



The SEEP Network Guidelines for Microenterprise
Development in HIV and AIDS-Impacted Communities:
Supporting Economic Security and Health

BOOK 1

For Public Health Professionals

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The SEEP Network Guidelines for Microenterprise Development in HIV & AIDS-Impacted Communities: Supporting Economic Security and Health (“*The SEEP Guidelines*”) is a product of The SEEP Network HIV & AIDS and Microenterprise Development Working Group.

The SEEP Guidelines call for and provide guidance for mobilizing microenterprise development (MED) expertise to join the public health community in combating HIV & AIDS. More and more, it is recognized that HIV & AIDS cause severe poverty, harshly affecting the already poor, and that poverty, in turn, slows down progress in responding to the disease. MED is a leading economic strengthening and development strategy to help the poor stabilize their income and assets and work their way out of poverty. To bring the power of MED to bear in an effective response to HIV & AIDS, public health and MED professionals need to understand how to partner in integrated programming. Together, these two sectors can fuel a positive spiral of economic security and wellness.

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INTRODUCTION

The SEEP Network Guidelines for Microenterprise Development in HIV & AIDS-Impacted Communities: Supporting Economic Security and Health (“*The SEEP Guidelines*”) present strategies for cross-sector partnership between the microenterprise development (MED) and public health communities. They are designed to help practitioners, funders, and other stakeholders stimulate a positive spiral of economic security and well-being for people and communities affected by HIV & AIDS, reversing the current downward spiral of sickness and poverty common in HIV & AIDS impacted communities. The guidelines offer principles and strategies for an integrated response to the HIV & AIDS pandemic. They explore how to use microenterprise development to reduce poverty in the HIV & AIDS context and, as a result, to enhance positive public health outcomes. And, they explore why and how MED programs can be effective in communities impacted by HIV & AIDS. The guidelines are most useful for planning and partnership development, rather than practical implementation. Written by experienced microenterprise development practitioners with input from public health professionals, *The SEEP Guidelines* speak to three audiences (some sections repeat):

- Public health professionals (including psycho-social health professionals)
- Microenterprise development practitioners
- Policy Makers: donors, strategic planners, and advocates

The SEEP Network welcomes your input and participation, so look for opportunities throughout to comment and share your work in the integration of microeconomic development and AIDS.

The Problem

Low-income people affected by HIV & AIDS are often caught in a downward spiral of sickness and poverty. Poverty fuels the epidemic: limited access to health care and education, minimal economic options, and lack of sexual rights for women are all contributing factors to the vulnerability of poor people to HIV infection and the development of AIDS. The epidemic exacerbates poverty. The onset of AIDS can quickly render the poor destitute and can create poverty among working class people as income and assets are depleted with the cost of health care, the burden of caring for the sick, funeral expenses, and the enfolding of orphans by the extended family unit.¹

Grace’s Problem

Grace, a widow in her 40s living in Western Kenya, was recently diagnosed with HIV. She is more fortunate than some because she was tested and counseled, and received anti-retroviral drugs. Soon after her treatment began, she walked into her counselor’s office and threw the drugs on the floor. “These drugs are making me sick!” she said. “The doctor says to eat five meals a day and keep a balanced diet. Where is the food? Where is the money for this food when my own children are hungry?”

¹ S. Holden, “Mainstreaming HIV/AIDS in Development and Humanitarian Programs” (Oxford: Oxfam Publishing, 2004); A. Alban and N.B. Andersen, “Putting It Together: AIDS and the Millennium Development Goals” (New York: International AIDS Vaccine Initiative, 2005); G. Mutangadura et al., “A Review of the Household and Community Responses to the HIV/AIDS Epidemic in Sub-Saharan Africa” (Geneva: UNAIDS 2000); L. Jones and M. McVay, “Economic Support and Income-Generating Programming for HIV- and AIDS-Impacted Communities,” Progress Note, no. 15 (Washington, DC: SEEP Network, 2006); International AIDS Alliance, “The Building Blocks: Africa-Wide Briefing Notes—Economic Strengthening” (Brighton, U.K.: International AIDS Alliance,

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The Problem for the Fish Sector

In Western Kenya around Lake Victoria, a life-threatening practice has emerged. Low-income women who process and sell fish often run out of capital to purchase fish from fishermen and resort to trading sex for fish to keep their businesses going. The incidence of HIV in this area is around 25%. A microenterprise development program, with the goal of generating sustainable income and economic growth, targeted the fish sector as a key employer in the region, particularly for women. An analysis of the sector revealed that the sex-for-fish trade and HIV were critical constraints to growth and equity.*

* M. Markussen, "Coping with Uncertainty: Women in the Informal Fish Processing and Marketing Sectors of Lake Victoria," Working Paper 2002:115 (Oslo: Norwegian Institute for Urban and Regional Research [NIBR], 2002).

At the macro-level, the negative spiral is reflected in the decline of local economies and the worsening of the epidemic. HIV & AIDS, unlike many illnesses, attack the most productive family members, depleting productive assets and leaving children and the elderly without key income sources. This results in reduced productivity, reduced investment, and market exit. As tax bases decline in the face of economic stagnation, health systems are even less well-equipped to confront the epidemic. The most promising developments in treating HIV & AIDS are threatened by poverty: if people cannot afford the necessary food required during treatment or transportation to health centers, even the best availability of life-saving anti-retroviral drugs will not help them, and the epidemic will march forward.

A Proposed Solution

Stopping the pandemic calls for a comprehensive approach, including an integrated package of health and economic support. Microenterprise development is a critical component to any economic development package targeting the poor. MED involves the sustainable delivery of services, such as access to financial services, technology, or markets that help very small businesses and farms stabilize and grow. Microenterprise development can be effective at the scale necessary to reach millions of affected families.

What is microenterprise development?

Microenterprise development (MED) is a sustainable poverty eradication strategy with two components:

- Microfinance: loans, savings, insurance, money transfer systems (think "money").
- Enterprise development: strengthening businesses, farms or other small income generation activities—linking them with markets (think "business").

MED can help families and communities address the economic challenges of HIV & AIDS in several ways:

- MED helps families develop more profitable or diverse income sources to increase and stabilize family income.
- Microfinance—savings, credit, insurance, and money transfer services—helps stabilize family cash flow to smooth consumption.
- MED helps families develop physical, human, financial, and social assets.

2003); C. Barnes, "Economic Strengthening Activities Benefiting Orphans and Vulnerable Children in Africa: Mapping of Field Programs" (Washington, DC: AED, 2005); W. Santis et al., "Involving Young People in Efforts to Combat HIV and AIDS in Africa: The Importance of Income-Generating Strategies" (Newton, MA: Education Development Center, Division of Health and Human Development Programs, 2007).

A Solution for Grace

The community-based organization supporting Grace gave her a grant to start selling vegetables in the market. They provided seeds and advice to help her plant beans, groundnuts, and greens, in addition to her maize. They helped her women's group save and invest in making medicinal soap and cream to sell at the local hospital to HIV and AIDS patients. The income from the soap- and cream-making enterprise helps pay for some of the food the women eat when they come for their weekly gatherings. Several years after the "medicine throwing" incident, Grace is strong, takes her medication, and runs her farm and her business to feed herself and her family. She is a leader of the home-based care team that rescues other women in the same situation. As her business stabilizes, she is considering expanding it with a loan from her local microfinance institution.

(Experience shared by Vumilia Community-Based Organization in western Kenya)

A Solution for the Fish Processors

A market development program targeting the fish industry teamed up with two leading microfinance institutions to address the problem. They created several lending products and marketing services to support the public health and social behavior messages disseminated by the health community. These included:

- savings clubs for fish processors (some of whom are buying boats),
- one-day loans for fish processors to give them immediate options, and
- links between fish processors and exporters who pay a higher price for fish.

Coupled with newly available anti-retroviral therapy, these microenterprise development services are providing hope to Lake Victoria's fishing communities.

(Experience shared by the Kenya Business Development Services program)

A more stable and increased income plus a strong asset base can help families and communities cope with typical challenges brought on by HIV & AIDS. MED can further help families:

- re-establish viable livelihoods, become self-sufficient, and recover from destitution;
- cope with the loss of an income earner by finding other sources of income;
- build financial safety nets to cushion the impact of HIV & AIDS;
- generate money to care for the sick and for orphans;
- generate increased income to support others who have become destitute; and
- improve their self esteem and status in the community as they become self-reliant or become leaders in supporting others.

It can also help community groups and social service agencies generate revenue to build stronger safety nets. In this manner, MED can contribute to stopping the downward spiral of sickness and poverty—at the family-, community-, and macro-levels. The rest of this book provides a more detailed description of this position.

Since the early 90s, the public health sector² has led the response to the growing HIV & AIDS pandemic. Public health programs focus on prevention, treatment, and care and support of people living with HIV & AIDS. In addition, public health teams help mobilize communities and offer support services to households made vulnerable by HIV. However, meeting the daily survival needs of those impacted by HIV & AIDS has become much more than a public health issue. The global pandemic of HIV & AIDS requires a concerted and collaborative effort—an "all hands on deck" response—to turn the tide.

² In this guide "public health" teams, professionals, and programs refer to a broad group of medical, psychological, social service, and community organizing professionals and initiatives. The term is used to distinguish this group from microenterprise development practitioners and specialists.

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These guidelines call for and provide guidance for mobilizing microenterprise development (MED) expertise to join the public health community in combating HIV & AIDS. More and more, it is recognized that HIV & AIDS cause severe poverty, severely affecting the already poor, and that poverty, in turn, slows down progress in responding to the disease. MED is a leading economic strengthening and development strategy to help the poor stabilize their income and assets and work their way out of poverty. To bring the power of MED to bear in an effective response to HIV & AIDS, public health and MED professionals need to understand how to partner in integrated programming. Together, these two sectors can fuel a positive spiral of economic security and wellness.

This book of *The SEEP Network Guidelines for Microenterprise Development in HIV & AIDS-Impacted Communities: Supporting Economic Security and Health* addresses critical questions for public health professionals who want to use MED strategies more effectively to help people escape the poverty-sickness trap that fuels the AIDS pandemic.

Key Questions

- What is microenterprise development? (see [section 1.1](#))
- Why is microenterprise development important for combating HIV & AIDS? (see [section 1.2](#))
- What kind of microenterprise development strategies work for HIV & AIDS impacted communities? (see [section 1.3](#))
- How can I facilitate cross-sectoral partnerships? (see [section 1.4](#))
- Where can I find technical resources for integrated programming? (see [section 1.5](#))
- Where can I get financial resources for microenterprise development in HIV & AIDS impacted communities? (see [section 1.6](#))
- Is there a glossary of MED terms? (see [appendix B](#))

Book 2 of *The SEEP Guidelines* addresses critical questions for microenterprise professionals who want to use MED strategies more effectively to help people escape the poverty-sickness trap that fuels the AIDS pandemic.

Book 3 of *The SEEP Guidelines* addresses critical questions for policy makers—donors, strategic planners, and advocates—who seek to support more effective ways to help people escape the poverty-sickness trap that fuels the AIDS pandemic.

1.1 WHAT IS MICROENTERPRISE DEVELOPMENT?

Microenterprise development (MED) consists of two overlapping development activities:

- Helping people start and run very small businesses and farms
- Helping people access financial services (i.e. loans, savings, insurance and remittances).

Together these two activities provide people with the capacity to manage crises and work their way out of poverty. Different donors and practitioners use different terms, but *The SEEP Guidelines* use these terms and definitions:

- Enterprise development (ED):³ Helping people establish and expand microenterprises through access to markets for inputs, for their products, and for business services, such as training, information, technology or transportation. Helping microenterprises enter, remain in, and benefit more from market participation.
- Microfinance: Financial services, such as lending, savings, insurance, and money transfer, designed for the needs of low-income populations.

What is a “microenterprise?”

A very small-scale business usually operating in the informal sector, a microenterprise is launched with limited capital by low-income people.

- A microenterprise can be any kind of income generating activity—a farm, a small vegetable selling business, a carpentry shop, etc.—here the owner works in the business, the business is started with minimal capital, and the business has fewer than 10 employees. The definition, however, varies in different countries.
- Some experts use the term “small enterprise” very generally to mean micro- small- and medium-size businesses or small-scale farms.
- Groups or cooperatives can also run enterprises together to generate income for group activities or individual income. In *The SEEP Guidelines*, we call these “group enterprises.”
- “Income generating activity” is used in a variety of ways. Sometimes it is a general word referring to all of the above, and sometimes it refers to self-employment by very poor people who have no employees. Often, it refers to group enterprises.

Many donors, including USAID, consider policy reform to be a third crucial component of microenterprise development, but this area is given less focus in *The SEEP Guidelines*.

A core principle of enterprise development and microfinance is achieving scale through financial sustainability. In enterprise development, best practices recommend taking a “market development” approach,⁴ in microfinance, a “financial systems” approach is advocated.⁵ These approaches involve developing businesses and offering services in the context of the market, and strengthening business and market capacity to respond to the needs of target populations. The strategies are in contrast to small-scale, subsidized, and highly targeted approaches. A central challenge for the MED industry at this time is how to use the power of these systems to reach the very poor. Because they are distinct communities of practice, each arena is presented separately here. Also in *The SEEP Guidelines*, we use the term “microenterprise” to refer to very small-

³ Also referred to as business development services, market development, and making markets work for the poor.

⁴ Donor Committee on Enterprise Development, *Business Development Services for Small Enterprises: Guiding Principles for Donor Intervention*. (Washington, DC: Donor Committee on Enterprise Development, 2001)

⁵ CGAP, *Good Practice Guidelines for Funders of Microfinance*, Microfinance Consensus Guidelines (Washington, DC: CGAP, 2006).

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scale business and farming activities run by individuals or families, and “group enterprise” to refer to their cooperative businesses.

Livelihood security has broader goals, including food security and general well-being (which may include health, psychosocial well-being, improved human rights, sustainable environment, etc.). Economic strengthening activities are very common in livelihood security programs, while more advanced MED initiatives tend to be run by specialist agencies and programs. Livelihood security, for example, tends to focus more on food security, whereas MED tends to focus more on marketing and selling cash crops.⁶

How does microenterprise development (MED) relate to economic strengthening and livelihood security?

MED is a tool to help accomplish the goals of livelihood security and economic strengthening, but both are broader. All three are overlapping concepts.

Economic strengthening is a term often used by those practitioners targeting orphans and vulnerable children. In addition to some types of MED, economic strengthening also tends to include cash transfers, vocational training and workforce development, and legal services. It is generally targeted at the very poor. Thus, for the purposes of *The SEEP Guidelines*, economic strengthening does not include more sophisticated enterprise development or microfinance work. MED focuses primarily on income generation and asset development and often has empowerment results.

1.1.1 Microfinance

Microfinance is often thought of as a tool for helping poor people access loans (microcredit), but it is much more than that. Microfinance includes credit, savings, insurance, and money transfer or remittance services. Microfinance is increasingly becoming linked to global financial markets as commercial banks look at products for lower income markets and microfinance institutions begin to be regulated by central banks. The microfinance industry claimed 3,133 microcredit institutions, which reported reaching 113,261,390 clients as of the end of 2005.⁷

Low-income people use financial services for a wide range of purposes, e.g., investing in farms and businesses, repairing homes, paying for funerals and weddings, meeting basic food needs before harvest, accessing health services, and paying for the education of their children. However, many poor people around the world do not have access to financial services because banks and other providers are not available where they live (for example, in rural locations or urban slums). The fees charged by these institutions make them cost-prohibitive for the small amounts transacted by the poor. Often low-income clients do not meet the criteria for accessing banking services. The products offered by formal financial service providers are poorly designed for the needs of the low-income market. The main philosophy of microfinance recognizes these needs and promotes access to financial services for the poor with specially tailored services and delivery channels.

⁶ Livelihoods Connect, website, “Guidance Sheets, ‘DFID Sustainable Livelihoods Guidance Sheets’” http://www.livelihoods.org/info/info_guidancesheets.html.

⁷ S. D. Harris, “Executive Summary,” in *The State of the Microcredit Summit Campaign Report 2006* (Washington, DC: Microcredit Summit Campaign, RESULTS Educational Fund, 2006), 2.

The types and variety of microfinance services offered to low-income people is expanding rapidly. While it is often believed that “poor people are too poor to save,” microfinance professionals have found that savings services are one of the most critical elements in assisting people to work their way out of poverty. Many individual savings products and group savings services are offered to help low-income populations build cash assets for their household needs or to start or expand a microenterprise activity. Micro-insurance is growing as a financial product for the poor, especially to cover loans when a borrower dies or to provide for healthcare expenses. Money transfers, sometimes called remittances, enable safe and affordable movement of funds from one location to another. These can be important sources of cash for poor households—for example, when family members working outside the country send money home or crop buyers transfer payments to farmers. Loans, popularly called “microcredit,” are one of the most well-known financial services for the poor. Used strategically, poor households can begin, expand, or diversify livelihood strategies through the use of credit.

Common Strategies in “Economic Strengthening Programs” and Their Relation to MED Terms

Economic strengthening		Microenterprise development categories
<i>Broad category</i>	<i>Specific category</i>	
Social assistance	Asset transfers	Asset transfers (i.e., donations of seeds and tools to jump start a farm)
Asset growth and protection	Collective and individual savings and insurance	Microfinance
	Legal services	Outside MED practice
Income growth	Business loans	Microfinance: credit
	Skills training and income generating projects	Enterprise development: (1) Subsidized market (re)entry; (2) general business management, general services, commercial business services; (3) sector- or industry-specific, value chain development
	Market linkages	Enterprise development: Value chain development
	Job creation	Enterprise development: Market (re)entry: asset transfer (food for work); not currently a major part of MED, could be incorporated into enterprise development as value chain development, especially social enterprise approaches

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What about grants for business development?

In general, microfinance supporters advise against providing cash grants—or other asset transfers—for business development for several reasons:

- Grants are not sustainable and reach fewer people.
- Grants distort the market for lending. If people in a community hear there are grants available, they may wait for a grant, rather than taking a loan, but the grant may not be targeted to them or there may not be enough grant money to go around.
- Grants are less empowering. If people receive technology or training along with a grant, they are less likely to provide critical feedback and demand good service than if they pay for the service.
- Grants can easily be diverted to meet basic household expenses, which means they might not generate a new livelihood or business opportunity.

Nevertheless, many microenterprise development experts recognize that the very poor, especially those in crisis, may require and benefit from grants. In these situations, experts recommend a matching, grant-to-loan strategy with these elements:

- Matching the grant to the client's investment of raw materials, labor or cash
- Issuing several grants in stages, so that constructive use of one grant leads to more money
- Tracking client performance and referring clients to a microfinance institution for borrowing when the client is ready
- Separating grant-making operations institutionally from lending, so that clients and staff are clear on which money is a grant and which is a loan

Microfinance institutions (MFIs), banks, and other lenders are able to make loans to the poor—on a sustainable basis—by adapting the products and delivery systems to meet the needs of low-income borrowers. These institutions, or microlenders, offer small loan amounts and cover their costs through interest rates that are generally higher than commercial bank rates (but lower than moneylenders) and through high client volume. They attempt to keep costs for the small loans low, often by lending to clients in groups. Group members also act as guarantors to each others' loans when other forms of collateral to guarantee the loan are not available. If one person is unable to pay, the other members—who have agreed to guarantee the loan—pay in order to continue accessing additional loans. Clients are often asked, either by the microfinance institution or by their group members, to put up small, reasonable collateral, such as home furnishings, bicycles, or tools to guarantee their loans. In some cases, savings also act as collateral and provide an incentive to repay the loan in order to get the money on deposit back. Some microlenders lend to individuals and ask for this type of collateral along with personal guarantors for the loan. MFIs often market aggressively to the economically active poor since reaching larger numbers of borrowers makes lending more efficient and sustainable when the amount generated per loan is often small.

A critical element of microfinance is sustainability, which requires charging fees and interest to cover the costs of small transactions and delivery systems to more isolated markets. MFIs are firmly dedicated to financial sustainability so that they can expand to provide more services to more people.

- When MFIs provide a return on capital investment, they can mobilize external investment. There is an MFI investment market now that links MFIs with private investment funds, which is expanding the industry exponentially.

- When MFIs prove good stewardship of their resources, in some countries they can apply to be regulated financial institutions (banks). This enables them to lend out the savings that they mobilize, increasing returns to savers and capital available for lending.
- Empowerment is engendered when individual clients realize that they are paying for a service, and can in many institutions demand good service. Using credit to build a microenterprise and successfully repaying the loan can motivate microentrepreneurs, especially if they have felt marginalized by HIV. Likewise, mobilizing savings for use in the future can empower poor households that have not been able to pay for certain expenses in the past (e.g., school fees). Some microfinance services are delivered through self-financing groups: they generate their own savings and lend it out to each other. They are effectively managing their own community bank, which generates pride and social status for group members.

The poor are viable clients. Although there are people who are vulnerable or are in crisis and would not be good loan clients, larger numbers of poor people with viable businesses or farms can and do borrow and pay interest. Many more use a variety of strategies to save.

Some microfinance institutions are involved in helping clients access non-financial business and social services. These models may be of particular interest to people affected by HIV & AIDS, who may need a wider range of service, for example:

- *Credit with Education*—In this model, microfinance institutions offer credit and savings to groups of individuals. The institution takes advantage of the regular group meetings to offer clients information and training on topics, such as:
 - empowerment,
 - literacy,
 - health,
 - financial management, and
 - basic business management.
- *Parallel programs*—Some broad development organizations conduct integrated development programs on health and agriculture, and also support independent microfinance institutions which serve their eligible clients. Clients can access a range of financial services when needed, but the microfinance institutions can make independent decisions about each client's creditworthiness.
- *Strategic alliances*—Some microfinance institutions are entering partnerships with business development or health organizations who want to add microfinance to the package of services they offer clients. In these situations, MFIs devise services appropriate for the target market and make financial services available to eligible clients.

Microfinance institutions, by definition, are social enterprises with a double bottom line of providing services to the poor and generating financial sustainability or profitability. As sustainability—and profitability—is achieved, the MFI industry can increasingly focus on measuring its social goals—poverty reduction, empowerment, etc. For more information, see the “SEEP Initiative” on Social Performance (<http://communities.seepnetwork.org/edexchange/opportunities/initiatives>).

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SEEP Member Programs That Illustrate the Strategy and Outcomes of Microfinance

Kenya Rural Enterprise Program (K-Rep)

K-Rep is a leading African microfinance institution, founded in 1984 as a project of USAID. The project developed into an NGO, and between 1997 and 2001, it transformed into the K-Rep Group, comprising a regulated bank, a development agency, and a consulting firm. This transformation enabled K-REP to increase its outreach from 15,000 clients to more than 90,000 in four years. This number included clients of K-Rep and the other MFIs it works to strengthen. K-Rep has led a transformation of the financial system in Kenya, such that now microfinance institutions are a specific category of regulated financial institution, enabling them to mobilize and lend out savings and investment. In this transformation process, K-Rep remains focused on serving the poor.*

Microfinance in Bangladesh

The microfinance industry in Bangladesh provides financial services to over 13 million people. The lead organizations are Grameen Bank, BRAC, ASA, and Proshika. Bangladesh is home to the “Grameen model,” the most widely recognized and transferred microfinance service globally. The microfinance apex institution, Palli Karma Sahayak Foundation (PKSF), helped advance the Bangladesh microfinance industry by lending money to MFIs, building capacity, setting industry standards, and advocating for an appropriate enabling environment for MFIs.*

* GCAP (Consultative Group To Assist The Poor) and World Bank Financial Sector Network, “Scaling Up Poverty Reduction: Case Studies In Microfinance” (Washington, DC: CGAP and World Bank, 2004).

1.1.2 Enterprise Development

Enterprise development helps people start, run, and grow businesses. Enterprise development encompasses a wide range of strategies and means different things to different communities of practice. Here, we attempt to reflect The SEEP Network perspective on enterprise development.

The SEEP Network recommends a “market development” approach to enterprise development. The main strategy for helping people start, stabilize, or expand enterprises is to help them participate in rewarding markets. These markets may be local, regional, or global. Fundamentally, enterprise development needs to be market-driven. It is the customer (the market) that puts cash into the hands of enterprise owners, and it is the market that delivers inputs, equipment, and business services, such as information, training, transportation, etc. Programs need to strengthen the market as well as businesses or entrepreneurs themselves in order to help people participate more effectively in markets.

Market-driven enterprise development can be targeted to any group of economically active people. We present three strategies for enterprise development:

- Market (re)entry services are basic (often subsidized) business services that help destitute or very poor people to (re)start microenterprises and (re)enter markets.
- Commercial business services include business management planning or technical training, information and communications, technology, product development, transportation and other infrastructure or policy advocacy services, which are delivered through commercial business service markets.

- Value-chain development is the concept of sustainable packages of services that link microenterprises to stable or higher value markets and help local industries function and compete better.

Market (re)entry services. People with very low assets or skill bases need to (re)enter the market or (re)start a microenterprise (such as after the loss of an income earner) and need to diversify income sources (such as after the loss of a business or other assets due to crisis). Market (re)entry strategies are subsidized services that build skills and help people access technology, inputs, and markets to (re)start a microenterprise. It is important, especially when targeting vulnerable populations, to reduce the risk of market (re)entry by supporting market-driven enterprise development. Typical strategies used for market (re)entry include asset transfers, basic skills development, and group organizing and group businesses.

- *Asset transfers:* Rotating livestock is one example of an asset transfer program. This program works by donating livestock to vulnerable community members who, in turn, pass along the offspring to other people in the village who are in need. This leverages an initial donation and creates a revolving community safety net. Other asset transfer programs include items, such as seeds and tools, irrigation equipment, and food processing equipment. These programs are sometimes established as “banks” that lend tools to community members.
- *“Food-for-work”:* This program can be used to help people (re)enter the workforce and gain some skills, while earning their daily bread. Labor can be used for both community initiatives and for supplying labor to poor farmers in labor-scarce situations, for example to widows, grandparents, or orphan-headed households affected by HIV & AIDS.

As mentioned in the question about grants for business development (see text box above), cash grants are also often provided to (re)start businesses.

- *Basic skills development:* This includes basic business education and technical skills development. Basic business education is most often delivered for free to people just getting started in business or who are running very marginal businesses. Topics include how to select a business idea, how to keep business money separate from personal money, how to determine if you are making a profit, basic selling techniques, etc. Few people are willing or able to pay for these services and many are not aware that they need to know these basics. This kind of basic education is often rolled into other services, such as group lending, training at technical and trade schools, or rotating business grant programs. When directed toward illiterate people, it is often taught using pictures, stories, role playing, and group dialogue—all of which reflect the culture and circumstances of target clients. Other educational messages, including HIV & AIDS education, are sometimes integrated with basic business education.

Although group enterprises are a very common response in HIV- and AIDS-impacted communities, practical experience drives *The SEEP Guidelines* to advise caution and encourage programs to explore first the wider range of options presented here. There are advantages and disadvantages to group enterprises. See **Annex D** for guidance on group-run businesses.

Technical skill development is crucial because the very poor have had little access to training opportunities. They can benefit from additional technical training through apprenticeships and short-courses to help launch successful businesses and to refine and improve existing businesses and/or product.

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- *Group organizing and group businesses:* Three elements, business group formation, group enterprises, and social enterprises, make up this (re)entry strategy. Business group formations help people excluded from groups join or form new business groups in order to take advantage of economies of scale, market linkages, and the social benefits of working cooperatively. Group enterprises help people run a group business, sometimes known as “income generating activities.” Social enterprises are run by community-based organizations (CBOs) or non-governmental organizations (NGOs). Although many organizations support group businesses, sometimes group management of more sophisticated businesses is a significant burden for the very poor. Some NGO- and CBO- run businesses sell to or purchase products and services from clients. These take advantage of economies of scale without burdening clients with extra management responsibilities. Sometimes they generate income for the CBO or NGO to cover costs or support their social initiatives. Social enterprises require a particular combination of business and social skills to run effectively. CBOs and NGOs pursuing this strategy are encouraged to get training and advice.

Commercial business services. These can be any activity that helps a microenterprise get started, grow, or expand, and is made available on a sustainable basis. The “providers” of these services are usually private businesses. They can be other microenterprises, small-scale suppliers, or large-scale businesses. Whether a service is “commercial” or not is more about its delivery strategy than the service itself. For example, rather than providing irrigation equipment to a women’s group for free, a commercial business service program would establish a commercial distribution system for affordable irrigation equipment, perhaps with a financing component to make it easier to acquire.

Since 2001, when the Donor Committee on Enterprise Development issued guidelines on business development services for small enterprises, experts have recommended delivering business services through sustainable markets—rather than through subsidized NGOs. This “market development” approach puts financial pressure on service providers to offer good services and motivates them to reach larger numbers of microenterprise, because the service providers earn a living from reaching more people. The role of the donor in this model is to develop the capacity of the business service providers, help them understand and respond to microenterprise demand, and help them stimulate awareness and demand for even more valuable services. There are several delivery models that help poor people access these commercial services:

- *Fee-for-service*—Some services, such as cell phone, transportation, and photo-copying, are made affordable to the poor through reduced cost and improved distribution. This is most relevant for the near poor.
- *Advertising*—Some services are free to microenterprises because they are paid for through advertising. For example, radio programming targeted to microenterprise listeners in

Types of Business Services

There are many different ways to categorize business services. Here’s a list developed by The SEEP Network:

- Training and technical assistance.
- Technology and product development
- Market linkages
- Infrastructure
- Policy advocacy

In this list, information and communication technologies and association development are seen as ways of delivering other value-added services.

For more information, see

<http://www.seepnetwork.org/marketdev>

Africa is free for the listener, but the radio station earns a profit from advertising to cell phone companies, travel agents, and microfinance institutions. This is most relevant for the poor or very poor.

- *Embedded*—Some services reach the poor through their business partners, especially their suppliers and buyers. For example, avocado exporters in Kenya provide their small-scale out-grower farmers with technical advice and tree grafting and spraying services. In turn, the farmers sell their product to the exporter. Farmers do not have to pay up-front for these embedded services, which makes them most relevant for the poor or very poor.

As with microfinance, these sustainability strategies help market development to reach larger numbers of people and serve them well over time.

A Leading Commercial Business Services Initiative

ILO FIT/SEMA Small Enterprise Radio Program, Africa

In six years and spending less than US \$1 million, the ILO FIT/SEMA project has stimulated 34 commercial radio stations to profitably air small enterprise radio programming, primarily in Uganda. Audience research showed that 74% of adults were regular listeners to one or more of these programs, representing a total audience of 7 million people across the country. Of these listeners, 96% stated that these programs benefited their businesses; enhanced access to knowledge and information; and influenced policy, legal, and regulatory processes. The interactive radio shows discuss concrete policy and governance issues, pressure leaders to make changes, and provide market linkage and business development information. Listeners report benefits to their businesses in terms of empowerment, finding business linkages, getting information on business opportunities, solving or avoiding crises, enjoying a better operating environment, finding sources for business services, and better understanding safety and employee issues. Specific programs have helped microenterprise owners confront corrupt market association managers, advocate for appropriate regulation of the informal milk distribution system, start lucrative bee-keeping activities and find markets for honey, and more. The programs are free to listeners and profitable to radio stations. The programs earn revenue through advertising from cell phone, solar electric, microfinance, and other businesses marketing to the informal sector.*

* Miehlsbradt, Alexandra and Mary McVay, *From BDS to Making Market Work for the Poor: The 2005 Reader*. Annual BDS Seminar (Geneva: ILO, 2005).

Value chain development (market linkages). A third enterprise development strategy is value chain development.⁸ Value chain development is fundamentally about helping microenterprises link with higher value, higher volume, or more stable markets, so that they can earn more. It involves strengthening local industries to improve performance and competitiveness. For example, rather than helping a small group of women raise chickens to market, a value-chain development program would identify strong market demand for higher quality chickens. The program would work to improve the quality of chicks, feed, and medicines for a large number of chicken farmers and attract buyers to a region by significantly increasing the volume of quality production.

Value chain development seeks to help businesses participate in and benefit from a growing economy. Pro-poor value chain development links the poor with market opportunities and

⁸ Often, community development programs begin programs by stimulating production and then work on market linkages. In value chain development, there is a market-driven plan from the beginning to help target communities improve production to meet market demand and to reach markets on a sustainable basis.

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develops sustainable ways for the poor to gain access to the resources they need to take advantage of growing markets (thus working themselves and their communities out of poverty). Pro-poor value chain programs build the competitiveness of growing industries while at the same time increasing benefits to micro enterprises working within the chain.

This is accomplished by:

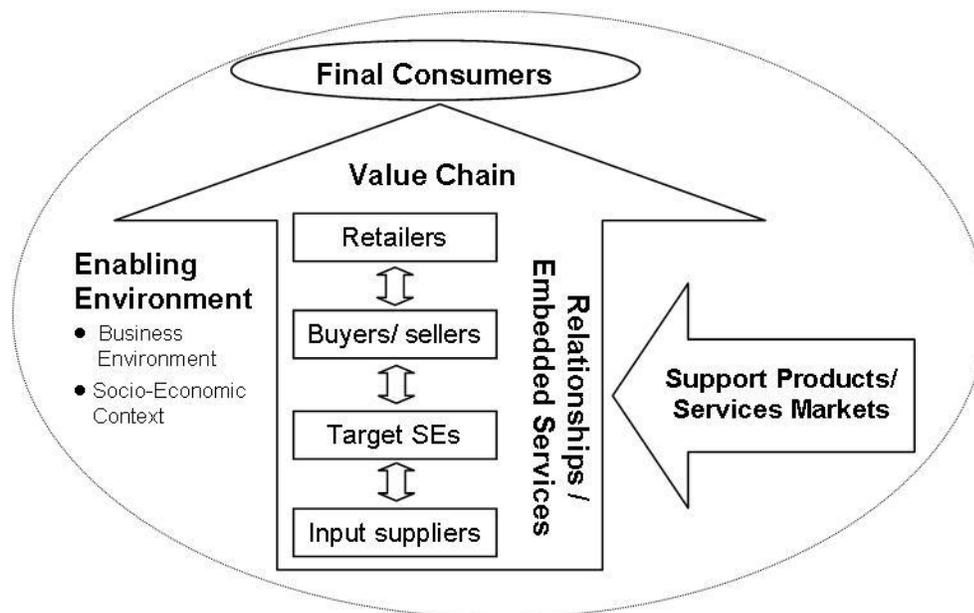
- supporting sustainable ways to improve the business enabling environment,
- strengthening business linkages, and
- upgrading business performance.

Sustainability and scale are fostered by stimulating commercial markets for business services, such as product design, productivity improvement, technology, marketing, and market linkages, etc. Value-chain development programs also leverage the capability and outreach of larger (lead) firms who buy from and sell to micro and small enterprises. Value chain programs build the capacity of associations and industry leaders to continuously lead efforts to improve industry competitiveness.

What is a value chain?

Value chains encompass the full range of activities and services required to bring a product or service from its conception to sale in its final markets—whether local, national, regional, or global. Value chains include input suppliers, producers, processors, and buyers. They are supported by a range of technical, business and financial service providers.

Value Chain Elements



Value chain development is often conducted on behalf of export industries dominated by larger firms, but it can be used in targeting the poor. Organizations targeting lower income people often help microenterprises link to more accessible but still high-value local or regional markets. The poverty focus of the program depends on its design and the commitment of the implementing

agency to ensuring that the poor benefit. The SEEP Network supports strategies within value chain development that promote stronger benefits to the poor. For example, programs can:

- organize associations of producers who have more bargaining power in the market;
- introduce a number of suppliers, buyers, or service providers so that these “intermediaries” compete for microenterprise business and so that microenterprises have choices of who to do business with;
- help microenterprises sustainably access and market information to help them bargain and make good choices; and
- support social enterprises—business with both a profit and a social objective—to be active in target industries and to promote positive social ethics—such as fair wage or working conditions—in the target industry.

The SEEP Network also supports a sustainable approach to value chain development that applies the market development strategies described above to stimulate commercial business service markets.

Examples of Strategy and Outcomes of Value Chain Development

Aid to Artisans and AGEXPRONT, Guatemala

After years of decline in craft exports, the USAID-funded Guatemala Craft Sector Export Initiative strengthened the Guatemalan craft sector by assisting exporters in gaining access to international markets. The program stimulated a private sector market for design services, built exporter capacity to participate in international trade shows, hosted buyer visits, and developed business models for the association to offer these services on a sustainable basis. Three years and US \$800,000 later, Guatemalan craft exports rates shifted from an annual decline of 30% to an annual growth rate of 7%. Exporters directly assisted by the program generated \$1.53 million in export earnings and purchased crafts from 8,900 artisans, 75% of whom are women. A recent impact study concluded that artisans affiliated with these exporters experienced higher sales than others. Exporters reported that the primary reasons for their increased sales were improved designs and market linkages, rather than a general shift in market demand. *Sustainability:* A Guatemalan design institute, trains new designers whom AGEXPRONT links with exporters. Exporters attend international trade shows, and AGEXPRONT facilitates design workshops and buyer visits for fees and commissions.*

* A. Miehbradt and M. McVay, *Implementing Sustainable Private Sector Development: Striving for Tangible Results for the Poor: The 2006 Reader*, Annual BDS Seminar (Geneva: ILO, 2006); Aid to Artisans, “Impact Assessment of the GCSEI Program” (Hartford, CT: Aid to Artisans, 2007).

Mercy Corps, Azerbaijan

This international NGO has helped 11,500 remote, rural livestock farmers gain sustainable access to commercial veterinary services. Mercy Corps organized farmers into clusters and developed a cadre of commercial “village vets” who provide basic services and link farmers more efficiently to higher level veterinarians. The farmers, 36% of whom are women, contribute some \$13.4 million to the regional economy and have increased their income by 40%, due to improved animal health and related productivity increases. This was achieved in 4–5 years, with a program cost of under \$600,000. *Sustainability:* Commercial “village” vets have formed collaborative clusters themselves to continuously organize more livestock farmers into viable clusters, offer farmers access to new services, and expand the village vet system by bringing in more junior vets under the lead vets.**

** A. Miehbradt and M. McVay, *BDS Readers 2000–2006* (Geneva: ILO, 2000–2006).

What about social enterprise? A social enterprise is a non-profit organization or socially oriented venture that advances its social mission through entrepreneurial and market-oriented approaches. Social enterprises have a double bottom line—financial sustainability and social

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impact—and range in size from micro to global. Microfinance institutions are social enterprise; other examples are milk cooperatives that help farmers market milk at better prices, a community-based women’s group that makes and sells soap in order to buy food for grandmothers caring for orphans, and the exporters association and the village vets in the above box on value chain development. Social enterprises can be involved in all aspects of microenterprise development:

- Clients can form a group and run a social enterprise.
- MFIs with goals beyond profitability are social enterprises.
- NGOs or CBOs can sell business services or operate marketing companies as a social enterprise.
- Commercial-business service providers or private businesses doing business with very poor people can be social enterprises, or at least, businesses with a social mission.⁹

⁹ S. K. Alter, *Managing the Double Bottom Line: A Business Planning Reference Guide for Social Enterprises*, rev. ed. (Online source: Virtue Ventures, 2008). <http://www.virtueventures.com/mdbl.php>.

1.2 WHY IS MICROENTERPRISE DEVELOPMENT IMPORTANT FOR COMBATING HIV & AIDS?

The SEEP Network proposes that HIV & AIDS prevention, care and treatment initiatives, and microenterprise development programs work hand-in-hand at the community level. Poor people affected by HIV & AIDS need access to health care along with a sustainable livelihood to fuel a positive spiral of improved wellness and economic security. Income and savings become crucial as households struggle to build and protect their economic resources to mitigate the impact of HIV & AIDS. Engaging in business and gaining access to support services will assist in prevention, care, and treatment efforts undertaken by the health and social services sectors.

This kind of integrated programming requires action by funders, program strategists and designers, strategic-implementation organizations, and on-the-ground practitioners—in both MED and public health. It requires a seminal change in how we all work together. This section of *The SEEP Guidelines* provides a more detailed explanation of this position in order to help public health professionals better understand and make the case for integrated programming. It includes these sub-sections:

- Poverty and AIDS: A Downward Spiral
- Reversing the Downward Spiral of Poverty and Illness: The Role of MED
- Matching Needs to the Right MED Services and Tools
- The Case for Integrated Services—Summary

1.2.1 Poverty and AIDS: A Downward Spiral

The impact of the AIDS pandemic on the poor is intensified by a downward spiral of increasing sickness and poverty. HIV & AIDS can push economically secure households into poverty and poor households into destitution. The loss of income earners, medical expenses, funerals, and the enfolding of orphans drain household income and deplete savings and productive assets needed for survival. The predictable series of economic shocks that accompany HIV & AIDS put enormous economic stresses on affected families, making the slide from relative comfort and security to destitution and despair frighteningly fast.¹⁰

¹⁰ J. Thompson (formerly Donahue), “Economic Impacts of AIDS” (Baltimore, MD: CRS/South African Regional Poverty Network, 2001).

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How Does AIDS Affect Poor Households?



Joan Parker, "Microfinance and HIV/AIDS" (Washington, DC: CGAP-DIRECT, 2003)

As resources are used up, the stresses of illness and death and the uncertainty about the future can be overwhelming. Adding a further burden is the stigma surrounding the disease, making it more difficult for people living with HIV & AIDS, and even their families, to participate in the local economy. This discrimination can block even motivated families from opportunities to earn an income or ease the burden of care for their sick and orphaned family members.

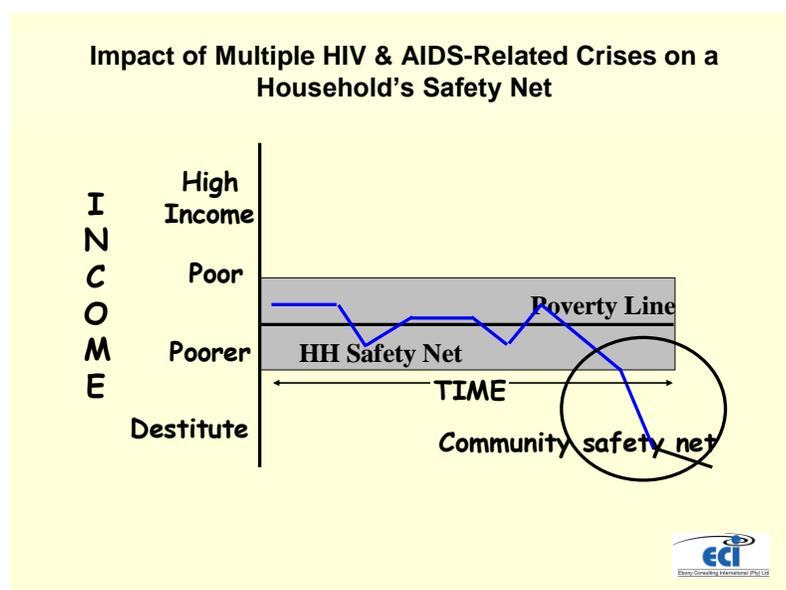
The cumulative effect of these downward trends also has profound effects on future household security, as families invest less in education for their children and key skill sets of productive adults are lost and not passed from generation to generation. For example, family members who get sick or pass away may be the link between their farm or business and local markets. Remaining family members often do not have the social relationships to carry on selling or producing for these markets, and thus these vulnerable people, in need of consistent income, exit the cash economy. In such situations, HIV & AIDS deepen poverty, leaving people even more prone to destitution and disease.

Efforts to prevent HIV and provide care and treatment services to the poor are compromised by this deepening poverty.

Prevention. Poor people generally have less access to health care services and basic education, and are less aware of how to prevent HIV infection and receive available treatment. Many seek long-term work outside their communities and are away from their spouses and family, which creates opportunities for multiple partners. Poor women are more vulnerable to sexual harassment and exploitation at work or in the marketplace and may have little control over sexual practices, both within and outside of marriage. Financial pressures and power imbalances undermine prevention programs because, even when effective messages reach women, many are unable to apply them in practice.

Testing and treatment. Very poor people can seldom afford transportation to clinics and hospitals for testing, care, and the cost of treatment. They cannot afford food and essential nutrients required for effective treatment therapies. Extreme poverty threatens to erode recent breakthroughs in the availability of treatments.

Care and support. The care and support of people impacted by HIV & AIDS is provided first by households. Household members rely on wages, savings, and assets to provide a household safety net. This safety net is compromised when the primary income earner becomes sick or dies, and when other income is reduced due to the time required to caring for sick family members. When crisis hits, households may sell off replaceable assets first, but eventually must sell productive and irreplaceable assets. This leads to destitution for surviving household members. The most vulnerable of these survivors are children and the elderly, who have extremely limited means of generating a livelihood. Children are often pulled from school due to lack of fee money or the need for them to work on farms or as care-givers. This is psychologically damaging and severely limits their future income-earning potential. Often, if a parent dies, the transfer of their assets is not planned for and may not benefit the remaining family members. This is especially true in communities where women may not be able to inherit property, homes, and productive assets.



Graphic from ECI Ebony Consulting International Pty

To prevent this decline or to support people who have become destitute, community safety nets are activated by extended families, neighbors, and community-based organizations. This safety net is comprised of economically secure households who provide homes and education for orphans, food, clothing, labor for orphan- and grandparent-headed households, child-care, home repair, and other goods and services to people in need. In high prevalence areas, the significant burden of caring for the sick, for orphans, and the elderly is eroding these community safety nets. There are simply fewer economically-secure households that reach out beyond the family.¹¹

Stigma, psychosocial dynamics, and economic pressure erode household and community safety nets. For example, in many parts of Africa, widows are blamed for the death of their spouse and are “dis-inherited,” and the extended family lays claim to their land or business. In areas where groups of HIV-positive people come together to support one another, there is often little support forthcoming from the broader community. This can be due to the social stigma and to the high

¹¹ Thompson, “Economic Impacts of AIDS” (2001).

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economic burden already borne by economically secure. When household and community safety nets fail, people affected by HIV & AIDS fall into destitution unless they have access to external relief support. Relief is necessarily temporary and, because of the expense, limited in scale.¹²

1.2.2 Reversing the Downward Spiral of Poverty and Illness: The Role of MED

As a leading global strategy for poverty reduction and economic strengthening, microenterprise development can play a crucial role in sustainably reversing this downward spiral of poverty and illness on a large scale. The vast majority of poor people earn their livelihood from microenterprises and small-scale farms. MED helps households and community-based groups to establish, stabilize, and grow their microenterprises; MED also trains them to manage household financial flows. MED can contribute to more effective prevention, treatment, and care and support of people affected by HIV & AIDS.

Prevention. MED can increase household income, protect household assets, and provide women and children with alternatives to seeking high-risk livelihoods. MED often incorporates women's empowerment as a goal and can help women gain more power and status in the market and the household to provide better control over sexual practices. Microfinance institutions, which reach thousands of clients, have been effective in delivering basic HIV & AIDS education—which has been responsible for increasing people's willingness to be tested for HIV and breaking down stigma and discrimination. Economically stable households are better able to access and apply health information. When community-based organizations successfully run profitable microenterprises, they can generate funds to support community education efforts.

Treatment. MED stabilizes household income and can help HIV-positive people or their household members identify and launch appropriate businesses that use less labor and more efficient and appropriate farming practices to produce a good mix of nutritious food and cash crops with fewer inputs and less labor. Economically stable households can better afford transportation, appropriate food, and related medical services to treat opportunistic infections, etc. When community-based organizations run successful microenterprises, they can generate funds to support transportation, home-based care, supply of basic medications, etc.

Care and support. MED can help households in crisis recover and develop household safety nets. MED offers access to assets, grants, savings, livestock, seeds and tools, etc., as well as training and market access to help families (re)start microenterprises and farms. For economically stable households that support orphans and other vulnerable people, MED develops income and assets, provides loans and insurance for emergencies, and strengthens microenterprises. MED also helps with succession planning to protect survivors' assets and transfer knowledge and market linkages. At the community level, more economically secure households are better able to contribute to and provide a community safety net. MED also encourages community safety nets that build both social and financial assets through credit

¹² For more information on this topic, see J. Thompson (formerly Donahue) "Positive Change: Children, Communities, and Care (PC³) Program in Ethiopia—A Livelihood Development Approach," Promising Practices Series, MED and HIV and AIDS Integrated Programming Case Study (Washington, DC: The SEEP Network, 2008).

groups, emergency funds, producer associations, and assistance to existing support groups in pursuing income generating goals.

MED strives for significant scale and sustainable services, for example, by minimizing short-term, more expensive, and smaller-scale relief interventions. It helps meet the care and support needs of HIV & AIDS-impacted households by strengthening sustainable household and community safety nets, for larger numbers of people. Microenterprise development is a critical component to fueling a positive spiral of health and economic security.

1.2.3 Matching Needs to the Right MED Services and Tools

While MED can and does help to reverse the impacts of AIDS, communities impacted by the epidemic will include people at various levels of economic need. Different needs and situations must be matched with the right assistance and solutions.

There are fundamental differences in how the health and economic sectors identify populations which should be considered before providing services: HIV & AIDS-support organizations typically target the most poor and vulnerable and address their needs according to their social or health status— orphan, widow, caregiver, person living with AIDS, etc. MED programs typically target the economically active poor and address their needs according to their economic status— skill set, asset type and level, and social capital—because different services are needed for different capacities and economic needs.

Below are several examples that consider social, health, economic needs, and contexts and attempt to bridge existing categorical frameworks.

Case #1: Orphans and vulnerable children. This group needs psychosocial support as well food, clothing, shelter, and education. Vocational training followed by apprenticeship programs with entrepreneurs or artisans can help prepare them for a livelihood. Programs should not overlook linking graduates to viable markets and ensuring the participants have the tools and resources needed to start microenterprises or group-run enterprises after training. Efforts should proactively prevent trafficking and forced labor and discourage street begging and petty theft. Youth also need life skills for HIV prevention and protection from sexual exploitation. Minor children are not eligible for most credit programs, but MED services could be offered to caregivers of orphans and vulnerable children. Community resource mobilization can offer sustainable support options.

Case #2: An extended family with multiple AIDS-infected members who need care and support. This family has experienced the loss of multiple income earners. Medical and funeral costs have drained savings and productive assets. The remaining family members need assistance in learning how to care for sick family members as well as ways to engage surviving members of the family in microenterprise development. Productive family members may need grants to help them (re)start businesses and purchase productive assets to increase earning potential. Depending on market readiness and capacity, economically active family members are good candidates for credit programs. They also need technical assistance, materials, and financial support to pursue high value businesses with less intensive labor (moving from service to manufacturing, for

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example) or cottage industry (working from their home or community) if they need to be available to care for the sick. Promotion of testing and provision of treatment could keep HIV-positive adults productive longer. Rural farmers might need technical guidance and access to technology and markets to pursue less labor-intensive agriculture and appropriate cottage industries. Programs that improve farm-to-market linkages and protect growers, as well as livestock propagation programs to rebuild reserves (e.g., the Heifer Project) would also help strengthen household security. Wills and protection of assets for widows and orphans may also be necessary.

Case #3: A single woman not infected with HIV, without a productive livelihood, heading a household of dependant children. This woman could be at risk for HIV infection if forced into transactional sex to support her family. She needs prevention education, as well as a livelihood that will provide regular income. If she lives in an urban setting, she may need business training to prepare her for a loan to start or improve a market-viable enterprise, perhaps working from her home so she can continue to care for her children. Savings services would also strengthen her household security. If in a rural setting, farm-to-market linkages, savings cooperatives for improved agriculture, or livestock propagation programs would improve and smooth sustainable income streams. Legal information regarding inheritance and property rights would help make her less vulnerable to exploitation if her husband has died.

Case #4: An economically secure household that has recently taken over care of four orphans (nieces and nephews) and whose primary income earner (father) recently tested positive for HIV. This family is currently economically secure and is an active part of the community safety net, but is on the brink of crisis. They could benefit by having access to treatment and education to prevent further spread of HIV. The family needs a support group and counseling and the community around them needs awareness education, so that the family is supported and not stigmatized. They need succession planning to protect surviving adults and children, including vocational mentorship for the children. Information, technology, and financing could help them grow nutritional foods. If she doesn't have one, the mother needs to develop a livelihood, and the father needs to increase returns from his farm and any other enterprises. Labor-saving technology can help to reduce the demand for labor around the house and farm. They may need help in planning and managing these more complex undertakings.

1.2.4 The Case for Integrated Services—Summary

The cases above illustrate that households and communities benefit most when they have access to both health and MED services at the same time. This calls for integrated programming. Microenterprise development is already playing a crucial part in mitigating and ending the HIV & AIDS epidemic. *The SEEP Guidelines* advocates more intentional, integrated programming approaches to help people and communities affected by HIV & AIDS access MED services. This requires the international health and MED communities to talk together and find effective ways to work together. The fundamental challenge to project designers and policy makers should be to develop coordinated, multi-sectoral interventions that make a difference over the long haul and at a scale that approaches the magnitude of the pandemic.

Awareness of and understanding one another's operating principles needs to precede partnership and collaboration. MED is a specialized technical field that attempts to change operating systems and markets. However, poorly programmed initiatives that do not follow best practices can undermine MED initiatives that would otherwise benefit HIV & AIDS-impacted communities. MED programming, if not coordinated with AIDS support organizations, could miss opportunities to serve HIV & AIDS-affected populations effectively. When operating in high HIV-prevalent areas, MED programs that ignore HIV risk poor performance due to the impact on clients and markets. Poorly programmed HIV messages disseminated by MFIs and MED programs run the risk of stimulating discrimination against HIV-positive people. Together, health and MED professionals can enhance each other's outcomes, leverage resources, and have a significantly higher impact in communities.

In an effort to promote healthy collaboration and field focused strategic partnerships, *The SEEP Guidelines* strives to help each sector understand one another's operational realities, programming potential and most importantly to identify common ground, reflected in those they seek to serve and assist.

1.3 WHAT KIND OF MICROENTERPRISE DEVELOPMENT STRATEGIES WORK FOR HIV & AIDS-IMPACTED COMMUNITIES?

Microenterprise development (MED) is a crucial element of a holistic approach to HIV & AIDS prevention and mitigation. (See sections 1.3, 2.2, and 3.2 for further elaboration.) MED presents opportunities to prevent people from falling into destitution and to establish a secure livelihood and the potential to create a strong community safety net for the most vulnerable. By addressing HIV & AIDS issues in its initiatives and institutions, MED programs can be more effective in those communities and markets impacted by HIV & AIDS. The MED strategies that work in HIV & AIDS-affected communities are the same strategies that work for poverty eradication in general, with adaptations for the impact of HIV. HIV-affected people span the income spectrum, and the way the crisis affects communities also varies depending on the stage of the epidemic—localized or generalized; low-, mid-, or high-prevalence; and whether households are in crisis or recovery stages.

What is microenterprise development (MED)?

Microenterprise development consists of two overlapping development activities: helping people start and run very small businesses and farms, and helping people access financial services. Together these two activities provide people with the capacity to manage crises and work their way out of poverty. Different donors and practitioners use different terms. *The SEEP Guidelines* refer to the following:

- **Enterprise development:*** Helping people establish and expand microenterprises through access to markets for inputs, for their products, and for business services such as training, information, technology or transportation; helping microenterprises enter, remain in and benefit more from market participation.
- **Microfinance:** Financial services such as lending, savings, insurance and money transfer, designed for the needs of low-income populations.

For a more details, see Book 1, section 1.3, What Is Microenterprise Development?

* Also referred to as business development services, market development, and making markets work for the poor.

1.3.1 Specific Challenges Posed by HIV & AIDS and MED Program Implications

There are several critical challenges to MED for HIV & AIDS-affected populations and communities. Understanding these challenges helps to design programs to overcome them.

Rapidly changing circumstances. People affected by HIV & AIDS can rapidly shift from economic security to destitution. With access to anti-retroviral therapies increasing, many people can recover from debilitating circumstances and once again participate actively in income generation.

Implication—Provide access to a range of MED services appropriate for different circumstances (such as disaster preparation and asset protection) through insurance, resources, or savings services to help businesses (re)start and facilitate rapid recovery, provide services for business growth, and encourage diversification to achieve economic security.

Loss of skilled income earners. When HIV & AIDS claim the lives of trained and experienced adults, their families, local communities, and youth lose knowledge and skills.

Implication—Incorporate knowledge transfer, apprenticeships, mentorship, and skills development into MED programs.

Labor shortages and unemployment. Some families experience labor shortages due to loss or reduction in energy levels of adults, and/or the burden of caring for the sick or for orphans. At the same time, large numbers of young people have missed the opportunity for education and are now above school age, unskilled, and often responsible for caring for siblings or grandparents.

Implication—Look for labor-saving techniques to avoid or decrease unpaid labor and promote strategies to create employment opportunities for youth (i.e., social marketing, food-for-work, apprenticeships, etc.)

Stigma. Stigma can present barriers for HIV-positive people or their affected families. They can be excluded from group-based financial services and business or farming associations. People known to be HIV-positive may face difficulties in running a business in communities where stigma is high and there is reticence to buy goods or services from people who are HIV positive.

Implication—Integrate HIV & AIDS education into MED programs to reduce stigma and target according to economic circumstance, rather than HIV status. For groups that are already socially marginalized or isolated, devise appropriate strategies for their economic circumstance and/or serve them separately.

Health challenges for PLWHA. People living with HIV & AIDS can lead productive lives with drug treatment. However, their HIV status may require extra attention and resources to ensure a balanced diet, adequate sleep, access to regular health care, support for psychosocial and emotional well-being, attention during periods of illness, and times of lower energy.

Implication—Agricultural strategies should address the need for people to grow nutritious food (beans, groundnuts, etc.). Value chain programs might consider devising products that serve HIV-positive customers, such as nutritional flour mixes, nutritional crops, soaps and creams for the skin, etc.; pro-actively stimulating and supporting emergency funds and insurance; identifying or counseling clients to identify businesses with low labor demands; investing in labor saving technologies and/or finding employees who can take up the labor burden; encouraging flexibility about meeting attendance in case of illness or emergency.

Gender discrimination. Women in many cultures are more heavily impacted by HIV & AIDS. For example, in most parts of Africa, widows may be blamed for their husbands' deaths from AIDS, are not able to inherit their husband's land or business, and may be cast out from the family and made homeless. Young women and teen girls may be especially vulnerable to sexual exploitation by older men offering money in exchange for sex. Destitute or very poor women may engage in transactional sex or be especially vulnerable to sexual harassment in the market or workplace.

Implication—Conduct gender analysis of potential MED initiatives and create a gender action plan to ensure gender equity and promote women's empowerment; consider women-targeted programming with attention to the needs of mothers with small children (such as ensuring that children are safe when mothers are engaged in business or group meetings); incorporate or separately target young women with appropriate services; coordinate MED programs with social services (family intervention counseling, HIV & AIDS awareness) and legal rights initiatives; and integrate succession planning and/or legal assistance into programs.

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Pressure on community safety nets. In most developing countries, where government social services are not able to care for the most vulnerable, extended family and community members provide a “community safety net.” This can provide food and labor, money for medical expenses and school fees, and care of orphans within their extended family. In areas of high HIV prevalence, this system is strained to the breaking point.

Implication—Pro-actively support emergency funds and charity funds as part of MED programming. This is not to say that MED programs should manage emergency funds. Rather, they should explore building the capacity of clients to manage their own emergency funds.

1.3.2 SEEP MED Model for Poverty Eradication

The United Nations established a Millennium Development Goal to reduce by half the number of people living in extreme poverty by the year 2015.¹³ Muhammad Yunus, a global leader in microenterprise development and a Nobel Peace Prize Laureate, puts forward a vision for eliminating poverty from the real world and putting poverty into the museums of the future, where our children will go and be shocked by the abhorrent conditions we tolerated.¹⁴ At its 20-year anniversary, The SEEP Network adopted its own 20/20 vision statement, “Poor No More.” There is a global movement to eradicate poverty, which is a significant challenge. The SEEP MED Model proposes how MED can play a more significant role—alongside many other initiatives on both micro- and macro-levels—in eradicating poverty.

This MED model for poverty eradication is adapted to address the impacts of HIV & AIDS (see SEEP MED Model, p. 28). It is based on practical experience, but is not “proven.” Rather, it is an aggregation of practitioner lessons learned and represents the approach SEEP suggests that practitioners apply. It is evolving, and SEEP invites you to share your opinions and experiences.

Join the online dialogue around this framework and share your program experience with us.

<http://communities.seepnetwork.org/urban/discussion>

1.3.3 The Limitations of Narrow MED Programming

MED work is limited by its narrow focus in two ways. First, MED programs tend to operate in isolation, outside other programs, such as public health initiatives. However, communities impacted by HIV & AIDS have significant need for other development services. Second, MED programs tend to be specialized in order to achieve high quality and scale in specific service areas or markets. MED responses are isolated due to the outreach or institutional parameters of the supplier—the microfinance institution or the enterprise development program, for example. This leaves gaps in service between what is needed by the household and the interventions offered.

¹³ UN Millennium Development Goals, website, “Goal 1,” <http://www.un.org/millenniumgoals/#>.

¹⁴ Mohamed Yunis, “Nobel Peace Prize 2006 Lecture,” Oslo, Norway, online source. http://nobelprize.org/nobel_prizes/peace/laureates/2006/yunus-lecture.html

As MED practitioners try to find ways of reaching and serving the very poor, they tend to look at the problem from a supply point of view—how can they get their services to the very poor? HIV & AIDS-response practitioners tend to do the same—asking MFIs and MED programs to serve their clients (generally the most poor and vulnerable people). However, there is often a mismatch between client needs and service availability.

Defining Poverty Strata

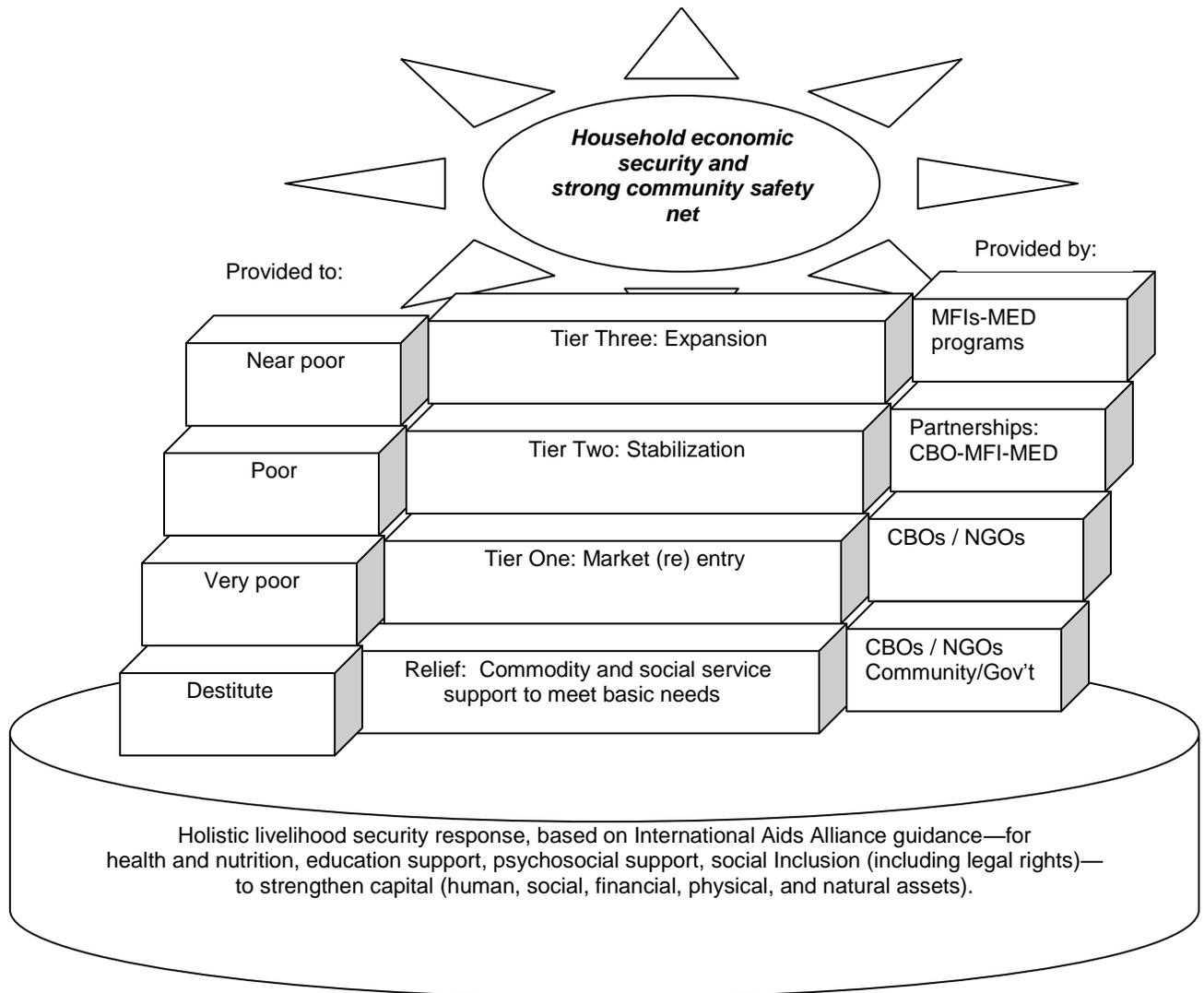
The global community is in the process of defining poverty strata. The global standard of individuals living on US \$1 and \$2 per day is very popular and simplified systems are emerging to facilitate measurement. Most practitioners recognize that there are multiple dimensions to poverty. For example, on average, a household may earn more than \$1 per day per person, but some women in the household may not have access to their “share,” either in terms of cash or consumable goods and services. Some women live well physically, but are not mobile or able to own property, and do not control their work or sexual lives. In this document, we use the following working definitions:

- **Destitute**—Those unable to earn a living, whether temporarily, short- or long-term, or permanently. For example, this could be a household headed by a grandmother, who is aging and unable to perform regular income-generating activities and whose oldest grandchild is only ten. It could also be a working-class family whose home and business were destroyed in a hurricane and who have no savings.
- **Very poor**—Individuals in a household living on less than \$1 per day, 50% below the national poverty line (or some proxy indicator for this measure). Targeted individuals may or may not have an economic activity, but if they do, it is very weak or young. Sometimes they are engaged in subsistence farming or have low paid employment. Returns to labor are low.
- **Poor**—Individuals in a household living on less than \$2 per day (but more than \$1), living below the poverty line, but not more than 50% below the poverty line (or some other proxy for this indicator). Targeted individuals often actively run a business or some kind of commercial farming. They may be starting a new business (their spouse may have a job or viable business) or they may be recently unemployed. They may be subjected to monopolistic or sexist market conditions, exploitative money lenders, or they may have low social autonomy or status within the household.
- **Near poor**—No quantitative definition yet, but this refers to people living near the poverty line—perhaps only up to 50% above the poverty line—and vulnerable to falling back into poverty. This group has a viable business and/or commercial farm and some assets or savings to turn to in case of emergency. They have limited choices in their work and social lives.
- **Economically secure**—the goal. This refers to families living well above the poverty line, who are not in danger of becoming poor unless hit by a very significant crisis. They are, in fact, prepared for crises with insurance, savings, other assets, and an action plan. They have a regular income, their children are in school, and they are able to assist less fortunate relatives and neighbors. They have economic and social autonomy and choices.

To address these challenges, practitioners need to look more at demand: what do the poor and very poor need? What do people living with and affected by HIV at different poverty levels need? What services can prevent households from falling into poverty, and what can help the destitute and very poor who are dealing with HIV to work their way back to a more secure economic position?

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SEEP MED Model for Poverty Eradication



1.3.4 A Proposed Solution

The SEEP Network proposes a more holistic and coordinated approach to poverty eradication, particularly for people affected by HIV & AIDS. The model here considers what people need to work their way out of poverty on a sustainable basis. It suggests a staircase of economic strengthening and MED services appropriate for people experiencing different levels of poverty, and notes which institutions might provide those services. The model is fundamentally based on the principle that different strategies or tools are appropriate for different populations and require specialized skill sets to deliver them. Therefore, strategies should be well-matched to target

populations and delivered by institutions or specialists who know how to implement them or use the tools.

The foundation of the framework is holistic programming that will support a strong livelihood security response to HIV & AIDS-affected households. The circle at the bottom of the SEEP MED model represents this foundation.¹⁵ The staircase represents the different tiers of MED services. The boxes to the left of the staircase represent the economic strata and vulnerability of target populations. The boxes on the right of the staircase represent the institutions typically appropriate for delivering these services. Economic security and a strong community safety net is the goal at the top of the model.

This model is intended to depict dynamic movement of people up and down economic strata, as well as the requirement for a diversity of services to:

- support people’s transition from less vulnerable to more secure, and
- prevent significant slide from more secure to more vulnerable.

MED programs can be “stand-alone” institutions or can be part of larger development initiatives. Microfinance institutions however, are always “stand-alone” institutions due to their financial sustainability requirement.

As each person benefits from the tool appropriate for them, as they move from poverty to greater economic security, they are then positioned to benefit from the next tool to move further and more sustainably out of poverty. Conversely, if individuals experience a crisis and extreme reduction in income or assets, they may need a different set of tools to prevent further slide into extreme poverty and to quickly recover. It is assumed that people need a similar ladder of services in other sectors—housing, water and sanitation, health, education, environmental protection, etc.

1.3.5 Core Principles

1) **The goal is household economic security and a strong community safety net.**

While each program may define economic security differently, here we specifically mean increased and more stable income; increased productive and non-productive assets; and increased autonomy and power in households, communities, and markets. Economic-strengthening and MED programs can and should contribute to a stronger community safety net. The community safety net refers to the capacity for social groups—the extended family, community-base organizations (CBOs), and NGOs—to provide sustainable relief to the destitute and emergency assistance to families in crisis so that they do not become destitute.

2) **A holistic response (through partnership) is required.**

Microenterprise development should occur in the context of a broader development initiative that will help people address their multiple resource limitations and build on their existing asset base. Everyone needs access to basic health and human services. MED programs can work with partners to assess and ensure that their target clients have access to the wide range

¹⁵ This information refers to livelihood security frameworks, such as DFID’s *Sustainable Livelihoods Guidance Sheets*, found on the Livelihoods Connect website, see “Guidance Sheets,” http://www.livelihoods.org/info/info_guidancesheets.html.

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of services they need. For example, in high HIV-prevalent areas, MED programs could partner with health organizations to ensure that people have access to appropriate health, education and social services to address HIV & AIDS.

3) Customize dynamic solutions.

People enter the staircase to economic security where it is appropriate for them and work their way up, building stronger livelihoods strategies along the way:

- The destitute may need relief to regain their health, property rights, and/or secure housing before they start to think about earning a living.
- The very poor might focus on market (re)entry strategies and asset transfers or savings to (re)start a business. They may start to develop emergency funds for future crisis.
- Poor people with more business experience and resources may be ready to borrow small amounts to increase their business volume, access local markets, and to absorb and use business services. They may be able to increase their emergency funds and diversify their livelihoods strategies further.
- People who are just above the poverty line may be more able to save and borrow larger amounts, access a wider range of insurance, reach high value more distant markets, and purchase commercial business services.
- If economic shocks occur (severe illness, death of an income earner, entrance of orphans in the household, etc.), people should be able to access lower-tier services in order to work their way back up the income ladder.

4) Partnership is key.

Although some larger organizations may be equipped to provide holistic services, the broader development and different MED services can also be provided through partnerships. Microfinance services in particular are best provided by microfinance institutions. Commercial business services are best provided by other businesses supported by professional microenterprise development programs. Grant-based services and basic training might be best delivered by NGOs and CBOs, trained or staffed by MED specialists.

Public health organizations can use this tool to help identify an appropriate strategy for their goals and clients, to identify appropriate roles for themselves and their NGO/CBO partners, and to identify when they should hire or seek partnerships with MED specialists and MFIs. MFIs and MED programs can use this tool to locate their services in the framework, and then seek partnerships to ensure that the communities they serve have access to a wider range of MED and development services.

5) All services should be tailored and demand-driven, but need not be targeted to one group exclusively.

At all levels, services should be adapted to the specific capacities and vulnerabilities of the target population and should be demand-driven.¹⁶ Clients at various levels of poverty will

¹⁶ Two key elements of demand include some financial pressure on providers (often participant fees or labor contributions) and a choice of services, rather than having some services required in order to access others.

have different needs for MED services based on their livelihoods strategies and experience. Conducting effective market research prior to initiating activities is crucial to assessing the need for specific services, the availability of potential partners, and the viability of sustaining them. Services should be targeted at people based on their poverty level and economic capacity, rather than their HIV status. Instead of targeting HIV-positive individuals directly, programs can adapt their services to ensure that they are open to HIV-affected households and have the flexibility required when confronting issues of HIV. In high HIV-prevalent areas, programs should be sure to spread services among the most vulnerable and stronger households who provide a community safety net.

6) **Ensure that a range of services is available.**

It is rare that one program would attempt to offer all these services. Most programs will focus on a specific tier and work toward helping them move to the next tier. Or, they might provide services that are primarily targeted at one group, but benefit a mixed income group. The challenge put forth by this framework is for MED programs to pro-actively ensure that the other services in the model are available to the communities they serve, usually through partnerships. For example, MFIs might partner with other organizations that will serve the very poor and prepare them to graduate to mainstream MFI services. Value-chain development programs may not be able to offer financing, but they can partner with an MFI to do so. A partnership with a vocational school or business to offer basic skills training can help bring unskilled workers into the more lucrative value chain.

7) **Design for transition.**

Most MED programs are designed for stagnant conditions, focusing on matching services to client demand at a fixed point in time. The SEEP Model challenges MED programs to design for transitions, particularly for the transition from relief and asset-transfer services to more sustainable, commercial services. It can be challenging for families to maintain an adequate livelihood while transitioning from receiving subsidies to participating more fully in the market. Grants-to-loans and rotating livestock programs are examples of programs designed to support effective transitions. The word “transition” can be threatening to some MFIs which wish to keep successful clients. In such cases, a “transition” may mean graduating clients from a simpler set of financial services to a more advanced set.

We welcome your comments.
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1.3.6 Specific MED Strategies

The table below elaborates on specific MED strategies at each level in specific categories. It lists each tier with reference to the target population served, as well as a category of service within the two broad areas of MED: microfinance (saving, credit, insurance) and enterprise development (market [re]entry, commercial business services, and value chain development).

Next, the table elaborates specific services or features in each of these categories, the appropriate institutions for delivering these services and any adaptations recommended increase effectiveness in HIV & AIDS-impacted areas. As with the rest of the SEEP MED Model, this table is an aggregation of tools and lessons from practitioner experience and continues to evolve.

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Specific MED Strategies for Different Tiers and Target Groups

Tier and target group	Category of service	Specific services and features	Best provided by
<p>Relief for Destitute Individuals</p> <p>Appropriate for the bedridden, families whose sole income earner has recently passed away, and children and grandparents who head households and who are unable to earn a living</p>	<p>Cash transfers, food supplements, commodities, scholarships, and social services to meet basic needs</p>	<ul style="list-style-type: none"> • Possibly very short term (less than a month): food, medical, housing support • Possibly long term: scholarships, child-care for orphans, food and child care for child-headed households and grandparents • For able bodied people, best delivered with a strategy for transferring to more sustainable livelihood sources. • Best delivered in conjunction with MED services to other strata, so that community safety nets can take over this role. 	<p>CBOs/NGOs/government; community safety net</p>
	<p>Microfinance: Money transfer or remittances</p>	<ul style="list-style-type: none"> • Facilities to enable working relatives to easily transfer money to relatives at home 	<p>MFIs</p>
<p>Tier One: Market (re) Entry For Very Poor Households*</p> <p>Appropriate for households which have become very poor due to crisis, and for households which were very poor before the crisis; appropriate for youth, widows, orphan- and grandparent-headed households in which heads of households are able to work</p> <p>* Mainstream MFIs can serve the very poor in mixed-income programs in which clients select each other and therefore vouch for borrower readiness, in spite of very low incomes.</p>	<p>Microfinance: Savings and money transfer or remittances</p>	<ul style="list-style-type: none"> • Rotating savings and credit associations (ROSCAs) in which fixed contributions are made and the total group fund is given to one person on a rotational basis (possible donations to match savings, but no external borrowing) • Integrated literacy, empowerment, health, money management, or other basic skills (especially HIV & AIDS education) • Facilities to enable working relatives to easily transfer money to relatives at home 	<p>MED programs or NGOs/CBOs trained by MED programs</p>
	<p>Enterprise development (ED): Market (re)entry with asset transfer</p>	<ul style="list-style-type: none"> • Food-for-work or supported employment (providing food to the worker and labor plus childcare and farming labor, etc. for HIV-affected households) • Rotating livestock initiatives (i.e., offspring of initial livestock are given to other community members in succession); community tool banks; grants of seeds, inputs, and tools • Cash or matching grants for business or farm (re)starts 	<p>NGOs/CBOs or MED programs trained by NGOs and CBOs</p>
	<p>Support for emergency funds</p>	<ul style="list-style-type: none"> • Guidance for voluntary group emergency funds, managed by the group, in HIV-prevalent areas, possibly matched 	<p>NGOs/CBOs/MFIs</p>
	<p>ED: Market (re)entry with basic skill development</p>	<ul style="list-style-type: none"> • Technical skill development (such as apprenticeships with other businesses, short courses) (Important for orphans) • Basic business education (literacy), including business identification, basic business finance, basic marketing 	<ul style="list-style-type: none"> • MED programs or NGOs/CBOs trained by MED programs • MFIs with integrated "Credit with Education"

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	ED: Market (re)entry with group organization and group enterprise	<ul style="list-style-type: none"> • Social enterprise run by CBO or NGO to sell to or purchase from clients • Business Group formation (i.e., farmers associations) or links to existing groups and associations 	MED programs or NGOs/CBOs trained by MED programs
<p>Tier Two: Stabilization for Poor Households*</p> <p>Appropriate for general population in HIV & AIDS-affected areas; important to prevent families from sliding into deeper poverty and destitution, and to strengthen and maintain community safety nets</p> <p>* For this income group and above, grants are generally not recommended because for this group, they can distort the market for commercial credit.</p>	Microfinance: Savings and credit	<ul style="list-style-type: none"> • Village banks (accumulating savings and credit association, which could be financed in part by loans from an external MFI) • Group lending • Specialized lending products, i.e., dairy cow loan, loan to enter a value chain with significant supportive technical services 	MFIs, in strong partnership with HIV & AIDS-response programs to ensure that target population has access to essential health and prevention services
	Microfinance: Insurance and support for emergency funds	<ul style="list-style-type: none"> • Loan insurance to guarantee repayment of loan in case of borrower's death • Guidance for voluntary group emergency funds, managed by the group, in HIV-prevalent areas, possible matched 	Private insurance companies, with MFIs as brokers
	ED: Commercial business services	<ul style="list-style-type: none"> • “Embedded” services—linked to purchase of necessary inputs • “Village” business services, i.e., village vets, village agro-advisors • Business information services, i.e., radio that is free to the listener and paid for through advertising • Group-based service delivery, i.e., business planning, financial management, operations and marketing training • Physical market development (clarifying regulations and fees, creating affordable legal space) • Cell phone service • Cooperative business: very simple, low risk, group-managed income-generation activities • Education integrated into microfinance or value chain services: empowerment, business planning, health, HIV & AIDS education, etc. 	<ul style="list-style-type: none"> • These services should be provided by private businesses, stimulated and supported by MED programs • CBOs and MFIs possibly help clients access information and organize themselves into groups to better afford and access appropriate services. • MED programs or apex cooperative to organize cooperatives • All in strong partnership with HIV & AIDS-response programs, to ensure that target population has access to essential health, prevention, and care services

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	ED: Value chain development	<ul style="list-style-type: none"> Value chain development to access local or national markets Value chain development that offers clients a complete package of services, i.e., inputs, advice, marketing Social enterprises that offers clients a complete package of services, i.e., inputs, advice, marketing 	<ul style="list-style-type: none"> MED programs NGO established as a social enterprise
<p>Tier Three: Expansion for Near Poor Households</p> <p>Important for preventing slide into poverty and for strengthening community safety net</p>	Microfinance: Credit and savings	<ul style="list-style-type: none"> Village banking, graduating to “apex” financial institutions Group lending in smaller groups (less frequent meetings, larger loans) Individual lending Specialized loan products for asset investment Value chain finance 	MFIs
	Microfinance: Insurance and support for emergency funds	<ul style="list-style-type: none"> Larger group emergency funds Credit Insurance Crop or other product insurance Life and death insurance Linkages to health insurance Guidance for voluntary group emergency funds, managed by the group, in HIV-prevalent areas, possible matched 	MFIs or village savings and loan type groups administering social funds to help those in need
	ED: Commercial business services	<ul style="list-style-type: none"> Fee-based commercial business services, such as consulting, access to information and communications technology, written publications, SMS (cell phone) information services Development of business associations for advocacy or location promotion activities Larger cooperatives taking on more sophisticated processing and marketing functions Education integrated into microfinance or value chain services, i.e., empowerment, business planning, health, HIV & AIDS education, etc.) 	Private businesses or cooperatives, stimulated and supported by MED programs or apex business associations
	ED: Value chain development	<ul style="list-style-type: none"> Value chain development linking to more formal national, regional, and international markets More minimalist value chain development Value chain development that offers clients a broader choice of commercial services providers and market linkage options Profitable social enterprises sell to or buy from the lower income strata 	<ul style="list-style-type: none"> MED programs NGOs established as social enterprises or businesses with a strong corporate social responsibility value

1.4 HOW CAN WE FACILITATE CROSS-SECTOR PARTNERSHIPS?

Implementing integrated programming is challenging. It requires bringing together diverse technical approaches, different program priorities, and—sometimes—competing institutional and professional interests. The key to addressing these challenges is facilitating effective cross-sector partnerships among public health and MED professionals and organizations. This is easy to say, harder to accomplish. Challenges to effective cross-sector partnership exist at all programmatic levels—from funder, to technical specialists and umbrella implementing agencies, to community-based organizations. Changes are needed at all levels. *The SEEP Guidelines* fundamentally call for donors and strategic implementing partners in both public health and MED to make strategic shifts in the way they fund and design programs, so that they drive and better support program integration at the community level. This section is presented to funders and strategic implementing partners—and to on-the-ground practitioners who may be in a position to influence their strategic partners and funders.

The following specific strategies have emerged from cross-sector dialogue¹⁷ to support cross-sector partnership:

- Guiding principles for observing good practice in both disciplines
- Structural (institutional) challenges and strategies for cross-sector collaboration
- Technical challenges and strategies for cross-sector collaboration
- Necessary expertise for integrated programming
- Partnership tips and tools
- Responses to “Frequently Asked Questions” from one technical community to another—MED and HIV & AIDS professionals—see [Annex C](#).

Have an additional suggestion or lesson learned for joint programming that you'd like to share?
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For technical resources on how to implement specific MED strategies, see [section 1.5](#).

1.4.1 Guiding Principles

One critical obstacle facing MED and HIV & AIDS specialists as they attempt integrated programming is a lack of common understanding of the basic principles of each professional discipline. This section of *The SEEP Guidelines* shares the key principles of each discipline and lays out some emerging principles for joint programming.

Principles for Joint Programming. The guiding principles for integrated programming are evolving quickly as increasing numbers of programs test new strategies. Experts from different

¹⁷ Over the course of five years, The SEEP Network’s HIV & AIDS and Microenterprise Development (HAMED) Working Group explored these issues and facilitated dialogues with public health practitioners to identify challenges and solutions to cross-sector partnerships. The Working Group will continue its endeavors. For more information, see <http://communities.seepnetwork.org/hamed>.

disciplines come together to bring their own practices and adapt them to face the challenge of HIV & AIDS.¹⁸ These recommendations are offered for effective integrated programming.

1. Support a holistic set of specialized services that meet the dynamic needs of targeted communities.

- Work with partners to assess the holistic needs of target communities and ensure that diverse services (health, sanitation, education, human rights, etc.) are available to target clients.
- Account for dynamic change: plan for clients to graduate from destitute to vulnerable to secure, as well as for people in the community to fall from more to less secure. Ensure that a range of services are available to your clients as they advance economically or fall into crisis.
- Specialize and encourage others to specialize in their core competency, while mobilizing partners to provide complimentary services for an effective, holistic response. For example, the same institution should not provide grants and loans because clients receive mixed messages about the intention of the organization and the need to repay. Another example is if a microfinance institution provides health information, then curriculum development, training of trainers, and quality control should be conducted by public health specialists.

2. Match the support to the situation.

- Assess the economic strength and vulnerability of target populations in their economic context. Select MED strategies that build on their economic capacity and address their economic constraints to earning a more viable and secure living.
- Assess the physical and social strengths and vulnerability of target populations, in their health and social context. Select MED strategies that build on their physical and social capacity and reduce health and social barriers to business and market participation.

3. Target appropriately.

- Target economic programming based on economic status (i.e., skill base, level of poverty, extent of current and past economic engagement), not HIV status.
- Stimulate formation of groups for economic purposes when group-based activities are most appropriate for microfinance and other business activities.
- Engage community groups judiciously and effectively. Follow best practices in cooperative and association development and in microfinance:
 - Groups with a clear and necessary purpose
 - Self-selected membership
 - Transparent rules for operation
 - Clear individual benefits according to individual time
 - Financial investment and autonomous operation, with an external dispute resolution process

¹⁸ This list benefited significantly from USAID, AED, and Save the Children, “Economic Strengthening for Vulnerable Children: Principles of Program Design and Technical Recommendations for Effective Field Interventions” (Washington DC: USAID, 2008), <http://www.crin.org/docs/Economic%20Strengthening.pdf>.

4. **Take a cross-sectoral approach and ensure open dialogue throughout the program.**
 - Involve a variety of actors from all relevant sectors at key program funding and design points.
 - Inform programming decisions through a sound, cross-sector needs analysis, such as situation assessment or market research.
 - Create ongoing opportunities for dialogue among professionals of different disciplines.
5. **Adapt MED programs and strategies to the HIV & AIDS context.**
 - Consider the specific circumstances of HIV & AIDS-impacted communities, including the level of economic vulnerability, asset depletion, economically active children and youth in vulnerable households, the presence of youth-headed households, large families, elderly caregivers, and health and legal issues. Ensure that products and services are designed to respond to these needs, which might be different than other low-income market segments (e.g., the need for labor-saving technologies, home-based enterprise activities, or additional skill training).
 - Adapt MED programs to accommodate high incidence of HIV & AIDS in target communities to mitigate risks to the institution, program, and community. Leverage program activities to contribute to positive health outcomes at the institutional, program, and community level. Examples of this are adding loans, adding life insurance to loan products, or training more than one person in a household on enterprise development strategies. MED programs may need to take into account the stage of the disease in target communities as they consider which elements of an HIV & AIDS response to embrace.
6. **Build capacity through effective technical and institutional partnerships for integrated programming.**
 - Ensure that the design and implementation team includes and empowers both public health and MED experts.
 - Embrace and build capacity for partnerships among specialist departments and organizations.
 - Require a strong project plan, clear terms of reference and deliverables, consequences for non-compliance, and clear funding allocations for partnerships.
 - Identify processes for dispute resolution.
7. **Develop demand-driven, market-based interventions for sustainability and scalability**
 - Build on existing skills, capacities, and markets.
 - Respond to client demand for services and help clients respond to viable market opportunities.
 - Define and plan for sustainability appropriately for the program context.
 - Envision and plan for scale-up; design pilot initiatives in the context of the scale of the epidemic in the target area.
 - Minimize the cost per participant by calculating and comparing costs for various outcomes and impact.
 - Maximize the outcomes.

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- Envision the future and plan an effective exit strategy; the exit strategy should be part of the entry strategy into the community.

8. Identify common, robust indicators to effectively track performance and outcomes, and invest sufficiently in monitoring and evaluation.

Integrated programs with integrated goals should have log frames that reflect program integration. They should have objectives that reflect both public health and enterprise development goals, and these should rely on best practice in each field. This means that the effort to develop and track indicators may be as much as double that of a single-sector program. Thus, the budget for monitoring and evaluation needs to be greater than in a single sector program.

9. Apply good practice principles from MED and HIV & AIDS (or other relevant sectors) to integrated programming.

Microfinance and enterprise development have different core principles, presented separately in the boxes below. These are followed by core principles for HIV & AIDS programming, as articulated in the International AIDS Alliance “Code of Practice.”¹⁹ It is important that both technical areas respect one another’s programming principles as they consider how best to address field needs.

Key Principles of Microfinance

CGAP is a consortium of 33 public and private development agencies working together to expand access to financial services for the poor, referred to as microfinance. These key principles* were developed and endorsed by CGAP and its members, and further endorsed by the Group of Eight leaders at the G8 Summit on June 10, 2004.

1. Poor people need a variety of financial services, not just loans.
2. Microfinance is a powerful tool to fight poverty.
3. Microfinance means building financial systems that serve the poor.
4. Microfinance can pay for itself and must do so if it is to reach very large numbers of poor people.
5. Microfinance is about building permanent local financial institutions.
6. Microcredit is not always the answer. Microcredit is not always the best tool for everyone in every situation.
7. Interest rate ceilings hurt poor people by making it harder for them to get credit.
8. The role of government is to enable financial services, not to provide them directly.
9. Donor funds should complement private capital, not compete within it.
10. The key bottleneck is the shortage of strong institutions and managers.
11. Microfinance works best when it measures—and discloses—its performance.

* CGAP (Consultative Group to Assist the Poor), “Key Principles of Microfinance” (Washington, DC: CGAP, 2004).

¹⁹ NGO HIV/AIDS Code of Practice Project, “Renewing Our Voice: Code of Conduct for NGOs Responding to HIV/AIDS,” (Geneva: NGO HIV/AIDS Code of Practice Project, 2004), <http://www.ifrc.org/Docs/pubs/health/hiv aids/NGOCode.pdf?health/hiv aids/NGOCode.pdf>.

Key Principles of Enterprise Development

The following principles, put forward by several reputable experts in the field, are based on earlier standards developed by the Donor Committee on Enterprise Development, but they have not been vetted by a wide group of practitioners and do not represent agreed-upon industry standards.*

The three components of enterprise development have slightly different principles, as follows:

- Market (re)entry helps the destitute and very poor transition back into market participation. It may involve subsidies that are counter to approaches used, once microenterprises are up and running. Thus, Principles 1–3 below apply, but principles 4–5 may not.
 - Commercial business services—all principles apply
 - Value Chain development—all principles apply
1. **Impact:** Aim for measurable, significant poverty eradication.
 2. **Demand:** Tailor program strategies to specific, demand-driven opportunities and problems.
 - Tailoring means customizing services to the specific type and conditions of target enterprises, needs of the client, and pressures of the market.
 - Demand-driven means that there is financial pressure on the provider to give good service, either because the enterprises are paying for the service or because the provider is running a business that depends on positive engagement with enterprise owners. For example, a vegetable wholesaler may need to ensure that crops are of the right variety, and so might supply farmers with appropriate seeds and some advice or input on growing. The wholesaler has more financial motivation to provide good seeds and advice than a community group or NGO that is providing free seeds and advice.
 3. **Sustainability:** Support sustainable business models for the delivery of enterprise development services and market linkages.
 - Sustainability refers to the continual generation of benefits to small enterprises, and to continuously reaching increasing numbers of small enterprises through financially sustainable delivery mechanisms, institutions, and markets.
 - Generally, business services should ultimately be delivered by private firms (or viable social enterprises — rather than by NGOs or government).
 4. **Market development:** Develop competitive, vibrant markets.
 - Help small enterprises reach more stable, higher-volume, or higher-value markets by strengthening the market systems that engage small enterprises.
 - Develop a market for business services and other support products. Rather than supporting one business or social enterprise that supports small enterprises, or linking small enterprises with one big customer, it is important to develop multiple businesses or social enterprises and multiple market linkages.
 5. **Replication and resiliency—or market up-take:** In more advanced market development, increase expansion and sustainability by building market facilitation capacity. Establish trade associations and professional training institutions for trainers and technicians; support consulting services that create market linkages; develop market leadership; and seek other sustainable ways for the market to continue to grow and expand after the program ends.

* Committee of Donor Agencies on Small Enterprise Development, “Business Development Services for Small Enterprises: Guiding Principles for Donor Intervention (Washington, DC: Committee of Donor Agencies on Small Enterprise Development, 2001); M. McVay, A. Snelgrove, and L. Jones, “Program Design Toolkit,” Toolkit # 3, in *Information to Action: A Value Chain Toolkit Series for Practitioners* (Waterloo, Canada: Mennonite Economic Development Associates—MEDA, 2007); A.O. Mielhbradt and Mary McVay, *Implementing Sustainable Private Sector Development: Striving for Tangible Results for the Poor*, Annual Seminar Reader (Geneva: International Labor Organization, 2006); *ibid.*, *From BDS to Making Markets Work for the Poor*, Annual Seminar Reader (Geneva: International Labor Organization, 2005).

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Core Principles for HIV & AIDS Programming

“Code of Practice for NGOs Responding to HIV/AIDS” (International HIV and AIDS Alliance) *

Drawing on 20 years of knowledge and experience, the Code sets out key principles, practice and evidence required for successful responses to HIV. When it was published in 2004, 160 NGOs signed on. As of December, 2007, a process was launched for additional NGOs to publicly sign on. Signatory NGOs are provided with a Code logo and may use the tagline “We endorse the Code of Good Practice for NGOs Responding to HIV/AIDS” in printed materials and on their websites. To find out more about signing on to the code, see www.hivcode.org.

▪ **Guiding Principles**

- “We advocate for the meaningful involvement of people living with HIV and AIDS- (PLHA) affected communities in all aspects of the HIV and AIDS response.”
- “We protect and promote human rights in our work.”
- “We apply public health principles within our work.”
- “We address the causes of vulnerability to HIV infection and the impacts of HIV/AIDS.”

“Our programs are informed by evidence in order to respond to the needs of those most vulnerable to HIV and AIDS and its consequences.”

The code continues on to address the following program components:

- **Organizational principles** which suggest involving PLHA in programming decisions, ensuring non-discrimination, engaging in multi-sectoral partnership, and elements of good governance and operations. The principles endorse rigorous research, planning, monitoring and evaluation. They support advocacy for a position enabling environment, and strategies for scaling up.
- **Programming principles** include HIV prevention; voluntary testing and counseling; treatment, care, and support; and address stigma and discrimination. *The SEEP Guidelines* endorse mainstreaming HIV and AIDS programming into other development programs and engaging in multi-sector initiatives.
- **Three cross-cutting principles**
 - “Our HIV & AIDS programmes are integrated to reach and meet the diverse needs of PLHA and affected communities.”
 - “Our HIV & AIDS programmes raise awareness and build the capacity of communities to respond to HIV/AIDS.”
 - “We advocate for an enabling environment that protects and promotes the rights of PLHA and affected communities and supports effective HIV and AIDS programmes.”

* NGO HIV/AIDS Code of Practice Project, “Renewing Our Voice: Code of Conduct for NGOs Responding to HIV/AIDS,” (Geneva: NGO HIV/AIDS Code of Practice Project, 2004)

1.4.2 Structural (Institutional) Challenges and Strategies for Cross-Sector Collaboration

A second challenge to effective collaboration is institutional barriers. Currently, donor funding, most research and communities of practice, implementing agencies, and program targets are all structured according to technical areas—health on one hand and MED on the other. Public health professionals and MED specialists have little financial or professional incentive to work together because their funding, targets, and career paths are oriented toward sector goals. Specific structural changes are needed for collaboration to work effectively²⁰:

- Adoption of broader goals—and indicators—that provide stronger incentives for joint programming

²⁰ These recommendations emerged substantively from several presentations and discussions on cross-sector collaboration at The SEEP Network’s 2006 and 2007 annual conferences. For presentations, go to <http://www.seepnetwork.org>, click on publications, and search for HIV.

- Funding streams with joint goals that require collaboration
- Incentives for institutional collaboration built into programs at all relevant levels
- Adoption of effective institutional models for implementation
- Support for on-going research, active communities of practice, and leadership opportunities for professionals who advance practice in integrated programming

Commitment to Integrated Programming comes first

An important prerequisite to effective cross-sector collaboration is commitment to the endeavor. Readers can help bring reluctant colleagues on board by sharing and referring to materials in *The SEEP Guidelines*.

It will take a coordinated effort of funders, strategic planners, experts, and practitioners to make these kinds of structural changes. They are discussed in more detail below.

Adopting broader goals that provide stronger incentives for joint programming. The primary incentives for good program performance are currently sector specific, which leaves little incentive for integrated programming. These are examples of typical program targets:

- The main indicators for the “Global Fund to Fight AIDS, Tuberculosis (TB), and Malaria” are the number of people with access to treatment (antiretroviral therapy), TB therapy, and insecticide-treated mosquito nets.²¹
- The goals of the President’s Emergency Plan for AIDS Relief (PEPFAR) are to provide treatment to 2 million people, prevent 7 million new infections, and to provide care to 10 million people infected and affected by HIV & AIDS, including orphans and vulnerable children.
- The microfinance community has historically focused on a target of helping people access credit and other financial services.
- Agricultural or other value-chain development programs typically focus on output targets, such as increasing maize production or horticultural exports, or on the number of farmers linked to services or markets.²² These targets lead programs to focus on better-off, larger, more productive farmers.

PEPFAR is being considered for re-authorization by the US Congress this year. Organizations lobbying for or discussing re-authorization and changes to PEPFAR include:

- PEPFAR Watch: www.pepfarwatch.org
- RESULTS International: www.results.org
- The Kaiser Foundation: www.kaisernetwork.org
- Center for Strategic and International Studies: www.csis.org/hivaids/prevention

Technical fields need specific indicators to drive good practices, but the attention paid to specific, sector outcomes undermines broader goals of joint programming. A focus on broader, common outcomes may help address this challenge. For example, recently, the MicroCredit Summit Campaign has added a poverty targeting focus and an impact goal:

Working to ensure that 175 million of the world’s poorest families, especially the women of those families, are receiving credit for self-employment and other financial and business services by the

²¹ Global Fund website, “How the Global Fund Works,” <http://www.theglobalfund.org/en/about/how/>.

²² Miehlabradt and McVay, 2006.

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end of 2015. Working to ensure that 100 million families rise above the US\$1 a day threshold adjusted for purchasing power parity (PPP), between 1990 and 2015.²³

With a focus on this broader poverty eradication goal, it becomes more apparent that other aspects of clients' lives—specifically good health—can support their ability to work their way out of poverty. MFIs are also currently developing social performance indicators that will better express and benchmark MFIs' social goals. There is an opportunity to incorporate HIV & AIDS indicators into an industry standard. To get involved, contact The SEEP Network Social Performance Working Group.

In the arena of integrated HIV & AIDS and MED programming, donors and strategic implementing agencies might consider adopting joint program goals that express the need for progress in both arenas—for example, enhancing health, economic security and community safety nets in HIV & AIDS impacted communities.

Add a comment. Do you have a joint goal statement you'd like to share?

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Finding funding streams with joint goals that require collaboration. Fundamentally, funding for integrated programming has to incorporate integrated goals that require collaboration. These funding streams can emerge from several sources:

- Allocate more significant portions of HIV & AIDS funding toward integrated programming, and either increase the allocation of funds or raise its profile from a sub-portion of care and support to a more mainstream part of programming.
- Allocate MED funding toward integrated programming.
- Allocate special funds for integrated programming, so that each group does not feel threatened that their funding is being eroded.
- Bring existing pools of funds into the mainstream:
 - Require that HIV & AIDS programs address economic and livelihood factors in their plans for prevention, treatment, care, and support.
 - Require that MED programs address HIV & AIDS in their programming to mitigate risk and to positively contribute to prevention, treatment, care, and support.

Changing funding streams requires advocacy. For example, RESULTS, the advocacy group that hosts the MicroCredit Summit Campaign, launched an initiative to require that a specific percentage of USAID-microenterprise development funding be allocated to communities significantly impacted by HIV & AIDS.²⁴ To get more involved with advocacy around funding streams, see *Book 3 for Policy Makers: Donors, Strategic Planners and Advocates*.

Building incentives for institutional collaboration into programs at all relevant levels.

Currently, there are disincentives for integrated or collaborative programming at all program levels. The following table illustrates some of these disincentives and suggests positive incentives that could support integrated programming at that level. This kind of professional and institutional incentive is essential to support positive intentions of funders and practitioners to implement integrated programming.

²³ Microcredit Summit Campaign website (homepage), <http://www.microcreditsummit.org>.

²⁴ For more information or to support this effort, see www.results.org

Disincentives and Incentives for Integrated Programming

Level	Disincentive	Incentive	Who puts the incentive in place?
Donor	<ul style="list-style-type: none"> • Specific sector goals and targets • Sectoral institutional departments • Sectoral budgets • Sectoral promotion paths 	<ul style="list-style-type: none"> • Broader goals and targets • Budget allocations for integrated programming • Task forces for integrated programming • Recognition and leadership opportunities for professionals focused on integrated programming 	Donor strategists, leaders, legislation (advocates could suggest alternatives)
Umbrella public health-implementing agency and/or broad community development NGOs, child-focused charity organizations	<ul style="list-style-type: none"> • Sectoral external funding streams • Specific sector goals and targets • Sectoral institutional departments • Sectoral budgets • Sectoral promotion paths 	<ul style="list-style-type: none"> • Funding streams for integrated programming • Broader goals and targets • Budget allocations for integrated programming • Task forces for integrated programming • Recognition and leadership opportunities for professionals focused on integrated programming 	<ul style="list-style-type: none"> • Donors • Leaders and strategists in umbrella public health implementing agencies • Leaders in research and communities of practice, and advocates can influence
MFIs and other social enterprises	<ul style="list-style-type: none"> • Sectoral funding streams • Investment funding with expectation for return on investment • Institutional sustainability and profit goals • Specific sector goals and targets • No or low professional capacity for addressing social issues • No staff incentives or professional recognition around social issues • No or low understanding for how to conduct outreach among HIV & AIDS-impacted individuals and communities 	<ul style="list-style-type: none"> • Integrated funding streams—separate from investment funds • Incorporating HIV & AIDS goals into social performance indicators • Forming partnerships with public health practitioners • Forming task forces or departments to address social performance; developing and implementing incentives around social performance. • Work with NGOs and CBOs that target HIV & AIDS-impacted communities to market opportunities to participate; build NGO and CBO capacity to screen and prepare clients for program participation. 	<ul style="list-style-type: none"> • Donors and funders • Industry leaders, acting through, e.g., The SEEP Network and CGAP • MFI leaders
Enterprise development programs	<ul style="list-style-type: none"> • Sectoral funding streams • Specific sector goals and targets, especially around 	<ul style="list-style-type: none"> • Funding streams for integrated programming • Broader goals and targets • Budget allocations for integrated programming 	<ul style="list-style-type: none"> • Donors • Market development program leaders • Leaders in

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	<p>outputs, sustainability, linking to high value markets</p> <ul style="list-style-type: none"> • No or low professional capacity for addressing social issues • Lack of expertise and on-the-ground presence to reach out to HIV & AIDS-impacted individuals and families • No incentives or career path for addressing social issues 	<ul style="list-style-type: none"> • Task forces for integrated programming • Recognition and leadership opportunities for professionals focused on social issues or integrated programming • Work with NGOs and CBOs that target HIV & AIDS-impacted communities to market opportunities to participate; build NGO and CBO capacity to screen and prepare clients for program participation. 	<p>research and communities of practice, and advocates can influence</p>
<p>Community-based organizations working with HIV & AIDS-impacted communities</p>	<ul style="list-style-type: none"> • Sectoral funding streams • No or low professional capacity in MED • No MED program operating in their geographic area that is willing to work with their target clients 	<ul style="list-style-type: none"> • Funding for integrated programming • Capacity building initiatives for CBOs for appropriate, targeted MED strategies • Strategic planning among larger organizations and programs to better coordinate initiatives • Referring clients to existing MED programs, when they overlap geographically and in terms of target population; working to understand requirements and prepare clients for entry 	<ul style="list-style-type: none"> • Donors • Donors, umbrella NGOs, and MED strategic planners • CBOs

Adopting effective institutional models for implementation. To move forward on a large scale, funders and practitioners need examples and proven models. There are several emerging models for “strategic alliances” among MED programs and other development initiatives.²⁵ These strategic alliances are relevant for HIV & AIDS and for other sector collaborations:

- *Parallel programming*—When two programs operate in the same geographic area and target the same clients, but operate entirely autonomously. Coordination can occur at the strategic planning level when funds are allocated and institutional plans are made to target the geographic area. Parallel programming can evolve when leaders meet regularly, educate each others’ staff about their programs, share outreach information with clients, and/or monitor the extent to which clients are accessing both services. Generally in such an arrangement, each organization has its own funding, but one organization could also contract or fund the other.

²⁵ M. Sievers and P. Vandenberg, “Synergies through Linkages: Who Benefits from Linking Finance and BDS?” *World Development* 35, no. 8 (2007): 1341–58. L. Diaz Villeda and J. Hansel, “The Missing Link in the Value Chain: Financing for Rural Farmers and Microentrepreneurs,” Concept Note (Washington, DC: SEEP Network for USAID, 2005).

- *Partnerships*—When two programs offer their clients each other’s services through one door. These are examples of possible effective partnerships:
 - An MFI invites a public health program to conduct HIV & AIDS awareness and prevention workshops for staff and members and/or offers onsite voluntary counseling and testing (VCT) services.
 - An MFI markets its services through public health organizations.
 - A public health organization contracts experts in accumulated savings and credit associations to facilitate the formation of accumulated savings and credit associations (ASCAs) among its target population.
 - In these partnerships, different funding arrangements apply. Each program funds its own costs or perhaps one program contracts or funds the other, with either taking the lead role.
- *Fully integrated programming*—When one organization hires technical experts from both disciplines and operates an integrated initiative:
 - A public health organization hires an MED expert to run a market development initiative in a target community that is at risk or already impacted by HIV & AIDS.
 - A multi-sector NGO creates an integrated program with experts from both professional disciplines.
 - An MFI hires a public health expert to manage its HIV & AIDS-mitigation strategy.

Who should be bankers?

The MFI industry recommends that MFIs stand alone as financially autonomous and sustainable institutions. Savings and lending activities should not be conducted by NGOs or governments. They should only be conducted by:

- 1) community groups trained in an appropriate methodology for operating an accumulated savings and credit group, or
- 2) an autonomous MFI.

Support on-going research, active communities of practice, and leadership opportunities for professionals who advance practice in integrated programming. At a 2006 global industry conference on market development, a prestigious technical leader in the field gave a plenary presentation on the importance of economic strengthening for people impacted by HIV & AIDS. She received a standing ovation, but when it came time for small groups to form around topics for follow-up, her table was empty. The professionals all flocked to other topics that were thought to be more critical to the industry—and better funded. This pattern is repeated in other venues where the interest in integrated programming is high, but secondary.

[Propose a discussion on this topic!](#)
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For integrated programming to become a first priority for more professionals there needs to be support for ongoing research, active communities of practice, and leadership opportunities for professionals who advance practice in integrated programming. Look into these examples of momentum building in this area of practice:

- *The SEEP Guidelines* and The SEEP Network online community of practice (<http://communities.seepnetwork.org/hamed>)

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- The SEEP Network’s practitioner learning program: Building Alliances to Serve HIV/AIDS Impacted Communities in Sub-Saharan Africa (BASICS)
(<http://communities.seepnetwork.org/edexchange/node/222>)
- The USAID-funded “Economic Strengthening for Children Affected by HIV/AIDS: Principles of Program Design and Technical Recommendations for Effective Field Interventions,” http://www.microlinks.org/ev_en.php?ID=21730_201&ID2=DO_TOPIC
- The series of technical notes from USAID on MED and HIV/AIDS,
http://www.microlinks.org/ev_en.php?ID=12666_201&ID2=DO_TOPIC
- The AIDS 2008 Conference has as one of its key objectives to “increase understanding of the contribution made by the HIV global response to broader social, economic, and health issues.” A core theme is to “respect and promotion of human rights and gender equality as a framework for all aspects of the response.”²⁶ UNAIDS further prioritized economic empowerment as a key issue in addressing gender equality.²⁷ There is a track at the 2008 conference on social, behavioral, and economic issues where further dialogue can take place.
- The global dialogue is advancing, but more investment is needed to advance knowledge, practice, and support of professionals dedicated to integrated programming.

1.4.3 Technical Challenges and Strategies for Cross-Sector Collaboration

A third barrier to cross-sector collaboration is the technical challenges to integrated programming. This section addresses several common and central issues and offers suggested strategies for overcoming these particular challenges:

- Different targeting strategies
- Different terminology
- Risk to MFI, social enterprise, or market development performance
- Need for focus and technical specialization to achieve good practices and results
- Small scale of market development and other—non MFI—MED initiatives

Have another technical challenge not listed here? Let’s talk about it!
[Use our on-line discussion page!](#)

Different targeting strategies. Public health programs target clients primarily according to their demographic and HIV status. They target people at all levels of “health impact”: from healthy and non-infected to the severely ill and dying. They form groups based on common psychosocial and health goals and personal trust. MED programs target clients based on economic status and form groups based on common business interests and financial trust. They target people at different levels of economic security: from stable to destitute. There is overlap in who these programs can serve. The challenge is to merge targeting strategies in order to supply appropriate public health and microenterprise development services.

²⁶ AIDS 2008, 17th Annual AIDS Conference website, “2008 Vision and Objectives,” <http://www.aids2008.org/mainpage.aspx?pageId=3>. Accessed May 2, 2008.

²⁷ www.unaids.org

The following are effective targeting strategies for integrated programming:

- *Public health programs* can target a specific population of affected people and work with MED experts to identify appropriate strategies for the target population(s). Many organizations may work with people with common economic status and challenges. For example, organizations may target marginalized transactional sex workers to help them transition to economic activities with lower risk for spreading HIV. These women probably have common livelihood security capacities and challenges. A public health and MED program could work together to design a set of services, to be delivered by CBOs, and establish linkages to larger MED programs that would be effective for this group. However, organizations working with a more diverse population—such as PLWHA who are productive, PLWHA who are very sick, families hosting orphans, child-headed households—will have to assess the economic status of their client base, categorize them in terms of their economic status, and customize different MED strategies for these different populations. See Book 2, section 2.3, What Kind of MED Strategies Work for HIV & AIDS-Impacted Communities, for an elaboration of how to design and deliver a range of effective services to diverse populations.
- *MED programs hoping to address HIV & AIDS* can work with public health professionals to assess the demographics and health situation of target clients. Appropriate strategies can be devised for each situation and for different populations. There is not a “one message for all” education strategy for HIV & AIDS.
- *Professionals designing integrated programs* can work with experts from both professions to identify and support a range of MED and public health solutions for targeted geographic areas. Microfinance, credit, training, or group organizations working in isolation are rarely sufficient to support economic security. See Book 2, section 2.3, What Kind of MED Strategies Work for HIV & AIDS-Impacted Communities, for a framework list of options.

The recommendation is to customize public health and MED programs to the health and economic-security needs of specific populations, which may require supporting a range of solutions. This kind of demand-driven response is clearly more expensive and complex to implement, but the vision is for more effective and sustainable results.

Different terminology. Is MED short for “medical” or does it stand for “microenterprise development”? Does “risk” mean risk of infection or does it mean risk of borrowers not paying

Targeting Strategies to Avoid

Sometimes, public health programs assume that all their clients need one service: savings, microfinance, or group-run enterprises, for example. This may be true, but the economic status of clients needs to be assessed to be sure.

Sometimes, microfinance or MED programs assume that clients need basic education about HIV and AIDS. In fact, they may be well informed, but directly need access to public health services.

Heightened awareness without access to services can simply lead to discrimination.

One social enterprise manager in East Africa, not having thought much about HIV and AIDS, assumed the prevalence rate in his target area was 7%, which was the national average. Upon further research, it turned out that the prevalence rate was 25% in his target area—one in four people was infected. The farmers’ groups he works with are deeply affected and concerned, but they didn’t bring the issue up for fear that the program would close and move to another community.

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back their loans? What is a value chain? Is it similar to a “cold chain” for vaccines? What is IGA—is it a group or individual activity?

It is challenging to move forward as a community of practice when we are constantly talking across one another. The solution is translation. *The SEEP Guidelines* contain a Glossary of Microenterprise Development Terms ([Annex B](#)), as well as HIV & AIDS Terms and Acronyms ([Annex A](#)). We hope that, over time, this will facilitate communication among technical specialists.

Risk to MED program performance. MFIs, social enterprises, and enterprise development programs have financial and output goals that need to be satisfied for their own sustainability and their donor requirements. Having a high proportion of clients impacted by HIV & AIDS can be a risk factor for achieving these goals. Unfortunately, some programs have dealt with this risk by discriminating against HIV-positive clients or communities or by ignoring the issue, assuming that not many clients are impacted because the programs have not reached out to these clients. These are negative risk-mitigation strategies.

In the first situation, discrimination (which includes turning a blind eye to client or market-level discrimination) is morally abhorrent and/or against agency policy: in many countries, it is illegal. In the second situation, programs ignore HIV & AIDS—particularly in Africa and other high prevalence areas—at their peril. HIV is a disease that carries stigma; communities and staff will often not raise it as an issue of concern for fear that the organization or program will discriminate against them. Leaders need to be pro-active in assessing the risks of HIV & AIDS to the program, staff, and target communities, and in supporting risk mitigation efforts. For details on how to adapt MFI and MED programs to manage risk and pro-actively contribute to HIV & AIDS prevention, treatment, care, and support, Book 2, see section 2.3, What Kind of MED Strategies Work for HIV & AIDS-Impacted Communities.

Striving for scale and significant impact. Both MED and public health practitioners are striving for significant outreach and impact. The challenge of HIV & AIDS is staggering, especially in sub-Saharan Africa where the majority of the world’s cases exist. The challenge of poverty is also overwhelming, especially in Africa. While leaders strive for sustainable, large-scale initiatives that have a significant impact, practitioners also call for community ownership and engagement and observe many small-scale, community-level programs—some are innovative, some have very poor practices, and many lie in between. What, exactly, is the appropriate scale for programs and the appropriate role for community ownership in these programs? First, innovations and pilot programming are an appropriate part of the life cycle for good practice. It is important now to capture lessons from innovative, on-the-ground practitioners and to support these approaches, however small-scale. As effective and high-impact innovations are identified and documented, attention can then be paid to how to scale them up. See Promising Practices at <http://communities.seepnetwork.org/hamed/node/29>.

Second, it is important that strategies for scaling up include how to engage community groups on a large scale. Community ownership is critical to sustainability, to leveraging local resources, and to ensuring relevance. Community ownership and scale are not mutually exclusive. For example, ASCAs are an example of a model for a community-owned bank that can be stimulated

on a widespread basis. The SEEP Network is currently supporting a practitioner learning program for MED practitioners operating large-scale programs on how to engage with CBOs who work with HIV & AIDS-impacted communities.²⁸

Third, the concepts of significant scale and impact need to incorporate the concept of sustainability. It is through sustainability that outreach and impact increase over time without further external resources. MED is a critical part of helping communities and local economies support their own, sustainable strategies for coping with HIV & AIDS.

Need for focus and technical specialization to achieve good practices and results. Both sets of professionals become nervous with the idea that unqualified organizations or staff might assume their roles. Although there is some territorialism involved, this response mostly comes from concern that poor quality programming will undermine success.²⁹ For example, one MFI offered HIV & AIDS-awareness and -education workshops to its clients, with the result that many HIV-positive clients were kicked out of their borrower groups by nervous clients. The poor quality of this program caused more problems than it solved.

Public health professionals often lament that MFIs charge high interest rates for loans to their target clients, while MFIs complain about health programs that offer clients grants or low-interest loans. Subsidized or below-market interest rates for credit distort the market for professional lending. This makes it more difficult and expensive for MFIs to successfully operate and serve large numbers of people. Enterprise development specialists criticize health programs for helping people launch microenterprises for group-run enterprises that have no market demand or are managed by groups that quickly disintegrate due to poor management.

The strategy to address this challenge is for integrated programs to engage quality experts from both fields of practice in the entire program cycle, at the levels of:

- funding,
- program design,
- program implementation,
- quality control, and
- monitoring and evaluation.

And, it means that guidance for good practices in integrated programming should be developed jointly by experts in both disciplines.

1.4.4 Necessary Expertise for Integrated Programming

Yet another challenge to integrated programming is the need for qualified technical experts from both disciplines—public health and MED. Effective integrated programming engages both

²⁸ The Enterprise Development Exchange, website, “Building Alliances to Serve HIV/AIDS Impacted Communities in Sub-Saharan Africa (BASICS),” <http://communities.seepnetwork.org/edexchange/node/222>.

²⁹ This is a reflection heard in a number of sessions and discussions at The SEEP Network’s 2006 and 2007 annual conferences.

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public health and MED technical experts at all stages of the program, from funder to field staff. Different kinds of experts are useful at different program stages and for different programming strategies. The table here lays out the kinds of technical expertise needed for different program stages and strategies.

Technical Expertise Required for Program Stages and Strategies

Program stage	MED expertise	Public health expertise	Other
Design of funding mechanism	Broad MED and/or livelihood security expertise, or a combination of different MED specialists, such as microfinance, market development, agricultural development, workforce or vocational training, and/or livelihood security	Broad experience working with AIDS-support organizations; prevention, care, support, and treatment programs; knowledge of ministry of health protocols and priorities in host country	Partnership expertise to establish the parameters for ensuring strong partnering among implementing agencies
Program design	Broad MED expertise or a combination of specialists	Broad experience in comprehensive AIDS responses and field work, and understanding of local context, ministry of health priorities, and cultural barriers	Partnership experts to help negotiate each partner's responsibility, authority, and allocated resources for implementation
Strategic implementation (i.e., consulting companies, international NGOs, and national NGOs)	Specialists in the specific MED strategy(s) selected for the program	Knowledge of and experience with comprehensive AIDS responses (MPH** preferred), knowledge of ministry of health protocols and priorities in host country	Monitoring and evaluation specialists to help the team remain focused on joint outcomes and to track success toward program indicators
On-the-ground implementation (i.e., implementing partners, sub-grantees and CBOs)	Expertise tailored to the specific role each implementing partner will play	Understanding of socio-cultural context and barriers to change; knowledge of local service provision and ministry of health guidelines; awareness of ASOs	Involvement of local leadership representing the community, government, and civil society agencies
<p>* The field of market development is broad, encompassing people experiences in different areas, such as value chain development, market linkages, business or enterprise development, business development services, etc.</p> <p>** Master of public health degree</p>			

Qualifications of good practice MED experts—program design and strategic planning level. It is important when designing and planning **microenterprise development initiatives** to engage MED experts of sufficient caliber with certain qualifications:

- Relevant university degree
- 5–10 years of experience in enterprise development, microfinance, agricultural market development, or livelihood security work
- Experience in developing sustainable, large-scale initiatives

- Professional development (certificate course) or the equivalent at a recognized international institute for microenterprise development, including:
 - Boulder Institute of Microfinance, <http://www.bouldermicrofinance.org>
 - CGAP Skills for Microfinance Managers Training Program, <http://www.cgap.org/projects/SMM.html>
 - Microfin training, <http://www.microfin.com/>
 - Springfield Centre for Business Development, <http://www.springfieldcentre.com/index.php>
 - Action for Enterprise, <http://www.actionforenterprise.org/>
 - Southern New Hampshire University’s Microenterprise Development Institute, <http://www.snhu.edu/746.asp>
 - The International Training Center, International Labor Organization, <http://www.itcilo.org/en>
 - Hans Posthumus Consultancy, <http://www.hposthumus.nl/>
 - The SEEP Network, <http://www.seepnetwork.org/>
- Demonstrated knowledge of key industry terms and principles (can be ascertained by asking broad interview questions about how they would approach this work, and by comparing the response to the principles and strategies in *The SEEP Guidelines*)
- Openness to adapting good practice approaches to the HIV & AIDS context and a dedication to supporting communities impacted by HIV & AIDS

Please note that these qualifications are not necessary for field-level implementation.

Qualifications of good practice public health experts—program design and strategic planning level. It is important when designing and planning **public health initiatives** to engage public health experts of sufficient caliber, with certain qualifications:

- Advanced degree—master’s in public health—or 10-plus years of experience in AIDS and/or international health
- Five years successful experience in AIDS programming, program design, and community-based program implementation
- Relevant experience in health education, clinic-based HIV & AIDS-service provision and management, community health, behavior-change communication, community mobilization, psychosocial support, nursing, nutrition
- Openness to adapting good practice approaches for livelihood security and economic development

Please note that these qualifications are not necessary for field-level implementation staff.

Cambridge University offers a certificate in cross-sector partnership; for more information, see its web site:

http://www.cpi.cam.ac.uk/programmes/partnerships%2C_ethics_governance/pccp/about_the_programme.aspx. Also see [Annex C](#), Frequently Asked Questions.

1.5 WHERE CAN I FIND TECHNICAL RESOURCES FOR INTEGRATED PROGRAMMING?

For healthy collaboration, it is important for each sector to understand one another's operational realities and programming potential while seeing the desired outcomes for each sector. The following sets of key resources for each sector can help you find and keep up to date with information, tools, and technical experts. We present the following groups of resources:

1.5.1 Microenterprise Development

MicroLINKS, <http://www.microlinks.org>

A USAID-hosted site containing tools, research, on-line discussions, and more.

Donor Committee for Enterprise Development, <http://www.sedonors.org>

A good place to keep up with donor dialogue and policies and to get a list of official donor contact information for donors that fund microenterprise development.

The SEEP Network, <http://www.seepnetwork.org>

Connects microenterprise practitioners in a global learning community. It contains a wealth of learning documents and announcements about learning events and grants. SEEP is a membership organization. The home site contains a practitioner directory of microenterprise development practitioners around the globe.

We welcome your suggestions for additional key resources.
[Use our on-line discussion page!](#)

1.5.2 Microfinance

Microfinance Gateway, <http://www.microfinancegateway.org>

A comprehensive online resource for the global microfinance community. It includes research and publications, featured articles, organization and consultant profiles, and the latest news, events, and job opportunities in microfinance

The MicroInsurance Center, LLC, <http://www.microinsurancecentre.org>

Works with insurers and delivery channels to develop partnerships that help low-income people around the world gaining access to quality microinsurance products, since its inception in 2002.

Consultative Group to Assist the Poor (CGAP) <http://www.cgap.org>

A global center for donor support and dialogue around microfinance. The site contains a wealth of research, guidelines, funding information, and donor policies.

1.5.3 Enterprise Development

Enterprise Development Exchange, <http://edexchange.seepnetwork.org>

This SEEP Network site links communities of practice to advance sustainable poverty eradication. It contains a carefully selected set of key resources—tools, promising practices, training events—on enterprise development, value chain development, social enterprise, and urban development. It hosts online discussion and lists a wide range of technical experts, training events, and potential practitioner partners.

BDS Knowledge, <http://www.bdsknowledge.org>

An online library containing a wide range of publications and program documents. For an overview, see the “ILO Seminar Readers,” for example, the “Eighth Annual Seminar on Developing Service Markets and Value Chains,”

<http://www.bdsknowledge.org/dyn/bds/docs/detail/587/6>

1.5.4 HIV & AIDS

UNAIDS, *2007 AIDS Epidemic Update*,

http://www.unaids.org/en/HIV_data/2007EpiUpdate/default.asp

An annual update produced each year in December to report the latest developments in the global AIDS epidemic. The 2007 edition provides the most recent estimates of the AIDS epidemic and explores new findings and trends in the epidemic’s evolution.

AVERT.Org, <http://www.avert.org>

An international HIV & AIDS charity based in the U.K., working to avert HIV & AIDS worldwide. This site provides basic information and statistics, and it offers tools and useful resources in a user-friendly format.

The International Alliance for HIV/AIDS, <http://www.aidsalliance.org/>

Its publications webpage brings together a number of resources—into one searchable area—such as training resources and programming tools produced by the Alliance and its partners. The “Useful Links” section of its website has more HIV & AIDS resources and information, <http://www.aidsalliance.org/sw6987.asp>.

Facing AIDS Together, <http://www.wr.org/aids/resources/index.asp>

An AIDS training curriculum for use in community banks, featuring “Credit with Education” methodology, available from Freedom from Hunger

(<http://www.freefromhunger.org>) and World Relief (<http://www.worldrelief.org>).

1.5.5 Integrated Programming

HIV & AIDS and Microenterprise Development website,

<http://communities.seepnetwork.org/hamed/>

This SEEP Network site is the only global platform linking microenterprise development and public health practitioners around the challenge of HIV & AIDS. The site hosts:

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- *The SEEP Network Guidelines for Microenterprise Development in HIV & AIDS-Impacted Communities: Supporting Economic Security and Health*
- "Promising Practices Series" case studies
- A library of resources on integrated programming for microenterprise development in HIV & AIDS impacted communities
- Online discussions
- A community directory of implementing agencies with interest and skills in integrated programming.

Save the Children, http://www.microlinks.org/ev_en.php?ID=21730_201&ID2=DO_TOPIC
"Economic Strengthening for Children Affected by HIV/AIDS: Principles of Program Design and Technical Recommendations for Effective Field Interventions" (AED with field support from USAID, 2008).

F. Fraser, C. Green, and M. Miller, "Microfinance and HIV/AIDS: Tools for Making Institutional Changes in Response to HIV/AIDS—A Four-Part Series,"
http://www.microlinks.org/ev_en.php?ID=6376_201&ID2=DO_TOPIC
(Development Alternatives, Inc., for Accelerated Microenterprise Advancement Project, USAID, 2004).

C. Gatera and C. Gommans, "Report of the Workshop: HIV/AIDS and Microinsurance in the Microfinance Sector in Africa (2005),
<http://www.microinsurancecentre.org/index.cfm?fuseaction=resources.detaildoc&showcontributorID=89>

Partners in Action: Financial Institutions and Health, HIV & AIDS Risk Management (A Microfinance Risk Program), <http://www.microfinancerisk.org>
This website helps financial institutions figure out their exposure to health and HIV & AIDS risks, strategies to manage these risks, and potential partners, and find information, case studies, and other useful resources. See, especially, C. Gommans and D. Liber, "Guidebook—Partners and Action: Financial Institutions and Health and AIDS Risk Management" (2006) <http://www.microfinancerisk.org/pages/Content.asp?SectionID=32>

GTZ (Gesellschaft für Technische Zusammenarbeit), <http://www.gtz.de/en/>
Germany's federal ministry for economic cooperation and development. See especially "HIV/AIDS and Microfinance Systems: Fact Sheet" (Eschborn, Germany: GTZ, 2005), http://www.afronets.kabissa.org/docs/FactSheetAIDS_MFI.pdf

1.6 WHERE CAN I GET FINANCIAL RESOURCES FOR MICROENTERPRISE DEVELOPMENT IN HIV & AIDS-IMPACTED COMMUNITIES?

Where can one get funding for integrated programming, to address HIV & AIDS in a MED program and to conduct MED work in HIV & AIDS-impacted communities? As of this writing (May 2008), funding for integrated microenterprise development and HIV & AIDS work remains a significant challenge. Funding for MED and for HIV & AIDS is often separated into areas of specialization, except in large integrated programs. Even then, there is often a focus on one sector, limiting the ability to do quality work in both areas on a large scale. Health programs funding HIV & AIDS generally allocate minimal resources, if any, to microenterprise development or limit the uses of their funding (as is often the case with PEPFAR funding). The funding available is usually for “livelihood security” or activities that fall under market (re)entry. Microenterprise-development funding programs rarely allocate funding specifically to people and communities impacted by HIV & AIDS.

It is challenging for practitioners to patch together funding from different sources, due to often contradictory objectives and strategies emerging from funders, specifically those who are focused on best practices in their technical areas of practice.

For example, health funders generally require practitioners to target funding to the most vulnerable families, often in specific social categories, whereas MED funders require practitioners to focus on sustainability or economic growth

results (e.g., increased maize production). This pushes MED practitioners to target the more economically viable farms and businesses, and they may look past those people struggling with HIV & AIDS. The main funding for integrated programming currently available is often pilot money for learning initiatives or small grants from private sources.

Are you aware of a source of funding for integrated programming? Please let us know!
[Use our on-line discussion page!](#)

1.6.1 Who Are the Largest Funders of HIV & AIDS Programming?

Global funding for HIV & AIDS is concentrated in a few significant sources. In 2006, the largest funder was the U.S. President’s Emergency Program for AIDS Relief (PEPFAR), which allocated \$1.7 billion to AIDS relief. The second largest was the Global Fund to Fight AIDS, Tuberculosis, and Malaria, with \$1.1 billion (for all 3 diseases). Total private foundation money amounted to \$979 million, 75 percent of which was contributed by the Bill and Melinda Gates Foundation.

Worldwide Spending for HIV & AIDS: 2006 (in US\$)

Total private and foundations	979,000,000
Global Fund	1,100,000,000
PEPFAR	1,717,000,000

Do these large funders support MED?

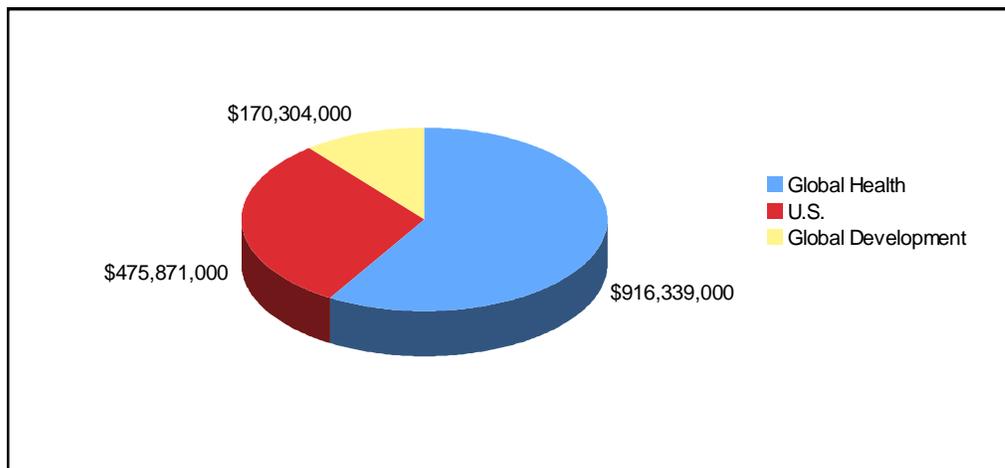
PEPFAR’s strategic objectives focus on prevention of HIV & AIDS, care and

support of people living with AIDS and orphans and vulnerable children, and treatment. MED is mentioned as a fundable strategy under “Gender”—number 5 of 6 activities mentioned. It is

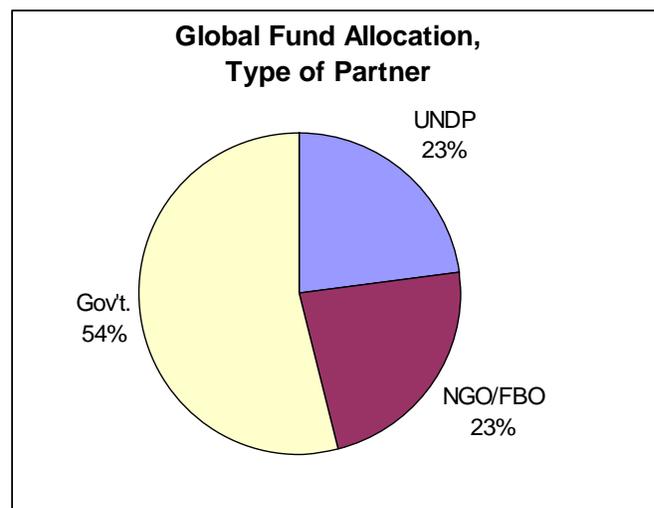
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generally not acknowledged that MED can also contribute to effective prevention and treatment. The Global Fund focuses exclusively on health programming to address the eradication of tuberculosis, malaria, and AIDS. The Bill and Melinda Gates Foundation is a significant global supporter of MED, but to date their global health funds are discrete from global development funds and they pursue best practices in their HIV & AIDS and MED programs separately.

Bill and Melinda Gates Foundation: Grants Paid Summary, 2006



Do these large funders support private volunteer organizations (PVOs) and NGOs? The Global Fund is an international foundation originally established by the UN, leaders of the G8 countries, and leaders of African governments. It is governed by representatives of governments, practitioners, and communities living with AIDS. UNAIDS, World Health Organization, and the World Bank have implemented partnership agreements and are non-voting members of the board. Through 2006, 95 percent of the funding for the Global Fund has come from governments. Funds are allocated through country coordinating mechanisms facilitated by host governments. In 2006, the majority of funding was allocated to government agencies and the United Nations Development Programme (UNDP), with 23 percent going to community or faith-based organizations (FBOs).

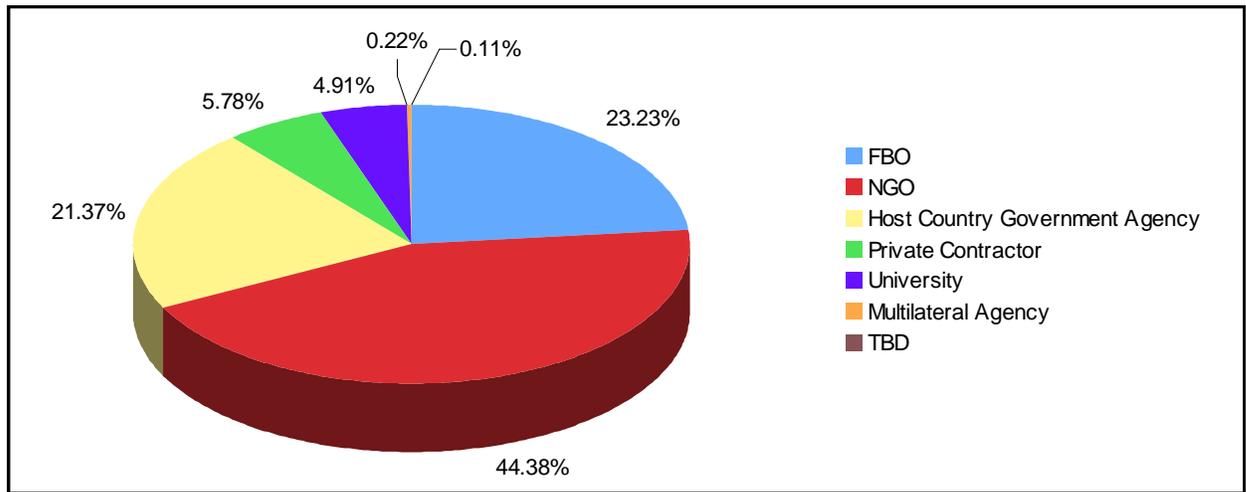


In 2005, PEPFAR allocated over half (57 percent) of its funding to NGOs and FBOs. PEPFAR funding is dispersed centrally, with the majority of grants being distributed by U.S. government country missions in 16 target countries. In these target countries, the funds are implemented through U.S. embassies and USAID, often in conjunction with other health initiatives. Most

PEPFAR funding is channeled through large NGOs, contractors, and research or clinical agencies, many of whom sub-grant or develop agreements with other partners. In many cases, there are tiers of partnerships that funnel financial resources (and in some cases technical assistance) to more community-based organizations. Some SEEP Network members have received PEPFAR grants for care and support programs and are using a small portion of the funds to support innovative pilot programming that integrate MED and HIV & AIDS mitigation strategies.

The Bill and Melinda Gates Foundation supports not-for profit organizations, including MED and health practitioners and universities. The foundation has also contributed to the Global Fund.

PEPFAR Sub-prime Partner Breakdown, 2005



1.6.2 What Are the Opportunities to Influence the Dialogue, Spending, and Strategies of Major Funders in HIV & AIDS and Microenterprise Development?

Practitioners have a voice in many of the key funding agencies. In general, practitioners can raise the issue of integrated programming in online fora, at conferences, and within their own organizations to colleagues and partners. More formally, practitioners can seek opportunities to advise funders. The Global Fund has country coordinating mechanisms in each implementing country, for example. The Global Fund also hosts a partnership forum from time to time, which solicits feedback from practitioners and other leaders. The Global Fund is advised by a technical evaluation reference group, which currently is comprised only of health experts.

PEPFAR is funded by U.S. Congressional mandate. Having been in existence for five years, the program is due for “re-authorization” and is currently under discussion and review in the U.S. Congress (early 2008). Practitioners have an opportunity to influence PEPFAR directions by contacting their representatives or senators or through the Microfinance Coalition, which is the main U.S. advocacy group for international microenterprise development. The RESULTS advocacy organization,³⁰ the host of the Microcredit Summit Campaign, is advocating for

³⁰ <http://www.results.org>

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USAID to target some microenterprise funding towards people and communities impacted by HIV & AIDS.

The Bill and Melinda Gates Foundation has program advisory panels for each of its global strategies, comprised of global experts. Practitioners could seek opportunities to dialogue with these experts. Other private foundations also have advisory panels that function in a similar way.

1.6.3 Who Are the Largest Funders of MED?

MED funding is harder to track because it is so widely dispersed. The bulk of funds go toward supporting savings and credit services through microfinance institutions. CGAP, housed at the World Bank, coordinates a donor aid-effectiveness group of more than 30 multilateral donors, bilateral partners, and private organizations to improve the quality of aid flowing specifically to microfinance.³¹ Public sector funders, with USAID in the lead, were the original donors to microfinance institutions, which emerged from NGOs. Now, the leading MFIs seek and receive loans or investment funds. Public commercial-investment agencies, such as the IFC (International Finance Corporation), Germany's KfW (Kreditanstalt für Wiederaufbau), and the European Investment Bank, are currently the largest investors in microfinance. IFC, for example, currently has US\$ 640 million in outstanding commitments to microfinance and plans to double this amount over the next three years. These investors offer equity, loans, and guarantees and were a natural follow-on to the early grant money that helped build microfinance institutions into credit-worthy investments. Grant funding is generally targeted at helping develop institutional capacity and new, innovative approaches, rather than providing capital and expenses for loan administration or simple program expansion.

Market or enterprise development funding is also scattered and exists under different program names and facilities, including value chain development, business development services, enterprise development, making markets work for the poor, and income-generation activities. The international Donor Committee on Enterprise Development (<http://www.sedonors.org>) is a network of predominantly government donors who support MED.

1.6.4 Who Supports Pilot Programs and Learning Initiatives for Integrated Programming?

Mobilizing funding for integrated programming requires demonstrating success at the field level. A number of initiatives are underway that support pilot programming and learning. *The SEEP Guidelines*, and the accompanying online community of practice, represents one such initiative. Others include “The SEEP Practitioner Learning Program on HIV & AIDS”³² (case study

PEPFAR

PEPFAR is under review for re-authorization by the U.S. Congress this year. Organizations lobbying for or discussing re-authorization and changes to PEPFAR include:

- PEPFAR Watch, <http://www.pepfarwatch.org>
- RESULTS International, <http://www.results.org>
- The Kaiser Foundation, <http://www.kaisernetwork.org>
- Center for Strategic and International Studies, <http://www.csis.org/hivaids/prevention/>

³¹ <http://www.cgap.org/direct/index.php>

³² The SEEP Network, “SEEP Practitioner Learning Program on HIV and AIDS,” online source, <http://communities.seepnetwork.org/hamed/>.

research) and the “Displaced Orphans and Children’s Fund” (DCOF) of USAID, managed through the AED-led STRIVE program.³³

Are you aware of a program not listed here? Please share it with us!
[Use our on-line discussion page!](#)

³³ AED website, “Supporting Transformation by Reducing Insecurity and Vulnerability with Economic Strengthening” (STRIVE): A Program to Benefit Vulnerable Children,” <http://www.aed.org/Projects/STRIVE.cfm>.

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ANNEX A. HIV & AIDS TERMS AND ACRONYMS

ABC: A behavior-based prevention strategy that focuses on **a**bstinence, **b**e faithful, and (correct and consistent) condom use. Note that being faithful as a prevention strategy requires that both members of a couple must be HIV-negative and only have sex with one another.

Adherence: Refers to how closely a treatment regimen is followed. In this case, adherence refers to **HIV** and taking anti-retroviral (**ARV**) drugs. When a person does not adhere to their treatment regimen, there is the chance that the body will develop resistance to the drug and the drug may not work as well anymore (see **resistance**).

AIDS: Acquired immunodeficiency syndrome, a condition in which the body's weakened immune system is unable to fight off opportunistic infections. These infections can, if untreated, result in death.

ART: Anti-retroviral therapy is when a combination of drugs is given that delays **HIV** replication and immune system deterioration and allows for increased survival and better quality of life. They are called anti-retrovirals because HIV is a retrovirus.

ARVs: Anti-retrovirals are compounds that inhibit the replication of **HIV** and make up **ART**. These are the special drugs being used to treat people with HIV and prevent further immune suppression. Examples of the key ARV drug classes are nucleoside(tide) reverse transcriptase inhibitor (NRTI), non-nucleoside(tide) reverse transcriptase inhibitor (NNRTI) and protease inhibitor (PI).

BCC: Behavior change communication (sometimes referred to as CBC, or communication for behavior change) refers to an interactive process used by engaging communities to develop tailored messages that may be delivered through various channels of communication. The goal is to develop messages that lead to changes in behavior that eventually lead to HIV prevention.

CD4: A protein present on T-helper cells in the body. Counting the level of CD4 proteins via a laboratory test can help practitioners learn how strong a person's immune system is. This test is used in combination with the **viral load** test, which measures the amount of **HIV** in the blood. Both tests are used to predict staging of HIV and help determine the proper medical treatment a patient requires. The number of CD4 cells we have is called our CD4 count. The lower one's CD4 count, the more likely one is to show signs of illness. A low CD4 count is less than 200: at this stage, treatment is usually considered.

Co-infection: Infection with more than one virus, bacterium, or other micro-organism at a given time. For example, an **HIV**-infected individual may be co-infected with the hepatitis C virus (HCV) or tuberculosis (TB).

GIPA: Greater involvement of people living with or affected by **HIV & AIDS**.

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HBC: Home-based care. HBC programs provide support to people living with **HIV (PLWH)**, their families, and communities to provide holistic, culturally appropriate care on a variety of levels. Care may include medical and nursing care, counseling and psychosocial support, socioeconomic support, and referral. HBC may be carried out by community volunteers or medical professionals, depending on the type of service that is being provided. The programs are often used in conjunction with **palliative care** which usually includes clinical, social, psychological, spiritual, and positive prevention efforts.

Highly active anti-retroviral therapy (HAART): The name given to treatment regimens that aggressively suppress **HIV** replication and progression of HIV disease. The usual HAART regimen combines three or more anti-HIV drugs.

HIV counseling and testing (HCT) and voluntary counseling and testing (VCT): HIV counseling and testing is used to help people ascertain their **HIV** status. A blood or saliva test detects the presence of HIV-antibodies and usually involves a pre-test counseling session and a post-test session, where the test results are shared and clients are counseled about prevention or treatment depending on their test results. If the test shows that antibodies are present, the person is HIV-positive; if not, the person is most likely HIV-negative or within the **window period**.

VCT means an HIV test that is offered to patients on a voluntary basis including pre- and post-test counseling. Some countries and health care facilities are promoting “opt out” testing, in which people seeking medical care at a health facility are routinely screened for HIV in high prevalence areas, unless they “opt out.” Part of the underlying motivation for this approach is to de-stigmatize HIV, so that it is considered like any other disease. Voluntary counseling and testing (VCT) is considered to be an “opt in” program because the person takes the initiative voluntarily.

HIV: Human immunodeficiency virus, technically classified as a retrovirus, is a disease of the immune system that progressively weakens the body’s ability to fight infection. There are four modes of transmission of HIV: (1) sexual intercourse; (2) blood; (3) in utero, primarily during childbirth; and (4) breastfeeding.

HIV incidence: The number of new **HIV** infections or cases in a population reported over a certain period of time, for example, one year.

HIV prevalence: Usually given as a percentage, this is the estimated number of people in a population living with **HIV & AIDS** at a specified point in time (like a camera snapshot). UNAIDS normally reports HIV prevalence among adults aged 15–49 years. We do not say “prevalence rates” because a time period of observation is generally not involved. “Prevalence” alone is sufficient, e.g., “the Caribbean region, with estimated adult HIV prevalence of 2.3 percent in 2003, is an area to focus on in the future.”

IEC: Information, education, and communication. An IEC campaign is a set of organized communication activities designed and implemented to achieve specific objectives with intended audiences for a specific period of time.

OI: Opportunistic infection (as related to **AIDS**) refers to an infection caused by organisms that do not affect a person with a healthy immune system. Some opportunistic infections experienced by people with advanced **HIV** infection include pneumocystic carinii pneumonia; Kaposi's sarcoma; cryptosporidiosis; histoplasmosis; other parasitic, viral and fungal infections; and some other types of cancers.

OGAC: Office of the Global AIDS Coordinator. The global AIDS coordinator oversees the President's Emergency Plan for AIDS Relief (**PEPFAR**).

OVC: Orphans and vulnerable children.

Palliative care: Programs that address pain and symptom management (treatment and prevention of **OIs**) in people living with **HIV & AIDS**. This approach is often used in combination with home based care (**HBC**). According to **PEPFAR** and other funders, palliative care should provide services which support quality of life for **HIV**-positive adults and children. Although traditional palliative care has focused on pain and symptom relief at the end of life, **PEPFAR** programs take a broader view, incorporating clinical, psychological, spiritual, social, and preventive care services. It begins with the **HIV**-positive diagnosis and extends though the end of life, using a family-centered approach. In best practices, palliative care is provided with respect for patient autonomy and choice, support for care givers, and appreciation and respect for cultural values, beliefs, and customs. It should provide the routine monitoring that is essential for determining the optimal time to initiate anti-retroviral therapy (**ART**), and it continues during and after the initiation of treatment. Palliative care includes and goes beyond the medical management of infectious, neurological, or oncological complications of **HIV & AIDS** to comprehensively address symptoms and suffering throughout the continuum of **HIV** disease

PEPFAR: The U.S. President's Emergency Plan for AIDS Relief, a \$15-billion fund initiated in 2003 by President George W. Bush to address **HIV** prevention (\$10 million), **AIDS** and **OVC** care and support (\$7 million) and **AIDS** treatment (\$2 million) over 5 years. Approved by the U.S. Congress in 2003, the first funds were distributed in 2004. A fund of \$50 billion is expected when and if **PEPFAR** is reauthorized by the U.S. Congress.

PLWH or PLHIV: Person living with **HIV**, preferable to "AIDS victim."

Positive living: Refers to the concept of living "positively" with **HIV**. Positive living can be accomplished when a person has a good attitude about their **HIV** status. A positive attitude can be achieved when a person has the knowledge and the medical and economic tools to live a normal, productive life as an **HIV**-positive individual.

Re-infection: Refers to a person with **HIV** becoming infected again with **HIV** (with the same strain, a different strain, or a drug-resistant strain).

Resistance: When a person does not take their **ART** properly or uses a particular **ARV** for a long time, there is the chance that the body will develop resistance to the drug. When the body develops resistance, the drug does not work as well to delay **HIV** replication. In turn, the person's immune system will become weaker. This is why it is important to focus heavily on

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adherence to ART and ensure people who are taking ARVs are monitored regularly by their health care provider.

Retrovirus: A type of virus that replicates through a reverse transcriptase process (such as the **HIV** virus). This reverse process makes the HIV infection complex to treat.

Safe sex and safer sex: Sex is 100-percent safe from **HIV** transmission when both partners know their **sero-status** is HIV-negative and neither partner is in the **window period** between HIV exposure and HIV antibodies detected by the HIV test. In other circumstances, reduction in the numbers of sexual partners and correct and consistent use of male or female condoms can reduce the risk of HIV transmission. The term **safer sex** more accurately reflects the idea that choices can be made and behaviors adopted to reduce or minimize risk.

Sero-status: A generic term that refers to the presence or absence of antibodies in the blood. Often, the term refers to **HIV**-antibody status.

Sexually transmitted infection (STI): Also called venereal disease (VD)—an older public health term—or sexually transmitted disease (STD)—a term that does not convey the concept of asymptomatic sexually transmitted infections. Sexually transmitted infections are spread by the transfer of organisms from person to person during sexual contact. In addition to the “traditional” STIs (syphilis and gonorrhoea), the spectrum of STIs now includes **HIV**, which causes AIDS; chlamydia trachomatis; human papilloma virus (HPV), which can cause cervical or anal cancer; genital herpes; chancroid; genital mycoplasmas; hepatitis B; and trichomoniasis. Many STIs increase the risk of HIV transmission because of breaks in the skin that allow the virus to enter more easily.

Side effects: Refers to unpleasant reactions that the body has as a result of **ART**. Often side effects cause people to stop taking their **ARVs**. It is the goal of **HIV** practitioners to help patients to reduce and manage the side effects they experience from ARVs effectively, in order to maximize treatment benefits.

Vertical transmission: In the context of **HIV**, this indicates transmission of HIV from mother to fetus or baby during pregnancy or birth.

Viral load: The number of copies of the virus in the body per unit of blood. This is used in combination with the **CD4** level, which is a protein present on T-helper cells. Counting the level of CD4 proteins via a laboratory test can help practitioners learn how strong a person’s immune system is. Both tests are used to predict staging of **HIV** and help determine the proper medical treatment a patient requires.

Window period: The time period between a person’s infection with **HIV** and the appearance of detectable anti-HIV antibodies. Because antibodies to HIV take some time to form, an HIV-antibody test will not be positive immediately after a person is infected. The time delay typically ranges from 14 to 21 days, but varies for different people. Nearly everyone infected with HIV will have detectable antibodies by three months after infection.

ANNEX B. GLOSSARY OF MICROENTERPRISE DEVELOPMENT TERMS

ASCA: Accumulated savings and credit association. An informal community group where the savings of the members accumulate instead of being emptied to one member every collection day (as in a rotating savings and credit association—**ROSCA**). Loans can be provided from the pot of mobilized savings. ASCAs may be time-bound or they can last indefinitely, but sound practice encourages time-bound ASCAs.

Asset transfers: When productive goods—livestock, seeds, tools, cash—are given to people to help them re-establish their livelihood.

Bank: The formal institution for holding savings and extending credit that is regulated by the central bank of the country.

Business services (or products): Formerly referred to as “business development services,” or BDS. These are activities and items that help businesses become more productive, reach market, or reduce costs. They can exist in stand-alone markets or strengthen a value chain. Some refer to these as “support services” or products because they support the value chain.

Client assessment: Collecting information from existing and potential clients in order to better understand their needs and demands for services, especially microfinance services.

Commercial business services: Business services offered to an enterprise to assist in business functioning or growth that is delivered by other businesses, through the market. See also **business services**.

Credit unions and cooperatives: Credit unions, or savings and credit cooperatives, are user-owned, democratically controlled, not-for-profit microfinance institutions that offer savings, credit, insurance, and remittance services to their members.

Credit with Education: In this model, microfinance institutions offer credit and savings to groups of individuals. The institution takes advantage of the regular group meetings to offer clients information and training.

Demand: A combination of awareness of a need, the need itself, and the ability to pay for solutions to the need, such as products or services.

Demand-driven: Means responding to high-priority small enterprise need for services and the existence of financial pressure on the provider to deliver a valuable service to the small enterprise.

Economic strengthening: A term often used by practitioners targeting orphans and vulnerable children and the very poor. In addition to some types of microenterprise development, economic

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strengthening also tends to include cash transfers, vocational training, work-force development, and legal services.

Enterprise development: Helping people establish and expand businesses and farms, including small and very-small scale businesses and farms, through access to markets for inputs, for their products, and for business services, such as training, information, technology, or transportation. It means helping enterprises enter, remain in, and benefit more from market participation. It also includes market development, business services, value chain development, commercial business services, social enterprise, etc.

Enabling environment or business environment: The wide range of issues and institutions that lie outside the value chain, but affect how it works: for example, policies and regulations, trade issues, cultural norms, infrastructure, government agencies, associations, informal networks, and non-governmental organizations (NGOs).

Facilitation: Conducting temporary activities within a value chain in order to permanently overcome constraints and develop the value chain.

Facilitator or facilitating organization: An international or local institution that uses public funds to promote the development of specific value chains.

Financial systems approach: The development of regulations and institutions to support broad expansion of the microfinance industry, in addition to supporting individual, sustainable microfinance institutions.

Group enterprises: Businesses owned and launched by small groups of target clients, often referred to as “income-generating activities.” (“Income generating activities” is not recommended as a term in *The SEEP Guidelines*.)

Group lending: Lending mechanism which allows a group of individuals—either a solidarity group or a village bank—to provide collateral or a loan guarantee through a group repayment pledge. The incentive to repay the loan is based on peer pressure—if one group member defaults, the other group members make up the payment amount.

Higher-value market: Groups of consumers that are more stable, are able and willing to higher prices, or offer higher volume than the usual, local small enterprise markets.

Impact: Long-term result in a market system and/or among the target population as a consequence of program activities and outcomes.

Income-generating activity: Used in a variety of ways and not recommended as a term in *The SEEP Guidelines*. Sometimes it is a general word referring to microenterprises. Sometimes it refers to self-employment by very poor people who have no employees. Often, it refers to group enterprises.

Industry: A sector (or subsector) which produces a particular product or service. The term includes the broader market systems involved in the production of a product or service beyond a single value chain.

Input: A material good required to produce another good or product.

Intervention: A temporary activity conducted by a development or government agency designed to permanently overcome a particular constraint and develop one or several value chains.

Livelihood security: A livelihood is the as a combination of the resources used and the activities undertaken in order to live. The resources might consist of individual skills and abilities (human capital), land, savings, and equipment (natural, financial, and physical capital, respectively) and formal support groups or informal networks that assist in the activities being undertaken (social capital). Livelihood security refers to the community of practice that helps people obtain and maintain strong livelihoods.

Market: The interaction of demand and supply for a particular product or service and the factors that affect these. It also refers to a consumer segment for a particular product or service, for example, the export market or an urban market.

Market analysis, assessment, research: Gathering information about potential clients, their industry, and the end-customer demand for one's products and services. It includes processing and presenting this information for use in making key program design and implementation decisions. It is often used in enterprise development.

Market development approach: An approach to enterprise promotion which focuses on developing private sector markets for goods and services to make them more inclusive of and beneficial to specific groups of enterprises or people. It includes both value chain development and commercial business services.

Market linkages: Relationships in any market between buyers and sellers. This term is often used to describe activities that help clients find customers or "markets" for their products. Here, we advance the strategy of "value chain development" that strengthens market linkages among all businesses in a specific industry or value chain—from input supplier through intermediaries and on to the final customer.

Market opportunity: End markets or consumer segments that are growing and/or offer the potential for sales of higher value products or services.

Market research: Gathering information about a value chain to inform program design decisions. The research includes information collected about all parts of the value chain, as well as on the end markets for the products or services of program clients, the enabling environment, and related socioeconomic issues. This process is also called **market assessment**.

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Market (re)entry services: Basic (often subsidized) business services that help destitute or very poor people (re)start microenterprises and (re)enter markets.

Microcredit: A part of the field of microfinance, microcredit is the provision of credit services to low-income entrepreneurs. Microcredit can also refer to the actual microloan.

Microenterprise: A small-scale business in the informal sector. Microenterprises often employ fewer than five people and can be based out of the home. Microenterprise is often the sole source of family income, but can also act as a supplement to other forms of income. Examples of microenterprises include small retail kiosks, sewing workshops, carpentry shops, and market stalls.

Microentrepreneur: The owner or proprietor of a microenterprise.

Microenterprise development: Two overlapping development activities:

- Helping people start and run very small businesses and farms
- Helping people access financial services (i.e., loans, savings, insurance, and remittances).

Together these two activities provide people with the capacity to manage crises and work their way out of poverty.

Microfinance: Financial services, such as lending, savings, insurance, and money transfer that are designed for the needs of low-income populations.

Microinsurance: A developing field of microfinance that provides health insurance and other insurance products to microentrepreneurs and employees in the informal sector.

Microloan: A loan imparted by a microfinance institution to a microentrepreneur, to be used in the development of the borrower's small business. Microloans are used for working capital in the purchase of raw materials and goods for the microenterprise, as capital for construction or in the purchase of fixed assets that aid in production, among other things. The loans can also be for improving a microentrepreneur's house.

Money transfer or remittance services: Facilities that help people move money from one location to another.

Operational self-sufficiency (OSS): A measure of financial efficiency equal to total operating revenues divided by total administrative and financial expenses. If the resulting figure is greater than 100 percent, the organization under evaluation is considered to be operationally self-sufficient. In microfinance, operationally sustainable institutions are able to cover administrative costs with client revenues.

Parallel programs: Some broad development organizations conduct integrated development programs on health and agriculture and also support independent microfinance institutions who serve their eligible clients. Clients can access a range of financial services when needed, but the microfinance institutions can make independent decisions about each client's creditworthiness.

Portfolio at risk: Measurement of the total outstanding balance of loans past due—not late payments or payments not yet due—divided by the active portfolio. This is a more rigorous manner of assessing portfolio quality than portfolio past due or delinquent portfolio. Portfolio at risk can be 1 day, 30 days, 90 days, or more late, but usually 30 days late is the most common measure.

Provider: A firm or institution that provides support products or services to enterprises. Providers include private for-profit firms, NGOs, government agencies, industry associations, and individuals.

ROSCA: Rotating savings and credit association. A financial-services group where all members contribute equally and receive the pot once per cycle on a pre-scheduled basis. (i.e., weekly meetings, with the distribution schedule set by lottery).

Scale: Reaching larger numbers of clients

Small- and medium-scale enterprises (SMEs): Enterprises employing 5 to 10 workers (small scale) or between 10 and 50 workers (medium scale).

Social enterprise: A not-for-profit organization or socially oriented venture that advances its social mission through entrepreneurial market-based approaches to increase its effectiveness and financial sustainability with the ultimate goal of creating social impact or change.

Strategic alliances: Some microfinance institutions are entering partnerships with business development or health organizations which want to add microfinance to the package of services they offer clients. In these situations, MFIs devise services appropriate for the target market and make financial services available to eligible clients.

Supplier: A seller of products to other businesses. “Supplier” often refers to those companies that sell inputs to value chain players.

Sustainability: The capacity of a business, solution, service, or market to continue on an ongoing basis without financial support from government or charity (NGO) organizations.

- In the market development context, it refers to the functioning of a market: the durability and financial viability of market linkages and the availability of support products and services on a commercial basis. It implies the ability of the market to respond to shifts in demand and competition.
- In the microfinance context, it refers to the sustainability of the microfinance institution.

Target group (client): Often part of an organization’s mission or value, it refers to the ultimate program clients and beneficiaries.

Value chain: A market system. The network of firms that buy and sell to each other in order to supply a particular set of products or services to a particular group of final consumers. A value chain includes both those market players directly involved in the production and distribution of the end products or services and those that provide support products and services.

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Value chain analysis: Analyzing market information about a particular value chain in order to understand various aspects of the value chain, including value chain players, value chain characteristics, and the enabling environment.

Village banking: A lending methodology in which clients—typically women—form groups of approximately 10–30 individuals that are autonomously responsible for leadership, bylaws, bookkeeping, fund management, and loan supervision. The group pools funds to use for business loans, savings, and mutual support, and members cross-guarantee individual loans.

ANNEX C. FREQUENTLY ASKED QUESTIONS

The following is a list of questions that MED and public health professionals often ask each other. This tool can be helpful for bringing colleagues and funders on board with integrated programming.

Questions about MED Commonly Asked by Public Health Professionals

QUESTION: Isn't it irresponsible to load poor people, particularly those with HIV, with debt? How can people with HIV pay loans?

MED perspective: Most people, including the poor, want the opportunity to support themselves and their families. The poor can use financial services to smooth their income, reduce their vulnerability, and manage life-cycle events, such as weddings, funerals, and children's education. If they don't have access to fair financial services, they often turn to loan sharks, moneylenders, or hard-pressed family members, or deplete their few assets to manage any crisis. Many MFIs or community banks in areas of high HIV prevalence have HIV-positive clients. As long as they are able to engage in enterprise, they have no problem repaying their loans on time. Those who know their status are often highly motivated to build their businesses and save. In addition, increased access to treatment (HAART and ART) has prolonged productivity for many of those living with HIV, allowing them to reenter the market.³⁴

QUESTION: How can you ask poor people to save when they are too poor to afford the basics?

MED perspective: Although the most destitute people may not be in a position to save, traditionally, poor people save in the form of assets, such as animals or jewelry. Microfinance programs have demonstrated that most poor people want to and do save. They seek safe, accessible ways to keep their money safe and to earn some interest if possible. The amounts may be small, so they do not attract the attention of banks, but for them, the amounts add up and provide a safety net.

QUESTION: What is microfinance? MED? Microcredit? Do all these terms mean the same thing?

MED perspective: Microenterprise development encompasses a range of financial and non-financial services targeted at poor entrepreneurs and their businesses, including business credit, training, market development, etc. Holistic approaches also include "credit with education" that uses credit programs as a vehicle to provide training in business skills, leadership development, personal development, women's empowerment, health, and other areas. Microfinance is a range of primarily financial services for poor households, including all types of credit, savings, insurance, and remittances. Microcredit refers to very small loans, a key service of the

³⁴ A.L. Stangl, N. Wamai, J. Mermin et al., "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 2007): 626–36. <http://www.ingentaconnect.com/content/routledg/caic;jsessionid=6kv3goltnvo97.alexandra>. Accessed May 2008

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microfinance field. These services are often targeted at poor entrepreneurs, but can be for anybody who is excluded from the formal financial sector.

QUESTION: Why do MFIs and MED program resist serving our clients?

MED perspective: For many MED programs, funding and program targets are already established, so changing gears mid-program to focus more on HIV & AIDS threatens program performance and achieving established donor targets. Partnerships are best explored when adding HIV & AIDS components, when seeking new funding opportunities, or when engaging in strategic planning.

QUESTION: Doesn't it make sense to start by tackling HIV & AIDS and then add MED?

MED perspective: MED programming can take place at any stage during the life cycle of the disease and its impact on a family or community. Different strategies are effective for different levels of economic vulnerability, which may broadly coincide with different stages of the disease, depending on the economic status of a family or community at the beginning of the epidemic. However, starting MED before HIV impacts a household can actually help them deal with any financial shocks—such as the need to pay for healthcare or increase spending on food, transportation or medication—before they occur. Savings and asset building, particularly productive assets—machines for production or service delivery, livestock, and land—can help create an economic safety net for households affected by HIV.

QUESTION: Aren't most MED practitioners focused purely on financial success so they don't care about social issues such as health, poverty eradication, or empowerment? How much of a real need is cross-sector partnership for the MED community?

MED perspective: MED has the same objective as other aspects of development: to reduce poverty and improve quality of life. Many MED practitioners choose their specialization because they see economic independence as particularly empowering, especially for women. Even MFIs set up as commercial banks include social goals in their mission statements. MFIs are accurately described as social enterprises, meaning that they use business practice and principles to achieve social goals. Unlike many other development initiatives, they are under pressure to be financially sustainable while serving the poor. Therefore, they have to balance financial and social goals.

QUESTION: I thought MED programs and MFIs work with the middle class and working poor only, not the truly poor in the community. Is that true?

MED perspective: Different MED strategies are appropriate for different levels of economic vulnerability. Attempting to attract MFIs or value-chain development programs into programs that serve only the very poor is a mismatch of resources. Program strategists should work together to mobilize a wide range of MED services delivered by a range of organizations to serve people at different levels. Currently, MFIs and MED programs are focused on developing innovative ideas for how to best reach and serve the very poor.

QUESTION: Why do MFIs have to charge market (high) interest rates?

MED perspective: MFIs have to charge market interest rates that may seem high. They do this in order to cover the high cost of administering very small loans. Normally, these interest rates are lower than informal-sector money lenders, but higher than banks. If the administrative costs of very small loans are similar to large loans, then MFIs must charge higher interest rates on the very small loans to earn enough to stay self supporting and sustainable. To protect against abuse, the MFI industry has developed “consumer protection” guidelines to protect borrowers against exploitative interest rates and other fees. MFIs are often under the authority of the commercial banking regulators that hold them accountable.³⁵

QUESTION: What does a lender do if a borrower becomes too ill to work and therefore cannot repay a loan?

MED perspective and response:

- In a group setting, others from the group will be responsible for paying the loan. They will make the decision about whether to collect any collateral, such as a bicycle. Collecting these items can help the group off-set the cost of paying for their member’s loan.
- If the individual has savings, these will be seized in order to compensate the loan fund for the loss. If an individual has offered collateral, this will be seized in order to off-set the lender’s loss.
- Some MFIs offer or require loan insurance, which protects the borrower from having savings and collateral seized and protects the lender and other group members from having to pay off the loan.

QUESTION: Why do MFIs need to be separate institutions? Why do MFIs discourage health and social service organizations from operating loan funds and providing grants?

MED perspective and response:

- Lending is a specialized technical service. Good practice requires specialized skills that consider both the needs of the client, the credit environment, and the sustainability of the microfinance institution.
- MFIs believe in achieving financial sustainability in order to continuously make capital available in poor communities and to continuously expand to reach more people. To achieve this requires large scale operation, often not achievable with the resources invested in small loan funds. In addition, MFIs require sophisticated accounting systems to track loan activity and the flow of capital and income into and out of the MFI. MFIs also require strategic leadership that understands the requirements of the industry and how to operate under legal authorities.
- Loan funds run by NGOs (non-governmental organizations) from other sectors often do not follow best practices. This can endanger the local “credit culture.” They often charge below-market interest rates or have very flexible debt-forgiveness policies. These practices can

³⁵ To learn more, see The SEEP Network Initiative on Consumer Protection (<http://communities.seepnetwork.org/edexchange/opportunities/initiatives>) and the working group, http://www.seepnetwork.org/section/programs_workinggroups/action_research/working_groups/pc

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undermine the practices and policies of MFIs and limit their activity in certain markets where people do not take loan repayment seriously or expect subsidized interest rates.

- Grants can provide a disincentive for people to borrow and can create dependency. Also, it is hard to reach sustainability and scale with grants.

QUESTION: Why do MED programs ask the public health community for funding? Don't they have plenty of funding?

MED perspective: Many MFIs worked for years to provide HIV & AIDS-prevention and -awareness education to their clients and to design their products and services to help with orphan care and the financial needs of those affected and infected. They have become engaged because their clients and staff members have been affected. MFIs have significant independent sources of funding and generally do not seek HIV & AIDS funding. Other types of MED programming may require allocations of HIV & AIDS funding, however, since funding for non-microfinance MED is very limited.

QUESTION: Why must microloans to HIV & AIDS-impacted people be repaid?

MED perspective and response:

- Because microenterprise loans are expected to be repaid by everyone. It is also empowering for people impacted by HIV & AIDS to repay because they remain capable, remain a part of the community, and retain their good reputation, which allows them continued access to financial services in the future.
- Repaying the loan is essential for the sustainability of the microlender and allows others in a community, who may also be affected by HIV & AIDS, to be approved for loans.
- Repayment enables the sustainable system of lending to continue. When one borrower doesn't pay, it can encourage others to default and can lead to the collapse of the loan fund

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Questions about HIV & AIDS Programming Commonly Asked by MED Professionals

QUESTION: Are HIV & AIDS programs sustainable?

Public health perspective: Definitions regarding sustainability may differ from the MED sector, but HIV & AIDS programs strive to engage existing community structures, build local capacity, and make sure their interventions are cost effective. In addition, they follow national strategies and protocols and are often linked with government programs and services.

QUESTION: Can people living with HIV repay loans?

Public health perspective: HIV-positive clients (both those who know their HIV status and those who do not) have proved to be reliable members of community banks. As long as they are able to engage in their enterprise, they have no problem repaying their loans on time. Those who

know their status are often highly motivated to build their businesses and save. People with access to medicine can live long, productive lives.

QUESTION: Aren't HIV & AIDS program designers focused on short-term emergency health needs, rather than long-term practical financial matters?

Public health perspective: Many HIV & AIDS program designers and managers are planning for the long term, while addressing emergency needs. For example, they develop health delivery systems to sustain service delivery. Many are intensely focused on identifying and supporting large-scale solutions.

QUESTION: Why do HIV & AIDS programs use inappropriate MED practices that undermine MFIs and markets?

Public health perspective: Most MED approaches and programs have excluded people and communities impacted by HIV & AIDS. Effective strategies were not developed, so public health practitioners have had to innovate and use what tools were available to the non-expert.

QUESTION: Why do HIV & AIDS experts say they do not have enough funding? Surely, they have more than MED programs?

Public health perspective: While more funding has been allocated to address prevention, treatment, and care, there are not enough resources to meet the needs of the millions affected by this pandemic. Funding is still scarce, compared to the need. Once a program has been funded, often money has been allocated to specific partners or initiatives and there is no flexible funding to channel to an MED program.

QUESTION: Aren't integrated programs hard to implement? Don't they undermine MED outcomes?

Public health perspective: Integrated programming carries some risks. But, without integration, programs often do not address the full problem or needs of the people and are not sustainable. The challenge is to design programs well so that they are worth the cost to implement.

ANNEX D. GROUP-MANAGED BUSINESSES

Although group enterprises are a common response in HIV- and AIDS-impacted communities, practical experience drives *The SEEP Guidelines* to advise caution and encourage programs to explore the wider range of options presented here. There are advantages and disadvantages to group enterprises.

Advantages of Group Enterprises

- *Efficiency*: Programs can reach a group of people with one technical visit or service.
- *Leverage*: Programs can be tacked on to existing groups that are already formed for social purposes.
- *Demand*: Clients in social groups demand assistance with income generation.
- *Economies of scale and market leverage*: Groups enable poor people to accumulate capital and invest in equipment or purchase and produce in bulk, and to link to market with a single transaction.
- *Access to higher volume, steadier, or higher-value markets*: Often individual enterprises are run by poor people selling to poor people in very low volume. Higher margins are possible when selling to others with higher incomes or high-volume purchasers, such as schools or traders.

Disadvantages and Risks of Group Enterprises

- Group enterprises can offer a way for households to get a higher return on investment, to take a relatively safe risk with a small amount of capital and time, and to diversify household income.
- Often, programs promote the same productive enterprises (pig rearing, for example) with little regard for the market for the product.
- Groups are more difficult to manage than individual enterprises. They are easily co-opted by individuals or a few leaders or can present an undue burden on very weak members.
- When health or social services organizations support group enterprises, it can be challenging to provide the right technical, business management, group management, and marketing advice—particularly if there is a wide range of group enterprises.
- A group enterprise is usually a secondary activity for members, so when crisis hits, it is a lower priority which then affects other members.
- Group enterprises in which all members are living with HIV or AIDS or are heavily impacted by HIV & AIDS may have lower success rates because everyone is struggling. On the other hand, in groups with a mixed membership, there may be resentment against people who are more affected and not able to contribute.

Recommendations

- Explore a range of options before determining that group enterprises be a core strategy.
- Help groups choose the minimal function and simplest level of engagement first, building up to more complex arrangements. For example, groups can send a representative to the market or to a trade to negotiate on their behalf, but the trader can purchase individually from each member on a specific day; or the group can send two representatives to procure inputs for the group, but members can manufacture and market their goods individually, etc.
- Access effective group management training materials that, at a minimum, ensure that
 - leadership is fairly elected and rotated;
 - more than one leader has control over the money;
 - finances are reported transparently to all members regularly;
 - individuals have the option to invest money and get a return without working, returns are relative to the amount invested, and the amount invested is sometimes fixed and sometimes flexible;
 - people who put in time are appropriately compensated for that time or for their output;
 - there are consequences for non-payment or non-participation, and policies in place in case of emergencies; and
 - there are succession plans and policies in case of illness or death.
- Develop technical capacity in a few types of enterprises. Conduct business feasibility on the group enterprises to ensure their viability. Develop standard business models, plans, and manuals and instructions to help many groups efficiently. Ensure effective and sufficient market linkages for inputs and products so as not to saturate the market with a few enterprises.
- Concentrate on accessible, higher-value markets that present an added return for individuals, but are not too risky.
- Use local traders and intermediaries. Do not use the group or an NGO to “go around the market.” Create sustainable market linkages.

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