morbidity data to price their insurance products, and design benefit packages and levels of coverage based on willingness to pay. All group members within a certain parameter set by the village or town should buy coverage to prevent self-selection by the sick, aged, or other high-risk groups. Also ensure that members are able to contribute a premium on a regular basis (Roth et al. 2007; Chandani 2008).

### 5.2.3 Income Growth

#### Donors:

- **Recognize that income growth and enterprise development are long-term business propositions.** Programs related to protecting and growing the assets of clients should be designed with sustainability objectives so they can provide low-income groups with services over time. Thus, such programs may not be suited to serve the most vulnerable who are more risky as borrowers (in the case of financial services), or may require more intensive subsidies and therefore compromise the long-term sustainability of institutions (Odek et al. 2002).
- **Focus on working through sustainable institutions that provide loans and ensure arms-length relationships with clients.** Microfinance programs that have become sustainable have adhered to tested operational practices. This includes managing their institutional risk by lending only to borrowers with the capacity to pay back the loans, as well as ensuring that clients adhere to strict financial discipline and are not given mixed messages about accessing loans and grants under the same roof (James-Wilson et al. 2008).

#### Practitioners:

- **Conduct market research to understand the business needs of each target group (eg. youth, or women) to match their capacity and situational context.** This relates to whether vocational or management training, business loans, market linkages, or a package of such activities are required, and the design of these services. Upfront investments in market analysis and sector-specific studies are indispensable for facilitating the growth of sustainable enterprises among new or existing entrepreneurs (James-Wilson et al. 2008).
- **Reserve business loans for people have the capacity to engage in income-generating activities.** Loans may not be appropriate for the most vulnerable families or individuals, especially those who are living with AIDS. Moreover, not everyone needs a loan to start a business or to improve their economic situation and may be better off by accessing savings as a way to build their physical assets, protect against shocks, and become familiar with the culture of regular payments. Where loans are targeted to the vulnerable, they should build on savings programs or be carefully designed to graduate clients from safety-net services (seed grants, training or public employment programs, for example) to a loan facility (James-Wilson et al. 2008).
- **Assess the capacity of beneficiaries to engage in productive enterprises or employment and match them with appropriate services.** Loans may not be appropriate for people living with AIDS, especially at the symptomatic stages. Other groups, such as adolescent or first-time borrowers, may be better served by vocational training, mentoring services, or skill building to build

their confidence and capacity; others may prefer to work in group employment rather than start an enterprise [7]. When households with **chronically ill** people are targeted, programs should consider the additional demands on household productive labor with new business responsibilities – which, for example, may lead to children being taken out of school to work in the enterprise (James-Wilson et al. 2008).

- **Carefully design interventions that link financial with nonfinancial services, such as vocational training.** When offered as a package, these services can be extremely valuable and indispensable for clients. It can also help graduate them to self-sufficiency. Nonfinancial business support services must be carefully designed and provided by economic development specialists. Where necessary, provide these services independently of financial services to avoid giving conflicting messages to clients, i.e., of receiving services for free versus at a cost (Hashemi et al. 1996).
- **Identify viable markets and sectors that have potential for growth when considering skills training and enterprise development projects.** It is essential for programs that are centered on improving access to broader, more productive markets for vulnerable groups to engage in extensive market analysis at the start, and to match the needs, skills, and resources of target groups with suitable sectors. It is important to involve target communities and households in the selection and identification of specific sectors, ensure there is strong demand for the end product, and help facilitate strong linkages between the small or medium enterprise in which the client or group of clients is involved and broader markets (Interview, Margie Brand, Eco-Ventures International).
- **Integrate complementary training, health education, and literacy services where possible, to build confidence and knowledge among beneficiaries.** Complementary services can be integrated cost effectively and lead to risk reduction of HIV among beneficiaries. Savings and insurance groups can also be an important source of psycho-social support among group members (Erulkar and Chong 2005).

## **CROSS-CUTTING RECOMMENDATIONS FOR ECONOMIC STRENGTHENING IMPLEMENTATION:**

### **Donors and Practitioners:**

- **Avoid targeting based on HIV/AIDS status** because of the difficulty in *accurately* reaching affected families, *stigma* and *equity concerns* which may result from targeting services to HIV status, rather than considering other types of vulnerabilities, such as old-age, disabilities, or other illness (Adato and Bassett 2007, Schubert 2007).
- **Assess intra-household dynamics to ensure optimal use of benefits.** Many studies suggest that targeting women and the elderly is one way to ensure high impacts on households and children [1, 3, 4, 5, 6] (Pfeiffer 2003).
- **Link economic strengthening (particularly for the most vulnerable) to voluntary, complementary services to ensure the effective use of resources.** Access to support services including health, counseling, and adherence to ART, and other family welfare services are critical for all economically vulnerable families - especially those affected by the multiple impacts of HIV/AIDS. PLWHA adherence to ART can complement cash transfer interventions that reach significant numbers of families affected by HIV/AIDS (Adato and Bassett 2007; Schubert 2007).

- **Ensure that implementing partners have the capacity to administer services regularly, reliably, and over the long term.** Generally, the size of the cash transfers has been found to correlate with the level of impact – though even small cash transfers have been shown to have strong impact (Devereux et al. 2005).
- **Consider the existing safety nets available to vulnerable groups.** Identify and build on economic interventions available to target households. Map existing economic strengthening programs to understand opportunities, gaps, and potential partnerships. This includes national-level social assistance programs to agencies involved in economic development work. This may reveal that beneficiaries of a health program may already be participating – or eligible to participate – in a national cash transfer program (James-Wilson et al. 2008).
- **Involve different specialists at the initial phase of designing multisectoral programs to define an approach that reflects best practices in different sectors.** Rather than directly providing loans, health sector initiatives should identify strong partners that have a core competency in financial service delivery. Be aware of potential differences in institutional mandate and orientation and thus spend time upfront to define mutual objectives, outcomes, and approach (Miller and Tsoka 2008).
- **Institute strategies for graduating clients between different types of economic strengthening programs.** Link programs to prepare individuals to build their economic capacity and improve their prospects for accessing services from formal financial institutions. From an institutional standpoint, verification that an individual has successfully graduated from a safety-net program will also help to mitigate risk. This requires building and maintaining partnerships from different sectors, which can draw on each other’s core expertise and improve standards of professional practice (James-Wilson et al. 2008).
- **Carefully consider how to include supportive services for any economic strengthening approach that may change perceived gender roles.** Microfinance programs have been found to be a powerful tool to increase women’s confidence, self-efficacy and social networks, which in turn may contribute to decreased HIV risk behaviors. Women’s economic empowerment may however, be perceived as a threat to traditional gender roles. Donors and practitioners should facilitate partner and community support of women’s increased resources, and should ensure that women have access to appropriate services. Further research is also needed to investigate how to mitigate unintended negative consequences, such as intimate partner violence.
- **Stay abreast of impending research conclusions.** Some of the gaps in research mentioned above are being addressed by a few groundbreaking research programs that assess how economic strengthening program affect HIV/AIDS-affected households. The Boston University Child Policy Research Center’s is conducting an ongoing evaluation of the Mchinji Cash Transfer scheme. The research has already shed light on how cash transfers change health seeking behaviors, school enrollment and absenteeism, nutritional intake, and illness frequency. It will further uncover how cash transfers impact ART compliance, a variable that has not been thoroughly investigated given the lack of intrahousehold data regarding spending patterns.<sup>17</sup>

<sup>17</sup> See <http://www.childresearchpolicy.org/mchinjicashtransfer.html>

The Supporting Transformation by Reducing Vulnerability with Economic Strengthening (STRIVE) project, supported by USAID's Displaced Children and Orphan's Fund (2007-2012) will design, implement, and monitor initiatives in five countries to demonstrate effective means of sustainably improving the economic circumstances of vulnerable children, many of whom are orphaned and vulnerable due to HIV/AIDS.<sup>18</sup>

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<sup>18</sup>See <http://www.cyesnetwork.org/strive>



# CONCLUSION

Families and communities affected by HIV/AIDS experience sustained shocks as a result of the epidemic, often leading to devastating health, social, and economic consequences. The impact of health-centered HIV/AIDS programs can be expanded and sustained when coupled with economic strengthening interventions. Many small- and larger-scale multisectoral initiatives are being tested to improve access to medical treatment and care *and* mitigate the financial impacts of the epidemic on vulnerable individuals and households. Empirical evidence of their impact is still limited as few have undergone rigorous evaluation. Nonetheless, the evidence that exists points to positive correlations between participation in economic safety-net programs, savings facilities, and income growth programs, with improvements in household welfare. Where programs have intentionally introduced education, social support, and confidence building, they exhibit some reduction in risky behaviors that are known to transmit HIV/AIDS. Education is particularly important because it is a predictor of health status, irrespective of wealth.

There is enormous need and potential to continue forging partnerships between health and economic strengthening programs to counter the sheer scale and impact of the HIV/AIDS epidemic. Health-focused programs should consider the broader safety nets of individuals deemed most vulnerable, such as caregivers in the households, extended families, and communities. Effective partnerships with economic strengthening programs will build on these existing safety nets to ensure that vulnerable livelihoods are protected over time.

Depending on their economic vulnerability, individuals and families can benefit from different economic strengthening programs. Households that are not able to engage in productive activities generally require relief or **social assistance** services such as cash transfers that provide for their basic needs around food, shelter, health, and education. **Asset protection** services can help to stabilize families by preventing the loss of their asset base and provide the initial capital and business confidence to consider growing income. Activities that are centered on **income growth** can help to diversify the economic activities in which a family is involved and strengthen their longer-term resilience to crises. Programs should carefully match the capacities of different individuals and groups with the type of economic strengthening support; for instance, the elderly may require ongoing cash subsidies to care for children in the household, adolescents may require access to savings and vocational training services to build their financial base and confidence, and women may choose to access business loans to start a new enterprise.

Multisectoral programs must invest resources to understand local contexts, market opportunities, and barriers before designing economic development interventions. Understanding local culture and social dynamics is also critical to designing targeting mechanisms to identify households in need. Further, incorporating robust monitoring and evaluation plans that draw on expertise from different disciplines will be critical for assessing the impact of economic strengthening programs for HIV/AIDS-affected households and for informing future interventions.



# ANNEX A. RELEVANT WEBSITES

## Enterprise Development and Microfinance

- Consultative Group to Assist the Poorest ([www.cgap.org](http://www.cgap.org))
- MicroFinance Gateway ([www.microfinancegateway.org](http://www.microfinancegateway.org))
- Small Enterprise Education and Promotion Network (SEEP) and network on HIV/AIDS and Microenterprise (HAMED) ([www.seepnetwork.org](http://www.seepnetwork.org))
- MicroLinks ([www.microlinks.org](http://www.microlinks.org))
- Microinsurance Center ([www.microinsurancecenter.org](http://www.microinsurancecenter.org))
- UN Capital Development Fund (UNCDF) ([www.uncdf.org](http://www.uncdf.org))

## HIV and AIDS

- AIDS Alliance ([www.aidsalliance.org](http://www.aidsalliance.org))
- UNAIDS ([www.unaids.org](http://www.unaids.org))
- Joint Learning Initiative on Children and HIV/AIDS (JLICA) ([www.jlica.org](http://www.jlica.org))
- Synergy AIDS ([www.synergyaids.com](http://www.synergyaids.com))

## Youth and Vulnerable Children

- Children's Rights Information Network (CRIN) and Better Care Network ([www.crin.org](http://www.crin.org))
- Children and Youth Economic Strengthening Network (CYES)

## Research Institutes / NGOs

- Academy for Educational Development (AED) ([www.aed.org](http://www.aed.org))
- SARA Project ([sara.aed.org](http://sara.aed.org))
- CARE ([www.care.org](http://www.care.org))
- Child Research Center (<http://childresearchpolicy.org/mchinjicashtransfer.html>)
- Center for Strategic International Studies (CSIS) ([www.csis.org](http://www.csis.org))
- Save the Children ([www.savethechildren.org](http://www.savethechildren.org))
- International Center for Research on Women ([www.icrw.org](http://www.icrw.org))
- Family Health International ([www.fhi.org](http://www.fhi.org))
- The Policy Project ([www.policyproject.com](http://www.policyproject.com))
- Population Council ([www.popcouncil.org](http://www.popcouncil.org))
- Human Sciences Research Council (HSRC) ([www.hsrbpress.ac.za](http://www.hsrbpress.ac.za))
- Global Assets Project ([www.globalassetsproject.org](http://www.globalassetsproject.org))



## ANNEX B. KEY INFORMANTS

Name	Affiliation
Thierry van Bastelaer	Save the Children
Colette Bottini	U.S Agency for International Development (USAID)
Margie Brand	Eco Ventures International / STRIVE Project
John Bronson	Project HOPE
Ben Fowler	MEDA
Victoria Francis	Emerging Markets Group
Aaron Greenberg	UNICEF
Karen Hardee	Population Action International
Ruth Hope	Independent Consultant
Dr. Candace Miller	Child Research Policy Center, Boston University
Patricia Lim Ah Kim	UNICEF
Beatrice Kinyanjui	Emerging Markets Group
Laura Meissner	SEEP Network
Annie Michaelis	Independent Consultant / Population Council
Allyn Moushey	U.S Agency for International Development (USAID)
Geeta Nagarajan	IRIS Center
Bill Philbrick	CARE USA
Diana Prieto	U.S Agency for International Development (USAID)
Cathy Ratcliff	Mercy Corps Ethiopia
Sabina Rogers	SEEP Network
Laura Skolnik	U.S Agency for International Development (USAID)
Evelyn Stark	Consultative Group to Assist the Poorest (CGAP)
Linda Sussman	International Center for Research on Women (ICRW)
John Williamson	U.S Agency for International Development (USAID)



## ANNEX C. CASE STUDY: THE MCHINJI PILOT SOCIAL CASH TRANSFER SCHEME

The Mchinji Pilot Social Cash Transfer scheme in Malawi is an example of a cash transfer effort that has been designed to reach HIV/AIDS-affected families within a broader mandate of reaching the most vulnerable. Funded by UNICEF and the Global Fund to Fight AIDS, Tuberculosis and Malaria, the scheme was launched in 2006 by the Malawian Government to reduce poverty and hunger in extremely poor households. Preliminary baseline data indicate that 70 percent of the households are HIV/AIDS affected and care for OVC or the chronically ill, or have had an AIDS-related death in the household (Schubert 2007).

The scheme also set out to increase school attendance and improve the health, nutrition, and protection of OVCs. Under the scheme, households receive \$4 to \$13 based on the number of persons in the household, with a bonus of between \$1.5 to \$3 offered for children who attend primary and secondary school respectively. By 2007, the scheme reached 3,000 households and has plans for scaling up to 28 districts and 250,000 households by 2015, at an estimated cost of \$42 million.

At the one-year follow-up impact study, conducted by Boston University's Child Research Policy Center, households reported that they achieved significant increase in productive assets, basic necessities, and livestock. They also reported fewer missed meals, fewer days without adequate food, and greater food diversity. Children exhibited a 2.2 percent point reduction in wasting (weight for height), 4.2 percentage point difference in stunting (height for age), and a notable 10.5 percentage point difference in underweight among children under 5 years of age.

Households reported greater demand for health care and higher health care expenditures. Incidence of reported illness declined by 7.9 percent per month among adults and 10.9 percent per month among children.

Child labor outside the home decreased by 10.7 percent. Increased expenditures on children's schooling led to a small, but statistically significant 4.9 percentage point difference in school enrollment for 6-17 year-olds.

The scheme has also instituted linkages to early childhood development services for beneficiaries by working with community-based organizations and child protection workers, as well as instituted channels to provide home-based care to PLWHA, including adherence support for ART, counseling, and psychosocial support (UNICEF 2007).

An extensive external evaluation of the scheme is being conducted by Boston University and the Center for Social Research in Malawi with funding from UNICEF and USAID (Miller and Tsoka 2008). The evaluation will comprise an impact evaluation and an assessment of the effectiveness of targeting and operations. The impact study will utilize a quantitative randomized survey of 400 households interviewed in three rounds (baseline, mid-term, and final) with a control group. Qualitative focus group discussions and key informant interviews will complement the survey. Final results are expected to be available in 2009 (Miller and Tsoka 2008).



## ANNEX D. CASE STUDY: VALUE CHAIN PROGRAMS FOR CAREGIVERS AND YOUTH

The Community-Based Orphan Child Protection and Empowerment Project (COPE), a USAID-supported partnership between Africare and Emerging Markets Group, Ltd (EMG), works in Tanzania, Uganda, Rwanda, and Mozambique to support enterprise development and income growth among caregivers and OVC. They also provide education and nutrition support to clients in their programs. The project takes a value chain approach in linking small-scale enterprises within productive sectors. The project considers the broader market dynamics to define the type of income-generating activities that will best link them to productive markets. In Uganda, COPE identified the dried fruit sector as a viable and appropriate market for caregivers, and facilitated a relationship with an export company to sell the dried fruit overseas. Caregivers are organized into clusters to produce and sell dried apples, bogoya, banana, and pineapples; they are also involved in a savings scheme. More than 800 caregivers - responsible for more than 2,000 OVC - are now linked to this activity and sell directly to the export company. Besides making a profit, the caregivers have acquired technical skills and gained experience running enterprises that are serving a market beyond their local area. Key challenges that the program has faced relate to targeting caregivers, facilitating the formation of groups, and ensuring that members understand the implications of having a business relationship with the export company (Interview: Beatrice Kinyanjuyi and Victoria Francis, EMG).

Similar projects are carried out in Haiti among Eco-Ventures International, a market linkages and entrepreneurial program that seeks to reduce risk to HIV/AIDS among out-of-school youth in high prevalence areas. Challenges include social isolation, jealousy, and vulnerability to violence among youth that successfully earn money from the project (Interview: Margie Brand, Eco-Ventures International).



## ANNEX E. EVIDENCE SUMMARY

In the table below, citations that are bold are relatively strong indicators, while those that are not bolded and in italics demonstrated only weak impacts. See Annex I for more specific details. The table reviews only components of health and wellbeing. Financial gains were strong for every program, except for the SHAZ microfinance interventions, which targeted young girls (16-19).

Though the evidence base did not disaggregate and assess the impacts on PLWHA, the literature suggests that the cash transfers and savings opportunities for PLWHA are extremely important. Also important are transfer vouchers and other economic assistance that can be provided alongside medical care to discreetly and appropriately target PLWA, while reducing the economic burden of the disease on the household (Adato and Bassett 2007; Schubert 2007).

It also should be noted that data to distinguish between resource allocation at the household level between girls and boys are limited. Though household gender dynamics clearly have a role to play in how resources are designated, the expenditures on girls vs. boys requires further research.

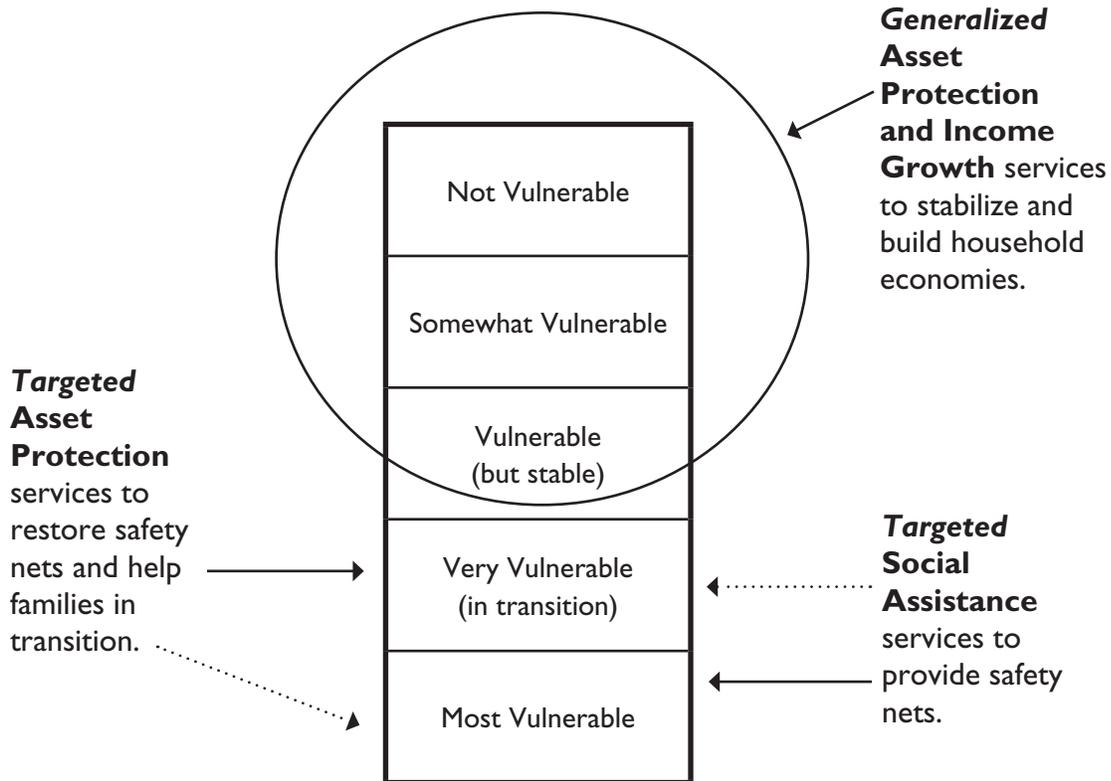
Target Groups	Rationale for Economic Strengthening	Evidence of Impact*		
		Cash Transfers	Asset Protection	Income Growth
<b>Poor HIV/AIDS -affected households</b>	Reduction in illness reported	<b>1,3, 6</b>	<b>9</b>	
	Improved ability to seek health care when needed	<b>1, 3, 6</b>	<b>9, 10</b>	10
	Increased school enrollment	<i>1, 3, 6</i>	<i>9, 10</i>	<i>10-boys only</i>
	Improve nutrition	<b>1, 3, 2, 6</b>	<b>9</b>	<b>10</b>
	Reduce their risk to HIV/AIDS			<b>11, 14</b>
<b>Orphans and vulnerable children</b>	Reduction in illness reported	<b>1, 3, 6</b>	<b>9</b>	<b>12</b>
	Improved ability to seek health care	<b>1, 3, 6</b>	<b>5, 9</b>	<i>10, 12</i>
	Increased school enrollment	<i>1, 3, 6</i>	<i>5, 8, 9</i>	<i>10-boys only</i>
	Improve nutrition	<b>1,3, 6</b>	<b>5, 9</b>	<b>10, 12</b>
	Reduce their risk to HIV/AIDS	3	8	

Target groups	Rationale for Economic Strengthening	Evidence of Impact <i>Numbers Correspond to Studies in Tables 1-3.</i>		
		Cash Transfers	Asset Protection	Income Growth
<b>Adolescent girls</b>	Reduction in illness reported	<b>1</b>	<b>9</b>	
	Improved ability to seek health care when needed	<b>1, 6</b>	<b>5, 9</b>	<i>10</i>
	Increased school enrollment	<i>1, 6</i>	<i>5, 9</i>	
	Improve nutrition	<b>1, 3, 2, 6</b>	<b>5, 9</b>	<b>10</b>
	Reduce their risk to HIV/AIDS		<i>7</i>	<i>11, 14</i>
<b>Women</b>	Reduction in illness reported	<b>1, 3, 6</b>	<b>9</b>	
	Improved ability to seek health care when needed	<b>1, 3, 6</b>	<b>9, 10</b>	<i>10</i>
	Increased school enrollment	<i>1, 3, 6</i>	<i>9, 10</i>	<i>10-boys only</i>
	Improve nutrition	<b>1, 3, 2, 6</b>	<b>9</b>	<b>10</b>
	Reduce their risk to HIV/AIDS			<b>11, 14</b>
<b>Elderly</b> <b>Only in the cash transfer schemes are the elderly explicitly targeted in evidence reviewed</b>	Reduction in illness reported	<b>1, 3, 6</b>		
	Improved ability to seek health care when needed	<b>1, 3, 6</b>		
	Increased school enrollment	<i>1, 3, 6</i>		
	Improve nutrition	<b>1, 3, 2, 6</b>		
	Reduce their risk to HIV/AIDS			

Note: Numbers in cells below correspond to studies in Tables 3 and 4, and Annex I. Bolded numbers indicate strong evidence of change, italicized numbers indicate weak evidence of change.

# ANNEX F. A FRAMEWORK FOR TARGETING ECONOMIC STRENGTHENING INITIATIVES

A framework for targeting economic strengthening initiatives has been well articulated by Donohue’s (2005) “dual approach” which combines targeted services (eg. social cash and food transfers) to those who are very vulnerable and most vulnerable. Generalized, asset protection and income growth services are best targeted toward less vulnerable groups to protect clients and help them grow their asset base. These generalized services should be made available to those who have adequate productive capacity.





## ANNEX G. TARGETING EVALUATION: MALAWI AND ZAMBIA PILOT CASH TRANSFER SCHEMES

Targeting households by extreme poverty and constrained ability to engage in productive work is an indirect way of reaching HIV/AIDS-affected households, and AIDS-affected OVC. The estimates provided below reveal targeted estimates of HIV/AIDS-affected households and OVC reached by the Mchinji Cash Transfer scheme and Kalomo District (Zambia) Trust Cash Transfer program. Notably, both schemes employed a multi-tiered system of review with community participation, applications from beneficiaries, community prioritization of the poor, and public pay points.

As an added mechanism to identify the poorest and most labor-constrained households, the Kalomo District (Zambia) Trust Cash Transfer program targeted households consuming less than 1,400 kcal per day per household member.

Estimates by Household	Mchinji Pilot (Malawi)	Kalomo Pilot (Zambia)
% of households expected to be HIV/AIDS affected	69%	69%
% of households that have lost an adult to HIV/AIDS	53%	55%
Of remaining households; % estimated to have absorbed one/more children orphaned by HIV/AIDS	16%  34% of remaining 47% of households estimated to have absorbed an OVC due to HIV/AIDS (34% * 47%)=16%	13%  29% of the remaining 45% households estimated to have absorbed an OVC due to HIV/AIDS (29%*45%)=13%
% of the beneficiary households headed by the elderly or by a woman under age 55	88% - includes 1% of child-headed households	91%
% of households “incomplete” because one/more adults (adult children or spouses) have died	80% (based on anecdotal evidence from the field)	80% (based on anecdotal evidence from the field)
75% of the deaths above are estimated to be due to AIDS	75%	75% (Central Statistics Office, Zambia 2005). Of the 129,556 reported deaths among persons 15-64 years, 98,000 were due to AIDS
% of all beneficiary households with children	70%	75%
% of children in targeted households estimated to be orphans	85% are orphans (internal documents, Mchinji scheme)	68% (citing Zambia’s Ministry of Community Development and Social Services)
% of all orphans in the country expected to be orphaned by HIV/AIDS	57%	57%

Source: Estimates published in Schubert (2007).



## ANNEX H: GLOSSARY

<b>Accumulating Savings and Credit Associations (ASCAs)</b>	<p>Informal savings groups that resemble rotating credit and savings associations, but are slightly more complex. In an ASCA, all members regularly save the same fixed amount while some participants borrow from the group. Interest is usually charged on loans. Some members borrow while others are savers only, and borrowers may borrow different amounts on different dates for different periods. If members pay interest on their loans, the return to savings is calculated individually and fairly shared among the group.</p>
<b>Asset</b>	<p>Any physical, financial, human or social item of <u>economic value</u> owned by an individual or <u>corporation</u>, especially that which could be converted to <u>cash</u>. Assets can be categorized as human, physical, natural, financial and social.</p>
<b>Asset transfer</b>	<p>One tool that government or donors can use to create a social safety net by providing assets or cash directly to the poor in order to lessen the severity of poverty, prevent households from falling into poverty, or helping them emerge from poverty.</p>
<b>Business development services</b>	<p>Comprise a wide range of nonfinancial services (marketing, financial/strategic planning, access to finance, links to input suppliers) provided by donors, governments, or private suppliers to entrepreneurs who use them to efficiently operate and make their businesses grow.</p>
<b>Cash transfer programs</b>	<p>A type of social safety net, cash transfers are often direct, unconditional governmental emergency assistance to households in the form of cash. Conditional cash transfers are also common, whereby cash is given to households based on certain conditions, such as the enrollment of a child in school or regular, preventive check-ups at a health clinic.</p>
<b>Coping mechanisms</b>	<p>Various ways in which HIV/AIDS-affected households may approach the financial and social burdens associated with the disease, to prevent households from resorting to damaging behaviors to survive, including selling productive assets or engaging in transactional sexual practices. Informal and formal safety nets are common examples of coping mechanisms.</p>
<b>Economic strengthening</b>	<p>The portfolio of strategies and interventions that supply, protect, and/or grow physical, natural, financial, human, and social assets of households.</p>
<b>Economic vulnerability</b>	<p>The possibility that a household or individual will experience a reduction in wellbeing, and the exposure to risk that might lead to the realization of this outcome.</p>

<b>Financial education</b>	Financial education empowers recipients to make wise financial decisions. It teaches people how to save more, spend less, borrow prudently, and manage their debt with discipline. It can also help more experienced program clients understand an array of financial services from money transfers to insurance.
<b>Grassroots/Community-based initiatives</b>	Initiatives that take a “bottom-up” approach in responding to the immediate needs of families affected by HIV and AIDS, relying largely on resources within the community. They offer a wide range of social and economic services including home-based care, psychosocial support and counseling, and income-generating activities such as loans or vocational training. Generally, these programs are driven to strengthen community capacities and provide immediate safety nets for vulnerable and marginalized groups.
<b>Group guarantee</b>	Financial liability system whereby the individual collateral for loans is replaced by social collateral: members of a credit group are jointly responsible for repayment by individual members.
<b>Horizontal efficiency</b>	The extent to which a program reaches all the poor.
<b>Income-generating activity</b>	Any legal activity that can boost household income and living standards, such as agricultural/livestock production, horticulture, microenterprises, handicrafts, etc.
<b>Labor-constrained households</b>	A household is labor constrained when it has no able-bodied household member in the age group 19-64 who is fit for work (all are chronically sick, disabled, elderly, or children), or when one household member who is fit for work has to care for more than three dependents.
<b>Labor-saving technologies</b>	Technologies (including fuel-efficient stoves, water filters, transport, agro-processing equipment) that help limit the time and energy spent by women, children, and those living with HIV/AIDS or chronic illnesses.
<b>Livelihoods</b>	Capabilities, assets, and strategies that families use to make a living (i.e., assure access to adequate food, goods and services – especially health and education, to ensure their survival, and better withstand shock).
<b>Market distortion</b>	A specific type of <u>market failure</u> (or inefficiency) brought about by deliberate government/donor regulation or subsidies that prevent economic agents from freely establishing a clearing price, thereby hurting society as a whole.
<b>Market linkages/facilitation</b>	Linkages refer to information on or contact with buyers of products or services, and/or with input suppliers. Facilitation helps ensure that entrepreneurs have contact with buyers/suppliers and access to this information.

<b>Market research</b>	The systematic collection, analysis, and reporting of data about the market (customers, competitors, and other market actors) and its preferences, opinions, and trends.
<b>Microcredit</b>	A sub-segment of microfinance that focuses on giving small loans to low-income people for the purpose of allowing them to earn additional income by investing in the establishment or expansion of microenterprises.
<b>Microenterprise</b>	A market-oriented economic activity with – in most definitions – 10 or fewer employees (including the owner and unpaid family members).
<b>Microfinance</b>	The provision of financial services adapted to the needs of microentrepreneurs, low-income persons, or persons otherwise systematically excluded from formal financial services, especially small loans, small savings deposits, insurance, remittances, and payments services.
<b>Microinsurance</b>	A sub-sector of microfinance that provides insurance products to micro- and small business owners, their employees, and low-income persons.
<b>Nonproductive assets</b>	Important household assets that may not particularly contribute to the financial furthering of a household. These may include cooking and eating utensils.
<b>Output Indicators</b>	Specific categories of data or results from a program that are used to gauge the effectiveness of that program. Example output indicators include the number of beneficiaries trained or the volume of savings generated.
<b>Poverty gap index</b>	A measure of the intensity or depth of poverty, corresponding to how far the poor fall below the poverty line.
<b>Poverty headcount measure</b>	A measurement of poverty that represents the share of the population falling below the poverty line.
<b>President’s Emergency Plan for AIDS Relief (PEPFAR)</b>	A commitment of \$15 billion over five years (2003–2008) from U.S. States President George W. Bush to fight the global HIV/AIDS pandemic. As the largest international health initiative ever initiated by one nation to address a single disease, the program aimed to provide antiretroviral treatment (ART) to 2 million HIV-infected people in resource-limited settings, to prevent 7 million new infections, and to support care for 10 million people.
<b>Productive assets</b>	Important, tangible assets which can be used to forward the financial strength of a household. Examples are livestock or tools.
<b>“Protective” services</b>	Services that can help to stabilize families by preventing the loss of their asset base and helping to restore their resources.

<b>Proxy indicators</b>	Third-party indicators used to classify the degree to which an individual was affected by HIV and AIDS. These include chronic illness or death of an adult household member, and absorption of orphans or sick persons into the household.
<b>Rotating Savings and Credit Associations (ROSCAs)</b>	An informal savings and credit group that operates through a commitment of group members to contribute periodic fixed sums to a common savings fund that is lent in succession to all group members based on pre-existing distribution rules. Once one group member repays the loan, the fund is re-lent to another group member. This process continues until each group member has had the opportunity to borrow the fund amount. The process differs from an accumulating savings and credit association in that all group members receive loans.
<b>Satiation</b>	A variable that is often used to self-report access to food. Satiation levels refer to whether or not individuals feel as if they have eaten enough at mealtime. Researchers often provide individuals with a predetermined scale to standardize self-reported responses about quantities of food consumed by household members.
<b>Savings schemes</b>	Small, autonomous, self-managing groups who engage in group-based savings programs.
<b>Severity of poverty measure</b>	A measurement of poverty that accounts for the level of inequality among the poor.
<b>(Social) Safety nets</b>	A collection of services provided by the state that prevents individuals from falling into poverty beyond a certain level. Regarding HIV/AIDS, examples of safety nets may be asset or cash transfers.
<b>Shocks</b>	Regarding HIV/AIDS, this refers to largely financially devastating events for a household which can increase its vulnerability. A shock may be the death of a breadwinner or loss of a major asset.
<b>Situation analysis</b>	A process of gathering and analyzing information, building consensus among key stakeholders, and identifying strengths and weakness in existing responses to a policy or program in order to guide planning and action.
<b>Skills training</b>	Refers to the purposeful activity to transfer skills and knowledge that will be used to secure a livelihood or pursue an occupation.
<b>Social assistance</b>	Noncontributory transfer programs targeted to the poor or those vulnerable to poverty and shocks. They include: cash transfers, food programs, price and related subsidies, pensions, public works, health care services and education, electricity and housing.

<b>Social performance measurement indicators</b>	Types of indicators used to go hand-in-hand with and complement financial indicators that microfinance institutions usually use to assess the viability of a program. These may include percentage of female-headed households as borrowers, or the percentage of clients who were selected with direct poverty targeting tools.
<b>Structural factors</b>	With regard to the spread of HIV/AIDS, structural factors may include such things as poverty, mobility of population groups, and gender inequality.
<b>“Supply” services</b>	Usually applied to households that are unable to engage in any type of economy growth activity, i.e., services that provide for a household’s basic needs and prevent it from adopting risky or destructive coping strategies
<b>Sustainability</b>	A goal of economic strengthening initiatives is to help beneficiaries become donor-free and self-financing from revenue generated by the service.
<b>Value chain</b>	A sequence or “chain” of activities carried out by multiple enterprises to produce and sell goods and services. As a raw material travels along this chain, each company adds to the value of the good or service until the final product is delivered to the consumer.
<b>Vertical efficiency</b>	The extent to which a program reaches its target and does not leak to the nonpoor.
<b>Village savings and loans</b>	An informal microfinance model based solely on member savings and small, community-managed groups. Members pool savings and provide loans with interest to each other. The interest is then disbursed to group members, based on their level of savings, at the end of a time-limited cycle.



# ANNEX I. SOCIAL ASSISTANCE (CASH OR FOOD) TRANSFERS

TABLE I-I. SOCIAL ASSISTANCE (CASH OR FOOD) TRANSFERS

Program/ Target	Impact	Scope/Cost and Evaluation Design
<p><b>(I) Kalomo District Pilot Social Cash Transfer scheme</b> (\$7.5-\$10 or \$12 with additional children) Zambia.</p> <p><b>Target Group:</b> Poor elderly and children, i.e., “generation gap households.”</p>	<p><b>Economic Impact:</b> At baseline households (hh) earned on average \$10/mo. The transfer increased cash and in-kind revenue by 75-100%.</p> <p><b>Nutritional Status:</b> Hh with 1 meal/day decreased 19.3%-13.3%. hh with 2 meals/day remained the same; hh with 3 meals/day increased 17.8%-23.7%. Satiation Improved: Households reporting feeling hungry after meals decreased 56.3%-34.6%. hh reporting enough food increased 42.6%-65.2%. Food quality: Carbohydrate, protein, fat, protein and vitamin consumption increased.</p> <p><b>Health Status:</b> Illness incidence decreased, especially for the aged (65+). Partial blindness reduced by more than half, and may be due to affordability of transport to eye clinics. Cash used primarily to buy food (42%), invest in small livestock/income-generation activities (29%), access health services (including transport to health facilities) and on school uniforms, books, pens, fees and soap, debt repayment.</p> <p><b>School Enrollment:</b> Increased only 3% among children 7-18. Younger children, had no school within walking distance. Reduced absenteeism among older kids: 40%-24% after the cash transfer was introduced (MCDSS/PWA/GTZ 2005).</p> <p><b>HIV/AIDS Risk/Status and Knowledge:</b> Not Studied, though reduction in destitution may have indirect outcomes. Health and Nutritional outcomes were positive (important for HIV/AIDS-affected households, of which 70% are estimated to be affected).</p>	<p><b>Scope:</b> 1000 hh in the pilot Kaloma district (among the 10% most destitute households). Cost of targeting: \$20/hh.</p> <p><b>Scale up:</b> If extended to all 200,000 destitute hh in Zambia, cost would be \$16 Million (4% of foreign aid inflow) or 0.4% of Zambian GDP.</p> <p><b>Evaluation Design:</b> Randomized household survey on 303 hh baseline and 274 end line; no control group.</p> <p><b>Study Recommendations:</b> Cash transfer schemes must take into consideration local administrative capacity, especially when targeting and should focus on local capacity building for the long-term grant administration.</p>

Program/ Target	Impact	Scope/Cost and Evaluation Design
<p><b>(2) Doha Emergency Food Program</b> (DECT), Malawi.</p> <p><b>Target Group:</b> Women (in female- and male-headed households). Transfer of \$12/ month.</p>	<p><b>Economic Impact:</b> Consumption gaps narrow (hh ability to buy minimum level of food, hh assets to survive increased food prices) especially in female-headed households, improved ability to cope with economic crisis.</p> <p><b>Nutrition and Health::</b> Increased meals per day; no significant impact on food diversity; Health: N/A</p> <p><b>Study Recommendations</b> Cash transfers deemed more flexible than food aid. Transfers should be adjusted for hh size and local food prices (which vary by urban/rural and seasonally). Include cash for essential nonfood items to avoid sales of essential assets.</p> <p><b>HIV/AIDS Risk/Status and Knowledge:</b> HIV/AIDS messages were minimal, and represented a lost opportunity for education.</p>	<p><b>Scope:</b> 11,000 households in Dowa district.</p> <p><b>Evaluation Design:</b> Quantitative panel household survey on 506 beneficiaries; no control group.</p>

Program/Target	Impact	Scope/Cost and Evaluation Design
<p><b>(3) Mchinji Social Cash Transfer Scheme,</b> Malawi. Amount allocated: \$4-1 person/hh \$7-2pp/hh; \$10-3pp/hh; \$13-4+ pp/hh.</p> <p><b>Target Group:</b> Ultra-poor, labor-constrained hh, with &lt;1 meal/day and those without ability to pay for soap, school utensils, clothing, prone to begging, child labor, prostitution.</p> <p>Labor-constrained hh have 3 per productive adult.</p>	<p><b>Economic Impacts:</b> Significant increase in productive assets, basic necessities, and livestock.</p> <p><b>Nutrition:</b> 2.2% point difference in wasting; 4.2% point different in stunting; 10.5% point difference in underweight among children U5 among participating children (as compared to control groups). Improved food security, higher food expenditures, fewer missed meals, fewer days without adequate food, and greater food diversity, Difference in food diversity of three food groups consumed per week, MK3,125 difference in monthly food expenditures.</p> <p><b>Health Impact:</b> 7.9% less reported illness/month among adults, 10.9% less illness among children. Children’s health status reported to be better among intervention groups as opposed to control group. Caregivers reported children in excellent health 34.6% of time in intervention vs. controls 20.8%. Good health reported among 54.6% of intervention group as opposed to controls (48.3%). Health Care: Greater demand for health care and higher health care expenditures.</p> <p><b>Education:</b> Increased expenditures on children’s schooling, resulting in higher enrollment and fewer absences. MK333 per child and MK1,049 per household difference in monthly school expenditures; 4.9 percentage point difference in school enrolment for 6-17 year olds.</p> <p><b>Child Labor:</b> 10.7 percentage point decline in children working in someone else’s home.</p> <p><b>Targeting and Coverage:</b> Program intended for 10% of Malawi’s most destitute (labor constrained/ultra poor) hh, but 16-20% of hh may meet this definition.</p> <p><b>HIV/AIDS Risk/Status and Knowledge:</b> Not studied directly through 70% of households in the transfer are expected to be HIV/AIDS affected.</p>	<p>3,000 households (2007) with plans for scale-up. Program targeted. Cash per hh annually was up to \$144. Operational costs: \$24. \$42 million projected cost to scale up to all 250,000 destitute hh, that scheme would benefit 1 million people including 650,000 OVC.</p> <p><b>Evaluation Design:</b> Qualitative and quantitative case control, baseline+ 1-year follow-up.</p> <p><b>Study Lessons:</b> Mchinji cash transfer deemed as child-oriented program, and HIV/AIDS mitigation program, since majority of hh with OVC and hh affected by HIV/AIDS. Social cash transfer schemes are typically large enough to mitigate the effects of poverty, but not enough to lift hh out of poverty.</p>

Program/Target	Impact	Scope/Cost and Evaluation Design
<p><b>(4) Foster Care* (\$84/mo).</b> South Africa</p> <p><b>Care Dependency Grant (DG) (\$117/mo) for a caregiver of a seriously ill child.</b> South Africa.</p> <p>DG (\$113/mo) target disabled adults.</p> <p><b>Target:</b> hh caring for sick children and OVC, and disabled people.</p>	<p><b>Economic:</b> These grants all report statistically increased economic standing of hh receiving them. Statistically significant reduction in incidence and depth of poverty (Booyson 2004)</p> <p><b>Nutrition:</b> Not assessed</p> <p><b>Health:</b> Strong improvements for those who received the grant, though the exclusion error among eligible households was very high.</p> <p><b>Targeting and Coverage.</b> Note: many people entitled to the DG, cannot access it. Booyson’s study of 351 grant eligible, HIV/AIDS-affected household found that only 147 of 351 eligible households were able to access a grant.</p> <p><b>Education:</b> Not assessed.</p> <p><b>Targeting and Coverage:</b> Aside from the Old Age Pension, many of the social schemes in South Africa have a high exclusion error. Slow application procedures, lack of information, all lead to high exclusion errors.</p> <p><b>Targeting and Coverage:</b> &lt;20% of HIV/AIDS-affected women accessed a grant to which they were entitled. Another study on the DG found 73% of adults receiving DG are HIV/AIDS affected; 50% of the Foster Care and Care Dependency Grant is reached by people who are HIV/AIDS affected.</p> <p><b>HIV/AIDS Risk/Status and Knowledge:</b> Not assessed.</p>	<p>Cash transfer for the disabled, foster children, dependent children.</p> <p><b>Evaluation Design:</b> General household survey of 30,000 households.</p> <p><b>Lessons:</b> HH with member living with HIV/AIDS may use social cash transfers to care for the ill individual’s transport, Rx, and hospital fees. While the DG is designed to reduce strain on hh, there is low uptake of the DG and Care Dependency grants. Among those who do receive these grants, the DG, Care Dependency Grant, and the Old Age Pension have the highest affect on children in HIV/AIDS-affected hh.</p>
<p>*These dollar amounts were reported by Jacobs, M. et al (2005) South Africa’s child gauge 2005. Children’s Institute, University of Cape Town.</p>		

Program/ Target	Impact	Scope/Cost and Evaluation Design
<p><b>(5) Child Support Grant, South Africa.</b></p> <p>Target: Children up to age 14. Transfer of \$27/month.</p>	<p><b>Economic:</b> Reductions in poverty, especially the severity of poverty.</p> <p><b>Nutritional Status:</b> Additional evidence suggests that the support grant leads to statistically significant gains in child height (children accessing the Child Support Grant before 12 months of age until age 3 increased their adult height by 3.5 cm or a 2.1% gain in adult height. The magnitude impact was reduced for older children. Increased spending on food, reduced spending on medical care. The authors further estimate that the increase in height was correlated to between a monthly increase of \$27 to \$42 in monthly wages from age 25 to 65.</p> <p><b>Health Impact:</b> Increased spending on medical care.</p> <p><b>Education:</b> Increases in school enrollment; though grant not reaching all eligible hh. There was an 8.1% increase in school enrollment among 6 year olds and 1.8 increase among 7 year olds who were recipients of the Child Support Grants in 2002.</p> <p><b>Targeting and Coverage:</b> Grant reaches only 1/3rd of eligible children; among those most poor, only 50% are reached.</p> <p><b>HIV/AIDS Risk/Status and Knowledge:</b> N/A</p> <p><b>Lessons/Challenges:</b> Eligible children are significantly less likely to receive the grant if their mothers are absent. Caregivers seem misinformed about eligibility of the child support grant.</p>	<p>7 million households by 2007</p> <p><b>Evaluation Designs:</b> 1) Household questionnaire on 11,178 households; no strict control group (Case et al. 2005). 2) Econometric continuous treatment analysis in Kwa-Zulu Natal (Aguero 2007). 3) Microsimulation model on all grant recipients (Samson et al. 2005). 4) hh survey on 351 AIDS-affected hh in Free State Province (Booyesen 2004).</p>

Program/ Target	Impact	Scope/Cost and Evaluation Design
<p><b>(6) Disability Grant and Old Age Pension (OPA) Schemes</b> (both worth \$130/month) South Africa. Both have similar effects (though the DG stops once the ill people improve).</p> <p><b>Target:</b> poor elderly women (age 60+); men (65+)</p>	<p><b>Economic:</b> Value of transfer is \$130/month, greater than any other grant in South Africa.</p> <p><b>Nutrition:</b> Reduced probability of missing a meal; increases in child's height. Increased spending on food items; statistically significant.</p> <p><b>Health:</b> The generous amount of this grant has resulted in improved health status.</p> <p><b>Education:</b> Small higher enrollment for children in school (girls 6%; boys 3%).</p> <p><b>HIV/AIDS Risk/Status and Knowledge</b> Not assessed, though the OAP is also seen as a way to reach out to HIV/AIDS-affected population. Notably, in a survey of 296 HIV/AIDS-affected hh in South Africa, 80% accessed the Old Age Pension Scheme.</p>	<p><b>Scope:</b> OAP reaches 1.9 million beneficiaries. These cash transfers US \$130/month.</p> <p><b>Evaluation Designs:</b> 1) Randomized survey to 1300 individuals (300 households). Self-reported health status (Case et al. 2001); 2) Microsimulation model on all grant recipients; (Samson et al. 2005). HH survey on 351 AIDS-affected hh.</p>

[1] Schubert 2007; Devereux et al. 2007; Schubert 2005.

[2] Devereux et al. 2007.

[3] Schubert, 2007; Miller and Tsoka 2008.

[4] Schubert 2007; Booysen 2004.

[5] Schubert 2007 Case 2001; Case et al. 2005; Aguerro et al. 2007; Samson et al. 2005 ; Booysen 2004.

[6] Schubert 2007; Case 2001; Samson et al. 2001.

**TABLE I-2. ASSET GROWTH AND PROTECTION: SAVINGS SCHEMES**

Program/ Target	Impact	Scope/Cost and Evaluation Design
<p><b>(7) Tap and Reposition Youth (TRY), Nairobi, Kenya. Target:</b> Adolescent girls (16-22).</p> <p>Savings with HIV/AIDS education.</p>	<p><b>Economic Indicators:</b> At the evaluation end line (3 years after intervention), compared to controls: TRY participants were significantly more likely to have at least 7 or more household assets compared to controls (at baseline, assets were the same). TRY girls reported earning 20% more than controls, doubled savings compared to baseline, and statically increases in bank accounts.</p> <p><b>Nutrition:</b> Not assessed</p> <p><b>Health:</b> Not assessed, only looked at HIV/AIDS knowledge and behaviors, shown below.</p> <p><b>Targeting/Coverage:</b> 66% of girls dropped out due to an interruption in program due to loss of credit officer; and suspicion among girls that savings would not be available when they needed. 83% of controls could not be reached at end line.</p> <p><b>HIV/AIDS Risk/Status and Knowledge:</b> Inconclusive results. All girls' RH knowledge increased in the 3 years (likely due to age). Control girls were significantly more knowledgeable on 2 RH questions: safety of pills and knowing that there is no cure for HIV/AIDS. TRY girls were significantly more likely to be able to insist on condom use and refuse sex (but may have been biased by departure of some TRY girls with low baseline scores). Also these were only 2 of 14 indicators in which the TRY girls reported positive increases as compared to controls.</p> <p><b>Lessons:</b> Avoid solidarity loan guarantees with young girls, caused younger girls to drop out of program. Disperse loans to members at the same time; allow smaller loans with shorter terms; avoid creating solidarity groups among people with no connection. Make savings and credit products flexible, adaptable, optional and simple.</p> <p><b>Targeting</b> young girls' with microfinance to reduce risk to HIV/AIDS was not seen as successful or appropriate. Instead, targeting diverse age groups (thereby indirectly benefiting younger girls was seen as a more appropriate way of reducing risk to HIV/AIDS.</p>	<p>Savings, loans and social services for 100 – 534 girls.</p> <p><b>Evaluation Design:</b> Pre-Post Impact Design (longitudinal study) 3 years between baseline and end line. 326 matched (control and TRY participants) were interviewed at baseline; 222 matched pairs were interviewed at program exit/end line. Challenge: only 17% of controls were found; only 51% of respondents located.</p>

	Older girls were more successful. Girls need financial and business skills to become successful, MFIs should work with complementary programs that offer these services. Program design should allow lending activities to fit within girls' survival strategies and not overburden them, forcing them to choose between livelihood strategies. For adolescent girls' safe savings programs, mentorship was more valuable, whereas loans were not seen as appropriate.	
Program/Target	Impact	Scope/Cost and Evaluation Design
<p><b>(8) Child Development Savings Account and HIV/AIDS education, career and educational planning. Rural Uganda</b></p> <p><b>Target: OVC</b></p>	<p><b>Economic:</b> Increased significantly.</p> <p><b>Nutrition:</b> Not assessed.</p> <p><b>Health:</b> HIV prevention attitudes scale showed statistically significant increase.</p> <p><b>Education:</b> Statistically significant increase in reported planning for future education.</p> <p><b>Targeting/Coverage:</b> Not assessed.</p> <p><b>HIV/AIDS Risk/Status/Knowledge:</b> Mean level of child-caregiver communication increased in the experimental arm from 2.2 to 2.5 points while it decreased from 2.4 to 2.2 points in the control arm. No indication of whether this increase was statistically significant.</p>	<p><b>Scope:</b> The Child Development Account receives contributions from the child's family and friends plus a 2:1 matching grant from the program. The account can only be used for income generation or school fees.</p> <p><b>Evaluation Design:</b> OVC: 50 in experimental group; 47 controls from 7 primary schools in Rakai district, rural Uganda. Single and double OVC interviewed at baseline and at 1-year follow-up. HIV/AIDS attitudes, family cohesion and educational planning and savings trends. Small sample size.</p>

Program/ Target	Impact	Scope/Cost and Evaluation Design
<p><b>(9) CARE International Zimbabwe Village Savings Groups.</b></p> <p><b>Target:</b> Vulnerable members of communities, mainly rural and women (85%).</p>	<p><b>Economic:</b> Of the loans paid to group members, 68% used for production; 32% for consumption (9% consumption for food; 7% on school fees). HH productive assets (small livestock, tools etc.) and nonproductive (cooking and eating utensils) increased significantly by majority of members. Typical asset acquisition reported: Chickens (65%); hoes (41%), goats (39%), shovels (33%), cultivator (22%), cattle (12%), plates (76%), electricity (28%), bicycle (22%), bed (14%), radio (9%).</p> <p><b>Nutrition:</b> 45-85% reported increased consumption from all major food groups.</p> <p><b>Health:</b> 2/3 of respondents report improved access to health services, usually with revenue generated from microenterprises, internal group loans, or lump sums; 11% reported reduction in access to health services.</p> <p><b>Psychosocial:</b> 81% reported improvement in community standing; participation in other social groups increased by 83%, leadership positions in social/community committees increased by 77%.</p> <p><b>Education:</b> Statistically significant increase in reported planning for future education.</p> <p><b>Targeting/Coverage:</b> Not assessed</p> <p><b>HIV/AIDS Risk/Status/Knowledge:</b> HIV/AIDS-affected groups responded no differently to the savings and loan programs though more research is needed. HIV/AIDS-affected hh may welcome new program innovations (asset-based savings, social funds, participation of OVC).</p> <p><b>Lessons/Challenges/Recommendations:</b> CARE indicates that the ideal portfolio for microlending sustainability is \$1.2-\$1.5 million with (\$120-\$150 loans). Self-managed village savings/community lending groups are cost effective and transfer skills to local communities. They can mitigate economic shocks, diversify income sources, and enhance hh assets. Recommendations include: Vulnerable hh can manage own savings and loans but outside capital can destroy these programs. Allow no external borrowing/donations; Earnings from loans stay with group; Loan uses should be flexible for productive/consumptive use; transactions should occur within 60 minutes, do not require applications. Avoid beneficiary transport fees by doing village transactions; allow each group to determine loan conditions. Project can be replicable with community-based trainers.</p>	<p><b>Scope:</b> By mid 2004, the program had 49,086 members in 7114 groups; 85% women and 57 groups of OVC attending school. Scheme targeted a high HIV/AIDS prevalence area with a sister project that built capacity of HIV/AIDS support organizations. Evaluation of village savings was expected to serve many HIV/AIDS affected hh.</p> <p><b>Cost:</b> Village schemes cost only \$60/client; formal schemes cost \$500-\$1000 per client. Program inputs include: motorbikes with gear, fuel and maintenance, training materials, personnel for training, management, data collection.</p> <p><b>Evaluation Design:</b> Pre and post impact study June 2002 and February 2004.</p>

[7] Hall 2006; Erulkar and Chong 2005; Kim et al. 2008.

[8] Ssewamala et al. 2006.

[9] Allen 2002; CARE 2008.

**TABLE I-3. INCOME GROWTH: MICROFINANCE AND LOANS**

Program/Target	Impact	Scope/Cost and Evaluation Design
<p><b>(10) Zambuko Trust, Zimbabwe</b></p> <p><b>Target:</b> Microentrepreneurs, especially women.</p>	<p><b>Economic:</b> Increased income sources in the household; greater proportion with savings account. Helped hh make lump sum expenditures (e.g. more clients than non-clients bought a stove and refrigerator).</p> <p><b>Nutrition:</b> Clients ate animal proteins (fish, meat) an average of one day more than non-clients. The report indicates that client hh did use some of their loan money on food expenditures. Other food items (vegetables, milk, eggs) declined in consumption in both client and non-client groups (a possible cash management strategy during a high inflationary time period).</p> <p><b>Health:</b> Households with continuing microfinance clients reporting not seeking medical care 10% of the time (vs. loan drop outs reporting not seeking medical care due to lack of funds 15% of the time, and non-clients reporting this 12% of the time). Note: this should not be implied that the microlending necessarily led to greater medical care uptake, since other factors, such as presence of a chronically ill household member.</p> <p><b>Education:</b> Clients had a very small increase 97% to 98% in boys' school enrollment 1997 to 1999, while non-client had a small decrease (96% and 94%) in boys' school enrollment between 1997-1999.</p> <p><b>Targeting/Coverage:</b> Not Assessed.</p> <p><b>HIV/AIDS Risk/Status/Knowledge:</b> Not Assessed.</p> <p><b>Lessons/Challenges/Recommendations:</b> Repeat clients continuing with the loan scheme reported making greater annual expenditures than non-clients and clients who dropped out. It was found that clients were more apt to drop out if there was a chronically ill (including HIV+ household member).</p>	<p>Microfinance institution with 24 branches.</p> <p><b>Evaluation Design.</b> Longitudinal randomized study, using quantitative and qualitative methods. 338 clients and 241 matched non-clients.</p>

Program/Target	Impact	Scope/Cost and Evaluation Design
<p><b>(11) IMAGE: Intervention with Microfinance for AIDS, Gender and Equity.</b> Intimate partner violence training component.</p> <p><b>Target:</b> Poor females (14-35) in 8 rural villages in South Africa.</p>	<p><b>Economic:</b> Participating women were 15% more likely to have household assets with estimated value &gt; 2000 ZAR than women in control villages, Repayment was 99.7%.</p> <p><b>Nutrition:</b> No evidence of effect on food security.</p> <p><b>Health:</b> Health education (1 hour for 10 sessions) then community outreach to men and youth. The health education included topics of communication, domestic violence, religion but impact not assessed.</p> <p><b>Psychosocial:</b> Nine indicators of empowerment were found to be improved years after inception: self-confidence, financial confidence, challenging gender norms, autonomy in decision-making, perceived contributions to the hh, communication within the hh, relationship with partner, social group membership, and participation in collective action) were observed among IMAGE participants.</p> <p><b>Education:</b> No evidence of change in children attending school when parents are enrolled in microfinance. There is however evidence to suggest that increased education can empower women and girls, independently of wealth (Kim et al. 2008). There is also evidence to show that HIV/AIDS education in schools may reduce stigma, which allows increased uptake in voluntary counseling and testing. However school-based HIV/AIDS prevention programs need to be carefully designed and tested as suggested by research which reveals that some HIV/AIDS prevention programs can be ineffective (Jukes 2008).</p> <p><b>Targeting/Coverage:</b> High degree of coverage (&gt;78% of eligible women in intervention villages had taken out loans at follow-up. This program reaches 40,000 people.</p> <p><b>HIV/AIDS Risk/Status/Knowledge:</b> Strong evidence of reduced susceptibility to violence, increased communication about HIV/AIDS and increase in household assets. No evidence of change in HIV/AIDS incidence or having taken an HIV/AIDS test. Participants were 58% more likely to have communicated with hh members about sex in the past 12 months (Adj RR: 1.58, p&lt;0.05) than women in the control group; Women who participated in the program were 55% less likely to have experienced Intimate Partner Violence in the past 12 months than women in the control group. No other outcome measures were statistically significant. Indirect effect on household members living with IMAGE participants showed no sexual behavioral changes, but increased communication about HIV/AIDS and sex.</p>	<p>430 participants in 8 villages.</p> <p><b>Evaluation Design:</b> Longitudinal case controlled study with 8 villages pair-matched on size and accessibility to services. Villages were randomly allotted to be in the intervention group. 430 women age 14-35 program participants and 430 women age 14-15 from control villages. Also relatively limited follow-up time, only 3 years. Could take longer to see results.</p> <p>Small number of clusters, since only 4 villages in each group. Could have implications for statistical significance of results.</p>

	<p><b>Lessons/Challenges/Recommendations:</b> Combine microfinance with training on health and gender can reduce levels of intimate partner violence. Targeting community members indirectly (e.g., by reaching out to household members with HIV/AIDS and sexual empowerment education) may have a positive effect beyond direct participants.</p>	
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Program/Target	Impact	Scope/Cost and Evaluation Design
<p><b>(12) Project HOPE, Microloans for small business activities</b> in Namibia and Northern Mozambique.</p> <p><b>Target:</b> Caregivers of OVC.</p>	<p><b>Economic:</b> In Namibia, caregivers reported improvements in 12 of 14 indicators of economic status and achieved 50% growth in income. Permanent wall materials increased from (29%-34%); permanent roofing: (35%-49%); more than 4 rooms (48% to 69%), owning specific hh assets (87% to 91%), animal ownership (75%-80%), clothing meets needs (34% - 59%), send resources to others (62%-80%).</p> <p><b>Nutrition:</b> Reports of eating 4 meals in past 2 days increased 24%-58%. OVC specific nutritional indicators: Reports of 4 meals in last 2 days increased (55%-87%), 6 meals in last 2 days children U5 increased (49%- 77%).</p> <p><b>Health:</b> Statistically significant improvement in accessing health services. Always seeks necessary medical help (increased 40%-49%). <b>OVC specific health indicators:</b> Hospital last 3 times when needed (39%-95%), full immunization (96% to 99%).</p> <p><b>Education:</b> Improvements include positive impacts on OVC access to education and school materials. <b>OVC report regular</b> school attendance increased (93%-99%), Notebook &amp; pencil ownership (44%-75%).</p> <p><b>Other OVC specific economic and well being indicators:</b> Reg. visits from adults increased (61%-94%), Birth registered increased (85%-99%), same type bed as others (47%-100%), 2 pairs clothes (34%-52%), ownership of shoes increased (78%- 85%).</p> <p><b>Targeting/Coverage:</b> 45,000 OVC reached with improved economic status/quality of living; 75,000 OVC reached with improved care and support by a community-based network of volunteers who provide ongoing support/assistance to caregivers and OVC through home visits, training, peer counseling, and service referrals.</p> <p><b>HIV/AIDS Risk/Status/Knowledge:</b> HIV prevention training among OVC increased (51%-70%).</p>	<p><b>Evaluation Design:</b> Pre-Post evaluations carried out in Namibia. 146 caregivers interviewed before microcredit scheme and at 1-year follow-up. 86 children (75 school-age) interviewed before and at 1-year follow-up to assess parenting, home visits, counseling, surveillance, and referrals.</p>

	<p><b>Lessons/Challenges/Recommendations: Microloans</b> should be adaptable and flexible, target vulnerable groups (HIV+, OVC, children U5, build capacity (empowering + resources), complement a variety of programs (health/food security). To strengthen sustainability, link program sectors micro finance, agriculture, health care.</p>	
Program/Target	Impact	Scope/Cost and Evaluation Design
<p><b>(13) SHAZ! Project, Zimbabwe.</b></p> <p><b>Target:</b> Adolescent girls (16-19 yrs, orphaned and poor)</p>	<p><b>Economic:</b> Few girls this young (16-19) are targeted with microfinance programs, since they are seen as a credit risk due to migration, marriage, and lack of maturity. SHAZ did not achieve its goals of reducing transactional sex among young girls through microfinance and business training. Only 20% of girls' repaid the first loan installment and only 5% made a full repayment.</p> <p><b>Nutrition, Health, Education:</b> Not assessed.</p> <p><b>Targeting/Coverage:</b> Very small group.</p> <p><b>HIV/AIDS Risk/Status/Knowledge:</b> Anecdotal evidence of increased knowledge of HIV/AIDS but no statistical evidence cited.</p> <p><b>Lessons/Challenges/Recommendations:</b> Lessons from pilot questioning appropriateness of loans for young women; recognition of importance of family and support services. Girls may actually increase level of vulnerability to abuse due to income-generation project. Family support was mentioned as one of the most critical components of a girls' wellbeing and HIV/AIDS attitudes - it was cited as more critical than the loan itself. SHAZ ended its microfinance component, after evaluation proved that it was not a successful model among these young girls (who also faced high inflation and other pressures of the Harare slum). It moved instead to vocational and business training.</p>	<p>Integrated vocational training, life-skills training and access to credit.</p> <p><b>Evaluation Design:</b> 49 participants in original pilot; control randomized study planned for 350 adolescents.</p>

Program/Target	Impact	Scope/Cost and Evaluation Design
<p><b>(14) Sexually Transmitted Disease (STD)/ HIV Control Project, Kenya.</b></p> <p><b>Target:</b> Female commercial sex workers</p>	<p><b>Economic:</b> Repayment rate was 70% (lower than most microfinance programs).</p> <p><b>Nutrition and Education and Health:</b> Not assessed.</p> <p><b>Targeting/Coverage:</b> Small sample size.</p> <p><b>HIV/AIDS Risk/Status/Knowledge:</b> Reduced dependency on sex work and # of Sex Partners.</p>	<p>Peer education and condom promotion with microfinance.</p> <p><b>Evaluation Design:</b> Interviews with 120 participants at baseline and 18 months.</p>
Program/Target	Impact	Scope/Cost and Evaluation Design
<p><b>(15) Review of 9 livelihoods training activities that combined RH and FP (Colombia, India and Kenya).</b></p> <p><b>Target:</b> Poor adolescent girls.</p>	<p><b>Economic:</b> Some short-term gains were found in the review, with participants receiving jobs after the training program ended.</p> <p><b>Nutrition and Education:</b> Not assessed</p> <p><b>Health:</b> Results were largely inconclusive; 2 of the 9 interventions showed increase in self-confidence.</p> <p><b>HIV/AIDS:</b> No conclusive evidence could be drawn, as these interventions were seen to be in their early stages.</p> <p><b>Lessons:</b> Demand for linked programs (livelihood and RH) is coming directly from grassroot levels. ICRW recommends training program staff in both technical areas of livelihoods and RH so that a multiplier effect between the interventions can better be realized. This can be done through training, recruitment, and use of outside consultants or alliances with other organizations. Evaluation of linked programs must take place if there is no measured evidence-base. Build up toolkits and in-house expertise to assess and address market access opportunities for youth. Work also with communities so they recognize the importance of youth as a constituency and player in market-based livelihood activities (avoid excluding them) due to age.</p>	<p>ICRW assessed livelihoods programs aimed at youth that also aimed to combine health, education and other training components. ICRW contacted 300 organizations, searched 500 electronic and written secondary data sources and interviewed 10 US-based NGOs that specialize in adolescent empowerment.</p>

Program/Target	Impact	Scope/Cost and Evaluation Design
<p><b>(16)</b> Population Council provides financial literacy, mentorship business skills, HIV/AIDS education.</p> <p><b>Target:</b> Adolescent girls and boys in South Africa.</p>	<p><b>Economic:</b> Promising though inconclusive results.</p> <p><b>Nutrition and Education:</b> not assessed</p> <p><b>Health:</b> Promising though inconclusive results. See below.</p> <p><b>HIV/AIDS:</b> Promising though inconclusive results. Recall for discussions on self-esteem in past 12 months 70% among control vs. 26% among non-controls. Young women reported 11% and 7% increase in discussions about avoiding STDs, and HIV respectively. Controls reported 4% increase in discussions about STDs and 19% decrease in discussions about HIV. Discussions about sexuality increase 20% among intervention women vs. 5% among controls; contraception discussions increased 11% among intervention and decreased 5% among controls; discussions on violence/sexual abuse increased 16% among intervention, and decreased 3% among controls; discussions of condom use increased 17% among intervention girls and decreased 4% among controls.</p> <p><b>Lessons:</b> Population Council had investigated vulnerabilities of poverty and risk factors associated with HIV/AIDS: sexual debut, condom use, communication about safe sex practices, social isolation. They found that poor and orphaned children had higher risk factors across the board.</p> <p>This new type of way of engaging adolescent girls points to a new area of needed research.</p>	<p>Quasi-experimental design. Interviews of adolescent boys and girls enrolled in financial literacy and skills development that includes HIV/AIDS awareness. Baseline conducted in 2005 with follow-up 2 years later.</p>

[10] Barnes 2001.

[11] Pronyk et al. 2006; Kim et al. 2008.

[12] Bronson. Presentation. Economic Empowerment for Improved Health. Project HOPE 2008; Project HOPE

[13] Kim et al. 2008.

[14] Odek et al. 2002.

[15] ICRW 2001; Kim et al. 2008.

[16] Hallman et al. 2007; Kim et al. 2008



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