Partnering microfinance and HIV/AIDS training in rural South Africa

Lessons learned from a process evaluation of the IMAGE Intervention

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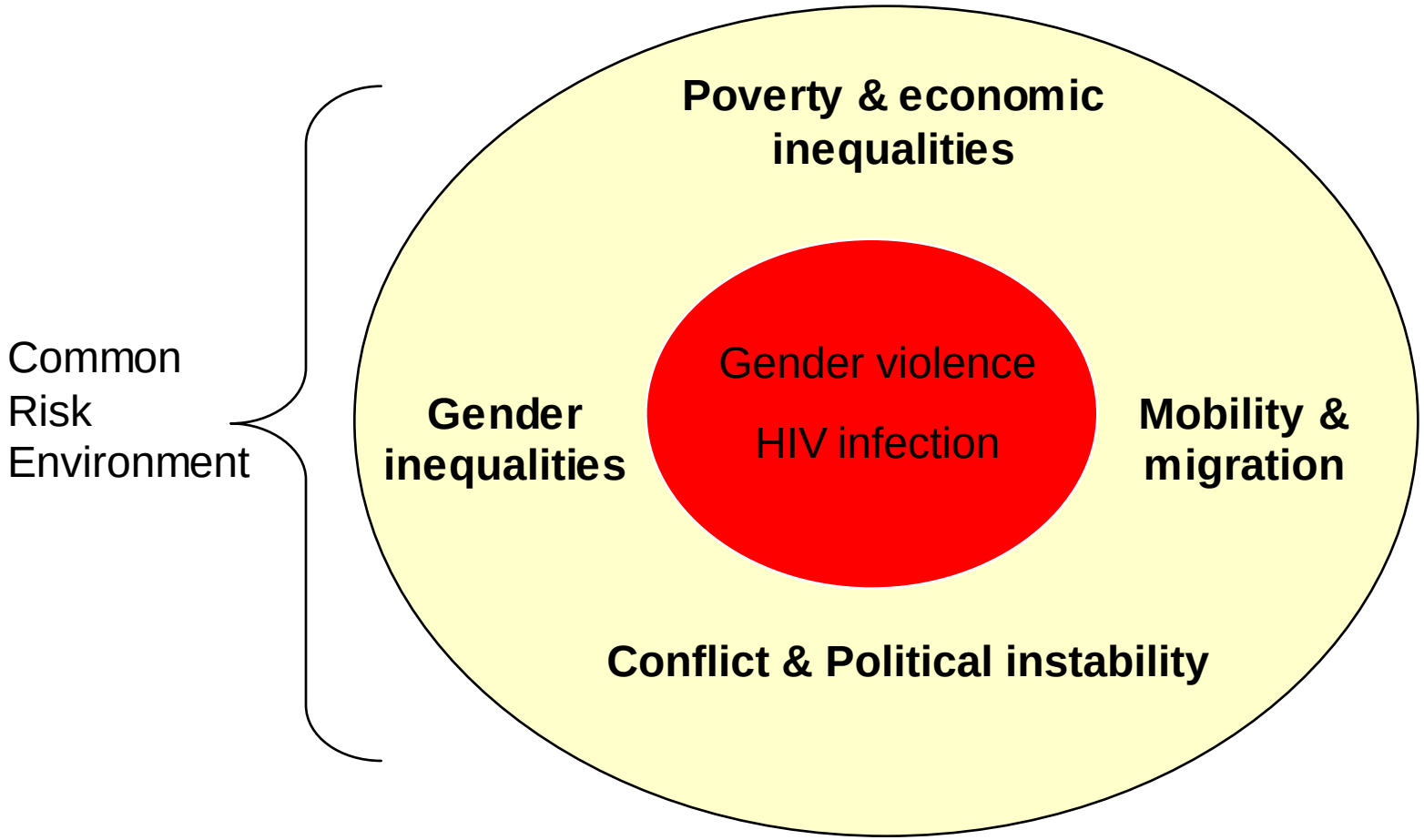
Structural factors influence gender violence and HIV in southern Africa:



Microfinance: Delivering credit for income generation to the poor

- Mohammed Yunus & Grameen Bank, Nobel Peace Prize 2006
- Millions of borrowers worldwide
- Group-based lending to poor women
- Evidence of poverty relief, female empowerment and health impacts
- High repayment rates

Microfinance plus ?

- Maximise benefits through piggy-backing credit and health interventions
- Pros
  - Impact synergy
  - Health promotion outreach to the poor
- Cons
  - Strength through specialisation
  - Lack of inter-sectoral communication – whose responsibility?

The Intervention with Microfinance for AIDS & Gender Equity (IMAGE)

Microfinance

- Established provider with 40,000 clients in South Africa
- 'Solidarity groups' of 5 women
- Poverty focused approach

Training: "Sisters for Life"

- Training integrated at fortnightly loan centre meetings (40 women)
- Training programme (15 months)
  - Phase 1: 10 structured sessions on gender and HIV
  - Phase 2: community mobilization

Delivered by 2 specialist organisations; over time attempt to integrate management

The IMAGE Study: Lancet (2006)

Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: a cluster randomised trial

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Summary

Background HIV infection and intimate-partner violence share a common risk environment in much of southern Africa. The aim of the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) study was to assess a structural intervention that combined a microfinance programme with a gender and HIV training curriculum.

Methods Villages in the rural Limpopo province of South Africa were pair-matched and randomly allocated to receive the intervention at study onset (intervention group, n=4) or 3 years later (comparison group, n=4). Loans were provided to poor women who enrolled in the intervention group. A participatory learning and action curriculum was integrated into loan meetings, which took place every 2 weeks. Both arms of the trial were divided into three groups: direct programme participants or matched controls (cohort one), randomly selected 14–35-year-old household co-residents (cohort two), and randomly selected community members (cohort three). Primary outcomes were experience of intimate-partner violence—either physical or sexual—in the past 12 months by a spouse or other sexual intimate (cohort one), unprotected sexual intercourse at last occurrence with a non-spousal partner in the past 12 months (cohorts two and three), and HIV incidence (cohort three). Analyses were done on a per-protocol basis. This trial is registered with ClinicalTrials.gov, number NCT00242957.

Findings In cohort one, experience of intimate-partner violence was reduced by 55% (adjusted risk ratio [aRR] 0·45, 95% CI 0·23–0·91; adjusted risk difference –7·3%, –16·2 to 1·5). The intervention did not affect the rate of unprotected sexual intercourse with a non-spousal partner in cohort two (aRR 1·02, 0·85–1·23), and there was no effect on the rate of unprotected sexual intercourse at last occurrence with a non-spousal partner (0·89, 0·66–1·19) or HIV incidence (1·06, 0·66–1·69) in cohort three.

Interpretation A combined microfinance and training intervention can lead to reductions in levels of intimate-partner violence in programme participants. Social and economic development interventions have the potential to alter risk environments for HIV and intimate-partner violence in southern Africa.

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Primary outcome results

	Baseline				Follow Up					
	Intervention		Comparison		Intervention		Comparison		Unadjusted RR (95% CI)	Adjusted RR (95% CI)
	n/N	%	n/N	%	n/N	%	n/N	%		
Participants Experience of intimate partner violence in past 12 months	22/193	11.4%	16/177	9.0%	17/290	5.9%	30/248	12.1%	**0.50 (0.28-0.89)**	**0.45 (0.23-0.91)**
Household residents (14-35) Unprotected sex with a non-spousal partner in past 12 months	326/724	45.0%	313/729	42.9%	259/539	48.1%	245/514	47.7%	**1.03 (0.82-1.29)**	**1.02 (0.85-1.23)**
Community residents (14-35) Unprotected sex with a non-spousal partner in past 12 months	635/1481	42.9%	545/1365	52.3%	498/1156	43.1%	538/1132	47.5%	**0.91 (0.68-1.22)**	**0.89 (0.66-1.19)**
Community residents (14-35) HIV incidence	-	-	-	-	70/647	10.8%	72/639	11.3%	**1.04 (0.67-1.61)**	**1.06 (0.66-1.69)**

IMAGE Process Evaluation: Research questions

1) Was the IMAGE intervention delivered as planned and what was the response to it?

2) What operational model was used to deliver the IMAGE intervention and did this change?

3) What are the views of external stakeholders on the potential transfer of interventions based on the IMAGE model?

Process Evaluation Methods

	2001-2004		2005-2007	
Qualitative data	**Data Source**	**Quantity**	**Data Source**	**Quantity**
	Participant observation notes	134 hours	*In-depth interviews:*	
	Reflection meeting notes		Opinion leader (HIV / Gender)	15
	Observation diaries of programme field staff	240 hours	Opinion leader (Microfinance / Development)	12
	Focus group discussions with programme clients	16	Programme client	24
	In-depth interviews:		Programme field staff	47
	Programme client	15	Programme management	22
	Programme drop-out	19	Programme sponsor	5
Quantitative data	**Data Source**	**Quantity**	**Data Source**	**Quantity**
	Attendance registers	406 clients x 20 sessions	Quarterly progress of scale-up	10 quarters
	Questionnaires on intervention acceptability	385 clients		

Lesson 1

- IMAGE successfully delivered an intervention combining microfinance and health promotion activities to at least 4500 clients in rural South Africa, 2001-2007
  - Low default and dropout rate from microfinance
  - High attendance and participation in SFL
  - Community mobilisation empowering for some, though collective action was complex

IMAGE was feasible

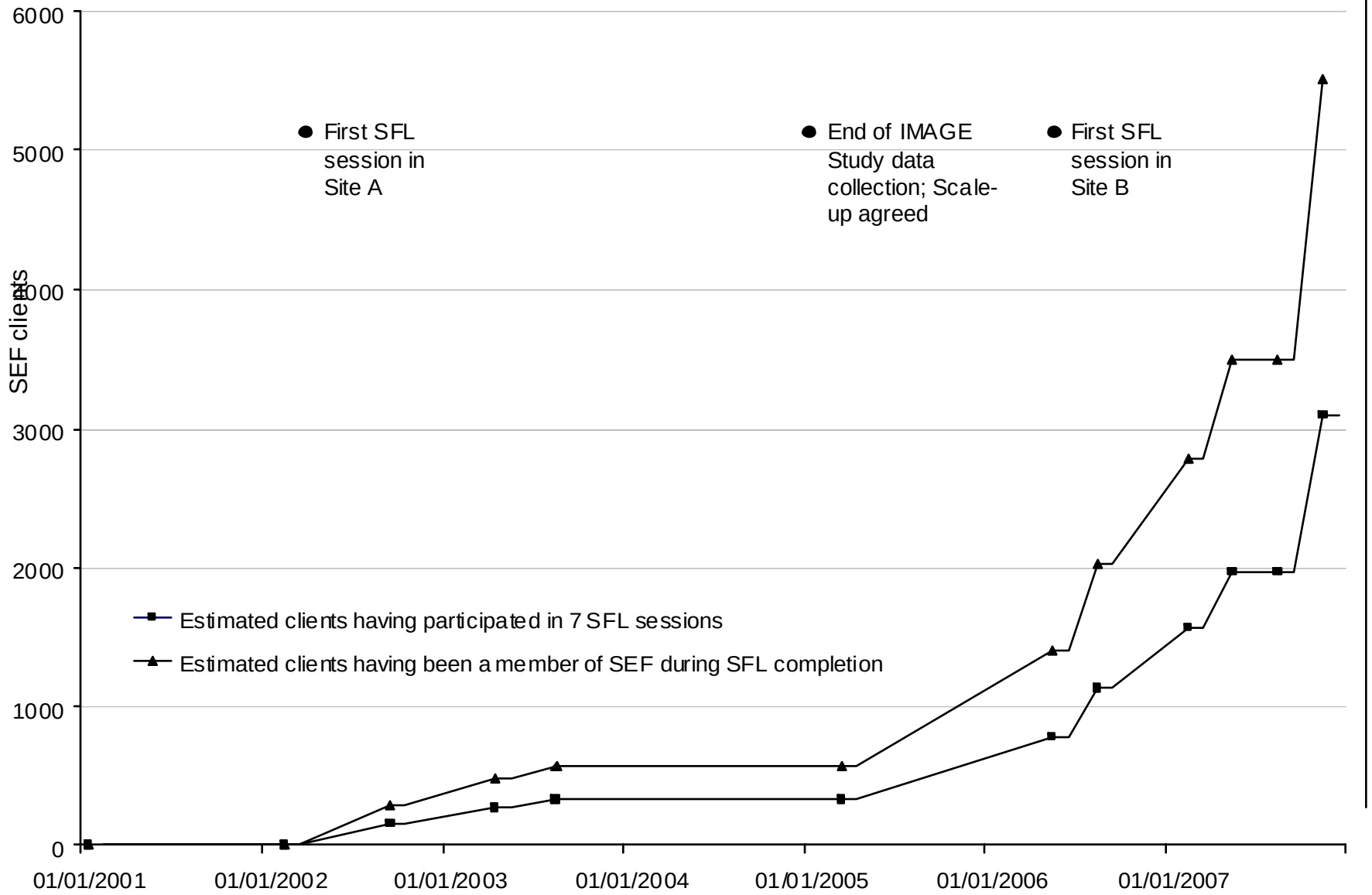

IMAGE was accessible

Attendance at Sisters for Life training sessions among first 430 IMAGE participants

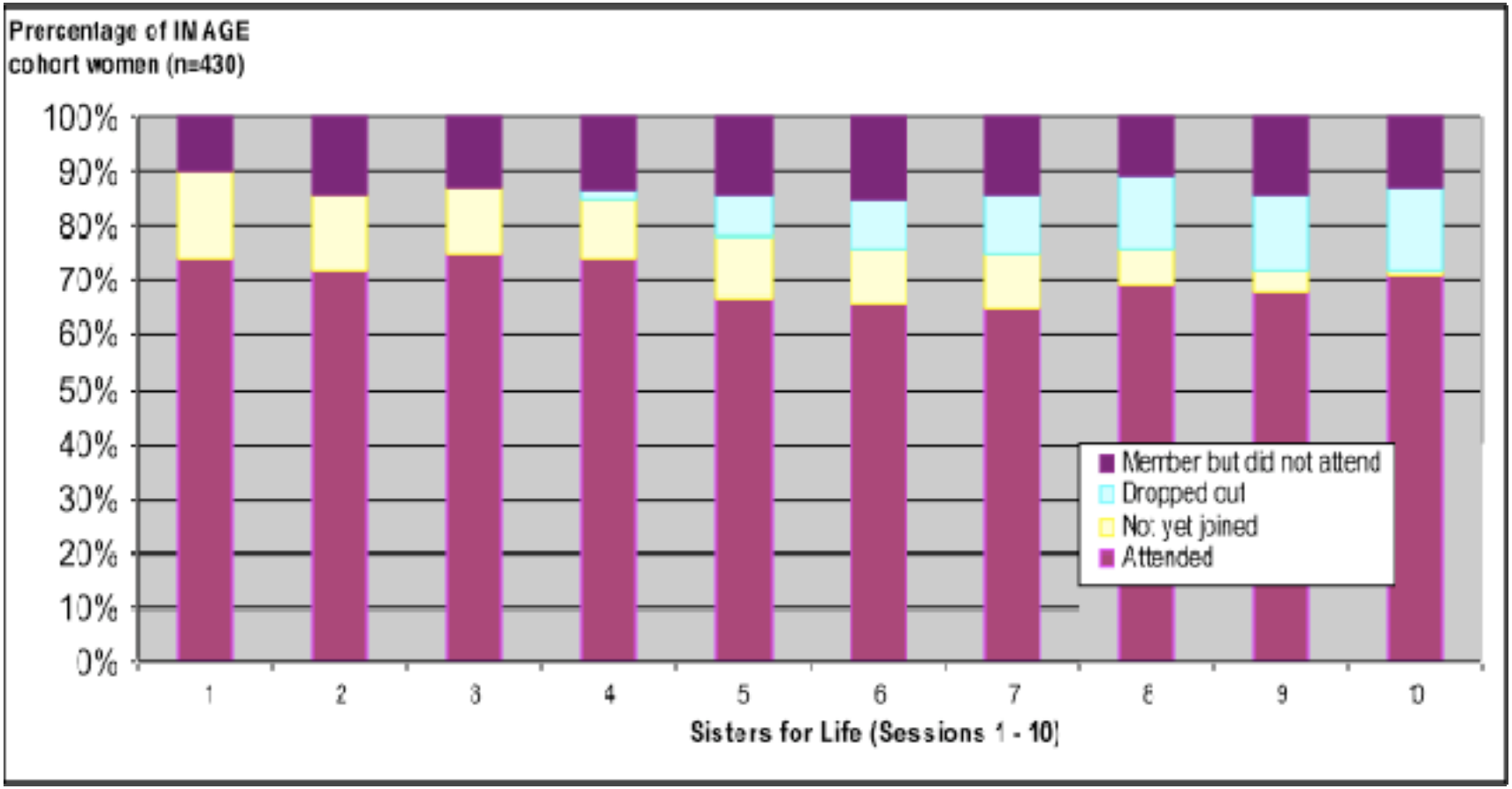

IMAGE was acceptable

"I think it is a good idea because having both money and health talks mean safety. On one hand you have got something that deals with poverty and the other hand deals with the diseases and oppression of unemployed women by their partners who ended up giving them AIDS. So money and knowledge give women power to protect themselves".

(IMAGE Client, 2002)

Lesson 2

- Intervention fidelity was largely maintained as productivity goals were expanded and the intervention scaled-up
  - Some lessons learnt to improve delivery; some slippage as scale and productivity targets increased
  - Importance of good functioning of microfinance before introducing health promotion confirmed
  - Sometimes ambiguous management systems during scale-up posed challenges to staff morale

Lesson 3

- “Linked” partnership between specialist microfinance and health promotion organisations working together in the field offered most sustainable delivery model
  - Linked model most successful and strongly favoured by microfinance groups
  - Widespread support to combine microfinance and health promotion among opinion leaders
  - Health stakeholders seek more evidence of impact; microfinance stakeholders seek more evidence of operational feasibility

"So we have made the decision that ideally Sisters for Life should go into a separate NGO ... We would like to carry on in very much the same way we were doing in the trial where [the health training team] was a separate body who asked to bring in trainers and then coordination happened at the fieldworker level."

(Microfinance manager, 2006)

"In a microfinance institution, aiming for sustainability, we account for every cent we spend […] and the moment you want to integrate [IMAGE] into your budget, into your sustainability, you will just not be able to. I don't think it is worthwhile to integrate it, and I think there are sufficient funders interested in the issue internationally to fund this. I really think [IMAGE] should always be externally funded."

(Microfinance opinion leader, 2006)

Lesson 4

- Successful implementation of IMAGE: Cannot explain the lack of sexual behaviour change among young people
  - Intra-household communication on HIV increased, but short duration of exposure may not have been sufficient to foster community-wide behavioural change
  - Microfinance penetration to 10-20% of households per community may be insufficient to stimulate wider effects
  - Collective action was complex and awareness of IMAGE among community residents was low; may explain lack of impact on HIV incidence

Conclusions

- Structural health promotion is essential to fight HIV/AIDS in Africa
- Microfinance may be one potential vehicle –inter-sectoral collaboration is essential and will require innovative thinking
- Large trials of combined interventions may meet needs of opinion leaders in microfinance and health