The SEEP NETWORK

THE PROMISING PRACTICES CASE STUDY SERIES

With support from Catholic Relief Services, Tanzania and the Diocese of Musoma

CASE STUDY:

The Kibara Mission Hospital HIV Project, Tanzania

Phase II: Savings and Internal Lending Communities

The HIV & AIDS and Microenterprise Development Working Group of The SEEP Network, "**Kibara Mission Hospital HIV Project, Tanzania. Phase II: Savings and Internal Lending Communities**."

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Kibara Mission Hospital
HIV Project, Tanzania

Phase II: Savings and Internal Lending Communities

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with support from CRS Tanzania

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ACRONYMS

ASO	AIDS Support Organization
ART	Antiretroviral Therapy
ARV	Antiretroviral Medication
BDS	Business Development Services
CRP	Community Resource Persons
CRS	Catholic Relief Services
ED	Economic Development
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
IGA	Income-Generating Activity
MFI	Microfinance Institution
MIS	Management Information System
OVC	Orphans and Vulnerable Children
PLHIV	People Living with HIV
SACCO	Savings And Credit Cooperative
SILC	Savings and Internal Lending Communities
VCT	Voluntary Counseling and Testing
VSLAS	Village Savings and Loan Sssociations

Exchange rate: Tsh 1,195 = US$ 1, as of March 18, 2008.

PREFACE

The consequences of HIV and AIDS are unprecedented and far-reaching. For many families, concerns about poverty subsume concerns about the effects of HIV and AIDS. Poverty and social factors, such as gender inequality, also increase the risks to which women are exposed, as well as their vulnerability to contracting HIV. Income and savings become crucial tools and safeguards as households struggle to build and protect their economic resources to offset the impact of HIV and AIDS. Engaging in business and gaining access to support services may, moreover, provide women with alternatives to risky sexual behavior.

Microenterprise development services[1] can help families cover basic expenses, ensure the well-being of their children, increase their incomes, and build their savings. In addition, the close relationship between providers of microenterprise services and their clients offers a powerful platform from which to launch awareness and community mobilization initiatives that go beyond the mitigation of the economic impact of HIV and AIDS to address issues of HIV prevention.

Microfinance practitioners have created an innovative system that provides poor people with access to capital, which in turn supports their economic activities. However, most microfinance institutions (MFIs) do not have information about how HIV and AIDS affect their operations or their clients, nor do they have the background to address the societal factors that underlie HIV and AIDS. A better appreciation of client realities could allow MFIs to develop demand-driven innovations that protect their institutions. Such awareness could also guide MFIs to seek to collaborate with AIDS support organizations (ASOs).

The **economic development** (ED) sector is developing effective ways to meet the non-financial needs of microentrepreneurs. ED initiatives typically seek to create access to market opportunities for microentrepreneurs and increase business growth in the various sectors in which they work. The services offered by ED initiatives include business management training, entrepreneurial development, and facilitating linkages between microenterprises and growing markets. New lessons are emerging, however, that may help ED providers meet client needs that microfinance is not suited to address.

Development practitioners involved in **HIV and AIDS programming** traditionally come from the public health or social welfare fields. Although they often understand the need for sustainable economic interventions, they may not have the necessary background either to design and implement such interventions effectively or to examine potential development tools in the context of the social and economic needs of HIV-affected populations.

[1] In general, the field of microenterprise development is comprised of initiatives in microfinance and economic development (also referred to as business development services).

Effective AIDS program responses have opened opportunities for more economic initiatives in AIDS-impacted communities. For example, with the availability of life-extending antiretroviral therapies, people living with HIV are able to regain and extend their productive capacity and stay involved in their enterprises and communities. Increased education and awareness campaigns have been effective in reducing stigma, thus making community members more inclusive of HIV-affected households.

Sharing information about current initiatives and sound practices in both the microenterprise industry and the HIV and AIDS field should lead to a better understanding of the issues faced by households coping with HIV and AIDS. Clarifying these issues and better defining potential strategies to address them will in turn lead to more effective collaboration and program design, helping catalyze strategic alliances between microenterprise development organizations and AIDS support organizations.

The purpose of The SEEP Network's "Promising Practices" case study series is to describe a variety of microenterprise services that:

- reach deeply into the poor socioeconomic strata of a given community and/or geographic area;
- show the potential to reach significant scale;
- enable clients to plan for future crises, anticipate needs for lump sums of cash, improve income flows, enhance the profitability of economic activities, and avoid selling productive assets; and
- strive to go beyond the economic dimension of clients' lives to address the underlying factors that contribute to the spread of HIV & AIDS (e.g., through collaboration with ASOs or educational initiatives, such as informing clients about HIV & AIDS issues in order to change their behavior and mobilize community action).

I. CONTEXT

Socioeconomic Overview

The Kibara Mission Hospital Community HIV Project (hereafter, the "Kibara Project") is located in the far northwest corner of Tanzania, along the shores of Lake Victoria. In its 2006 report, UNAIDS reported that the HIV epidemic in Tanzania was relatively stable, with a national prevalence of 6.5 percent.[2] This figure masks a great deal of variability among regions and between rural and urban areas. In the remote Bunda District of the Mara region, where the Kibara Project is situated, government statistics show a decline in HIV prevalence from 10.5 percent in 2001 to 7 percent in 2006. Despite this development, there is cause for concern. Projections suggest that the number of new HIV infections in rural areas (where about three-quarters of the country's population live) could be twice as high as that in urban areas by 2010.[3] The voluntary counseling and testing sites operated by the Kibara Project registered a 15-percent HIV prevalence rate in June 2007. This figure may indicate either a particularly high transmission area within Bunda District or a selection bias on the part of those who chose to be tested.

The impact of HIV and AIDS on households in Tanzania is further aggravated by poverty, which makes it difficult for those affected to afford the additional costs of care and treatment. While 36 percent of the total national population was living below the basic-needs poverty line in 2002, the *Tanzania Poverty and Human Development Report 2005* reported that the Bunda District was the poorest district in the country, with 68 percent of the population living below the poverty line.[4] Poor access to government healthcare facilities and other public services due to its remote location worsens the situation of people living with HIV.

Box 1
Bunda District

Bunda District, where the Kibara Project operates, is the poorest part of Tanzania: **68 percent of the local population lives below the basic-needs poverty line.**

Purpose of Intervention

The primary goal of the Kibara Project has always been to improve the quality of life of people living in target communities by reducing the spread of HIV and mitigating its effects. The project has had two different implementation phases, with Phase II (2005–2007) building on

[2] UNAIDS and WHO, 2006, "AIDS Epidemic Update 2006" (Geneva, Switzerland).

[3] Geofrey R. Somi, Mecky IN Matee, Roland O. Swai, et al., 2006, "Estimating and Projecting HIV Prevalence and AIDS Deaths in Tanzania using Antenatal Surveillance Data," *BMC Public Health* 6 (May): 120. Available on the PubMed Central website of the U.S. National Institutes of Health.

[4] Government of Tanzania (Research & Analysis Working Group), 2005, *Tanzania Poverty and Human Development Report 2005* (Dar es Salaam: Mkuki na Nyota Publishers).

Phase I (2002–2004) to create a base for the integrated activities currently offered. Financial support and technical assistance for the project have been provided by Catholic Relief Services (CRS) Tanzania. The Diocese of Musoma has served as the CRS implementing partner, working through the Kibara Mission Hospital, a private facility. Phase I was designed and managed primarily as a health project (see "Description of Methodology" below). It focused on HIV awareness building and behavioral change using the "Stepping Stones" curriculum[5], voluntary counseling and testing (VCT), and compassionate home-based care (HBC). Microenterprise activities to assist the neediest families affected by HIV were a minor component of the strategy; however, these initial efforts provided key lessons and a foundation for a more effective follow-on model.

In Phase II of the project, microenterprise development was purposefully added to support existing HIV programming. CRS Tanzania accordingly helped introduce savings and internal lending communities (SILC), a group-based, savings-led financial services model that CRS supports in several countries. **SILC was specifically added to improve the incomes and boost the nutritional status of people living with HIV (PLHIV), as well as those of their households.** The experience of Phase I showed that the project could not offer adequate food rations to the growing number of PLHIVs in the district, nor was such a strategy sustainable. Nevertheless, an improved diet was crucial for the therapy and home-based care of people testing positive for HIV.

SILC groups provide households an opportunity to increase their asset base and ensure a more even cash flow. The economic opportunities available through SILC (i.e., savings and microenterprise activities) have the potential to increase the number and quality of meals consumed, as well as to improve other aspects of their quality of life. In addition, SILC serves as a platform for education to curb the spread of HIV and reduce its stigma. These groups also help extend HBC services deeper into the community.

Phase II continued to build on the health programming of Phase I, with these objectives:

- Empowering youth, families, and communities to adopt positive behavior to reduce the risk of HIV infection (through the use of the Stepping Stones curriculum)
- Improving the capacity of dispensaries to offer VCT services and expand VCT to 4,400 people in the community
- Providing 100 PLHIVs with compassionate, home-based care.

In addition, the formation of SILC groups met a fourth objective related to microenterprise development: engaging 344 households affected by HIV or AIDS in livelihood amelioration activities.

[5] More information on Stepping Stones can be found on the website of Strategies for Hope, a not-for-profit organization based in the United Kingdom.

In March 2006, antiretroviral therapy (ART) became available in Kibara. Distribution of antiretroviral medications (ARVs) has since become an additional service offered by the project through the Kibara Mission Hospital during Phase II of the project. SILC and ART have the potential to complement each other well. SILC provides a way for HIV-positive people to smooth their income streams and potentially live healthier lives by gaining the resources to eat better.[6] Likewise, in an area where the stigma of HIV remains strong, ART allows individuals to live with fewer signs and symptoms of HIV and to participate more regularly in enterprise activities. ART can also improve the productive capacity of PLHIV so they are less reliant on others for their livelihoods. One study in nearby Uganda shows that one of the few indicators of improved quality of life for individuals using ART was their ability to maintain financial independence.[7]

There are four distinct ways that HIV programming and microenterprise development are integrated in the Kibara model:

1. Clients using VCT services are informed about the savings and internal lending groups, especially those who test positive and receive counseling. Along with psychosocial support, home-based care, and ART, SILC groups are offered to clients as a way to support their economic needs. Some HIV-positive clients have indeed joined SILC groups.
2. The "Stepping Stones" HIV and AIDS training is offered in nearly every SILC group, usually over a 16-week period.[8] The curriculum, which has been highly successful in sub-Saharan Africa, uses participatory learning groups to talk about HIV, with a focus on dialogue around issues related to HIV and behavioral change. In addition, Stepping Stones opens the door for information on HIV testing and the VCT services offered by the project, while helping reduce its stigma through community dialogue and openness about HIV status.
3. SILC groups contribute to a "social fund," which they use to support orphans, sick people, and other needy individuals in the community. Some groups openly explain that they are caring for people with AIDS by taking them food, assisting with household chores, or helping them during periods of sickness, thereby extending the HBC network.
4. Participants in SILC groups report that they become like family members, to the extent that if a fellow member falls sick or is in need, the group contributes and helps the

[6] Improving food and nutritional security is important for both PLHIVs and their households; the effectiveness of ART may, moreover, improve with more nutritious intake. See L. Highleyman, 2006, "Nutrition and HIV," *BETA* 18, no.2 (Winter): 18-32.

[7] A.L. Stangl, N. Wamai, J. Mermin, et al., 2007, "Trends and Predictors of Quality of Life among HIV-Infected Adults Taking Highly Active Antiretroviral Therapy in Rural Uganda," *AIDS Care* 19, no. 5 (May): 626-36.

[8] A summary of the Stepping Stones training can be found on the website of the Secretariat of the Pacific Community, Noumea, New Caledonia..

person as much as possible to remain a group member—even if the person or their household is suffering from illness or income problems related to HIV or AIDS. This social cohesion not only supports PLHIVs in the groups, but is beginning to erode the stigma associated with HIV.

Description of Target Group

The Kibara Project operates in the remote Mara District of Tanzania, specifically targeting the Nansimo Division, which is located at the end of a peninsula jutting into Lake Victoria. The project is the first health initiative to focus on HIV prevention and care strategies in the division. The economic situation in the area is poor; residents are primarily dependent on fishing and small-scale agriculture. Cotton is the predominant cash crop, but only two ginneries remain operational in the division. As a result, many families rely on subsistence crops of cassava, maize, rice, and millet.

Both the fishing industry and the cotton trade have created a high-risk environ-ment for HIV, particularly for villages along the lakeshore. The gravel road running parallel to the lake and through the project zone is the main artery connecting fish traders and cotton buyers to the places they purchase these commodities for cash. To capitalize on the disposable income of a transient population, including migrant laborers and fishermen, countless food stalls, bars, and guesthouses have been established in the community, all of which contribute to the spread of HIV. Around Lake Victoria, moreover, sex in exchange for fish is a common practice, which fuels the transmission of HIV. Women of all ages engage in sexual relations in order to gain priority access to fish on a boat, or at a cheaper price.[9] The stigma associated with HIV in the community is still quite noticeable. (ART did not become available in the area until 2006.)

Box 2

SILC in Action

Alima Juma lives in Nambubi village on the shores of Lake Victoria. Before joining a SILC group in 2005, she stayed at home with her six children, waiting for her husband, a local fisherman, to bring them food. A friend in her SILC group gave her Tsh 2,000 (US$ 1.60) to start a business making and selling *uji* (porridge) to fishermen in the morning. She used the income from her activity to begin saving with her SILC group. She is now an active and articulate member, with a thriving business that is helping her improve the quality of her housing and put her children through secondary school. Alima's SILC group has now purchased a boat and fishing equipment to earn income that they use for their social fund activities.

[9] Mark Markussen, 2002, "Coping with Uncertainty—Women in the Informal Fish Processing and Marketing Sectors of Lake Victoria," (Oslo: Norwegian Institute for Urban and Regional Research).

The most distinguishing face of poverty in the community is the quality of housing, which most SILC groups work to improve. Most people live in mud huts with grass-thatched roofs, but desire to build mud brick homes with iron sheet roofs. These enhanced structures are shown to improve health and reduce the risk of other diseases, such as malaria.[10]

Prior to introducing SILC, there were few financial options for the local community to secure savings, obtain loans to improve their housing, or afford other expenses, such as more nutritious foods, medical treatment, school fees, or supplies. The closest commercial bank is more than 60 kilometers away. The cost of transportation plus bank charges for operating an account or applying for a loan make its services inaccessible to the average SILC member. Two microfinance institutions offer group-based lending and a few savings and credit cooperatives (SACCOs) are operational in the project zone, but SILC members reported that these institutions charged extensive fees, such as loan processing charges, in addition to interest, making it more expensive to take loans from them. Likewise, some SILC members reported that they felt the SACCOs were not safe places to keep their savings.

The Kibara Project targets the community at large to build awareness of HIV, encouraging testing, and helping with livelihoods amelioration. However, the project has a particular interest in extending services to PLHIVs, households with PLHIVs, orphans or vulnerable children (OVCs), individuals receiving HBC, and youth. SILC groups are self-selecting, however, so HIV status is not a criteria for group formation. SILCs in Kibara generally have 15-30 members, with an average of 24 per group. More than 70 percent of SILC members are women, most of whom launch a microenterprise after joining a SILC. As of 2007, the project supported 35 active SILC groups, with a total of 794 members.

[10] Y. Yé, M. Hoshen, V. Louis, et al., 2006, "Housing Conditions and Plasmodium Falciparum Infection: Protective Effect of Iron-Sheet Roofed Houses," *Malaria Journal* 1, no. 5 (February): 8.

Summary of Design Concepts

Prior to beginning Phase I of the Kibara Project, an HIV situational analysis was conducted using qualitative tools to identify the causes of HIV transmission in the area, possible solutions, and the stakeholders that could potentially become involved in taking action. Poverty was identified as one of the root causes contributing to HIV transmission. Sadly, it was discovered that many young girls were sent to the lakeshore to come back with fish or money for the household. Without money to buy food or something to sell for an income, they resorted to transactional sex in exchange for the needed food.

Phase I of the project did not have the resources or the technical capacity to address poverty issues directly, particularly because it focused on health interventions. However, this phase made clear that individuals testing positive through the VCT sites would need economic support, particularly since ART was not available in Kibara at the time. Without ART, many of the people who tested positive for HIV developed AIDS, became critically ill, and were unable to support or care for themselves or their families.

Although home-based care was offered and more nutritious meals were stressed as an important part of these clients' overall therapy, most households were unable to afford adequate nutrition (e.g., more costly and less commonly available local foods, such as orange-flesh sweet potatoes, chickpeas, pigeon peas, and fruits). In addition, households supporting PLHIVs were stressed financially by drains on household finances, including medical expenses related to HIV, loss of income (if a PLHIV was unable to participate in labor-intensive livelihoods, such as farming and fishing), and the inability to participate in food production for household use. The death of the primary income-earner and associated funeral costs created additional financial stresses on HIV-affected households.

The first phase of the project offered some food support to the neediest households and a grant program was envisioned to support small groups of

Box 3

Community-Managed Savings and Loan Fund Programs

SILC is one model of a community-managed savings and loan fund program (also known as village savings and loan associations, or VSLAs). In each model, groups of people save small sums on a regular basis and then lend their pooled funds to group members. The methodology focuses on enabling poor households to build assets based on savings. A self-selected group of 10-30 people is trained to manage their own transactions. The group operates for a self-determined cycle of 6-12 months, after which their savings, plus interest earned from internal loans, is returned in proportion to their contributions. The only external input involves training the group in how to manage their funds. For more information, see the website of VSL Associates, a consortium of practitioners of this methodology: http://www.vsla.net.

people living with HIV. Post-test clubs[11] of five people were then formed as a mechanism to offer an economic strategy for PLHIVs. With assistance from an international NGO partner, these clubs were supposed to create a collective income-generating activity to support their respective members. Each club was provided with a grant of Tsh 50,000 (US$ 40) to start a project. However, since there was no direct monitoring of the groups and no technical advice was offered on how to use the funds, the individuals simply divided the money and the groups disbanded. Several of the original members died from AIDS-related illnesses.

In recognition of the fact that income generation was fundamental to the HIV issue in Kibara, SILC groups were introduced in Phase II of the project. Building on the experience of Phase I (i.e., that grants, poor monitoring, and lack of a model for increasing household income did not work), the SILC model was chosen because it encouraged members to generate their own resources by saving collectively and offering small loans to each other. CRS has been developing the SILC model, which is similar to the village savings and loan associations (pioneered by CARE and other international NGOs in various countries) and has published training materials and a monitoring system to support its implementation. SILC was a good fit for Kibara because the HIV components of the project had already established a working relationship with the target communities and used volunteers to train groups for other activities, such as Stepping Stones training. Home-based caregivers and VCT teams were thus in place to help mobilize SILC groups.

At its core, a SILC is a self-selected group of people who pool their money into a fund from which members can borrow. The group is not usually registered as a formal business. A number of key features of the SILC methodology that made it appropriate for the Kibara project:

- The ***financial services offered match the needs and capacity of the community.*** Each SILC group makes a series of decisions as part of its formation, including how they will save and lend out their funds. In Kibara, savings capital is accumulated via small fixed increments called "hisa" (shares). The SILC group sets a value in Tanzanian shillings for each hisa and members have the option to save up to five hisa per meeting. The SILC groups also create their own bylaws regarding borrowing, including the size and length of loans extended. ***Even the frequency of meetings,*** whether weekly or every two weeks, ***is determined by the group.*** Groups in Kibara have found that meeting weekly is most effective for building their savings capital and creating group cohesion. Essentially, SILC mobilizers introduce the pillars of the model and the groups then make their own decisions regarding rules and governing operating principles.
- The cycle of savings and lending is ***time bound.*** Members agree to save and borrow as they wish from their accumulated savings for a limited period of time (between 6 and 12 months). At the end of this period, the accumulated savings, interest earnings, and

[11] Post-test clubs are generally formed by individuals who have confirmed their HIV-positive status through VCT.

income from other economic activities undertaken by the SILC are shared with members in proportion to the amount that each has saved during the cycle.

- SILC groups offer ***attractive returns and limited transaction costs.*** During the operating cycle, each member of the group saves on a regular basis and the accumulated fund is lent out at each meeting. The loans, the terms of which vary from 1 to 3 months, charge an interest rate set by the group (for example, 10 percent). Interest is paid monthly, with the principal returned to the group when the loan falls due. The interest repaid continues to circulate, as do any other funds paid into the group. By the end of a cycle, an individual's savings will have rotated several times, earning significant interest. Unlike financial institutions, SILC participation requires a member's time and minimal costs (i.e., small contributions to a social fund or penalties established by the group, such as fines for late payments). Loans are taken with the backing of four guarantors in the group, who agree to repay if the borrower defaults, but there are no loan fees other than interest.
- SILC groups operate using ***simple, transparent systems.*** Each group selects a leadership committee of five individuals who help manage the transactions of the group: a chairperson, secretary, treasurer, and two money counters. These individuals maintain the group's records in a central ledger and complete transactions in the passbooks of individual members. The operating systems of the groups have been developed so that members can accurately record savings payments and track loans using clear, basic procedures, while keeping the social fund and other group resources distinct from individual savings. A SILC maintains a metal box with three locks to hold any group funds and, more importantly, all group records. The three key holders selected by the group are all present to open the box at each meeting and begin transactions. All payments are counted in front of the group and placed in appropriate baskets on the transaction table (i.e., the savings basket, loan/interest payment basket, fines basket, or social fund basket).
- The creation of a ***social fund*** is encouraged as a way for a SILC to cater to other needs identified by it, such as caring for the needy or sick in their community. In most groups, members agree to make a fixed monthly contribution to a social fund. Certain groups even operate several funds to address multiple needs (e.g., one fund for a group project and another to support orphans or widows). SILC groups in Kibara rotate the social fund as part of the lending process and typically use the accumulated interest to assist the community. They then invest the full amount of the fund in chosen activities at the end of the cycle.
- Because they meet regularly and share experiences regarding their savings and loan plans, SILC members develop ***strong cohesion and trust,*** which is the foundation for other activities and the basis of empowerment. The Kibara groups now participate in the Stepping Stones behavioral change education program, and certain groups have requested training in HBC to assist PLHIVs they know in their community. Other groups

have asked for additional information about improved farming techniques. In addition, the trust created by the groups has built the confidence of many members, encouraging them to try such things as starting a business or speaking in front of the group.

- SILC groups require ***minimal outside input*** and are encouraged to remain autonomous. SILC offers the benefit, particularly in an integrated programming setting, of self-management, creating more ownership of the effort, and reducing dependency on the project for sustainability. Once the methodology is put in place through effective training, SILC groups develop and grow independently with minimal input from the implementing organization.

Implementation Process

Developing a SILC program appears relatively simple, but several details must be carefully attended to in order to build solid, cohesive, and independent groups.

The Kibara team initially recruited coordinators for SILC by asking local leaders in the district wards to select mobilizers. Two CRS staff who had attended SILC training in Kenya then ran a complete training for these 12 individuals and selected the three strongest as the initial SILC coordinators. These coordinators were paid a small monthly salary (approximately US$ 50). After forming the first groups in late 2005, several lessons were learned and the approach was adjusted to improve group performance. For example, groups that initially chose to meet monthly did not expand their savings fast enough nor did they lend effectively to their group members. Once these groups changed their meeting frequency to weekly, they realized significant benefits.

At the same time, the Kibara Project underwent a change in management that led to a gap in field monitoring. When the new management team was in place, additional SILC groups were formed using a new strategy for mobilization and training. As with other aspects of the project, the SILC component decided to recruit volunteers to extend services more widely. These individuals were selected by SILC communities and referred to as community resource persons (CRPs). They received two days of SILC training (along with the initial SILC groups, who were retrained to improve their skills). The CRPs belong to SILC groups and understand the dynamics within them; they do not receive a salary. Their motivation to participate in managing several groups stems from the pride they take in helping groups organize, the provision of a bicycle that they may keep, and invitations to meetings and refresher trainings provided by the Kibara Project.

Once trained, a CRP follows a series of steps to create a SILC group:

- *Sensitization.* All members in a village are invited to a sensitization meeting where the benefits and principals of SILC are explained. These meetings have been effective in creating support for SILC among local leaders, particularly at the village level.
- *Group formation.* Following sensitization meetings in a given area, community members voluntarily form groups. These groups solicit the services of the CRP, or in some cases, find other SILC groups to help them become established.
- *Training in SILC methodology.* A newly formed group receives training in SILC through a series of six modules:
    - Module 1: Groups, Leadership, and Elections
    - Module 2: Development of Policies and Regulations Related to the Social Fund, Savings, and Credit Activities
    - Module 3: Development of SILC Constitution
    - Module 4: Written Recordkeeping and Managing a Meeting
    - Module 5: Meeting Procedures
    - Module 6: First Savings, Loan, and Repayment Meeting

As each training module is presented, a SILC is led through the activities related to that topic (e.g., electing leaders, developing policies, bylaws, etc.). The training can be organized in any way that meets the needs of the members. The Kibara team had very little experience in savings groups and learned as they implemented SILC, so they offered the training in two-day workshops. While this was a costly approach (some workshops attracted up to 100 participants), it allowed the project to establish norms and consistency in training. In the future, the project plans to allow each CRP to train new groups individually.

Box 4

Key Features of SILC:
Cycles, Share-Outs, and Action Audits

The **cycle** is an important feature of SILC groups. It provides a periodic "liquidation" point, at which time all the money lent out is paid back and savings are returned to members with accumulated interest. A cycle can last 6–12 months (the average is 8 months). A group then decides whether to start a new cycle, with each member free to join again or opt out. Without an end to the cycle, groups may lose track of accumulated savings and loans and individuals never receive interest income on their savings, a pitfall of group savings strategies tried in the past.

A **share-out** is the process of ending a cycle and distributing the profit (from interest earned on internal loans to members, fees, fines, and other economic activities undertaken by the group) in proportion to the amount each member has saved.

An **action audit** refers to an internal audit at the end of a SILC operating cycle that provides accountability at all levels. The recordkeeping is verified and leaders are held accountable for their actions during the terminating cycle, meaning that they are subject to scrutiny before elections for the next cycle.

- *Intensive follow-up.* During the training period, each SILC decides the frequency of its meetings. The CRP then attends all SILC meetings held for the next 16 weeks (16 meetings for SILCs that meet weekly, 8 for those that meet biweekly, and 4 for those that meet monthly). The CRP plays an active role during this time, helping the SILC follow proper procedures and keep accurate records.

- *Development follow-up.* During this time, the participants run the SILC themselves for at least another 16 weeks. The CRP visits the SILC less frequently during this period (he/she is present at about two-thirds of the meetings). The purpose of this phase is to oversee the smooth operation of the SILC, with the CRP acting solely as a technical resource in case of problems or disputes. Some SILC groups may choose to complete their operating cycle during this period. The CRP then assists them in their first share-out and action audit of the accumulated savings, interest, and fines, and helps members celebrate their achievements. During this period, the Stepping Stones behavioral change and stigma-reduction training for HIV is often introduced, with another volunteer trained in the course facilitating training sessions at each meeting.
- *Maturity follow-up.* Once the SILC has been active for several months, the CRP may occasionally visit to ensure that it is functioning independently. CRPs also tend to periodically attend meetings to collect monitoring information, but the SILC is able to manage its own affairs at this point and may only request specific assistance, for example, with a share-out or an audit. SILC groups can also request CRP assistance when needed; certain groups are even considering paying a CRP to visit them and provide additional training or internal audit assistance.

Indicators for Monitoring

SILC programs operated by CRS worldwide share a common management information system (MIS) for reporting. This system monitors group participation and financial indicators, as well as staff productivity. The data for the MIS is collected from each group on a monthly basis and consolidated into a project database, which is reported to CRS quarterly.

These are the standard SILC indicators:

- Percentage of women participating
- Membership growth rate
- Attendance rate
- Dropout rate
- Increase in value of SILC group savings
- Portfolio at risk (ratio describing late loans)
- Risk coverage ratio (ratio describing a group's ability to cover its loans)
- Average net profit per member to date

- Annualized average net profit per member
- Ratio of field staff to total staff (of CRS's local partner, the diocese of Musomo)
- Caseload: groups per coordinator or CRP
- Caseload: individuals per coordinator or CRP
- Active clients per staff member
- Portfolio utilization
- Cost per client
- Average loans outstanding per client

Since the SILC project is integrated into an HIV program, it is also helpful to monitor the outcomes expected on the health side. The three components of the HIV program (behavioral change training through Stepping Stones, VCT services, and HBC) each have their own indicators. The vast majority of these indicators track the number of people participating in a given intervention, for example, the number of Stepping Stones facilitators trained; the number of youth participating in Stepping Stones; the number of Kibara Mission Hospital/dispensary staff trained in HIV testing, counseling, and ethics; the number of people using VCT centers; the number of patients registered for HBC; etc. The project also tracks the number of individuals testing HIV-positive at VCT sites.

What is missing among the project indicators is evidence of the integration of its two components. For example, it would be useful to track the number of people who test HIV-positive and then join SILC groups (or members of such households who join groups). It would be difficult to collect this information at SILC meetings if members' sero-status is to remain confidential, but it might be feasible to do it from the ART or HBC side. This kind of data would provide evidence that the population targeted by the project was indeed being reached with integrated services. In addition, the integration of SILC and HIV programming was focused on improving the nutrition of PLHIVs and their households, yet no indicators specifically monitor this outcome. It would thus be helpful if integrated programs looked more closely at impact in the future to understand if PLHIVs are better off because SILC groups are operating in a given community, and/or whether or not the poverty level of their members change in a significant way.

III. Positive Results

Until the field assessment for this case study, there was no formal evaluation of the Kibara Project SILC program. However, CRS regional and country-level staff experienced in SILC methodology had visited several groups over the implementation period, providing feedback for improving the methodology and collecting success stories from clients and staff.

One of the innovations of the Kibara SILC groups is that members are beginning to write a savings goal in their personal passbooks for each operational cycle. At the end of the cycle, when savings and accumulated interest are returned to each individual, group members hold each other accountable for achieving their savings goals. From an economic development point of view, nearly every SILC group reported that several members had successfully saved to purchase housing materials or taken loans during the cycle to obtain the lump-sum capital needed to purchase land or upgrade their home. Numerous members also reported using savings to send their children to secondary school or to pay for school supplies. Many members also purchased physical assets, such as furniture, cooking utensils, beds, mattresses, and mosquito nets. Well over half the members of each group who were interviewed for this case study noted that they began an enterprise because of the SILC group and expanded it because they had access to capital and advice from other members. The types of businesses run by SILC members range from small-scale farming to food preparation, selling fish, and trade in other foodstuffs.

With respect to health outcomes, many SILC group members talk about how they have received more information regarding HIV and have gone for testing at local VCTs. Many are now aware of their HIV status, due to the Stepping Stones curriculum offered at SILC meetings. One group member proudly proclaimed that he was the first member of his group to be tested at the mobile VCT site. Many women reported improved eating habits and offered better foods in the home. One group asked CRS to assist them in obtaining root stock for orange-fleshed sweet potatoes (one of the recommended foods for PLHIVs), so that they could grow it for home consumption and sell it in the local market.

Box 5

SILC Member with HIV

Ambonisye Mwele, a member of the Nguvu Juu SILC group, was willing to share his story of living with HIV. When his wife discovered she was HIV-positive last year, he decided to be tested at one of the Kibara Hospital mobile VCT centers. He, along with two of his four children, also tested positive. As part of the VCT services, he was advised to start ART and was informed about the SILC groups. He joined his group when it began its second cycle and has taken two loans to expand his carpentry business. He provides the only income for his family. Although his group members are not aware of his status, he receives HBC services from the coordinator who manages his group, who was trained in SILC and HBC through the Kibara project. He said that he would not have had hope to face the future if it were not for SILC.

Some of the biggest success stories, however, emerged from the collective action of SILC groups. One group in Kisorya village purchased a

boat, fishing nets, and equipment to operate a fishing activity that generates income for their social fund. This fund is used to support people in the community living with HIV, orphans, and the elderly. In addition, the same group has set a goal of ensuring that all 24 members have improved brick houses with iron sheet roofs by 2010. Another group is farming a plot to earn additional income to add to their loan fund and use the interest income to support poorer people in the community.

An additional positive result of the Kibara Project is that groups are helping to replicate the methodology by teaching others in the community how to organize SILCs. One of the groups visited for this case study was formed after a neighboring group helped them organize and taught them the record-keeping system. The CRP in the area simply provided additional coaching and motivation through regular visits. This specific group is included in the number of groups formed and clients served by the project, but other replications may not be recorded in the program's MIS.

IV. COST TO THE INSTITUTION

The primary costs of operating a SILC program are those associated with training and motivating the mobilizers, along with instituting a monitoring framework. The Kibara Mission Hospital Community HIV Project estimates that it spent approximately Tsh 8 million (US$ 6,400) on SILC activities during Phase II of the project. This sum is about 2 percent of the overall budget of US$ 300,000 that CRS financed for Phase II activities. CRS incurred certain additional expenses for staff, travel, training, and monitoring in order to launch SILC in partnership with the Diocese of Musoma and the Kibara Mission Hospital, but these costs were not itemized specifically to SILC. As of late 2007, it was not possible to give a cost-per-beneficiary estimate for the SILC component, independent of the other components of the Kibara Project.

The synergy of the HIV programming (which supports Stepping Stones training, VCT, and HBC) with the SILCs is what makes the project effective. The four components of the project need to work together to achieve intended outcomes and have an impact on the transmission of HIV. Looking at overall costs would thus be valuable for understanding the model.

As part of the assessment conducted for this case study, a budget was developed for a future expansion of the Kibara SILC initiative. However, the costs for additional HIV programming activities were not included, save for those associated with training HIV teams in SILC methodology. In order to reach 60 additional groups, or approximately 1,500 individuals, the resources for the following key activities are required:

- Training of new CRPs and Kibara HIV project staff on SILC
- Sensitization and group identification meetings, including marketing leaflets
- Quarterly meetings with CRPs to motivate and learn from them
- Training materials and stationery
- Bicycles for CRPs
- Monitoring (requires fuel and CRS staff time)
- Overhead for the project as a whole

It was estimated that the above-mentioned expansion would cost approximately US$ 35–40 per participant. Global experience with the SILC methodology shows that new programs are often more expensive per individual, but that costs fall significantly as more individuals are trained in the methodology, the program expands, and economies of scale are achieved.

V. STRENGTHS AND LIMITATIONS

The integration of SILC groups into the HIV program of the Kibara Project has clearly diversified and strengthened the economic activities of targeted households in the community and created new opportunities, particularly for women, to accumulate savings and assets. For people participating in the HIV components of the project, SILC offers a new opportunity to receive financial services directly in their communities. SILC provides a safe place to save and easy, transparent systems for borrowing small lump sums of cash. Members benefit from lending activities by receiving interest on their savings at the end of each operating cycle. The use of savings goals has helped many members to focus on how to create their own opportunities to improve their lives. The social funds created by the groups have extended assistance not only to members in need, but to others in the community during times of sickness and loss. The groups receive additional information on HIV through the educational sessions and are more aware of HIV support services, such as VCT and HBC, in their community.

Not only is SILC a strong tool for members, it is relatively simple to operate from the project management point of view. Once CRPs are well trained, they have the skills to mobilize and prepare an unlimited number of groups in the community. Because groups become autonomous fairly quickly, a CRP can move on to other groups and invest the time needed to prepare them for self-management.

While the integrated SILC model has several strengths, it also has some specific challenges. The Kibara team, together with CRS, is looking at ways to develop the methodology in the future to address some of these limitations:

- *Scale.* The project has been operational for two years and has reached only a handful of individuals. While VCT services have been extended to thousands of individuals, the SILC livelihoods component has reached fewer than 800. The constraining factors during this phase were budget limitations (few resources to train, monitor, and extend services), lack of expertise in the SILC model, and changes in personnel throughout Phase II of the Kibara Project. One of the challenges of reaching scale in the future will be to recruit, train, motivate, and monitor a larger CRP volunteer team. The Kibara Project recognizes the importance of management and performance monitoring; it is debating how to best provide the amount of time to do so in a way that is most effective and cost efficient for expanding SILCs.
- *Evidence of impact.* As noted previously, no monitoring indicators clearly demonstrate a crossover between the HIV and SILC project components in terms of the population reached and outcomes envisioned. Only anecdotal evidence suggests that PLHIVs and their households benefit from the SILC groups. Informal discussions with SILC members indicate that the goal of improved nutrition and reduction of risky behaviors leading to HIV may indeed be happening, but there are no concrete indicators to measure this

effect. In addition, the SILC framework does not monitor changes in assets or income levels to see whether participants are able to confront issues of poverty. Although the entire catchment area is affected by poverty and SILC groups include members from different backgrounds (seen as a strength, as they support each other), it is not clear to what extent the model reaches poorer members of the targeted communities. The evidence of improved housing quality, number of meals consumed, and number of children attending school could be captured more effectively to demonstrate the impact of SILC.

- *Small, limited transactions.* SILC is built on simplicity. Savings are contributed in uniform "share" amounts (usually Tsh 500–1,000, approximately US $0.40 to 0.80), with up to five shares deposited per meeting. If a fisherman has a large catch, or a farmer harvests well and receives a lump-sum payment, he/she might have more cash than he/she is allowed to save at a meeting. Some SILC groups thus develop an additional product—a fixed deposit of sorts—that allows a member to deposit a large savings amount that is returned at the end of the cycle. However, this product has not been fully incorporated into the SILC operating systems and may need to be refined in the future. Likewise, the amount of capital that can be accessed through SILC, particularly during early stages of savings, is relatively small. If a member needs a larger loan for a more ambitious activity, it may be hard to borrow such an amount from a SILC. In addition, several members sometimes need a loan at the same time. SILC groups normally create a system for assessing credit needs and prioritizing them based on available funds, but occasionally members may find that loan funds are not available at convenient or appropriate times. The loan cycle is also typically short (1–3 months), which may constrain members with longer-term plans for agriculture or fixed assets.
- *Volunteer based.* The Kibara team has found that volunteer CRPs selected from the SILC groups are more effective than paid coordinators or mobilizers. Ensuring that volunteers perform to established standards and remain motivated is a challenge in many development projects. While incentives are built into the model to try to maintain the quality and involvement of CRPs, an idea for the future is to encourage SILC groups to pay a small sum to a CRP for his or her services, perhaps from the social fund or money accumulated from fines. It is believed that this would motivate the CRPs to demonstrate their value to the group, such as helping them organize the share-out at the end of the cycle and ensuring that the action audit is completed correctly.
- *Modified Stepping Stones curriculum.* The Stepping Stones curriculum offered through SILC members (as well as to young people aged 8–18 as part of the HIV and AIDS component) is highly successful in other parts of Tanzania and regarded as a pillar in changing risky behavior and reducing the stigma of HIV. However, the intervention is designed for single-sex groups of young women or men, who are then brought together for the last 20 percent of the course for mixed-sex dialogue. When offered within a SILC group, the audience is mixed in terms of both gender and age. It is unclear what

impact this has on the effectiveness of the training and its outcomes in terms of behavioral change. One facilitator noted that when issues were specific to one gender, she separated the SILC group into men and women so they could discuss topics in single-sex groups. In addition to Stepping Stones, other curriculums are designed to achieve outcomes related to HIV and AIDS, for example, the "Facing AIDS Together" education series developed by Freedom from Hunger and World Relief,[12] which could also be considered in an integrated strategy.

- *Introduction to income generation.* One discussion among SILC members revealed that they were unable to make their first savings payments on their own. Many members did not have microenterprise activities when they joined SILC and had to rely on family members or small jobs to make their first contributions. Once inspired to start a business, sometimes because of access to a loan from the group, most people were unsure how to manage the activity. Sometimes a group member would provide some coaching, but the model does not provide direction on how to successfully run a new income-generating activity. Many new businesses worldwide fail because of management inexperience. Future SILC programs may consider how to integrate information on business topics and/or improving agriculture output to help members operate successful economic activities. If such services are offered, it would be best to wait until a group has reached maturity, when the basics of financial operations and recordkeeping are well mastered.
- *Long-term monitoring.* As designed by CRS, a SILC program monitors individual groups actively for 10-12 months, then archives them in the project MIS. Because the premise is that groups can and should become autonomous, it becomes too costly to visit and track data related to mature self-managed groups, when a CRP could use his or her time to mobilize new groups. The model is not designed for long-term monitoring, unless a program wants to refer to archived records and follow up with "older" groups to see how they have evolved.
- *Self selection.* A key pillar of the SILC methodology is to allow groups to form independently in a self-selected manner. Using the other components of this project (e.g., Stepping Stones groups, VCT, HBC) to provide information on SILC might increase the project's chances of mobilizing more of the target population for these services, but HIV status should not be used as a "common criteria" to form groups. When SILC is integrated into an HIV program, therefore, care must be taken not to attempt to organize existing groups, such as home-based care groups or post-test clubs, into SILCs. Rather, it is better to publicize the benefits of SILC through these existing groups and allow individuals to self-organize as new groups.

[12] For more information on this training, see the "AIDS Resources" page of the international NGO, World Relief, Baltimore, Maryland, www.wr.org/aids/resources/index.asp.

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