Evaluation of the HIVOS - STOP AIDS NOW!

Pilot project 'Integrating HIV/AIDS into Microfinance'

General Report

STOP AIDS NOW!
is a partnership
between Aids Fonds,
Cordaid, Hivos, ICCO
and Oxfam Novib

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General Report

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Acronyms

ACORD	Agency for Cooperation and Research in Development
AHF	AIDS Healthcare Foundation
AIDS	Acquired Immune Deficiency Syndrome
AMFIU	Association of Microfinance Institutions of Uganda
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASO	AIDS Service Organization
BOT	Bank of Tanzania
BOU	Bank of Uganda
BUSODA	Budu Social Development Association
BUTO	Bunyoro Toro Development Company
CA	Central America
CBO	Community Based Organization
CDR	Foundation Rural Development Consult
CRC	Costa Rica Colones
FAIDERS	Facilitation for Integrated Development and Relief Services
FBO	Faith Based Organization
FGD	Focus Group Discussions
GTQ	Guatamala Quetzales
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HIVOS	Humanist Institute for Development Co-operation (The Netherlands)
HSSP	Health Sector Strategic Plan
IGA	Income Generating Activity
ILO	International Labour Organization
HOFOKAM	Hoima, Fort Portal, Kasese Microfinance
KADERES	Kagera Development Relief Services
KII	Key Informant Interviews
LPS	Lempiras from Honduras
M&E	Monitoring and Evaluation
MFI	Microfinance Institution
MoU	Memorandum of Understanding
NACWOLA	National Community of Women Living with HIV
NAFOPHANU	National Forum of People Living with HIV and AIDS Networks in Uganda
NGO	Non-Governmental Organization
NIO	Nicaragua Cordoba
OVC	Orphans and Other Vulnerable Children
PASADA	Pastoral Activities and Services for People with AIDS in Dar es Salaam Archdiocese
PLHIV	People Living with HIV
REDCA+	Central American Network of People with HIV-AIDS (*Red Centroamericana de Personas con VIH-Sida*)
REDCAMIF	Central American Network of Microfinance (*Red Centroamericana de Microfinanzas*)
SACCO	Savings and Credit Cooperative
SEEP	Socio-Economic Empowerment Program
SHIDEPHA	Service Health Development and Education for PLHIV
SPM	Social Performance Management
TACAIDS	Tanzania AIDS Commission
TAMFI	Tanzania Association of Microfinance Institutions
TANEPHA	Tanzania National Network of People with HIV
TASO	The AIDS Support Organization

TAWOLIHA	Tanzanian Women Living with HIV
ToR	Terms of Reference
TZS	Tanzanian Shilling
UAC	Uganda Aids Commission
UGX	Ugandan Shilling
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNASO	Uganda Network of AIDS Service Organizations
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USD	United States Dollar
UWESO	Ugandan Women's Effort to Save Orphans
VBS	Victoria Basin Savings and Microfinance
WHO	World Health Organization

Executive Summary

1. INTRODUCTION

1.1 HIV and microfinance
In 2007 STOP AIDS NOW! and Hivos started a pilot project "Integrating HIV and AIDS into Microfinance". HIV poses not only challenges for clients of microfinance institutions (MFIs) but also for the MFIs themselves. The rationale of the pilot is that that MFIs should cooperate with AIDS Service Organizations (ASOs) and networks of People Living with HIV (PLHIV) as poor people affected by HIV do not only have financial needs to generate an income for their household and cover extra costs that come with the illness, but also need information, medical and moral support.

1.2 Pilot project objectives

i) To set up good functioning coalitions of MFIs and ASOs and develop a proposal for scaling up the programme;
ii) To promote AIDS awareness among beneficiaries of microfinance and build HIV competence of MFIs;
iii) To inform the STOP AIDS NOW! partners and other Dutch actors on the prospects and challenges of microfinance in HIV prevention;
iv) To develop a strategy to promote access to microfinance among people and households who are vulnerable to HIV.

The pilot started in 2007 in 6 countries of Central America (Guatemala, Honduras, El Salvador, Nicaragua, Costa Rica, Panama), Tanzania (2008), and Uganda (2009) and ended in 2011.

1.3 Pilot project management
HIVOS managed and monitored the implementation of the pilot while STOP AIDS NOW! supported the process and managed the knowledge component by sharing progress information and facilitating learning and cooperation among its partners. In Central America the pilot project was formulated, implemented and monitored by the Gender Commission of the Central American Microfinance Network (REDCAMIF) and its members (6 National Networks and 35 affiliated MFIs). A total of 10 different ASOs as well as independent consultants were contracted in the different countries. In Uganda the Association of Microfinance Institutions (AMFIU) served as the lead agency that coordinated the pilot and formed a steering committee with the Agency for Cooperation and Research in Development (ACORD) and the National Forum of PLHIV and AIDS Networks (NAFOPHANU). The other 6 coalition partners were 4 MFIs, a PLHIV women based organization and Uganda Cares (a Ministry of Health initiative that offers medical care and microfinancing to PLHIV). In Tanzania the pilot was coordinated by ACORD. The other coalition partners were MFI apex organization TAMFI, 9 MFIs, and 19 HIV and AIDS support and research organizations.

1.4 Aim of evaluation and Research Team
STOP AIDS NOW! hired the Foundation Rural Development Consult (CDR) to undertake the evaluation of the pilot in order to assess the relevance, effectiveness, efficiency and sustainability of the pilot project and to draw lessons from it that can be used for developing a long-term follow up project in Uganda and Tanzania. CDR worked with a multidisciplinary and international team of consultants in Africa and Central America.

2. STUDY METHODOLOGY

The main research question of the evaluation was:

What determines successes and less successful results of a coalition (between ASOs, networks of MFIs and of PLHIV) in: enhancing access of PLHIV to microfinance and related services; encouraging MFIs to give attention to HIV and AIDS at their workplaces; and improving access to AIDS information and services to beneficiaries of microfinance?

2.1 Levels of research

The focus of the evaluation took place at three levels related to the progress in each of the countries:

a) Process level: to assess the process of development of partnerships between MFIs, PLHIV networks and ASOs (Central America, Uganda, Tanzania)
b) Platform level: to assess the functioning of the partnerships (Central America, Uganda)
c) Beneficiaries level: to assess the results for beneficiaries (Central America)

2.2 Data collection methods, tools, and sample size

The evaluation was based on the revision of secondary sources as well as primary information. In Central America a total of 109 persons participated in the evaluation. Semi-structured in-depth interviews were conducted with representatives of 19 MFIs, 7 ASOs, the regional and 6 national networks of MFIs. A total of 41 clients and 32 staff members of MFIs participated in focus group discussions. In Uganda and Tanzania a total of 45 representatives from 33 organisations were interviewed. Moreover, 3 program officers from HIVOS in Costa Rica and 10 representatives from STOP AIDS NOW! and partners participated in group discussions and interviews.

3. MAIN RESULTS

3.1 Relevance

The relevance of the project is considered high due to the context that it is set in. Uganda and Tanzania are experiencing a generalized epidemic, affecting all sectors and all levels of the population. In Central America incidence of HIV is relatively low but this is partially due to under-reporting. The relevance of addressing HIV in the microfinance sector is strongly linked to the necessity for people affected by HIV to access financial services.

PLHIV have a higher risk than other people of losing their job due to stigma; setting up their own businesses is more difficult as well due to a lack of access to financial services like credit and insurances (especially a life insurance). Specific social groups are affected more negatively, like is the case with women compared to men, due to high incidence rates as well as the traditional gender division of labour, which assigns them the role of caretakers of PLHIV. This is one of the reasons that in Central America the pilot project was implemented by the Gender Commission of REDCAMIF. Access to financial services can diminish vulnerability, even more so if combined with capacity building by financial and business development services.

Moreover, MFIs that integrate HIV in their work directly contribute to their core business: the health of their clients is strongly related to their payment capacity and thus the results of MFIs. HIV sensitization of decision makers in MFIs is key to avoid exclusion of people that are affected or susceptible to HIV.

3.2 Effectiveness

In Central America beneficiary level was achieved, whereas in East Africa only process (Tanzania and Uganda) and platform (Uganda) levels were reached. The focus on the creation of coalitions resulted however in a stronger platform (objective 1) in the case of Uganda and, to a lesser extend, Tanzania than in Central America. On the other hand, Central America is the only region where activities have been implemented to promote AIDS awareness among

clients of MFIs (part of objective 2) in addition to building HIV competence of MFIs (the other part of objective 2, which was also achieved in the African countries). A total of 1,400 staff members and 1,800 clients of MFIs participated in training sessions on HIV and a considerable amount of brochures (>15,000) and posters (>4,000) was issued to 53 MFIs in all six countries in Central America. A multiplier effect took place due to the fact that the clients and personnel of MFIs talked with friends and relatives after receiving the training and shared the printed material with them. However, a more profound and continuous sensitization process is required, also in view of prevailing stigma and lack of knowledge related to HIV in the whole region.

In order to *build HIV competence of MFIs* REDCAMIF contracted the systematization of the experience of two MFIs in Honduras with loans for people affected by HIV and the results were shared with other MFI members during a forum. To follow-up on this, a necessity - marketing study will be conducted in order to design financial products for people affected by HIV. The idea is that these financial products will be offered by MFIs in Honduras and Nicaragua, thus complying (although after the pilot period) in two of the six countries with **objective 4**.

In Uganda sensitisation workshops were held to: enhance the MFIs' knowledge of HIV, demystifying long held myths and misconceptions through increased information about HIV; agreeing that it needs to be addressed at both personal and institutional levels; introducing mainstreaming of HIV issues into microfinance, and; enhancing the ability of the MFIs to provide services that are responsive to the needs of PLHIV. Already four MFIs started to develop, and in one case implement, HIV workplace policies (**objective 2**). Due to the sensitization and capacity building process one of the MFIs in Uganda developed a specific product targeting PLHIV. Although the implementation of this product was not part of the pilot, the latter did contribute indirectly to it (**objective 4**).

In Tanzania a baseline study was conducted to identify potential coalition partners (**objective 1**), and sensitization workshops and HIV workplace policy trainings were held (**objective 2**). This generated interest and acceptance of the need for HIV workplace policies, but did not yield concrete steps for the MFIs to develop them, amongst others due to the lack of a designated ASO to assist with institutional capacity building among the 4 participating MFIs and the necessity for more training for the coalition members. This is now planned to take place during the follow up project. Also an "interactive event", attended by 15 representatives from MFIs, ASOs, media and government institutions, was held with the objective to share experiences, challenges and opportunities for the formulation of a strategy that strengthens the access of PLHIV to microfinance services (**objective 4**). This strategy has yet to be finalized and approved by the steering committee.

In case of **objective 3**: STOP AIDS NOW! partners and other Dutch actors were informed on the prospects and challenges of microfinance in AIDS prevention via the sharing of pilot information in quarterly meetings, regular updates on the STOP AIDS NOW! website, group discussions and presentations at different events, including the National Conference in Amsterdam (2007), and the International AIDS Conference in Mexico (2008), and Vienna (2010).

3.3 Efficiency

In Uganda and Tanzania the pilot experienced big delays and the final implementation period was cut down strongly (from 2 years to 5 - 7 months). This was mainly due to:

- The fact that senior MFI managers had to be sensitized in order to have them incorporate the pilot activities in their work plans (Uganda);
- Challenges in the constitution of a platform (Tanzania) because of the wide geographical size of the country, various long held myths and misconceptions that MFIs and ASOs had about each other, the lack of well-functioning apex organisations, difficulty in forming a steering committee.

In Central America the efficiency of the pilot has been quite good. More than half of all MFI members of REDCAMIF in the 6 countries of the pilot participated and 20% of MFIs personnel

was trained. A less positive result was that only 0,3% of the total clientele participated in the workshops and from the overall budget of 160,000 USD, only 55% has been implemented up to date. The financial investments made are however considered to be quite low with respect to the achieved results. The average amount spent per trained person on printing material and facilitating workshops is very low (around 10 USD).

3.4 Sustainability

The sustainability of the pilot is very questionable at this moment. In all countries continuation is strongly depending on external financial resources as no firm institutional policies or strategies have been established yet. Although in Central America certain “awareness” has been raised this requires a follow up and increased outreach. MFIs have shown an interest in continuing to work on the thematic but no long-term platforms have been created with ASOs or PLHIV networks in order to achieve this. This is especially important in view of the uncertainty regarding external financing. The MFIs that are most likely to give follow up on the topic are the ones that have an established training program for their clients from before the pilot started, which includes social and health care issues as an addition to the typical financial education that most MFIs are giving. In Africa an enabling environment for the integration of HIV in the MF sector has been created due to awareness raising workshops, the establishment of MFIs – ASO platforms and the formulation of HIV workplace policies in four Uganda MFIs. As a follow up of the pilot is likely to be implemented in this region, sustainability can be achieved.

4. MAIN CONCLUSIONS AND LESSONS LEARNED

4.1 Process level

Collaboration between MFIs and ASOs from the beginning of the project cycle is key for achieving ownership and building up successful platforms.
The existence of well-established apex bodies makes it easier to mobilise potential partners.
The support of an active donor organization like HIVOS made coalition building easier because of previous established contacts and mutual trust.
Non-profit MFIs have a comparative advantage over joint-stock financial institutions as they often already incorporated social or health care work into their core business, which generates them the necessary infrastructure, experience, and relationship with clients to include HIV.

4.2 Platform level

Awareness and knowledge creation at all levels of the MFIs is necessary, specifically for decision making people, as their commitment is required for institutionalization (which is key for a platform to function well and become sustainable).
Complementarities in roles between ASOs (implementing sensitization activities for personnel and clients of MFIs as well as mobilizing PLHIV to access financial products) and MFIs (providing business skills training and financial services to the PLHIV) can create synergies and cost- efficiency in achieving their respective organizational goals. Various models have proven to be effective; there is not a "one size fits all" solution.

4.3 Beneficiary level

The project provides an opportunity for the MFIs to acquire objective knowledge about HIV, thus enabling them to serve PLHIV and enter a hitherto neglected market segment.
The creation of coalitions between MFIs and ASOs can lead to a wider coverage, deeper outreach, and stronger impact (especially using PLHIV as trainers).

5. MAIN RECOMMENDATIONS

5.1 Process level

1. To form sustainable coalitions projects will have to be formulated in alliance between MFIs and ASOs.
2. Within donor organizations the program officers responsible for each theme should work together.
3. The role and responsibility of governments to support this kind of linkages and improve access to finance, ART/V and HIV information should be taken into account.

4. Linkage of small or non-profit MFIs with formal financial institutions, technical and business development service organizations will improve the outreach and the possibility of acquiring the necessary funds.

5.2 Platform level

5. A profound monitoring and evaluation system is key for the success of a planned 5-year project.
6. Insurance companies should be included in order to address their rooted perceptions of PLHIV as a high-risk group and develop insurance schemes for PLHIV clients.

5.3 Beneficiary level

7. A continued and broader sensitization and information campaign is necessary to reach more people and achieve a more profound and sustainable change in attitudes and knowledge.
8. Conduct a specific study on the advantages and disadvantages of developing a PLHIV tailored financial product that takes into consideration their specific economic, social and health challenges versus addressing them with the same products MFIs are offering to all clients. In the first case, a market study should determine the complete product features necessary to address PLHIV, including the possible use of a guarantee fund, insurance schemes, combining financial with technical and business development services and how to avoid stigmatization.
9. In addition to credit, the project should focus on other financial services. Savings can serve as insurance and risk prevention but also for empowerment, appropriation, and sustainability.

1 Introduction

HIVOS is a Dutch non-governmental organization (NGO) focused on humanist values, which is active in policy advocacy and strengthening civil society organizations in the following areas: financial services & enterprise development, sustainable production, human rights & democratisation, HIV and AIDS, art & culture, gender, women and development, ICT & media. In the early 1990s, HIVOS started supporting HIV programmes in developing countries. Around the time HIVOS began its work, the general trend among the development community was to approach the HIV epidemic as a health-sector specific issue. HIVOS' decision to treat the HIV epidemic as a broader multi-sector development issue is reflected in the policies and programs the organization develops. HIVOS has been supporting organizations that mobilise and provide care and treatment support to People Living with HIV (PLHIV) and prevention services to communities. These organizations are also referred to as AIDS Support Organizations (ASOs) and HIVOS supports many of these organizations operating in Central America and the East Africa region (Uganda and Tanzania) through organizational capacity building and strengthening HIV prevention activities, as part of their multi-sector approach towards response to HIV epidemic.

In 2000, Aids Fonds and four Dutch development organizations, HIVOS, ICCO, Cordaid and Oxfam Novib, decided to join forces and founded the independent Dutch organization STOP AIDS NOW! with a stated mission of "working together towards a world without AIDS". STOP AIDS NOW! aims to create more effective responses to the HIV epidemic in the South through their partners by working together to improve existing methods and come up with innovative forms of cooperation. The AIDS response is closely related to the fight against poverty: HIV and AIDS affect especially the poorer countries. Four out of five partner organizations joined in STOP AIDS NOW! –namely Cordaid, HIVOS, ICCO and Oxfam Novib– are concentrating on poverty reduction and development assistance. Through the partnership they are strengthened to further mainstream HIV and AIDS within their activities. On the other hand the Aids Fonds concentrates on service provision related activities, such as increasing access to treatment.

In 2007 STOP AIDS NOW! started a pilot project "Integrating HIV and AIDS into Microfinance". HIVOS managed and monitored the implementation of the pilot while STOP AIDS NOW! supported the process and managed the knowledge component of the project by sharing progress information and facilitating learning and cooperation among its partners. The microfinance industry gained popularity for creating access for the poor to financial resources. Microfinance is considered one of the potential strategies in HIV prevention and care and support programs to help stabilize households affected by HIV and AIDS, as well as creating a forum to disseminate HIV prevention information and being a model of psychosocial support to the group members. HIV poses not only challenges for clients of microfinance institutions (MFIs) but the impacts of HIV make it difficult for MFIs to build resilience and adequately respond to the needs of their clients. In the pilot, the assumption is that MFIs should cooperate with ASOs. The rationale behind this is that poor people affected by HIV do not only have financial needs to generate an income for their household and cover extra costs that come with the illness, but also need information and moral support. From a study in Uganda, it was indeed found that partnerships between MFIs and ASOs make it possible to meet the needs of clients and to reduce the risks of MFIs (Gietema, 2009).

1.1 Broad Objectives

The Pilot was conceived as a first step of a broader, 5 year, project that in the long run aims to improve household incomes and subsequently the livelihood of the targeted groups via increased access to microfinance and related services. Accordingly, the long-term project aims to achieve the following **broad objectives:**

1. Enhancing the access of PLHIV and other vulnerable groups to microfinance and related services.

2. Encouraging MFIs to give attention to HIV and AIDS at their workplace.
3. Improving access of HIV information and services to beneficiaries of microfinance.

1.2 Specific objectives

The Pilot had the following **specific objectives**:

I. To set up good functioning coalitions of MFIs and ASOs and develop a proposal for scaling up the programme.
II. To promote AIDS awareness among beneficiaries of microfinance and build HIV competence of MFIs.
III. To inform the STOP AIDS NOW! partners and other Dutch actors on the prospects and challenges of microfinance in HIV prevention.
IV. To develop a strategy to promote access to microfinance among people and households who are vulnerable to HIV.

The pilot phase, considered the first step of a broader project, started in 2007 and was initially supposed to end in 2009, with 2010 being a transition year, followed by the 5-year project (2011-2015). Specifically the pilot was initially planned to start in 2007, 2008 and 2009 for Central America, Tanzania and Uganda respectively. However, there was a delay in commencing implementation due to various challenges. Implementation of pilot activities by the partner organizations in Central America started at the end of 2008 and lasted two years. In the case of the East Africa region it commenced in July and November 2010 for Uganda and Tanzania respectively and lasted 7 and 5 months. Having implemented the pilot phase of the project activities, STOP AIDS NOW! hired the Foundation Rural Development Consult (CDR) to undertake the evaluation of this phase with the following main research question:

What determines successes and less successful results of a coalition (between ASOs, networks of MFIs and of PLHIV) in: enhancing access of PLHIV to microfinance and related services; encouraging MFIs to give attention to HIV and AIDS at their workplaces; and improving access to AIDS information and services to beneficiaries of microfinance?

This report presents the general findings of the CDR evaluation team starting with a conceptual framework in section 2, followed by a description of the methodological approach (section 3) and the main results in section 4. In addition to this document the following reports were presented[1]:

A. Regional report for East Africa: *Evaluation of the HIVOS - STOP AIDS NOW! Pilot Project 'Integrating HIV / AIDS into Microfinance' in Uganda and Tanzania*. This English written report contains the results of the evaluation done in Uganda and Tanzania.
B. Regional report for Central America: *Evaluación Proyecto piloto HIVOS - STOP AIDS NOW! 'Integración del VIH / SIDA en las Microfinanzas' en América Central*. This Spanish written report contains the results of the evaluation done in six countries of Central America: Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panamá.

For this evaluation CDR formed two evaluation teams, which consisted of the following people:

- Uganda / Tanzania team: Dr. Isaac Nkote, Richard Otim, Tabitha Kibuka, Fred Iga Luganda.
- Central America Team: Alejandro Uriza, Olivier Pierard, Marije van Lidth de Jeude
- Overall coordination: Marije van Lidth de Jeude

[1] In case you would like to receive a copy of these reports, please send an e-mail to STOP AIDS NOW! (info@stopaidsnow.nl), mentioning "regional report Microfinance and HIV" in the subject.

2 Conceptual Framework

2.1 Microfinance

Microfinance came up in order to provide financial products and services to the poor. MFIs have developed a broad range of products and services that seek to alleviate poverty. Microfinance involves activities directed at providing access to financial services for poor people or small and micro-enterprises. Microfinance products and services include micro credit, savings products (voluntary and compulsory), pension plans, micro insurances against (health) risks, micro leasing, and can be combined with services like financial education, business development services and different economic or social trainings and information provision (Sengupta and Aubuchon 2008; Sievers and Vandenberg 2007).

Microfinance programs usually involve small amounts of money and are especially vital for the poor who are often excluded from accessing products and services from the traditional financial institutions, like banks (Jurik 2005; Pearson 2001). The types of financial products offered have diversified over the years and MFIs have designed innovative methodologies to improve their outreach to the poor. These include group lending and individual lending methodologies (Morduch 1999; Copestake 2007). The aim of the innovation in the delivery approach has been shaped by the perceived risks associated with providing these services to poor people, since they often lack assets that can guarantee the repayment of the loans to the MFIs. Where the individual members lack collateral, the group lending methodology is favoured and group members act as co-guarantors. In the case that the borrower has adequate collateral to cover the loan an individual lending methodology can be applied. The poorest therefore are often restricted to access microfinance services through the group lending methodology.

Risks associated with microfinance lending include the small loan amounts that make it difficult for a bank or MFI to become profitable, long distances between the borrowers and the offices (especially in rural areas) which makes monitoring of portfolio performance a challenge, high transaction costs, lack of collateral among borrowers, potential decline in the health of the borrowers (due to their vulnerable living situation) which may affect the repayment of the loan. MFIs have responded to the latter by designing insurance schemes including insurance against death to protect both the clients and MFIs in the event of a borrower dying. The situation has been complicated with the advent of the more complicated health challenges associated with the HIV epidemic. In Uganda, a credit risk management measure undertaken by all leading financial institutions (banks, MFIs, credit institutions) is that the borrowers contribute between 0.5 - 1% of the loan amount for insurance against death (Bank of Uganda, 2011). The MFIs then insure the loan with a competent insurance firm that compensates the MFI only in the event of death of the borrower. When a member defaults, it is normally the group that pays the MFI and later on pursues the defaulter to recover the bad loan. Because of the perception by insurance companies, that the likelihood of death occurring amongst PLHIV is high (they are perceived to be a “high risk group”), they are often excluded from these insurance schemes. The MFIs therefore desist from lending to PLHIV as a way of mitigating the risk of loan loss.

It is important to take into account that the microfinance sector is not homogeneous; it includes different types of companies, from limited liabilities or joint-stock companies to non-profit organizations, cooperatives and community associations. The majority were founded with a social mission and their goal is to create social capital. However, undeniably, some MFIs don’t reaffirm this character and have evidentially showed distortions between their mission and practice. Overall there has been a tendency in the sector, specifically while MFIs grow, to lean towards a good financial performance, or in other words, to increasingly move from the double bottom line approach (social and commercial or business oriented) to largely commercial/business oriented entities as they aim to become both financially and operationally self-sufficient. This shift has been referred to as Mission Drift because MFIs are no longer

purely socially oriented organizations but are paying more attention to financial sustainability, even more so when donor support is dwindling (Mersland and Strom 2010). Social and financial sustainability are however not two opposites but complementary and even mutually beneficiary (to put it bluntly: a happy client is a returning client and nobody will benefit when an MFI goes bankrupt). The present tendency is to look for an integral assessment of the interventions and to create a balance between the social and financial performances, as MFIs increasingly understand the necessity to incorporate in their management processes, tools and strategies to plan, monitor and evaluate the achievement of their social mission and objectives. Thus Social Performance Management (SPM) emerged with which MFIs can put into practice efficiently the social component of their mission as well as monitor and evaluate it. A practical tool for this are the Social Performance Indicators (SPI) developed by CERISE (2005) by which an MFI can auto-evaluate the fulfilment of its own objectives in four main areas: (i) deepening their outreach (towards the poor and most excluded), (ii) adapting their products and services to their target group, (iii) improving the social and political capital of their clients and their families, and (iv) carry out their social responsibility.

2.2 Microfinance and HIV

Many poor people have been hit by the HIV epidemic, which has affected their economic empowerment and has made them socially and economically vulnerable. Many of these vulnerable poor are excluded from accessing credit due to the increased risk associated with the health problems in the case of HIV infection. Specific social groups are affected more negatively, like is the case with women compared to men. This is one of the reasons that in Central America the pilot project was implemented by the Gender Commission of the Regional Network of MFIs. “Millions of poor women around the world have already been reached through economic initiatives, and millions more who are at risk of HIV could feasibly be reached for prevention purposes.” It is likely that both development and HIV related organizations would increasingly seek such integrations out. Also the United Nations Millennium Development Goals include the tripartite commitment to improve women’s empowerment, decrease poverty, and respond to HIV, focusing to intervene simultaneously on women’s economic and sexual empowerment (Dworkin and Blankenship, 2009: 467).
The rationale behind the pilot project is to consider microfinance as one of the potential sources of income for households affected by HIV (specifically PLHIV and women affected by HIV) and promote their economic empowerment. In addition, HIV prevention education and skills training may be another service attached to microfinance programs, thus creating a forum to provide knowledge about HIV, how it affects patients, how to deal with stigma, disseminate HIV prevention information and being a model of psychosocial support for the group members. By combining HIV prevention and education with microfinance, important synergies may be produced that extend beyond the economic realm to provide more enduring ‘‘structural protection’’ from HIV risks and stigma due to lack of knowledge, than HIV prevention can do alone (Ibid: 463).

The growing popularity of integrating HIV programmes into microfinance agendas has been explained by Salerno and Mitten (2008) who support the idea that microfinance services are a promising strategy for mitigating the economic impact of HIV for those who are indirectly and directly affected by it. Given that MFIs operate in communities that have been impacted by HIV at many levels, MFIs operations are impacted two-fold: externally by any (potential) PLHIV clients in the community; and internally by any staff who might be living with HIV or discriminate against (potential) PLHIV clients (Ibid). There is a critical need for increased awareness about HIV (both internally and externally) through development of workplace policies and programmes and knowledge provision, amongst others to get rid of stigma and myths related to HIV or AIDS. A growing body of literature examines the sustainability of MFIs in settings where households and communities (and hence, microfinance clients) are greatly affected by HIV and AIDS (Barnes, 2002; Kassaye et al., 2008). Here, the microfinance industry is particularly concerned about clients’ ability to pay back loans in regions where there is a mature epidemic. However, not all PLHIV are actually ill or not able to work. Nor is it always clear who is living with HIV as sometimes people do not know themselves or do not want to disclose it. These are important aspects to take into account when discussing the possibility of offering financial products specifically designed for people living with or affected

by HIV.

While the subject of HIV and microfinance is relatively new, models have been discussed in regard to the most effective and efficient way of delivering microfinance services to PLHIV. Pronyk et al. (2005) contribute to the debate of enhancing the role of microfinance in combating HIV prevention activities by proposing three possible models in which this can be achieved. The three models are:

a) The Linked model where there is integration at the level of a shared clientele base by two, or more, institutions (MFI and ASOs). Under this model the ASOs and the MFIs operate independently of each other, however, the individual organizations do refer their clients to each other to access their respective service,
b) The Parallel model where there is limited coordination of activities between the ASOs and MFIs but the focus is on serving the same clientele base. Any coordination is intended to enable the respective organizations improve delivery of their services and is often on a short term basis,
c) The Unified model involves having one institution (either MFI or ASO) providing both microfinance and HIV services. The staff of the institution is equipped with the skills to deliver both microfinance and HIV related services.

The application of any particular model depends on the prevailing condition and circumstances in a given community. As can be read in the conclusions: all models were applied in the pilot project, with varying results.

3 Methodological approach

In this section we detail the methodology that we followed to undertake the study in the different countries.

3.1 Level of research

The focus of the evaluation took place at three levels, with the following research questions:

A) Process level: to assess the process of development of partnerships between MFIs and HIV and AIDS service organizations

I. How are platforms in Central America, Tanzania and Uganda composed?
II. What were factors that decelerated or smoothened forming a partnership?

B) Platform level: to assess the functioning of the partnerships

I. How are MFIs and HIV and AIDS service organizations mobilised?
II. How do coalitions between MFIs and HIV and AIDS service organizations target PLHIV?
III. How does a partnership between MFIs and HIV and AIDS service organizations reduce the risk of HIV and AIDS for MFIs?
IV. How do MFIs integrate HIV and AIDS in their work?
V. What does each of the institutions see as a benefit to cooperate?
VI. How are roles and responsibilities of the different partners defined?
VII. How have platforms reached consensus in expectations and ideas about the way forward?

C) Beneficiaries level: to assess the results for the beneficiaries in Central America

I. How have coalitions improved access to MFI Services
II. How have coalitions improved access to AIDS information?
III. What are results directly related to the Pilot and what are results from already existing interventions that can inform future interventions?

As illustrated in the table below, the different phases of the projects in Central America, Tanzania, and Uganda were taken into account. In Central America, the evaluation focused on all three levels, in Uganda, mostly on process and platform levels, while for Tanzania only process level was investigated.

Table 1: Focus on the three levels by each pilot area

	Process level	Platform level	Beneficiaries level
Central America	X	X	X
Uganda	X	X	
Tanzania	X		

Source: ToR of the Evaluation

These three levels were investigated according to the following OECD-DAC (2002) criteria:

1. **Relevance**: The extent to which the objectives of the pilot project were (at the moment of formulating the pilot) and still are consistent with the needs and requirements of PLHIV and microfinance clients and personnel as well as with national and donor strategies and priorities related to reducing HIV infections and discrimination and improving access to financial services for people affected by HIV and AIDS in Uganda, Tanzania and Central America.

2. **Effectiveness**: The extent to which the objectives of the pilot project were achieved, taking into account their relative importance. Secondly, the suitability of the planned activities in addressing the needs of PLHIV and microfinance clients and personnel in the countries of the project will be evaluated.
3. **Efficiency**: Measures the resources (human, financial) and inputs (expertise and time) invested in the pilot project in comparison to the yielded results.
4. **Sustainability**: Indicates the probability that benefits generated by the pilot project will continue on the long run in each country without the support of external funds or assistance. It specifically answers the question: Will coalition partners continue implementing the activities over time without external development assistance?
5. **Lessons learned**: The summary of generalizations based on evaluation experiences, which could be used in future phases of the project. In this section the evaluation team highlights strengths and weaknesses in the preparation, design, and implementation of the pilot that affected performance and outcome in Uganda, Tanzania and Central America.

Table 2: Set up for list of questions, analysis and reporting.

	Process level	Platform level	Beneficiaries level
Relevance			
Effectiveness			
Efficiency			
Lessons learned			
Sustainability			

Source: based on the ToR of the Evaluation, OECD-DAC criteria 2002.

3.2 Phase One: Literature Review

In the first phase of the research available documentation on the thematic was reviewed. These included the latest (2005-2011) literature and documents on MFIs and HIV in Uganda, Tanzania, Central America and worldwide (see bibliography used at the end of this report).

3.3 Phase Two: Fieldwork

Primary information was acquired via the realization of semi-structured in-depth interviews (face-to-face and by telephone) and focus group discussions (FGDs). The interviews were done with representatives from MFIs, ASOs, donor agencies and other stakeholders in the different countries. The interviewed participants were fully informed about the purpose of the research. The data collection was conducted between the 27th of January till the 23rd of March, 2011.

3.3.1 Central America

In line with the ToR of the evaluation no field trip was originally planned in Central America. However, in view of the fact that beneficiary level was only really reached and to be investigated in Central America STOP AIDS NOW! and CDR decided afterwards to still include a field trip to all six countries in this region. Therefore, semi-structured interviews were not only realized by phone or skype but also face-to-face, and FGDs as well as group interviews were conducted with personnel and clients of MFIs. For each of these methods and respondent groups (clients, personnel, national and regional coordinators, representatives from MFIs and ASOs) research instruments (see annex 2 of the Central America report[2]), like semi-structured question lists and focus group exercises, were prepared, taking into account the three levels of investigation (process, platform, beneficiaries level), the five OECD-DAC criteria (see table 2) and information acquired after careful revision of all thematic relevant documents, mainly those produced by the Central American Microfinance Network (REDCAMIF) and its members (National Networks of each Central American Country and affiliated MFIs).

As shown in annex 3 a total of 109 persons participated in the evaluation in Central America. Interviews were conducted with the project coordinators of all six national networks and the

[2] In case you would like to receive a copy of this report, please send an e-mail to STOP AIDS NOW! (info@stopaidsnow.nl), mentioning "regional report Microfinance and HIV" in the subject.

regional network as well as with representatives of 19 MFIs (more than half of the 35 MFIs involved in the project). Moreover, a total of 41 clients and 32 staff members of MFIs participated in the focus group discussions. This amount of respondents turned out to be sufficient as any additional interview was generating mainly repetitive answers and no new additional information was acquired. Moreover, the person responsible for the project at REDCAMIF's Working Group on Gender Mainstreaming in Central America (The Gender Commission) was also interviewed as REDCAMIF was the implementer of the project in the region and the project and its objectives were specifically linked with the Gender Commission. Regarding the ASOs, interviews were conducted with those that gave most of the HIV trainings in Costa Rica, Guatemala, Panama, and Nicaragua (7 of the total 10). Finally, interviews with three program officers responsible for HIV and microfinance at HIVOS Costa Rica were held.

The MFIs were selected from the group of MFIs that had been involved in the project in Central America, which are all associated with REDCAMIF. These are represented in Table 3, which also includes all ASOs that were involved in each country (for a complete list of the organizations and people interviewed, see annex 3).

Table 3: MFIs and ASOs that participated in the pilot in Central America, by country.

National MFI Network–Country	MFIs	ASOs
REDIMIF-Guatemala	FUNDESPE, FAFIDESS, FIACG, Fundación CRYSOL, AGUDESA, CDRO, ASDIR, MICROS, MUDE, FAPE	Gente Positiva (gave most of the workshops), ONU-SIDA
REDMICROH-Honduras	FAMA OPDF, FUNED Vision Fund OPDF, ODEF Financiera	CEVIFA
ASOMI-El Salvador	Asociación El Bálsamo, Micredito / Micronegocios, FADEMYPE, Apoyo Integral, Fundación Campo.	Independent Consultant (present director of Regulations at the Ministry for Health)
ASOMIF-Nicaragua	ProMujer, ADIM, FODEM, FDL, Fundación León 2000	ASONVIHSIDA, CISAS, personnel from HIVOS project "HIV & Rural World", independent consultant
REDCOM-Costa Rica	APACO, FUNDAOSA, Fundación Mujer, CREDIMUJER, FUNDECOCA	ASOVIH-SIDA
REDPAMIF-Panamá	CEPAS, Cooperativa Juan XXIII, Banco Delta, MICROSERFIN, PROCAJA, Banco GyT Continental, Cooperativa Juan Pablo I	PROBIDSIDA

3.3.2 East Africa

The main instrument of data collection in Uganda and Tanzania was a structured questionnaire (annex 1 of the Africa Report[3]) for the Key Informant Interviews (KIIs) with MFI and ASO management and staff. The questionnaire contained open-ended questions regarding three basic components: (i) basic organization information, (ii) questions related to platform level for Uganda and Tanzania and process level for Uganda, (iii) additional information shared by the respondents. The instrument was pilot tested with MEDNET and NACWOLA, and subsequently adjusted.

The evaluation team obtained the list of participating institutions (annex 2) from the lead agencies in Uganda (the Association of Microfinance Institutions in Uganda - AMFIU) and Tanzania (the Agency for Cooperation and Research in Development - ACORD).

[3] In case you would like to receive a copy of this report, please send an e-mail to STOP AIDS NOW! (info@stopaidsnow.nl), mentioning "regional report Microfinance and HIV" in the subject.

Uganda

Population and sample size

While carrying out an evaluation, there should be a population from which a sampling frame can be drawn. The Africa team focused on the institutions that were identified as being key stakeholders involved in HIV and microfinance work in Uganda. According to the Uganda Network of AIDS Service Organizations (UNASO) and AMFIU there are 79 MFIs and 91 organizations dealing with income generating activities (IGA) for PLHIV in Uganda. These are located throughout the country and therefore the sample was drawn from the four major regions of Uganda: the Eastern, Western, Central and Northern regions.

Using purposive sampling technique, the Africa team selected 19 institutions to be interviewed during the evaluation, based on the following criteria:

a) Participation as well as non participation (control group) in the pilot
b) Experience with PLHIV
c) High HIV prevalence in operational areas
d) Wide geographical areas of operations
e) Experience with economic empowerment programmes

The list of the interviewed institutions and respondents is included as annex 3 and 4 of the Africa report.

Data Collection

Fieldwork in Uganda commenced on the 22nd of February and ended on the 13th of March 2011. One team went to the Western region, one team to Northern region, one team to Eastern region and another team worked in Central region. Data collection in Uganda took longer than initially anticipated because the evaluation period coincided with the conduction of the election period in Uganda. During this period some of the respondents were not available.

The team conducted two FGDs (see annex 5 of the Africa report for guiding questions[4]) with beneficiaries of Uganda Cares[5], which is participating in the pilot and has a socio-economic empowerment component within its activities, as well as Victoria Basin Savings and Credit Cooperative (SACCO)[6], an MFI that developed a product specifically targeting PLHIV. One FGD constituted 8 participants (5 women and 3 men), all HIV+ clients of Uganda Cares while the second FGD consisted of 4 members (3 women and 1 man) of Bukobogo Farmers Group, a village savings and loan association (VSLA), clients of Victoria Basin.

Tanzania

In Tanzania, the team selected 11 organizations, (MFIs and ASOs) for the evaluation as well as the independent consultant hired by the coalition to facilitate the pilot processes (see annex 3). Of the 11 organizations, 8 are members of the pilot project. The other 3 organizations were relevant sources for related information, because of their long experience in coordinating HIV related programmes and also operating socio-economic empowerment programmes. The sampled institutions are located in Mwanza (in the Lake Zone) and Dar es Salaam.

Data collection commenced in Mwanza on the 14th of March ending on the 23rd of March 2011 in Dar es Salaam. At each selected MFI and ASO, KIIs were done with 1 or 2 members representing various levels of management and focal persons on HIV. No FGDs were

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[4] In case you would like to receive a copy of this report, please send an e-mail to STOP AIDS NOW! (info@stopaidsnow.nl), mentioning "regional report Microfinance and HIV" in the subject.

[5] Uganda CARES is a partnership between the Aids Healthcare Foundation (AHF) and the Uganda Ministry of Health. Uganda CARES was the first organization to provide Anti Retroviral Therapy (ART) outside of the capital city of Kampala and is one of Uganda's largest providers of HIV treatment and care (source: http://www.stopaidsnow.org/documents/AIDS_Service_Providers_Uganda.pdf).

[6] One of the 4 MFIs that participated in the pilot

conducted in Tanzania mainly because pilot activities stayed at process level and no activities at the beneficiary level had been executed yet.

3.4 Phase Three and Four: Data analysis and Reporting

This is the process of systematically applying statistical and/or logical techniques to describe and illustrate, condense, recap, and evaluate data. The specific approach taken and the type of data (field notes, documents, and audiotape) determined the form of analysis. An essential component was ensuring data integrity by focussing on accuracy and appropriateness of the analysis of research findings. The analysis of qualitative data from the KIIs was realized using NVIVO and LISREL. Based on the analysis draft reports were written for East Africa (four in total) and Central America (two).

3.5 Phase Five: Discussion of the evaluation report

This is the last stage, which will take place after the evaluation. The participants shall be all interested parties such as NGOs, government departments, program implementers and consumers. The idea is that the discussion focuses on how the lessons learned, as indicated in the evaluation reports, can be used for improvement of the formulation and implementation of future phases of the project.

In April 2011 the preliminary results of the evaluation were presented to STOP AIDS NOW! and its Dutch partners (see annex 1 for a list of the participants) with the goal to get their input and to follow up on specific objective three of the pilot: “To inform the STOP AIDS NOW! partners and other Dutch actors on the prospects and challenges of microfinance in HIV prevention”. On the same day the policy officer of STOP AIDS NOW! that was involved since the beginning of the pilot project was interviewed. The outcomes of both activities are presented in this report.

4 Main results

The next sections include a summary of the relevance, effectiveness, efficiency, sustainability, lessons learned and recommendations as an outcome of the overall evaluation. For more details, please see the two regional reports.

4.1 Relevance

The idea for the pilot project was developed in collaboration by HIVOS and STOP AIDS NOW! and occurred during a visit of two HIVOS headquarters program officers for HIV and financial services to MFIs and organizations specialised in HIV in Central America in 2006. In august 2007 the first Central American Workshop on Microfinance and HIV/AIDS was organized by REDCAMIF in Managua, Nicaragua with the support of HIVOS, STOP AIDS NOW! and Ford Foundation as a parallel event to the Second Forum on Microfinance and Gender. A policy officer from STOP AIDS NOW! as well as representatives from HIVOS and Ford Foundation participated in this workshop and started negotiation with REDCAMIF for the implementation of a pilot project on gender, HIV and microfinance. The director of REDCAMIF was also present at the AIDS congress in Amsterdam on the 1st of December 2007. Uganda and Tanzania were chosen based on the previous experience of HIVOS with MFIs and organizations specialized in HIV/AIDS in these countries.

As indicated in section 1, the microfinance industry gained popularity by creating access for the poor to financial resources. PLHIV and people affected by HIV are a highly vulnerable population in terms of being susceptible to internal or external risks (e.g. sickness or death in the family, financial crisis); their lack of access to assets, specifically financial assets because HIV is often related to poverty; and being socially excluded. Access to financial services can diminish their vulnerability. Even more so if combined with capacity building by financial and business development services.

In order to reduce stigma regarding HIV and AIDS an “enabling environment” has to be created. This requires not only a vertical approach (within the HIV sector) but also a horizontal approach: mainstreaming HIV in other sectors. Microfinance was targeted with this pilot due to a high level of stigma within this sector and because it offers an opportunity to strengthen economic empowerment of PLHIV. PLHIV have a higher risk than other people of losing their job due to stigma; setting up their own businesses is more difficult as well due to a lack of access to financial services like credit and insurances (especially a life insurance). In the two African countries where the pilot was implemented these issues are also partially addressed by national policies and strategies, in Central America the national governments of some countries have begun to address these issues, in others the topic is still very incipient (see the respective country reports for more information on national strategies and priorities related to HIV[7]).

Secondly, a growing literature examines the sustainability of MFIs in settings where households and communities (and hence, microfinance clients) are greatly affected by HIV; here, the microfinance industry is particularly concerned about clients’ ability to pay back loans in regions where there is a mature epidemic.

Finally, there is increased interest in whether microfinance can work as an HIV prevention strategy. Notably women groups that have adopted group lending have offered group solidarity and identity outside family ties. While these group processes are powerful and appear to show great potential as catalysts for social change, questions remain as to whether this is the mechanism through which HIV risks would be effectively reduced, or if it is the economic element, or both.

[7] In case you would like to receive a copy of these reports, please send an e-mail to STOP AIDS NOW! (info@stopaidsnow.nl), mentioning "regional report Microfinance and HIV” in the subject.

The idea of the pilot project was to focus on awareness raising within MFIs in order to stimulate them to develop HIV workplace policies and improve access to financial services for people affected by HIV and AIDS. In the case of Central America also a guarantee fund was supposed to be created, to cover the risk in case of sickness or death of a client due to AIDS as no life insurance is available for PLHIV.

In the case of Uganda the networks of MFIs and ASOs developed the pilot jointly. This has been important for the appropriation of the project by organizations of both sectors as well as a clear division of roles. Also in Tanzania PLHIV were present in the introduction workshop, but due to a lack of apex bodies, ACORD took on the implementation of the pilot in this country. In Central America the project was developed and implemented by the regional and national networks of MFIs, with varying results in terms of platform creation, none of them sustainable at the moment of evaluation.

In summary: findings from the pilot phase evaluation indicate that the overall project objectives are appropriate and relevant in the context of Uganda, Tanzania and Central America. They aim at mitigating and reducing the impact and spread of HIV by strengthening the economic situation of households that are most affected by or vulnerable to HIV via improved access to microfinance and related services as well as improving awareness and knowledge on HIV among staff and clients of MFIs. Some MFIs in all pilot countries, specifically the non-profit MFIs like cooperatives and associations, already give training on health and other social topics, in which HIV should be an integral part as any population groups should be informed about its causes, consequences, ways of protection and how to act in case of an infection. This is specifically the case for the vulnerable poor with low levels of education that are targeted by MFIs. In coalition with the MFIs, ASOs can more easily reach this population.

Finally, the relevance of MFIs integrating HIV in their work is directly related to their core business: the health of their clients is strongly related to their payment capacity and thus the results of the MFI. Moreover, HIV sensitization of decision makers in the MFIs is key for avoiding exclusion of people that are affected or highly susceptible to HIV.

4.2 Effectivity

In the Central America region beneficiary level was achieved, whereas in East Africa only process (Tanzania and Uganda) and platform (Uganda) levels were reached. The focus on the creation of coalitions resulted however in a stronger platform in the case of Uganda and, to a lesser extend, Tanzania than in the case of Central America. Overall **specific objective 1** of the pilot: *To set up good functioning coalitions of MFIs and AIDS organizations and develop a proposal for scaling up the programme* has been achieved in Uganda and most likely in Tanzania but not in Central America. In the latter region the existence of a network for MFIs has been key for the implementation of the project (and offers opportunities for continuation). However, the sole leadership role of REDCAMIF and subsequent lack of participation of ASOs and their representatives in the formulation and implementation of the project, clearly did not result in an appropriation of the project by the latter, due to which economies of scale were not sought for and sustainability is more difficult to achieve as it depends strongly on the MFIs. The role of ASOs was limited to giving workshops on a contractual and short-term basis. In the case of Uganda, the existence of active and legitimate apex bodies representing both MFIs and PLHIV has clearly resulted in the establishment of an effective platform (although the lack of a full time focal person affected the effective realization of some of the pilot activities), whereas in Tanzania the establishment of the platform experienced a slow start due to the lack of well functioning apex bodies, which was a challenge for mobilizing potential partners. How this will develop in the future is still to be seen.

In the case of Uganda also HIVOS, having earlier worked with the members of the steering committees, made coalition building much easier because of the mutual trust that had long been developed. The collaborative approach to developing the pilot activities gave the pilot partners adequate space to make valuable inputs into as well as enhancing ownership of the work plans. The sensitisation workshop, which was the initial pilot activity, introduced the

members to the pilot specific objectives as well as the broad objectives that are to be achieved with the long-term future project, and was very important in addressing expectations and clarifying roles before developing the pilot work plans. During this successful workshop the coalition partners affirmed their commitment to the pilot and subsequently developed work plans in which specific roles were assigned (see table 4).

Table 4: Uganda coalition partners and their roles

Coalition Partners	Roles in pilot
MFIs	Training in savings and credit, Provision of financial services, Linkages with the ASOs, Procure the insurance cover for our clients and staff as a mitigation factor, Provide psycho-social support, Assign a focal person on HIV, Put aside resources for catering for staff i.e. health care, separate pool for chronics, separate counsellor, Reporting
PLHIV NETWORKS	Mobilisation of beneficiaries, Monitoring and support, Sensitisation, Coordinating beneficiaries, Identification and formation of income generating initiatives (training, management, ensuring sustainability), Partnership meetings, Reporting (feedback and follow up)
AMFIU	Lobbying and advocacy, Capacity building (Training of Trainers), Coordination of MFIs and the networks, Fundraising and linking us to the development partners, Steering committee meetings on projects, Monitoring and evaluations
ACORD	Formulation and reviewing of work place policies, Advocacy and lobbying

Source: Fieldwork realized by the CDR evaluation team

With their participation the coalition partners expected to achieve the following benefits as documented in the sensitisation workshop report:

Table 5: Uganda coalition partners and their expected benefits

Coalition Partners	Expected benefits
MFIs	Increased outreach, Improved portfolio quality, Capacity building or skills gained by our staff, Enhanced positive living for both internal and external clients, Improved profits, Attracting increased funding from donors targeting such causes
PLHIV NETWORKS	Financial support leading to economic empowerment of PLHIV, Partnerships built/networking, Skills acquisition for PLHIV, Awareness raising and knowledge provision on HIV and AIDS with the aim to diminish discrimination/stigma, Prevention of HIV
AMFIU	Increased HIV awareness among staff and clients, Inclusiveness of all sectors of the target population, Improved outreach and portfolio
ACORD	Opportunity to share experiences with the MFIs in dealing with HIV issues, Increased partnerships, Visibility of HIV interventions realized by ACORD, A strengthened relationship between ACORD and AMFIU

Source: Fieldwork realized by the CDR evaluation team

In Uganda the major thrust of the activities at the platform level was internal mainstreaming of HIV issues into operations of the MFIs, with the principal activity focusing on the development of workplace policies in order to achieve with the future long-term project **broad objective 2:** *Encouraging MFIs to give attention to HIV and AIDS at their workplace*. One sensitisation workshop was held at the beginning of the implementation of the pilot (9th of July, 2010) to enhance the MFIs' knowledge of HIV and their acceptance of it as a reality as well as agreeing that it needs to be addressed at both personal and institutional levels. As a follow up activity to the sensitisation workshop, a two-day general workshop was held (on the 30th of September and 1st of October) to introduce mainstreaming of HIV issues into microfinance and to demystify long held myths and misconceptions through increased information about HIV. This workshop also had an overall aim of enhancing the ability of the MFIs to provide services that are responsive to the needs of PLHIV (thus complying with only **part of specific pilot**

objective 2: *build HIV competence of MFIs* as no *AIDS awareness was promoted among beneficiaries of microfinance*). Specifically, the aim was to introduce the concept of integrating HIV issues into programs and explore how it relates to microfinance. As a result of this workshop, the MFIs started viewing the ASOs as potential partners who can help deepen their outreach to this market segment (PLHIV). The ASOs on their part got to know the MFIs as potential partners in the realization of their economic empowerment goals, which were intended to improve the livelihood of PLHIV:

> *"We expect to work with AMFIU as partners and not clients or customers".*
> (Representative of an unspecified ASO)

Moreover, a collective workshop that focused on the internalisation and development of work policies was facilitated by ACORD for four MFIs. This workshop was followed by four customised workshops (in August and September 2010) that specifically focused on supporting each MFI to develop its workplace policy. The four MFIs that participated in the pilot are now at various stages of developing their workplace policy. They have encountered some challenges in the implementation of the policies like the inability to conduct staff sensitisation meetings because of the lack of a budget line. One MFI, HOFOKAM, had its policy approved by its Board of Directors and already commenced implementing it.

The positive effect of the sensitization and capacity building process is further evidenced by the initiatives undertaken by one of the participating MFIs, Victoria Basin Savings and Microfinance, which eventually developed a specific product targeting PLHIV. Although the implementation of this product was not part of the pilot project, the latter did have an influence on it by sensitizing personnel of Victoria Basin as shown in the textbox below. In Uganda, the pilot therefore contributed indirectly to specific objective 4: Develop a strategy to promote access to microfinance among people and households who are vulnerable to HIV and broad objective 1: Enhancing the access of PLHIV and other vulnerable groups to micro-finance and related services. Full achievement of this objective is to be reached with the follow-up 5-year project, for which a strategy has been developed but not approved yet.

> *"As a result of coming into the coalition, we realised some of the myths about PLHIV were not true. We therefore sought ways of how we could serve this market segment, especially given the high prevalence levels in our area of operation. We settled for the introduction of a specifically tailored product that target the PLHIV having realised that HIV doesn't automatically mean death and people must continue to live and work. The roll out of this product has been very successful and exceeded our expectation with a loan repayment rate of over 95%. The introduction has deepened our market outreach as well as increased our profitability thus leading to operational self-sustainability. Part of the product features include longer repayment period, which has been facilitated by accessing subsidized funds from development partners. The ASOs have also played a key role in sensitizing our clients on how to manage the HIV in addition to the provision of ARV. This has also reduced our clients' frequency of falling sick and increased productivity thus further alleviating our fear of risk with PLHIV."* (CEO from a SACCO in Uganda)

In Tanzania the pilot experienced challenges in the constitution of a platform to implement the pilot mainly due to three reasons: 1) the wide geographical size of the country (members of the steering committee had to travel long distances to get to meetings, which required time and money); 2) the various long held myths and misconceptions that MFIs and ASOs had about each other, specifically the fact that MFIs considered PLHIV as being a risky group and discriminated against them in a number of ways; and 3) the lack of well-functioning apex organizations, especially at MFI level, which resulted in the lack of clear leadership to take on the coordination role (establishment of a steering committee) and difficulties in mobilising potential partners. The initial pilot sensitisation workshop was held in April 2008 followed by two more workshops that were held in 2009 and attended by Kwasi Boahene (HIV/AIDS Sector, Hivos), Pieter Bas Schrieken (Financial Services Sector, Hivos) and Adolfo Lopez (policy officer at STOP AIDS NOW! at that time). All these workshops were aimed at

stimulating cooperation between the MFIs and AIDS organizations. A steering committee consisting of three organizations namely ACORD, PRIDE and KADERES was formed; however, owing to the lack of support from one of the partners (due to reasons unknown to the evaluation team), the pilot failed to take off as envisaged. The failure of the steering committee meant going back to the drawing table and reconstituting a new steering committee, an activity that took considerable amount of time (from 2008 to 2010).

Implementation of pilot activities in Tanzania eventually commenced in November 2010 with the first meeting of the steering committee. One of the first activities in the pilot had to be the conducting of a baseline to identify potential coalition partners (**specific pilot objective 1**). Another activity was the facilitation of an HIV workplace policy training workshop for the purpose of supporting MFIs to develop, implement and sustainably monitor HIV interventions at their workplaces (**specific pilot and broad long-term objective 2**). This workshop generated interest and acceptance of the need for HIV workplace policy, but did not yield concrete steps for the MFIs to develop a HIV workplace policy, amongst others due to the lack of a designated ASO to assist with institutional capacity building among the 4 participating MFIs and the necessity for more training for the coalition members. ACORD will assist MFIs with the development of workplace policies during the next phase. Also a methodological workshop was given, which was supposed to focus on documentation practices for platform members but rather facilitated cross learning and experience sharing, which strengthened the understanding of the coalition and improved working relations between MFIs and ASOs. During the workshop lessons learned from all organizations were shared, thus allowing all members to gain insight on each organization's strengths. This was very helpful in identifying each coalition member's roles for the strategic plan of the up scaling of the project. Input for this plan was provided during a so called "interactive event", which was attended by 15 representatives from MFIs, ASOs, media and government institutions with the objective to share experiences, challenges and opportunities toward the formulation of a strategy for mobilizing access of microfinance services for PLHIV in Tanzania (**specific pilot objective 4**). This strategy has yet to be finalized and approved by the steering committee.

Figure 1. Poster Central America

Central America is the only region where activities have already been implemented *to promote AIDS awareness among beneficiaries (clients) of MFIs* (the first part of **specific pilot objective 2)** in addition to *building HIV and AIDS competence of MFIs* (the second part of **specific pilot objective 2,** which was also achieved in the African countries). We can say that **broad objective 3:** *Improving access of HIV information and services to beneficiaries of microfinance* and **broad objective 2:** *Encouraging MFIs to give attention to HIV and AIDS at their workplace* have been achieved to a big extent in Central America. These objectives were not expected to be achieved with the pilot yet but were planned for the long-term follow up project. However, the latter will not be implemented with STOP AIDS NOW! funds in the case of Central America, which makes any progress on these broad objectives of specific value. In this region, more MFIs participated than expected and the targeted number of personnel trained was achieved on regional level, but with varying results on country level. Also clients were trained, but only a bit more than half of the goal was reached, mainly due to money and time constraints and the lack of well functioning coalitions with ASOs or networks of PLHIV. However, a considerable amount of brochures (>15,000) and posters (>4,000) was issued to the 53 participating MFIs in the six countries of Central America. Moreover, a multiplier effect took place due to the fact that the clients and personnel of the MFIs talked with friends and relatives after receiving the training and shared the printed material with them. It is however important to mention that attending one workshop and receiving a brochure does not raise real awareness, although participants still had a vivid memory of the workshop mainly because of the testimony of a PLHIV; a more profound and continuous sensitization process is required in order to achieve this. The majority of the participants that we interviewed indicated that they promote follow up trainings, for themselves as well as for those that have not been able to attend yet. This is also necessary in view of prevailing stigma and lack of knowledge related to HIV in the six countries of the region, including in the microfinance sector.

> *"In the workshop there was a person with HIV. The testimony of this person made a deep impression because you find out that the person you are working with has HIV and you become aware of the fact that we can all be at risk"* (MFI personnel in Nicaragua, translated from Spanish)

In order to *build HIV competence of MFIs* (**specific pilot objective 2**) apart from the above mentioned workshops for MFI personnel, REDCAMIF contracted the systematization of the experience of two MFIs in Honduras with loans for people affected by HIV and the results were shared with members of all national networks of MFIs in Central America during a forum on gender and microfinance (May 2010). To follow-up on this a necessity - marketing study was supposed to be conducted in order to design financial products for people affected by HIV. The contracting of this consultancy has endured some setbacks due to lack of funds and suitable proposals, and has therefore been postponed to later in the year 2011 as well as its implementation and validation. The idea is that these financial products will be offered by MFIs in Honduras and Nicaragua, thus complying (although after the pilot period) in two of the six countries with **broad long-term objective 1:** *Enhancing the access of PLHIV and other vulnerable groups to microfinance and related services* and **specific pilot objective 4:** *To develop a strategy to promote access to microfinance among people and households who are vulnerable to HIV.*

In case of **specific pilot objective 3:** To inform the STOP AIDS NOW! partners and other Dutch actors on the prospects and challenges of microfinance in AIDS prevention, this was mainly done by producing process reports of the realized activities for the donor agencies (specifically STOP AIDS NOW! and HIVOS) and systematizing experiences (like in the case of specific financial products offered to people affected by HIV in Honduras). The following activities took place to share pilot information: regular updates in quarterly meetings with representatives from the STOP AIDS NOW!-partners; regular updates on the website (including workshop documents); a presentation at the International AIDS Conference in Vienna (2010) in the so called STOP AIDS NOW! Networking Zone; a group discussion at the International AIDS Conference in Mexico (2008); presentations in the Netherlands, among

others during the Expert Tour in November 2010 (by the AMFIU representative), at Oxfam Novib in September 2009 and November 2008, and at the AIDS Congress in Amsterdam 2007 (a presentation given by REDCAMIF). Moreover, a presentation was given to STOP AIDS NOW! and its partners in April 2011 regarding the preliminary results of this evaluation, followed by a group discussion.
Some practical recommendations for improvement of the brochures given by clients in Central America:

- Institutions: include data of institutions where people can go to for information, support in case of PLHIV and psychological help.
- Symptoms: include information on symptoms of HIV and AIDS so people can identify if they have it.
- Incidence: include number of cases in each country and variances.
- Images: Include photography's and life stories from PLHIV (without showing their face for confidentiality).
- Language: Translate material in indigenous languages.

Table 6: Level in which specific objectives of the pilot project and broad objectives of the long-term future project have been achieved in Central America, Uganda and Tanzania

	CA	UGA	TAN	Overall
Broad objectives for long-term future project				
1. Enhancing access of PLHIV and other vulnerable groups to MF and related services.	1	5	1	2.3
2. Encouraging MFIs to give attention to HIV and AIDS at their workplace.	7	9	7	7.7
3. Improving access of HIV information and services to beneficiaries of microfinance.	8	3	1	4
Total	**5.3**	**5.7**	**3**	**4.7**
Specific objectives of the pilot project				
1. To set up good functioning coalitions of MFIs and ASOs and develop a proposal for scaling up the programme.	1	9	7	5.7
2. To promote AIDS awareness among beneficiaries of microfinance and build HIV competence of MFIs	9	7	5	7
3. To inform the STOP AIDS NOW! partners and other Dutch actors on the prospects and challenges of microfinance in HIV prevention.	n.a.	n.a.	n.a.	8
4. To develop a strategy to promote access to microfinance among people and households who are vulnerable to HIV.	5	8	7	6.7
Total	**5**	**8**	**6.3**	**6.9**

Note: the score goes from 1 to 10. A score of 1 is indicating that the objective is not achieved at all and a score of 10 that it has been achieved completely.
n.a. = not applicable
Source: CDR Evaluation team based on fieldwork

4.3 Efficiency

The efficiency of the pilot was supposed to be evaluated by looking into how financial and human resources, and inputs towards the pilot program yielded results in the most efficient way. In the case of East Africa however, due to a lack of access to the financial report of the pilot the evaluation team could not evaluate the use of financial resources and focused only on the time schedule and variances. In both countries the pilot experienced big delays and the final implementation period was cut down strongly (from 2 years to 5 - 7 months). This is also the reason that in both countries beneficiary level has not yet been reached.

In Uganda a workshop was held in March 2009 to introduce the pilot to the targeted institutions (MFIs and ASOs), but mobilisation and getting the critical stakeholders interested took longer than anticipated. The thematic of the project was new to the MFIs and senior managers had to be sensitized in order to have them incorporate the pilot activities in their work plans. Also the lack of a full time pilot project staff slowed down activities. The pilot was eventually implemented between July 2010 and February 2011. In view of the relatively short implementation period an efficient use of time was required in order to achieve the planned goals and objectives. As a result, workshops that aimed to achieve similar results were combined.

In Tanzania, besides the challenges encountered in the formation of the coalition (see section 4.2), the commencement of the pilot was also affected by similar factors like in Uganda (e.g. lack of a full time project staff and of awareness raising). The pilot activities were implemented over a period of five months from November 2010 to March 2011 and focused mostly on setting up a functioning coalition (process level activities). More time and financial resources have been invested in awareness creation workshops and meetings among the participating MFIs than planned, because the lack of a well-functioning apex body, which could have provided an entry point for the pilot. Furthermore, the size of the country was a challenge to implementation as long distances required investments in (travel) time and money. The additional efforts and time resources that were invested in the identification of potential coalition member and awareness creation activities, like the mapping exercise and baseline studies, resulted in the failure to realize all the pilot goals and objectives in the specified time. Some of the planned activities have therefore not been implemented (see table 5 in section 4.2.2 of the Africa report[8]) such as the second steering committee workshop and the broader project strategy development meeting.

In the case of Central America the efficiency of the pilot has been quite good. More than half of all MFI members of REDCAMIF in the 6 countries of the pilot participated, which is considered to be a positively high amount. The same accounts for the amount of personnel trained (1 out of 5). However, only 0,3% of the total clientele of REDCAMIF members (1,800 clients[9]) participated in the workshops. From the overall budget of 160,000 USD only 55% has been implemented up to date, mainly due to the fact that one component still has to be implemented, which is exactly the one that is quite costly but reasonable in view of its target: the design and implementation of financial products for people affected by HIV (specific objective 4). The financial investments made for achieving the other objectives are considered to be quite low with respect to its results. Although only a relatively low quantity of people has been trained, the effect has been quite intense (see section 4.2). Moreover, the average amount spent per trained person on printing the material and facilitating the workshops is very low (around 10 USD). Regarding the human investment it is important to mention that in each country in Central America the pilot was implemented by the gender commission of the national network of MFIs, in collaboration with the participating MFIs and contracted ASOs. Although this required quite some mobilisation of people, this was hardly a full time job as the already set up structure and work method of the gender commission helped to do this in a very efficient way. Also the human investment is therefore considered to have been efficient.

4.4 Sustainability

The sustainability of the pilot is very questionable at this moment. In all countries continuation is strongly depending on external financial resources as no firm policies and other institutionalisation strategies have been established yet. Financing from Dutch NGOs is increasingly more limited due to diminishing governmental support for international cooperation (as of 2011 the annual support from the Dutch Government for international cooperation will go down to 0,7% of GDP as opposed to 0,8% in previous years. Moreover, a

[8] In case you would like to receive a copy of this report, please send an e-mail to STOP AIDS NOW! (info@stopaidsnow.nl), mentioning "regional report Microfinance and HIV" in the subject.

[9] No specific clients were targeted, however, the majority are women as the majority of the clientele of REDCAMIF are women (64% according to Mayoux and de Montis, 2008). Moreover, specifically non-profit MFIs like cooperatives and community organizations, participated in the pilot and they target some of the most vulnerable poor.

bigger amount of these funds will be used for support of Dutch businesses abroad, environmental and peacekeeping programs). Financing by HIVOS depends on the commitment of the other co-financers. Financing from STOP AIDS NOW! will not continue in Central America but might continue in Uganda and maybe Tanzania. Possible financing from Ford Foundation or other donors in Central America is not yet clear.

In Central America, although a certain “awareness” has been raised with the people that participated in the workshops (evidenced by the information they are still able to reproduce and the fact that they shared their acquired knowledge with others), a continuation of awareness raising activities amongst personnel and clients, which is key for achieving full sustainability on beneficiary level, is very much depending on external financial resources. No long-term platforms have been created with organizations specialized in HIV in order to give continuation of the workshops given by them (ASOs were contracted for specific activities and never formed part of the project as equal partners of the MFIs, nor is there a Central American network of ASOs). The regional and national networks of MFIs and various of its individual members, have shown an interest in continuing to work on the thematic of HIV but no institutional policy on HIV has been created yet. The MFIs that are most likely to give follow up on the topic are the ones that have an established training program for their clients from before the pilot started, which includes social and health care issues as an addition to the typical financial education that most MFIs are giving. Specific possibilities are created in Panama via the training of trainers – representatives of some of the MFIs. Improved access to financial services for people affected by HIV depends on the results of the implementation of this component, which is programmed to start in 2011.

In Africa an enabling environment for the integration of HIV in the microfinance sector has been created due to awareness raising workshops (as a result of the MFIs’ participation in the pilot phase, their senior managers, both in Uganda and Tanzania, now recognize HIV as a human resource challenge), the establishment of MFIs – ASO platforms and the formulation of HIV workplace policies in four Uganda MFIs. As a follow up of the pilot is likely to be implemented in this region, sustainability can be achieved.

The complimentary roles of ASOs – implementing sensitization activities for personnel and clients of MFIs as well as mobilizing PLHIV to participate in the project and access financial products– and MFIs –providing business skills training and financial services to the PLHIV– can create synergies leading to a cost efficient approach to the achievement of their respective organizational goals (see section 4.2 for more information on the role division).

4.5 Lessons Learnt

The evaluation team subtracted the following lessons from the pilot on incorporating HIV in the microfinance sector. In the case the lesson is applicable to some countries only these are specified:

4.5.1 Process and platform level

1. Collaboration between MFIs and ASOs from the beginning of the project cycle (starting with problem identification and design) is key for achieving ownership and building up (potentially) successful platforms (see section 4.2). The existence of well-established and functioning apex bodies, seen as legitimate representatives, makes it easy to directly interest and gain the acceptance of stakeholders.
2. The collaborative approach to introducing and developing the pilot activities as used in Uganda and Tanzania demonstrated mutual respect for all actors in the pilot and gave them adequate space to make valuable inputs into (and therefore enhanced ownership of) the work plans. The sensitization workshop, which was the initial pilot activity, introduced the members (MFIs and ASOs) to the pilot broad and specific objectives and was very important for affirming their commitment as well as addressing expectations and clarifying roles that were integrated into the pilot work plans.

3. The establishment of platforms was limited by various long held myths and misconceptions that MFIs and ASOs had about each other. Specifically the fact that MFIs had previously considered PLHIV as being a risky group and discriminated against them in a number of ways. However, participating in the project and acquiring increased information about the other demystified these myths thus creating a favourable ambience for future collaboration. Also, some MFIs are already beginning to embrace the PLHIV as reliable clients (in Honduras and Uganda).
4. Close geographical proximity of parties makes coordination easier (e.g. in Uganda). In Tanzania, large distances affected coordination at process level. In Central America having six national coordinators in addition to the regional coordination solved this.
5. The existence of an active donor organization like HIVOS made coalition building easier because of previous established contacts and the mutual trust created by previous collaboration in the regions. However, HIVOS could play a more active role in bringing together the different types of counterparts (MFIs and ASOs), for example by supporting the organization of a forum on microfinance and HIV where both parties are equally represented. Moreover, according to the evaluation team and based on interviews with HIVOS representatives, close collaboration between the microfinance and HIV program officers of donor organizations like HIVOS can facilitate the integration between entities from both sectors in the field.
6. The type of MFI has influence on the possibility of collaborating with ASOs and incorporating HIV in their businesses. Non-profit organizations, like NGOs or cooperatives, often offer already complementary activities to their financial portfolio, like business development services, technical assistance, thematic talks on social issues or a health program (part of the concept of "livelihood finance"). This gives them a comparative advantage over joint-stock companies, like banks, that at most offer financial education, as they already incorporated non-financial themes into their core business and have the necessary infrastructure, experience, and relationship with clients in which they can include HIV. This can be part of a bigger SPM system, which is specifically aimed at improving outreach (towards the most vulnerable poor like PLHIV), product adaptation for a target population, strengthen social and political assets of clients and their families and the social responsibility of the institution in general. According to literature review these issues have a strong impact on client satisfaction and faithfulness and thus on the financial performance of the MFI. Therefore, the evaluation team considers, that SPM (including HIV indicators) could be presented to MFIs as a business opportunity.
7. For a platform to function well and become sustainable, MFIs will have to institutionalize the topic by adopting HIV workplace policies and strategies. This requires not only the involvement of human resource managers but also the commitment of the directors and other decision making people within the MFIs. Moreover, the involvement of operational staff (like the Chief Operations Officers and credit/loans officers) through training and counselling is needed, as they are the ones who largely interact with the beneficiaries, the MFI clients (including PLHIV). This requires awareness and knowledge creation at all levels of the MFIs. Awareness raising activities should focus on demystifying long held myths about HIV, in some cases linked to religion

4.5.2 Beneficiary level

8. By working together, both MFIs and ASOs can reach more people with their services: HIV prevention, care and awareness raising as well as offering financial products. Focusing on PLHIV can be a business opportunity for MFIs. As indicated by an employee from an MFI in Honduras:

"*People living with HIV have to climb up; giving them a loan improves their self-esteem. We feel good helping them by giving them a loan and seeing that their businesses flourish. They are very sincere people, very responsible with the loan they need*". (Employee from an MFI in Honduras, translated from Spanish)

9. Offering financial products to people affected by HIV has a social as well as commercial goal. Part of the HIV training for personnel of MFIs has to focus on recommending affected households the adequate financial products for their specific situation, thus avoiding over-indebtedness (a topic specifically important in Nicaragua and possibly also in other Central American countries in the near future)[10].
10. The evaluation in Africa found out that in spite of the stringent loan payments where there is no tolerance for default regardless of the borrowers' health conditions, many PLHIV are quite proactive and seek out loans from MFIs as indicated in one of the Ugandan SACCO's experiences (section 4.2). However, PLHIV had to make great personal sacrifices to comply because of the fear of losing personal property. Therefore, the development of tailored products might be a solution to create increased access to microfinance services. Additional research is necessary to sustain this assumption as well as to define the specific characteristics that such a tailored product should have (e.g. longer payment periods). One of the disadvantages could be possible stigmatization, although this can be avoided by keeping the identity of the PLHIV clients a secret (see also the study done on experiences in Honduras).

4.6 Conclusions

Table 7 below summarizes the overall performance of the pilot project by giving it a score between 0 and 10 (as minimum and maximum extremes), and taking into consideration both regions that it was implemented in. The score for each evaluation criterion is explained in the text below the table and is mostly used as a scale in order to show the evaluation teams assessment regarding each of the criteria and as a tool for comparison between them. In other words, the project is considered to have been more relevant than effective, a bit less efficient, and still far from sustainable.

The relevance of the project is considered high due to the context that it is set in. Specifically in Africa both countries where the project was implemented are experiencing a generalized epidemic, affecting all sectors and all levels of the population from national level down to household level. In Central America incidence of HIV infected people is relatively low but this is partially due to under-reporting. There is a clear lack of information and sensibilization as well as a possibility for higher numbers in the future due to incubation time. The relevance of addressing HIV in the microfinance sector is strongly linked to the necessity for people affected by HIV to access financial services.

Table 7: Summary of the overall performance of the project in Central America, Tanzania and Uganda

Relevance	8	Good
Effectiveness	7	Sufficient
Efficiency	6.5	Regular - sufficient
Sustainability	5	Hardly sufficient
Average	**6.6**	**Regular - sufficient**

Effectiveness has been sufficient, but not classified as good because not all objectives of the pilot have been achieved. In the case of East Africa the beneficiary level has not even been reached, thus making little sense of the platforms that were formed. In Central America activities have been executed at beneficiary level but with varying results and one of the main activities, design of financial products for PLHIV has not been implemented yet. However, in the case of Central America all objectives are likely to be achieved in 2011 and in the case of

[10] This lesson is based on interviews conducted during the fieldwork of this consultancy as well as outcomes of a previously conducted research on the microfinance sector in Nicaragua, done by CDR and assigned by the Ministry of Foreign Affairs of the Netherlands.

East Africa a firm base has been established for the follow up of the one-year pilot by a multiple year project, by which all objectives could be achieved.

Although efficiency has been quite good in the case of Central America, the evaluation team did not have access to the financial performance of the pilot in Africa because financial reports of the lead agencies in Uganda and Tanzania were not finalised yet. Therefore, this criterion has been classified as regular to sufficient.

The sustainability of the pilot is considered hardly sufficient due to the high dependence on external financial resources in both regions. Although in Africa platforms have been established and a few MFIs are formulating workplace policies, its effect at beneficiary level has still to be shown. In the case of Central America results have been achieved on beneficiary level but the integration of HIV within the institutions is far from being achieved.

In section 4.5 we answered the main research question: ***What determines successes and less successful results of a coalition (networks of MFIs and PLHIV) in: enhancing access of PLHIV to microfinance and related services; encouraging MFIs to give attention to HIV and AIDS at their workplaces; and improving access to HIV information and services to beneficiaries of microfinance?***

In conclusion we can say the following:

4.6.1 Conclusions on Process level

a) The existence of a well-established apex body makes it easier to mobilise potential partners.
b) Awareness raising and coalition building helps in demystifying long held myths and misconceptions about HIV.
c) Having a full-time coordinator could optimize the effectiveness of the project.
d) Close geographical proximity of stakeholders makes coordination easier.
e) A collaborative approach to the coalition formation results in ownership and commitment to the pilot.

4.6.2 Conclusions on Platform Level

The participating ASOs and MFIs can create programmes that maximize the strength of the organizations and deliver services adequately. However, this depends on the model that is being applied. In the case of Central America the **parallel model** of Pronyk et al. (2005) was used as there was limited coordination of activities between the ASOs and MFIs. The program was executed by the regional network of MFIs, which contracted on a short-term basis the services of ASOs and Networks of PLHIV to give awareness raising workshops to their personnel and clientele. In Uganda all three models of Pronyk et al. were (and are still) being used:

- Victoria Basin Microfinance SACCO uses the **linked model** in which it specialises in providing microfinance services while it leverages its partnership with an ASO to provide the HIV care and treatment services.
- NACWOLA adapted the **parallel model** by training the PLHIV and recommending them to the MFIs.
- Uganda Cares uses the **unified model** by providing not only HIV care and treatment services to PLHIV but also offering microfinance services through their socio economic empowerment programme.

Specifically the unified and linked models applied by Uganda Cares and Victoria Basin respectively have shown to be effective in the sense that they deliver both HIV and microfinance services to PLHIV, by which they are economically empowering PLHIV while at the same time reaching their goal of higher profits through an increased loan portfolio. These experiences can be used as models for other coalitions to adopt. Overall it is important to say that there is not a "one size fit all" solution possible. The leadership role of MFIs has proven to

be important for getting MFIs interested (e.g. in Central America and Uganda) but on the other hand can also lead to them taking full control over the project and leaving little space for appropriation of the project by ASOs and Networks of PLHIV (as was the case in Central America).

Other conclusions on platform level are:

a) Involvement of MFI operational staff and directors' commitment are key in workplace policy development and for the development of a PLHIV specific financial product.
b) Inclusion of the Human Resource personnel enhanced the development of HIV workplace policies and timely approval and implementation of the policy.

4.6.3 Conclusions on Beneficiary Level

Based on the fieldwork, the evaluation team is of the belief that the HIVOS and STOP AIDS NOW! Project provides an opportunity for the MFIs to acquire objective knowledge about HIV, thus enabling them to serve PLHIV and enter a hitherto neglected market segment because of the perceived high risk. However, integration of HIV in MFIs' business plans, requires smooth mainstreaming and implementation of an HIV focus in programs, operations and budgets, without overstretching resources of organizational core activities.

Regarding awareness raising it is important to acknowledge that the sensitization of social and human rights themes like HIV requires a long and intense process using a combination of tools (policy development, workshops, mass media campaign, leaflets, etcetera). In the microfinance sector, the directors of MFIs are the first that will have to be sensitized in order to get their commitment towards integrating the thematic into their operations and towards creating successful coalitions that can implement the process.

The creation of coalitions as well as the training of trainers can lead to a wider coverage and deeper outreach, while at the same time keeping costs of sensitization process low by achieving economies of scale. Collaboration with PLHIV networks is however recommendable above training trainers as the case of Central America, where the population has not been much in contact with HIV, has shown that the use of trainers that live with HIV themselves helps to achieve a strong impact onto the workshop participants.

The goal of "enhancing access of PLHIV to microfinance and related services" has not yet been achieved in any of the countries, although indirectly in Uganda and experiences in Honduras have been systematized, offering valuable inputs for the development of strategies in this regard. Tailored products might be helpful in accessing microfinance services but further research is necessary. In Uganda and Tanzania strategies have been developed for the following 5 years, which could offer a good chance of achieving fully all objectives of the pilot. In the next section the evaluation team gives some recommendations for achieving this goal.

4.7 Recommendations

In this section some of the main recommendations that were subtracted from the evaluation results are reflected. For additional information see also the section of recommendations in the Africa and Central America report.

4.7.1 Process level

1. The evaluation team recommends conducting further studies comparing the different models (linked, unified and parallel) of integrating HIV and AIDS in microfinance. Based on the experiences of the partners, the linked model of delivering microfinance services to PLHIV seems very appropriate and could be further implemented in the follow up of the project. In this model, the ASO should focus on their expertise of sensitising personnel and clients of MFIs as well as supporting the PLHIV and strengthen their capacities in areas like group dynamics (governance and leadership), business development and technical assistance. The MFIs should provide the

financial services and can give training on skills for running a small business. This results in synergies and the subsequent cost reductions hence sustainability.

2. To form sustainable coalitions projects will have to be formulated in alliance between MFIs and ASOs and time will have to be invested in realizing activities together, amongst others workshops to get to know each other. Also within donor organizations that support the integration of HIV in microfinance the program officers responsible for each thematic should work closely together.
3. Linkages can be formed by active promotion like bringing together ASO and MFI at fairs or forums. Dutch NGOs, specifically networks of partner organizations like STOP AIDS NOW!, or other donors could be more explored for this. As they work with different local counterpart organizations from both fields (HIV and Microfinance) they could support these events (financially and if necessary technically), addressing the needs of several of their counterparts, thus assuring participation.
4. The role and responsibility of governments to support these kind of linkages and improve access to finance, ART/V and HIV information should be taken into account in future phases of the project.
5. Moreover, based on the present as well as previously conducted fieldwork, the evaluation team considers that linkage of village banks, cooperatives, community organizations and other small or non-profit MFIs, with formal financial institutions and technical as well as business development or market service organizations, will greatly improve the outreach to people affected by HIV and the possibility of acquiring the necessary funds.

4.7.2 Platform level

6. Coalitions and up-scaling of project activities can be strengthened by recruiting a full time project coordinator to monitor the implementation of project activities as well as provide technical assistance to the coalition members. For sustainability purposes this person should be part of at least one of the implementing organizations and be partially paid by it. Also the thematic should be institutionalized and addressed transversally as successful implementation cannot depend on 1 person only.
7. The implementation by national networks of MFIs and ASOs is key for sustainability. However, the theme should be included in their strategic plans and policies (including those related to SPM and gender) as well as their training programmes with clear indicators for monitoring and evaluation (M&E).
8. A profound M&E system is key for the implementation of a planned 5-year project. For this purpose the evaluation team recommends to develop a base line study with clear indicators that can be monitored during project implementation in order to make necessary adjustments along the way. At the end of the project life cycle an impact study should be realized in order to evaluate the impact of the activities.
9. In order to assure a continued improved access to financial services by PLHIV and of awareness raising campaigns towards personnel and clients of MFIs the thematic of HIV and AIDS will have to be institutionalised within the microfinance sector. This requires the development of work place policies as well as the development of social performance indicators on HIV and AIDS. The MFIs should be provided with technical assistance in developing the HIV workplace policy until the policies are operationalised at the institutions.
10. In the next phase of the project it is important to also include insurance companies within the platforms. They need to be part of the awareness raising activities in order to address their rooted perceptions of PLHIV as a high-risk group. Moreover, collaboration between MFIs and insurance companies should be stimulated as well as the development of insurance schemes for PLHIV clients (see next section).

4.7.3 Beneficiary level

11. The evaluation of the Central America experience on beneficiary level has shown the importance of continued and broader sensitization and information campaigns in order to reach more people and achieve a more profound and sustainable change in attitudes and knowledge. For this purpose a combined use of methods is

recommended like trainings, exchange visits, media communication, use of illustrative materials (for bigger impact and wider reach, e.g. illiteracy in target population).

12. Regarding specialized financial products for PLHIV, the evaluation team recommends conducting a specific study on the advantages and disadvantages of not developing PLHIV specific products but addressing them with the products MFIs are offering to all clients versus the need to develop a PLHIV tailored financial product that takes into consideration their specific economic, social and health challenges. Within this study the evaluation team recommends systematizing positive experiences with a product specifically developed for PLHIV, which can serve as a base for implementation of these types of products by other MFIs (e.g. VBS experience and translation of the systematization done at two MFIs in Honduras). The coalition should conduct a market study to determine the complete product features necessary to address people affected by HIV (including repayment period, loan amount and interest rate). Other topics to address in this study are the possible use of a guarantee fund, possible different insurance schemes, the financing of such tools (donors, PLHIV, other clients, the MFIs, ASOs, government, other), the possibility of combining the financial product with technical and business development services as well as how to avoid stigmatization.
13. In addition to credit, the project should focus on other financial services, specifically insurance and savings. The characteristics of these financial products can be determined during the market / necessity study. Specifically, life insurances or security funds should be linked with savings accounts for more security. For this collaboration between MFIs and insurance companies is key.
14. Savings can serve as insurance and risk prevention but also for empowerment, appropriation, sustainability. This requires a strategy of offering specific saving services to this specific segment of the population (PLHIV and people affected by HIV), based on their necessities to access safe services for saving. This focus does not produce (at least in the beginning) a big flow of savings for the financial institutions but does contribute to a more profound outreach of saving services. According to a study conducted by CDR (2010) for ICCO on the topic of saving services in Honduras, aspects for outreach include:
    - Savings is the best mechanism for people living in conditions of poverty or vulnerability to construct a capital (= diminish their vulnerability), like people living with or affected by HIV.
    - The capital is constructed over a medium to long timeframe, thanks to organizations that focus on a long-term relationship with their clients.
    - Innovative savings products should be designed that focus on rural and vulnerable groups (youth, single mothers, indigenous people, etc.) and on the long-term, like retirement savings.
    - Transaction costs (of small amount savings for rural dispersed populations) have to be reduced for the saver as well as the financial institutions and be secured. Use of technologies.
    - The linkage of different types of financial institutions could support the attention to segments of the dispersed population.

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Annexes

1. Annex: List of Informants in The Netherlands

INTERVIEW WITH STOP AIDS NOW! AND HIVOS (28/04/2011)			
No.	**Name**	**Organization**	**Position**
1	Adolfo Lopez	Before: STOP AIDS NOW! Now: Aids Fonds	Policy officer
2	Nienke Westerhof	STOP AIDS NOW!	Program officer
3	Anita Jurgens	HIVOS	Program Officer Financial Services and Enterprise Development East Africa region
PRESENTATION OF PRELIMINARY RESULTS (28/04/2011)			
No.	**Name**	**Organization**	**Position**
1	Adolfo Lopez	Before: STOP AIDS NOW! Now: Aids Fonds	Policy Officer
2	Nienke Westerhof	STOP AIDS NOW!	Program Officer
3	Anita Jurgens	HIVOS	Program Officer Financial Services and Enterprise Development East Africa region
4	Jael van der Heijden	STOP AIDS NOW!	Program Manager
5	Janharmen Drost	Prisma	Program Coordinator HIV & Aids
6	Willeke Kempkes	ICCO	Policy Advisor Sexual & Reproductive Health & Rights, HIV & Aids
7	Irene Keizer	Aids Fonds	Program Manager
8	Bruno Molijn	Oxfam Novib	Policy Advisor Markets and Finance
9	Mark Vermeulen	STOP AIDS NOW!	Policy Advisor
10	Lincie Kusters	Oxfam Novib	Knowledge and Program Management Advisor

MFI national networks	MFIs	ASOs / PLHIV Networks that gave the trainings
REDIMIF-Guatemala	FUNDESPE, FAFIDESS, FIACG, Fundación CRYSOL, AGUDESA, CDRO, ASDIR, MICROS, MUDE, FAPE	Gente Positiva ONU-SIDA
REDMICROH-Honduras	FAMA OPDF, FUNED Vision Fund OPDF, ODEF Financiera	CEVIFA
ASOMI-El Salvador	Asociación El Bálsamo, Micredito / Micronegocios, FADEMYPE, Apoyo Integral, Fundación Campo.	Independent Consultant (present director of Regulations of the Ministry of Health)
ASOMIF-Nicaragua	ProMujer, ADIM, FODEM, FDL, Fundación León 2000	Independent Consultant, ASONVIHSIDA, personnel of the HIVOS project HIV and Rural World, CISAS

REDCOM-Costa Rica	APACO, FUNDAOSA, Fundación mujer, CREDIMUJER, FUNDECOCA	ASOVIH-SIDA
REDPAMIF-Panamá	CEPAS, Cooperativa Juan XXIII, Banco Delta, MICROSERFIN, PROCAJA, Banco GyT Continental, Cooperativa Juan Pablo I	PROBIDSIDA

2. Annex: List of organizations that participated in the pilot phase per country

Central America

MFI national networks	MFIs	ASOs / PLHIV Networks that gave the trainings
REDIMIF-Guatemala	FUNDESPE, FAFIDESS, FIACG, Fundación CRYSOL, AGUDESA, CDRO, ASDIR, MICROS, MUDE, FAPE	Gente Positiva ONU-SIDA
REDMICROH-Honduras	FAMA OPDF, FUNED Vision Fund OPDF, ODEF Financiera	CEVIFA
ASOMI-El Salvador	Asociación El Bálsamo, Micredito / Micronegocios, FADEMYPE, Apoyo Integral, Fundación Campo.	Independent Consultant (present director of Regulations of the Ministry of Health)
ASOMIF-Nicaragua	ProMujer, ADIM, FODEM, FDL, Fundación León 2000	Independent Consultant, ASONVIHSIDA, personnel of the HIVOS project HIV and Rural World, CISAS
REDCOM-Costa Rica	APACO, FUNDAOSA, Fundación mujer, CREDIMUJER, FUNDECOCA	ASOVIH-SIDA
REDPAMIF-Panamá	CEPAS, Cooperativa Juan XXIII, Banco Delta, MICROSERFIN, PROCAJA, Banco GyT Continental, Cooperativa Juan Pablo I	PROBIDSIDA

Uganda

1. ACORD — Agency for Cooperation and Research in Development
2. AMFIU — Association of Microfinance Institutions in Uganda
3. HOFOKAM — Hoima, Fort Portal, Kasese Microfinance
4. MEDNET — Micro Enterprise and Development Network
5. NACWOLA — National Community of Women Living with HIV
6. NAFOPHANU — National Forum of People Living with HIV and AIDS Networks in Uganda
7. PRIDE Microfinance
8. Uganda Cares
9. Victoria Basin (Kalisizo-Masaka)

Tanzania

1. ACORD — Agency for Co-operation and Research in Development
2. AGAPE
3. AMREF — Africa Medical Research Foundation
4. BANN — Biharamulo Aids Non governmental Network
5. BAPTIC — Bugogwa Amani Post Test Club
6. CHACC — City HIV/AIDS Council Coordinator
7. CODERT — MFI
8. CRS — Catholic Relief Services
9. FAIDERS — Facilitation for Integrated Development and Relief Services
10. FAIDIKA SACCOS
11. FINCA — Foundation for International Community Assistance
12. HIPWA+ — HIV Positive Women in Action
13. INHACNET — Ilemela HIV/AIDS Coordination Network
14. KADERES — Kagera Development and Relief Services
15. KUMEKUCHA-PLHIV group

16.	MPC	Mwanza Press Club
17.	MUCCoBS	Moshi University College of Co-operatives and Business Studies
18.	MWANDOI	Muungano wa wafanya biashara ndogondogo Igoma
19.	MWANET+	Mwanza Network People Living with HIV
20.	Mwanza SACCOS	
21.	MWDA	Mwanza Women Development Association
22.	SHALOOM Network of PLHIV	
23.	SHIDEPHA	Service Health Development and Education for PLHIV
24.	SIDO	Small Enterprises Development Organization
25.	TANEPHA+	Tanzania Network of People Living with HIV
26.	TAWOLIHA	Tanzania Women Living with HIV/AIDS
27.	TUJIJENGE AFRIKA	
28.	VICTORIA SACCOS	

3. Annex: List of organizations and people that participated in the evaluation

Costa Rica

FGD WITH MFI CLIENTS (14/03/2011)

No.	Name	Age	Profession	MFI
1	Bertilia Monge Gamboa	52	Housewife, her husband has an agricultural loan	APACO
2	Grisell Segura Picado	17	Secondary school student, her father has a loan	APACO
3	María Fernanda Gamboa	17	Secondary school student, her father has a loan	APACO
4	Ana Patricia Leiva Robles	38	Craftswoman, owner of a store (cloths and others)	APACO
5	Stephanny Venegas Monge	24	Housewife, her husband is a member of APACO	APACO
6	Ana Cecilia Monge Gamboa	48	Housewife, without a loan at the moment	APACO
7	Andrea Gamboa Monge	27	Housewife, her husband works at APACO	APACO
8	Marlen Leiva Gamboa	50	Housewife, IMF member	APACO
9	Grisel Monge Rivera	38	Hairstylist, her husband is a member	APACO

GROUP INTERVIEW WITH MFI STAFF (11/03/2011)

No.	Name	Age	MFI	Position
1	José Castro Guevara	52	Fundación Mujer	Loan Director
2	Iván Quesada Benavides	36	Fundación Mujer	Loan Advisor
3	Yaclin Araya López	20	Fundación Mujer	Loan Advisor
4	Teresita Cruz Conejo	58	Fundación Mujer	Loan Advisor
5	Grisel Zúñiga Parra	25	REDCOM	Directors Assistant

INTERVIEW WITH THE NATIONAL NETWORK / REDCOM (11/03/2011)

No.	Name	Age	MFI	Position
1	Zobeida Moya Lacayo	n.a.	Fundación Mujer / REDCOM	Director, coordinator of the Gender Commission
2	Grisel Zúñiga Parra	25	REDCOM	Directors Assistant
3	Roinel Vargas Blanco	n.a.	REDCOM	Executive Director

INTERVIEW WITH ASO (16/03/2011)

No.	Name	Age	NGO	Position
1	Edgar Briceño	n.a.	ASOVIH-SIDA[11]	Executive Director
2	Kattia López	n.a.	ASOVIH-SIDA	Facilitator
3	Hommer Montero	n.a.	ASOVIH-SIDA	Facilitator

INTERVIEW WITH MFI STAFF (14/03/2011)

No.	Name	Age	MFI	Position
1	Yorleni Gamboa	n.a.	APACO	Loan Advisor
2	Alejandra	n.a.	APACO	Assistant

INFORMAL INTERVIEW BY PHONE WITH HIVOS (27/01/2011)

No.	Name	Age	Organization	Position
1	Manine Arends	n.a.	HIVOS	Program Officer for HIV / Aids and Gender

INTERVIEW WITH HIVOS (16/03/2011)

No.	Name	Age	Organization	Position
1	Juan Pablo Solís	n.a.	HIVOS	Program Officer for Microfinance
2	Nubia Ferreyra	n.a.	HIVOS	Junior Program Officer for HIV / Aids and Gender

[11] Costa Rican Association of People Living with HIV

El Salvador

FGD WITH MFI CLIENTS (22/02/2011)				
No.	**Name**	**Age**	**Profession**	**MFI**
1	María Galia Orellana	44	Saleswoman	Micrédito
2	Teresa de Jesús Ramírez	52	Dressmaker	El bálsamo
GROUP INTERVIEW WITH MFI STAFF (22/02/2011)				
No.	**Name**	**Age**	**MFI**	**Position**
1	Eduir Caidenes	50	Integral	Social Welfare Administrator
2	Delmir Rosales	33	Micrédito	Director Assistant
3	Blanca Estela Pérez	45	El Bálsamo	Loan Advisor
4	Gustavo Vásquez Vásquez	23	El Bálsamo	Administration department
5	Roberto Montes	37	Micrédito	ICT manager
6	Dalya Karina Henríquez	21	Integral	Sponsorship Assistant
7	Norma Pereira	51	El Bálsamo	Director
INTERVIEW WITH TRAINING FACILITATOR (22/02/2011)				
No.	**Name**	**Age**	**Entity**	**Position**
1	Víctor Rivera	n.a.	Training facilitator	Director of Regulations at the Ministry of Health
INTERVIEW WITH THE PERSON RESPONSIBLE FOR THE PROJECT AT ASOMI (22/02/2011)				
No.	**Name**	**Age**	**MFI**	**Position**
1	Patricia Méndez	n.a.	ASOMI	Training Coordinator
INTERVIEW WITH THE NATIONAL NETWORK / ASOMI (22/02/2011)				
No.	**Name**	**Age**	**MFI**	**Position**
1	Franklin Montano	n.a.	ASOMI	Executive Director
SKYPE INTERVIEW WITH HIV SPECIFIC NGO (25/02/2011)				
No.	**Name**	**Age**	**NGO**	**Position**
1	Odir Miranda	n.a.	ATLACATL	Executive Director
PHONE INTERVIEW WITH THE NATIONAL NETWORK ASOMI AND MFI (12/02/2011)				
No.	**Name**	**Age**	**MFI**	**Position**
1	Norma Pereira	n.a.	El Bálsamo / ASOMI	Director El Bálsamo and coordinator of the Gender Commission at ASOMI

Guatemala

FGD WITH MFI CLIENTS (17/02/2011)				
No.	**Name**	**Age**	**Profession**	**MFI**
1	Claudia Marisol Molina Silva	35	Storekeeper and clerk at a farmacy	Grupo Comunal Luz y Esperanza, MUDE
2	Ericka Etelvina Floris Zisa	36	Bread Business	Grupo Comunal Mano del Cielo, MUDE
3	María Isabel Osorio	40	Tortilla Business	Mancomunal Esmeralda, MUDE
4	Odilia Vásquez Díaz	52	Dress maker	Grupo Lodecoy Mixco, MUDE
5	Miriam Noemí López	38	Saleswoman of Domestic Products	Grupo de mujeres Antigüeñas, MUDE

GROUP INTERVIEW WITH MFI STAFF (17/02/2011)				
No.	**Name**	**Age**	**MFI**	**Position**
1	Jadira Pérez	n.a.	MUDE	Loan Advisor
2	María de Los Ángeles	n.a.	MUDE	Head of the Agency in Chimaltenango
3	Salvador Jocop	n.a.	AGUDESA	Head of the Agency in San Juan Zacatepeques
4	Ligia Morales	n.a.	AGUDESA	Director Assistant and responsible for Human Resources
5	Jessica Valladares	n.a.	FAPE	Directors Assistant
6	Valezca Colidres	n.a.	FAFIDESS	Assistant Microfinance
7	Helena Zamora Castillanos	n.a.	FAFIDESS	Chief of Maintenance
8	Nidia Perir	n.a.	MUDE	Loan Advisor
9	Adilia González	n.a.	REDIMIF	General Accountant
10	Silvette Lemus	n.a.	REDIMIF	Director Assistant

INTERVIEW WITH THE NATIONAL NETWORK / REDIMIF (17/02/2011)				
No.	**Name**	**Age**	**MFI**	**Position**
1	Catarina Mendoza	n.a	MUDE / REDIMIF	Director MUDE, present coordinator of the Gender Commission of REDIMIF
2	Rocío Urizar	n.a.	FAFIDESS	Previous coordinator of the Gender Commission
3	Daniel Ruíz Arrivillaga	n.a.	REDIMIF	Executive Director
INTERVIEW WITH ASO (17/02/2011)				
No.	**Name**	**Age**	**NGO**	**Position**
1	Aldo Iván Dávila Morales	n.a.	Asociación Gente Positiva	Director
PHONE INTERVIEW WITH MFI (March 3 and 4, 2011)				
No.	**Name**	**Age**	**MFI**	**Position**
1	Olga Gutiérrez	n.a.	ASDIR	Director Assistant and representative at the REDIMMIF Gender Commission
2	Hugo Estrada	n.a.	CRYSOL	Executive Director
3	Vicky Sánchez	n.a.	CRYSOL	Training Coordinator

Honduras:

FGD WITH MFI CLIENTS (23/02/2011)				
No.	**Name**	**Age**	**Profession**	**MFI**
1	Delmis Iselma Alvarado	30	Saleswoman	FUNED
2	Dania Marlene Barrientos	26	Saleswoman	FUNED
3	Elizabeth Méndez	44	Saleswoman	FUNED
4	Candida Rosa Méndez	34	Saleswoman	FUNED
5	Jessi Carolina Méndez	29	Saleswoman	FUNED
6	María de la Rosario Ordóñez	46	Saleswoman	FUNED
7	Marisa Lisette Torres	39	Saleswoman	FUNED
8	Evangelina Méndez	69	Saleswoman	FUNED
9	Jeovany Zelaya	26	Saleswoman	FUNED
10	Brenda Berrios	19	Saleswoman	FUNED
INTERVIEW WITH MFI STAFF (23/02/2011)				
No.	**Name**	**Age**	**MFI**	**Position**
1	Lenis Alvarado	20	FUNED	Loan Advisor
2	Alejandro Valladares	28	FUNED	Loan Advisor

INTERVIEW WITH ASO (23/02/2011)				
No.	**Name**	**Age**	**NGO**	**Position**
1	María Elena Suazo	n.a.	CEVIFA	Executive Director
INTERVIEW WITH THE NATIONAL AND REGIONAL NETWORK / REDMICROH, REDCAMIF (23/02/2011)				
1	Eloisa Acosta	n.a.	FAMA / REDMICROH / REDCAMIF	Director of FAMA and coordinator of REDCAMIF and REDMICROH Gender Commissions

Nicaragua

INTERVIEW WITH THE CONSULTANT OF THE GENDER COMMISION / REDCAMIF (27/01 and 08/02/2011)				
No.	**Name**	**Age**	**MFI**	**Position**
1	Sonia Morín	n.a.	REDCAMIF	Consultant
INTERVIEW WITH ASO (25/02/2011)				
No.	**Name**	**Age**	**NGO**	**Position**
1	Arelys Cano	n.a.	ASONVIHSIDA	President
INTERVIEW WITH FUNDACION LEON 2000 (02/03/2011)				
No	**Name**	**Age**	**MFI**	**Position**
1	Raquel María Pastora	n.a.	Fundación León 2000	Project Responsible, Strategic Group
GROUP INTERVIEW WITH MFI STAFF (03/03/2011)				
No.	**Name**	**Age**	**MFI**	**Position**
1	Antonia Reyes	37	ADIM	Solicitor
2	Fatima Montes García	30	ADIM	Solicitor and Coordinator
3	María Esperanza Jiménez	45	ADIM	Reception
4	Dayla María Selva Lira	23	ADIM	Solicitor
5	Lucia Hernández M	33	FDL	Gender and Marketing Manager
6	Patricia Padilla	n.a.	ADIM	Director
FGD WITH MFI CLIENTS (03/03/2011)				
No.	**Name**	**Age**	**Profession**	**MFI**
1	Juana F Carmona	55	Storekeeper	FODEM
2	Petronila Guerrero García	48	Saleswoman of Nacatamales and Bread	FODEM
3	Luz Marina Reyes	58	Food Saleswoman	ADIM
4	Mayra García Alegría	59	Designer	ADIM
5	Hondra Sánchez García	30	Hairstylist	ADIM
6	Marta Dávila Siles	40	Juridical Promoter	ADIM
7	Margie Ramírez Avilés	33	Saleswoman Zermat	ADIM
8	Marta Gloria Marinero	63	Saleswoman of Pupusas	ADIM

FGD WITH MFI CLIENTS (02/03/2011)				
No.	**Name**	**Age**	**Profession**	**MFI**
1	Rusbelia Juanes	39	Housewife	PROMUJER
2	Ramora Lisette Soza	28	Transport and Food Saleswoman	PROMUJER
3	Francisca Emilia Calero	26	Saleswoman	PROMUJER
4	Irela Daleria Mairena	30	Saleswoman of Cosmetics	PROMUJER
INTERVIEW WITH THE NATIONAL NETWORK / ASOMIF (11/02/2011 and 04/03/2011)				
No.	**Name**	**Age**	**MFI**	**Position**
1	Patricia Padilla	n.a.	ADIM	Director

Panamá

INTERVIEWS WITH MFI CLIENTS (20/02/2011)				
No.	**Name**	**Age**	**Profession**	**MFI**
1	Guillermo Cruz	43	Vegetable store	MICROSERFIN
2	María Paula Montes	52	Saleswoman for Omnilife	MICROSERFIN
3	Mariela Leonidas Ng Nieto	60	Tortilla Saleswoman	MICROFSERFIN
INTERVIEWS WITH MFI STAFF (20/02/2011)				
No.	**Name**	**Age**	**MFI**	**Position**
1	Alonso	n.a.	MICROSERFIN	Loan Supervisor
2	Madeline	40	MICROSERFIN	Loan Advisor
INTERVIEW WITH THE NATIONAL NETWORK / REDPAMIF (20/02/2011)				
No.	**Name**	**Age**	**MFI**	**Position**
1	Jacqueline Rodríguez	n.a.	MICROSERFIN / REDPAMIF	Financial Manager MICROSERFIN, coordinator Gender Commission
INTERVIEW WITH ASO (21/02/2011)				
No.	**Name**	**Age**	**NGO**	**Position**
1	Carmen Arosemena	n.a.	PROBIDSIDA	Program Coordinator
2	Ariel Muñoz	n.a.	PROBIDSIDA	Program and Project Sub coordination, facilitator
3	Karina Solís	n.a.	PROBIDSIDA	Coordinator of the Department for Women and Children
INTERVIEWS WITH MFI (03/03/2011)				
No.	**Name**	**Age**	**MFI**	**POSITION**
1	Dilcia Mitre	n.a.	CEPAS	Consultant, representative of CEPAS at REDPAMIF

n.a. = not applicable

Organizations from Uganda

Organization	Brief Description	Type of Organization	Region	Part of pilot?
1. ACORD (Kampala)	Is one of the three steering members in Uganda responsible for the development of HIV workplace policy for the participating MFIs	CSO	Central	Yes
2. AMFIU (Kampala)	Is an apex organization for all MFIs in Uganda	MFI apex	Central	Yes
3. BRAC (Mbale)	Is an MFI operating in Uganda that provides social services alongside the loans to mainly poor women	MFI	Eastern	No
4. BUSODE (Masaka)	Is an NGO that operates in Masaka and Rwengo Districts in central Uganda. It manages income generating activities.	ASO	Central	No
5. BUTO (Kyenjojo Town)	Is an apex organization for SACCOs in Bunyoro and Toro Region	Apex for SACCOs	Western	No
6. Comboni Sumaritan (Gulu)	Is a Catholic Church operated ASO in northern Uganda	ASO	North	No
7. Gulu Municipality (GUM) SACCO (Gulu)	Is a leading MFI operating in Northern Uganda	MFI	North	No
8. HOFOKAM (Fort Portal Town)	Is an MFI that operates in western Uganda. It covers three dioceses of Hoima, Fort Portal and Kasese. It has five branches in these regions and its main clients are women that borrow in groups methodology.	MFI	Western	Yes
9. Kakuto SACCO	Is an MFI that operates in Central Uganda	MFI	Central	No
10. NAFOPHANU (Kampala)	Is a key coalition partner and the national apex of PLHIV member based organizations	PLHIV network Apex org	Central	Yes
11. MEDNET (Kampala)	Is a World Vision Uganda affiliated MFI operating across the country	MFI	Central	Yes
12. NACWOLA (Kampala)	Is a PLHIV women based organization with branches all over the country	PLHIV Network	Central	Yes
13. NACWOLA (Mbale)	Is a regional branch of NACWOLA	PLHIV Network	Eastern	No
14. Redeemed Bible Way Church Organization (RBWCO), (Gulu)	Is a Church based ASO in northern Uganda	ASO	North	No
15. Talanta Finance Microfinance (Gulu)	Is an MFI operating in Gulu in northern Uganda	MFI	North	No
16. TASO (Mbale)	Is an ASO that offers services to PLHIV	ASO	Eastern	No
17. Toro Diocese HIV Programme	Is a Church based ASO in western Uganda	ASO	Western	No
18. Uganda Cares (Kampala)	Is a project of the Ministry of Health that offers medical care and micro-lending to PLHIV	ASO	Central	Yes
19. UWESO (Mbale)	An NGO that focuses on caring for the orphans and widows. Offers VCT services and micro-lending and business skills to its members.	MFI	Eastern	No
20. UWMFO SACCO (Gulu)	Is a SACCO that operates in Gulu Municipality in northern Uganda	MFI	North	No

Organization	Brief Description	Type of Organization	Region	Part of pilot?
21. Victoria Basin (Kalisizo –Masaka)	Is a SACCO that operates in Masaka and Rakai Districts	MFI	Central	Yes

Organizations from Tanzania

Organization	Brief description	Location	Part of pilot?
1. ACORD Tanzania	Is the lead coalition partner in Tanzania	Mwanza Region	Yes
2. FAIDERS	Is an MFI based in Mwanza Region	Mwanza Region	Yes
3. KADERES*	Is an MFI based in Kagera Region	Kagera Region	Yes
4. Nyanza SACCO	Is a SACCO based in Mwanza Region	Mwanza	Yes
5. PASADA	Is an ASO affiliated to the Catholic Diocese of Dar es Salaam	Dar es Salaam	No
6. SHIDEPHA	Is a national umbrella organization of PLHIV based in Dar es Salaam	Dar es Salaam	Yes
7. TACAIDS	Is a Tanzanian government organization responsible for coordinating national response to HIV	Dar es Salaam	No
8. TAMFI	Is an apex organization of Tanzania MFIs that focuses on advocacy, training and capacity building	Dar es Salaam	Yes
9. TANEPHA+	Is a network that provides care and counselling services to the PLHIV in Tanzania.	Dar es Salaam	No
10. TAWOLIHA	Is an NGO and ASO	Mwanza	Yes
11. Tujijienge Afrika	Is an MFI that provides microfinance services to the poor in Tanzania	Dar es Salaam and Mwanza region	Yes
12. Independent Consultant, Moshi Cooperative College**	Is a training institution	Mwanza	No

Notes:
* KADERES was invited to participate in the evaluation but the key person was not interviewed due to unavailability. However, some organizational information was obtained from ACORD Tanzania.
** The independent consultant was hired by the coalition to facilitate the process.

People interviewed in Uganda

	Name	Organization
1	Solomon Kagaba	AMFIU
2	Carol Tumwesigye	AMFIU
3	Stella Kentutsi	NAFOPHANU
4	Anne Nabulya	NAFOPHANU
5	Lydia Mukasa	MEDNET
6	Jackie Nabwire	NACWOLA
7	Jacinta Magero	NACWOLA
8	James Balya	Uganda Cares
9	Flavia Birungi	ACORD
10	Doreen Atim Kwarimpa	Consultant
11	Grace Babisa	BUSODA
12	Susan Namajju	Victoria Basin Savings and Microfinance
13	Vincent Ssekyanzi	Formerly Victoria Basin Savings and Microfinance
14	Rev. Stephen Karebara	HIV Programme Toro Diocese
15	George William Kakyoma	BUTO
16	Charles Isingoma	HOFOKAM
17	Herbert Rusa	HOFOKAM
18	Emmanuel Muhumuza	Kakuto SACCO
19	Roberta Romano	Comboni Sumaritan
20	Godfrey Ejella	Comboni Sumaritan
21	Patrick Opolot	Talanta Finance Microfinance
22	Walter Ojaka	RBWCO
23	Tonny Okoya Kende	Gulu Municipality (GUM) SACCO
24	Benson Ochan	UWMFO SACCO
25	Patrick Oloya	Formerly with NACWOLA
26	Sarah	Formerly with NACWOLA Mbale
27	James	TASO Mbale
28	Mutebi Kimera	TASO Mbale
29	Bogere	BRAC Mbale
30	Gladys and Eddie Wambewo	UWESO Mbale

People interviewed in Tanzania

	Name	Organization
1.	Donald Kasinge	ACORD
2.	Glory Mlaki	ACORD
3.	Judith Charles	TAWOLIHA Mwanza
4.	Jessy Michael Balugala	Mwanza SACCO
5.	Stephen Nlugula	Mwanza SACCO
6.	Winnie Terry	TAMFI
7.	Anna Mulalo	TUJIJENGE Afrika

	Name	Organization
8.	Leonard Richards	PASADA
9.	Simon Yohana	PASADA
10.	Alex	TANEPHA
11.	Kamau	TANEPHA
12.	Joseph Katto	SHIDEPHA
13.	Christian Byamungu	FAIDERS
14.	Morris Lekule	TACAIDS
15.	Charles M. Malunde	Moshi University College of Cooperative and Business Studies Mwanza Centre (Independent Consultant)