

**Microfinance and OVC Households:  
A Report on Baseline Data for Impact  
Assessment of PRISMA**

Grace Bahng  
PhD Candidate  
School of Policy, Planning, and Development  
University of Southern California  
[gracebahng@gmail.com](mailto:gracebahng@gmail.com)

# TABLE OF CONTENTS

List of Abbreviations .....	3
Executive Summary .....	4
A. BACKGROUND .....	8
B. RESEARCH DESIGN.....	11
C. CONTEXT .....	12
D. METHODS .....	15
E. RESULTS.....	17
OVC Caregivers.....	17
OVC Caregivers Participating in Microfinance.....	19
Household Expenditures .....	22
Vulnerability and Assistance.....	23
Community Involvement.....	23
OVC Psychosocial Factors.....	23
COORDINATION BETWEEN WVE AND WISDOM.....	26
Credit+Edu Program .....	26
Role of Community Workers (CWs) .....	26
Targeting OVC Households for WISDOM .....	27
Appendix .....	29
References .....	38

## List of Abbreviations

ADP	Area Development Program
CCC	Community Care Coalitions
CIP	Children in Program
CW	Community Worker
IGA	Income Generating Activities
KA	Kebeles/Village
MFI	Microfinance Institution
OVC	Orphans and Vulnerable Children
WVE	World Vision Ethiopia

## **Executive Summary**

The AIDS epidemic in sub-Saharan Africa has resulted in millions of children who have been orphaned or left vulnerable due to the impact of HIV/AIDS on family members. Once the epidemic has infected a family member, the child is also impacted in several ways, both economically and psychosocially, that threaten their overall well-being. Furthermore, the sheer number of orphans and vulnerable children (OVCs) in the region has spread family networks thin and has weakened household and community safety nets.

The success and popularity of microfinance to alleviate poverty, empower individuals, and strengthen resilience has led to hopes that it might also be further used as a tool to mitigate the negative effects of the HIV/AIDS epidemic. In particular, many hope that microfinance can be used to strengthen household capacities, which can thereby improve OVC well-being. Furthermore, group methodologies employed in microfinance work to create incentive structures that can result in increased trust, information, and resources among its clients.

### **Objectives of the Report**

The objective of this report is to analyze baseline data that was collected in August 2007 for a longitudinal study examining the impact of the World Vision's Promoting Rural Integration and Security through Microfinance in Africa (PRISMA) initiative. The report focuses on the first round of data collection and compares differences between clients and non-clients who are caring for OVCs.

It provides a profile of OVC caregivers in general and of OVC caregivers who are participating in microfinance. It also uses a comparison between OVC caregivers who have participated in microfinance for longer than a year versus those who have participated for less than a year to observe differences in household capacity outcomes and OVC psychosocial well-being outcomes.

This report does not examine the impact of PRISMA yet since the program had not been fully implemented at the time of baseline data collection.

### **Methods**

The research design for the overall study was a two-year longitudinal study on the overall impact of the PRISMA project in two of World Vision Ethiopia (WVE)'s Area Development Programs (ADPs). The pre-test/post-test model was designed to compare OVC caregivers who were clients of WVE's affiliated microfinance institutions, WISDOM, to OVC caregivers who were not participating in microfinance. Data was collected in the Guraghe and Wonchi ADPs, which are located southwest of Addis Ababa. Analysis of the baseline data is reported here.

Households that were caring for OVCs were surveyed using an instrument based on the Community REACH protocol created for a USAID research project. The surveys included measures in the following areas: 1) household financial security, 2)

socioeconomic status, 3) social network, 4) income generating activities (IGA), and 5) food and health support. The survey included four parts:

- 1) Primary caregiver questionnaire
- 2) Primary caregiver questionnaire regarding their 6 to 12 year old child
- 3) OVC questionnaire for 6 to 12 year olds
- 4) OVC questionnaire for 13 to 19 year olds

The households surveyed for the first round of data collection was split into four groups: 1) **Clients > 1 yr** – WISDOM clients who have participated in microfinance for more than one year, 2) **Clients < 1 yr** – WISDOM clients who have participated in microfinance for less than one year, 3) **Non-clients with Access** – caregivers who are not clients but live in villages where WISDOM operates, and 4) **Non-clients without Access** – caregivers who are not clients and do not live in villages where WISDOM operates.

In addition to this, WVE and WISDOM staff members were interviewed concerning collaboration between the two organizations. Clients and non-clients also participated in structured interviews and client performance data was provided by WISDOM for the study.

Livestock assets were calculated based on prices obtained from USAID and NGOs. Household assets scores were calculated based on factor analysis. Psychosocial scores were calculated after testing for internal consistency and totaling the number of questions that respondents agreed with in each of four areas: 1) adolescent low self-esteem, 2) adolescent overburden/responsibility, 3) child worry/stress, and 4) child overburden/responsibility. (See Appendix for list of questions used.)

Data was entered in Ethiopia using SPSS statistical software. After data was checked for none responses and inconsistencies, the resulting sample was 279 OVC households (279 caregiver surveys, 173 adolescent surveys, and 221 child surveys). 162 households were from Guraghe (162 caregiver surveys, 95 adolescent surveys, and 119 child surveys) and 117 households were from Wonchi (117 caregiver surveys, 79 adolescent surveys, and 92 child surveys).

## **Key Findings**

### *OVC Caregivers*

- Overall, OVC caregivers tended to be in between the ages of 25 and 49 years old. In Guraghe, OVC caregivers were more likely to be widowed while OVC caregivers were more likely to be married in Wonchi. The most common occupation was farmer while Guraghe had a greater diversity of occupations than Wonchi. The average household size was 5.38 and paternal orphans were the highest proportion of OVCs.

### *OVC Caregivers Participating in Microfinance*

- Despite the assumptions of both WVE and WISDOM staff that few OVC caregivers were participating in WISDOM, data showed that 20.8% of the clients in eight kebeles (KAs) in Guraghe were caring for OVCs.

- Clients more likely to be older and married and less likely to be widowed when compared to non-clients among OVC caregivers. In Guraghe, clients tended to have lower percentages of OVC caregivers who were 'Not currently working'. In both ADPs, clients tended to have smaller households and fewer children. Clients were also less likely to have someone who was chronically ill in their household. Finally, clients were also less likely to have paternal orphans and more likely to have an orphan who had lost both of their parents.

#### *What Difference Does Microfinance Make?*

- Overall, clients who had participated in WISDOM longer than a year tended to eat more and were more likely to send the children in the household to school than clients less than a year. Livestock and household assets scores tended to be worse among clients longer than a year, however. This may be in part due to levels of assistance on which household are relying.
- Clients who have participated in WISDOM longer than a year tend to rely less on CIP and health assistance than newer clients. In addition, comparisons showed that clients longer than a year were less likely to sell their assets for basic needs in the past year than newer clients.
- Clients longer than a year were also more likely to have attended a meeting to discuss community concerns than newer clients.
- Finally, the strongest results showed a positive impact of microfinance participation on psychosocial well-being for adolescent OVCs. Regressions showed significant and positive impacts of the length of participation in WISDOM on OVC psychosocial well-being, such as adolescent self-esteem and adolescent overburden/responsibility.

#### **Coordination Between WISDOM and WVE**

- Implementation of the PRISMA project had not fully been implemented at the time of baseline data collection. Nevertheless, there were some efforts at coordination in the form of the Credit+Edu program that was implemented one year prior.
- The role of the community worker (CW) should not be overlooked since CWs are often the sources of the most accurate information on OVC caregivers. Regressions showed significant and positive impacts of a positive relationship between CWs and WISDOM staff on household outcomes, such as loan growth, livestock assets, and average meal per day per household member.
- Interviews with staff members from both organizations showed evidence of two assumptions inhibiting a more natural collaboration between WVE and WISDOM concerning OVC households. First, there was an assumption that microfinance was designed to benefit the able poor and not the very poor. Second, there was an assumption that OVC households were predominantly very poor.
- Whether these assumptions are true for the majority of OVC caregivers has yet to be shown. Data does show that there are already high percentages of WISDOM clients that are caring for OVCs. Nevertheless, whether WISDOM can expand and reach

the very poor OVC households remains in question. One major hurdle for this to occur seems to be the high minimum loans in WISDOM policies and the lack of savings among very poor households.

- However, if an OVC caregiver can remain and participate in microfinance for over a year, data suggests that they are less likely to rely on assistance, more resistant to unexpected events, more involved in community meetings, and more likely to have OVCs with healthier psychosocial well-beings.

## **A. BACKGROUND**

### **HIV/AIDS and Orphans and Vulnerable Children**

In 2001, the USAID in conjunction with UNICEF and UNAIDS estimated that 80% of the 14 million children worldwide who lost one or both parents to AIDS lived in sub-Saharan Africa (USAIDS, 2002; Shetty & Powell, 2003: 25; Foster et al., 2005: 5). Estimates expect the number of those orphaned due to AIDS in this region to reach 20 million by 2010 and remain exceptionally high until 2030 (USAIDS, 2002; Foster, 2000: S275).

The impact of living with a family member who is infected with HIV can be difficult for children because of the ensuing change that tends to occur in the distribution of resources and responsibilities in a household. While it has been recognized that there needs to be greater understanding of this impact (Foster, 2000: S275), initial research has pointed to negative economic and psychosocial effects for the child due to the directing of more resources away from the child to the person living with HIV/AIDS (PLWHA) and the directing of more responsibilities away from the PLWHA to the child (Foster, 2000; Shelly & Powell: 2005). New responsibilities can include: “cooking, cleaning, carrying water and laundry, care giving activities such as feeding, bathing, toileting, giving medication and accompanying relatives for treatment, agricultural or income generating activities and childcare duties” (Foster & Williamson, 2000: S278).

In addition, psychosocial affects have been observed on children with a parent who is positively infected. A study in Uganda showed that children were more likely to feel hopeless or angry while their parents were sick (Foster & Williamson, 2000: S282). In Zambia, one study showed children as being described as being “worried, sad, tried to help in the home and stopped playing to stay nearby” as well as “more likely to become solitary, appear to be miserable or distressed and be fearful of new situations” (Foster & Williamson, 2000: S276).

Furthermore, once a child has had one or both parents die from AIDS, the long-term effects of a loss of home and income need to be considered as well as the psychological effects of the loss of a parent, the changes in caretakers and family composition, and the stigma of having orphan status (Richter, 2006: 9-12). Researchers have identified that “stigmatization, dropping out of school, changed friends, increased workload, discrimination, and social isolation of orphans all increase the stress and trauma of parental death” (Foster & Williamson, 2000: S282). Orphans also tend to experience a lowering of expectations for their future, such as for their family and future job as self-esteem tends to suffer, although perhaps not sociability (Foster & Williamson, 2000: S282). See Figure 1 for the impact of HIV infection on child well-being.

### **Improving OVC Well-Being through Households**

While many fear that the impact of the AIDS epidemic in sub-Saharan Africa threatens to reverse much of the development gains over the past decades (USAID, 2001: 2), the role of the extended family network as a safety net for orphans and vulnerable children (OVCs) has become apparent as aunts, uncles, and sometimes grandparents often act as caregivers for children after a parent has passed away. As a result, interventions directed at working through households rather than resort to institutionalization are often

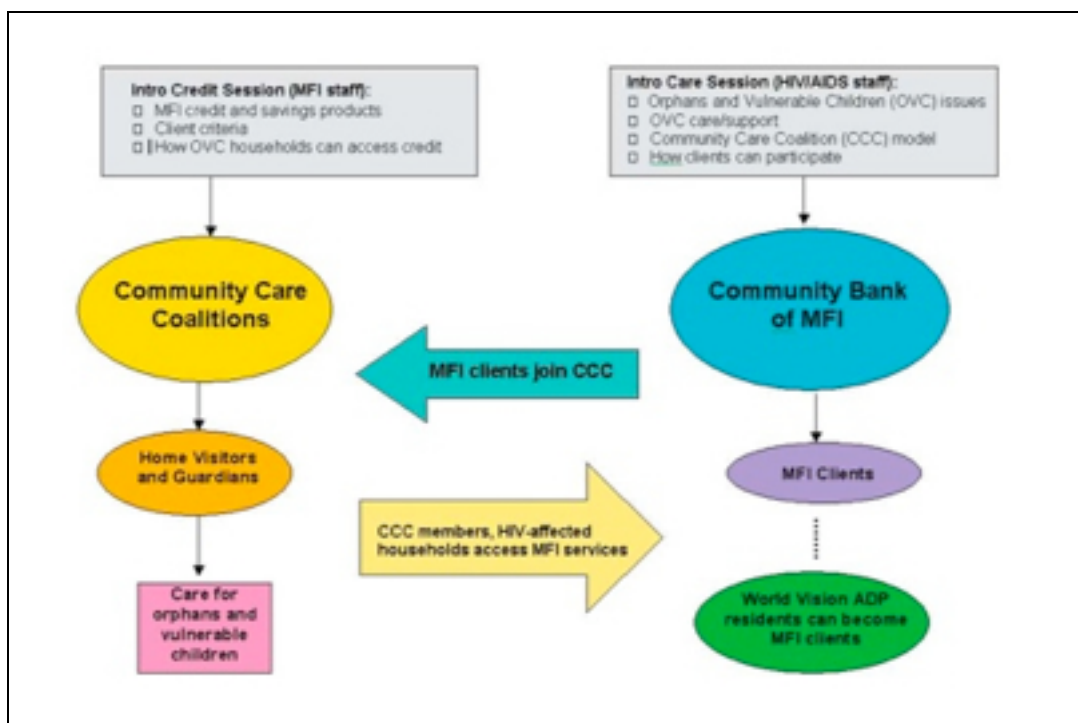




including Ethiopia, Kenya, Rwanda, Tanzania, and Uganda. The stated purpose of PRISMA was to “improve the lives of very poor women in rural East Africa by combining economic development assistance with improved access to HIV/AIDS care, mitigation services, and education” (Tegarden, 2006).

PRISMA was designed to achieve its program goal by using an integrated approach that involved close coordination between community development staff specializing in HIV/AIDS care and affiliated MFIs specializing in economic development assistance. Figure 2 shows the implementation model below. In particular, WV HIV/AIDS staff would collaborate with MFI loan officers to improve access to appropriate financial services for rural female clients, including those who are caring for OVCs. Integration of the services would include two key components: 1) MFIs would target an increasing number of caregivers, who are economically active, through its normal product lines, and 2) MFIs would connect recipients of group loans with the services of WV’s HIV/AIDS Community Care Coalitions (CCCs)<sup>1</sup> (Tegarden, 2006). In addition, WV HIV/AIDS development staff would connect with MFI community banks and educated them about OVC issues and help them to get involved with CCCs. Meanwhile, MFI loan officers would connect with CCCs and educate them concerning their products and services. Figure 2 shows the PRISMA integration model below.

**FIGURE 2: PRISMA IMPLEMENTATION MODEL**



<sup>1</sup> Community Care Coalitions (CCCs) are community-based support groups that work to identify, visit, monitor, assist, and protect OVCs in the community (WV CHARMS, 2006: 7). HIV/AIDS development staff work to mobilized and train CCCs in their Area Development Program (ADP).

## Ethiopia

As of 2004, approximately 11% of the 35 million children in Ethiopia are orphaned having lost one or both parents. By 2003, UNAIDS estimated that 720,000 of the 3.9 million orphans in Ethiopia had lost their parent or parents due to AIDS. It also projected that the number of orphans will grow to 4.7 million by 2010 (UNAIDS, 2004: 26).

### World Vision Ethiopia (WVE)

World Vision Ethiopia (WVE) has operated in Ethiopia since 1971 and works throughout the country in seven regional states. It has 61 Area Development Programs (ADPs). ADPs work on the frontline in program implementation and are organized according to a generic structure contextualized to the region.

### WISDOM, Micro Financing Institution S.C. (WISDOM)

WISDOM originally began under WVE's efforts to extend microcredit services after relief and rehabilitation efforts in the 1980s. Initial activities included in-kind loans with both agricultural and cash repayments. In 1996, WVE stopped its microfinance activities due to Proclamation No. 40 by the Ethiopian government, which limited microfinance activities to registered and regulated institutions that were established as share companies.

In 1998, WVE established WISDOM as a separate entity owned by 13 non-WVE staff and WVE senior staff and middle management. WISDOM, Micro Financing Institution, S.C. was issued a small-scale and micro-financing business license by the National Bank of Ethiopia. It was formed as a share company with a starting capital of 200,000 Birr.

## B. RESEARCH DESIGN

The purpose of the original research design was to determine the impact of integrating microfinance services with HIV/AIDS care on program capacity and effectiveness in a two-year longitudinal study. The design used a pre-test/post-test model aimed at comparing outcomes in household capacity and OVC well-being among one treatment group and two control groups in Ethiopia. The three groups of households who were caring for OVCs are as follows:

1. **Treatment Group** – Clients and Non-client were surveyed in kebeles (KA) or villages where WVE's development staff and its affiliated MFI, WISDOM's staff were working together to implement an integrated approach to care for OVC households through PRISMA.
2. **Control Group #1** – Clients and Non-clients were surveyed in KAs where WVE's development staff and WISDOM staff were *not* partnering together but were both present and active in the community.
3. **Control Group #2** – Non-clients were surveyed in KAs where WVE's development staff was working but WISDOM was not operating or available.

The first round of data collection was conducted in August 2007 with plans to interview the same respondents two years later. Research was conducted in areas covered by WVE Guraghe ADP and Wonchi ADP. Both areas are approximately 125-200 km southwest of Addis Ababa.

## **Objectives of the Report**

This report focuses on the baseline data that was collected in August 2007. Because PRISMA had yet to be significantly implemented in the areas where the study was conducted, the report will mainly focus on the impact of microfinance on households who are caring for OVC. In particular, the study will examine differences between clients and non-clients who are caring for OVCs comparing measures of: 1) household assets, 2) diet and health, 3) education, 4) OVC psychosocial well-being, 5) household vulnerability to unexpected events, and 5) community activities.

The households surveyed for the first round of data collection was split into four groups: 1) **Clients > 1 yr** – WISDOM clients who have participated in microfinance for more than one year, 2) **Clients < 1 yr** – WISDOM clients who have participated in microfinance for less than one year, 3) **Non-clients with Access** – caregivers who are not clients but live in villages where WISDOM operates, and 4) **Non-clients without Access** – caregivers who are not clients and do not live in villages where WISDOM operates. Guraghe contained OVC caregivers in each category while Wonchi did not have any OVC caregivers that were Clients < 1 yr.

For the purposes of the study, OVCs are defined as: 1) children who have either lost one or both parents for some reason, 2) children who are living with PLWHA, 3) children who have a parent who is chronically ill, or 4) children who are identified as vulnerable by some community standard. In addition, adolescents are defined as persons who are 13 to 19 years old. Children are defined as persons who are 6 to 12 years old.

## **C. CONTEXT**

### **Guraghe**

The Guraghe ADP is located in the Guraghe zone, which has an area of 5932 km<sup>2</sup> and is comprised of 15 woredas (districts) and 421 KAs. The area is divided into three zones according to the terrain of the land. The highland comprises about 45.1% of the land, the medium altitude comprises about 49.2% of the land, and the low land comprises about 5.7% of the land. Its total population is approximately 1.8 million people.

WVE's Guraghe ADP began in 2001 and operates in the Guraghe zone in the Edja and Muhurna Aklil woredas. It is approximately 195 km<sup>2</sup> southwest of Addis Ababa and has an approximate area of 767 km<sup>2</sup> with 40.7% of it being cultivated land. In addition, it receives an annual rainfall of approximately 1000 to 1250 mm. A map of the Edja woreda is provided in Figure 3. The towns of Agena, Cheza, and Tekle Haimanot make up the Guraghe ADP. Its total population is approximately 233,00 people with 42,000 households as of 2007.

FIGURE 3: EDJA DISTRICT MAP



### HIV/AIDS

Because there is much movement to and from Guraghe, the area is more vulnerable to diseases prevalent in urban areas as well. There are two Ethiopia holidays (Meskali and Arefa) that bring large numbers of people back to their locality in Guraghe from urban areas. In addition, many caregivers spend longer periods of time in urban areas away from their homes for business or employment reasons. WVE HIV/AIDS focal staff member for the Guraghe ADP estimated a prevalence rate of 4-6% for the Edja district. By August 2007, the Guraghe ADP had identified 9,798 OVCs in the two districts it oversees.

WVE's HIV/AIDS efforts in Guraghe have five areas of intervention: 1) prevention, 2) care and support for those affected by HIV/AIDS, 3) partnership with faith-based organizations (FBOs), 4) staff capacity building, and 5) advocacy for those affected and marginalized by HIV/AIDS. Different strategies are employed, such as mobilizing and training CCCs and conducting coffee ceremonies every week where leaders of the community gather.

Each KA has their own CCC comprised of 10 to 12 members, including the KA chairman and various community leaders. The CCC has agreed to meet twice a month, including one meeting a month with WVE's HIV/AIDS focal person for the Guraghe ADP. There is a home visitor for each sub-village and 10 to 12 sub-villages in each KA. Home visitors

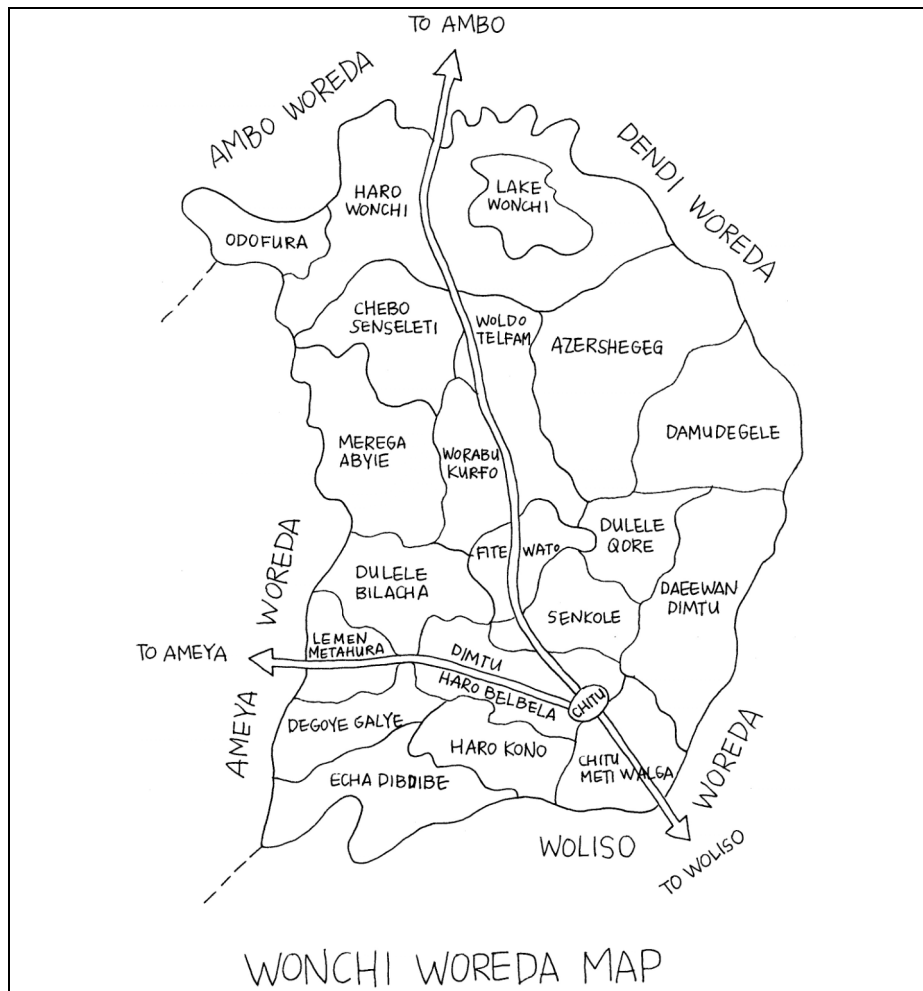
make 5 to 10 visits a week to households caring for OVCs that have been identified by the community and check on the OVCs education and health status.

### Wonchi

The Wonchi ADP is located in the Shoa zone and has and is about 123 km<sup>2</sup> southwest of Addis Ababa. It has 26 KAs and is part of the Oromia region where the local languages are Oromo and Amharic. The area is divided into two zones according to the terrain of the land. The highland comprises about 44% of the ADP and the midland comprises about 56% of the ADP. It has an altitude of 1800 to 3387 masi and typical rainfalls occur between the months of June and September for annual levels of 1200 to 1420 mm.

The Wonchi ADP has an approximate area of 475 km<sup>2</sup> with 96.8% of its population living in rural areas where subsistence agriculture is the predominant source of livelihood. The rest of the population lives in townships and periurban areas. There are approximately 110,000 people and 22,000 households who are direct beneficiaries of the ADP. Figure 4 shows a map of the Wonchi ADP.

**FIGURE 4: WONCHI DISTRICT MAP**



## *HIV/AIDS*

Similar to Guraghe, Wonchi also has large numbers of caregivers who travel back and forth to urban areas for employment. Often caregivers will have multiple wives or partners and can transmit diseases to and from Wonchi. By August 2007, there were nearly 5,000 OVCs identified and registered by WVE CCC's in the district. 1800 were also CIPs. WVE HIV/AIDS focal staff member for Wonchi was unsure of prevalence rates but estimated them to be similar to Guraghe.

Like Guraghe, each of the 24 KAs in the Wonchi ADP had formed their own CCC with a similar meeting structure. The HIV/AIDS focal staff member would meet with each CCC once a month to discuss issues and conduct training sessions. In addition, other programs were organized for OVC families, such as life skills and IGA training.

## **D. METHODS**

### **Survey Instruments**

Household surveys were based on the Community REACH survey instrument<sup>2</sup> that was constructed and used for a USAID research project on the well-being of children affected by HIV/AIDS in Zambia and Rwanda. Four of the original five parts of the survey instrument were used for the first round of data collection. The four parts included:

- 5) Primary caregiver questionnaire
- 6) Primary caregiver questionnaire regarding their 6 to 12 year old child
- 7) OVC questionnaire for 6 to 12 year olds
- 8) OVC questionnaire for 13 to 19 year olds

Surveys were adapted to context and included questions divided into the following sections: 1) household financial security, 2) socioeconomic status, 3) social network, 4) income generating activities (IGA), and 5) food and health support. Children and adolescents were also asked questions concerning psychosocial well-being around topics, such as worry/stress, overburden/responsibility, locus of control, and self-esteem (See Appendix for list of questions).

Household surveys were created in English and then translated to Amharic in Ethiopia. The instruments were then discussed during trainings and pilot testing with data collection team and revised where necessary.

In addition, structured interviews were conducted with staff members and OVC households. Staff interviews were based on structured interview protocols used at the University of Southern California's Collaborative Learning Project (CLP). Original protocols were developed to examine the nature of collaboration between neighborhood governance groups and city agencies. Instruments were then contextualized for

---

<sup>2</sup> Survey was accessed at: <http://www.pactworld.org/reach/OVCResources/>.

HIV/AIDS care and microfinance services. Interviews were conducted with translators from English to Amharic and a note taker to record the interviews.

### Description of Sample

A total of 316 households (316 caregivers, 265 adolescents, and 184 children) were interviewed in the first round of data collection. This includes 119 WISDOM clients were interviewed in addition to 197 non-clients. 169 households were interviewed from the Guraghe ADP (169 caregivers, 141 adolescents, and 98 children). 147 households were interviewed from the Wonchi ADP (147 caregivers, 124 adolescents, 86 children).

ADPs were selected in consultation with WVE and WISDOM managers based on ADPs that had started to implement a Credit+Edu in some KAs. Credit+Edu combined microfinance services with HIV/AIDS awareness education for WISDOM community banks. The KAs for the treatment group were then selected based on where the Credit+Edu program had already been implemented in at least one community bank.

Because both WISDOM and WVE HIV/AIDS staff members were unaware of which households were both caring for OVCs and participating in WISDOM services, coordination was needed to obtain a list. WISDOM loan officers consulted with WVE community workers to cross-reference client lists from WISDOM with OVC households from WVE. After household were identified, based on the numbers of WISDOM clients who were also caring for OVCs, KAs were selected for the first control group (WVE and WISDOM present but not coordinated) to sample as many client OVC households as possible. Non-client households who were caring for OVCs were then selected randomly from household lists.

KAs for the second control group (WVE present but no WISDOM) were selected in consultation with WVE ADP staff. Selection was based on accessibility. See Table 1 below.

**TABLE 1: KEBELES INCLUDED IN THE SAMPLE**

	<b>Treatment Group: Coordinated</b>	<b>Control Group #1: Uncoordinated</b>	<b>Control Group #2: Single Service</b>
<b>Guraghe</b>	Sheremo Shebraden Agena	Wasamer Yegobet Wadiye Desene	Ambagenet
<b>Wonchi</b>	Belabela	Dimtu	Fite

Data was entered in Ethiopia using SPSS statistical software. After data was checked for no responses and inconsistencies, the resulting sample was 279 OVC households (279 caregiver surveys, 173 adolescent surveys, and 221 child surveys). 162 households were from Guraghe (162 caregiver surveys, 95 adolescent surveys, and 119 child surveys) and 117 households were from Wonchi (117 caregiver surveys, 79 adolescent surveys, and 92 child surveys).



## Asset Scores

Livestock asset scores were calculated by surveying caregivers concerning the numbers of several different types of livestock that they owned, such as cows or goats. Prices from USAID Pastoralist Livelihoods Initiative Market Monitoring Bulletin as well as from NGO websites were used to approximate the market price of various livestock.

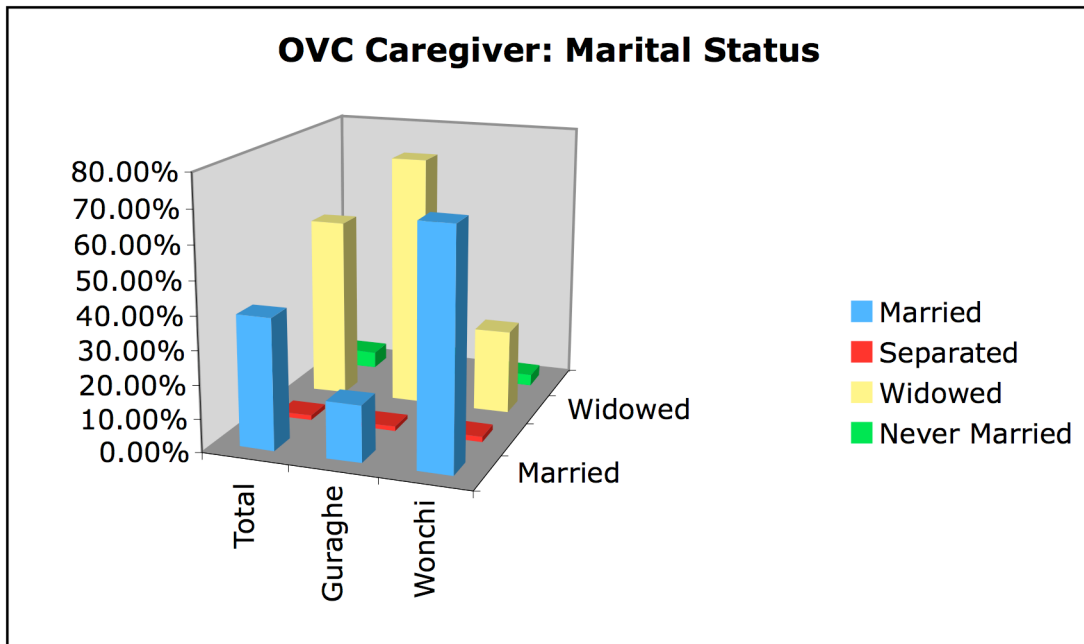
Household asset scores are based on a series of questions concerning what sort of assets the caregiver, adolescent, and child possessed. Data was then tested for internal consistency for a Cronbach alpha score of greater than 0.70 and factor scores were calculated using the principal components method with a varimax rotation.

## E. RESULTS

Bivariate analyses and Pearson chi-square tests were used to test associations among groups when comparing data.

### OVC Caregivers

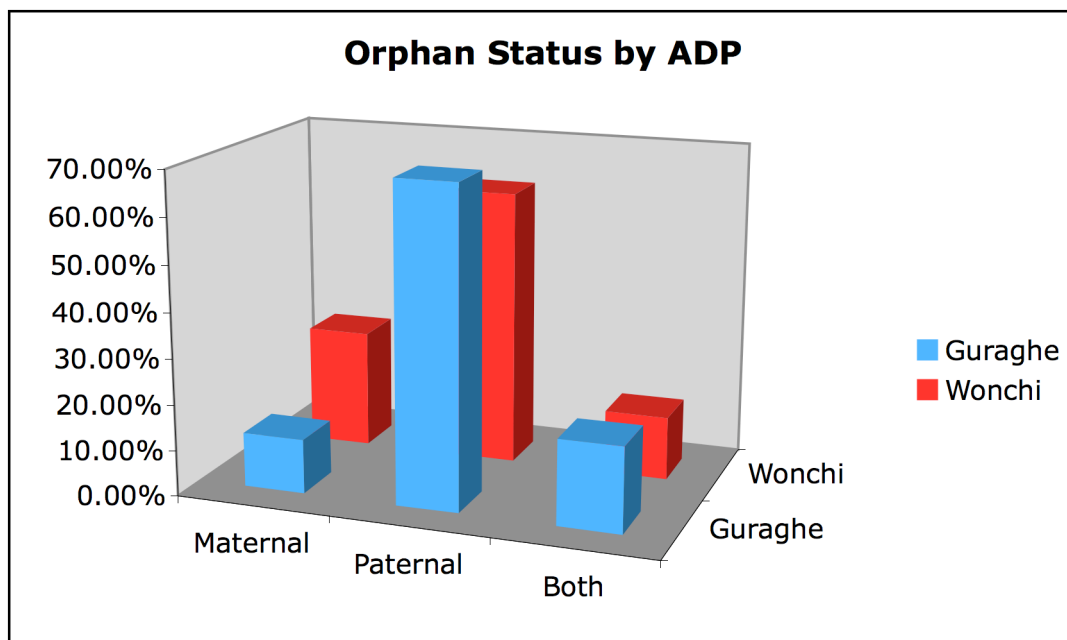
Data in our sample showed greater percentages of caregivers between the ages of 25 and 49 yrs old (55.3%) and greater percentages of caregivers who had been widowed (54.3%). In Guraghe, the percentage of widowed caregivers was higher (75.6%) than Wonchi. In Wonchi, there were higher percentages of caregivers who were married at 69.9%. This is likely due in part to the fact that there are higher percentages of maternal orphans in Wonchi (25.9%) than Guraghe (11.9%). Because it is often easier for men to remarry, the higher percentages of married OVC caregivers may be attributed to this. Other cases include situations where the OVC is living with a relative who is married, such as a grandparent, uncle/aunt, or sibling.



About a quarter (24.5%) of all OVC caregivers in the sample had ever attended school. Wonchi had higher proportions of caregivers who had attended school at 39.5%. The most common occupation for the OVC caregiver was farming at 68.3%. Nearly all the caregivers in Wonchi were farmers while occupations in Guraghe were more diverse and included farming, professional/civil servant, and trading as the top three specified occupations. There were also more caregivers not working in Guraghe at 8.9% than Wonchi. Wonchi caregivers were also more likely to have had some training in income generating activities (IGA) at 11.5%. This may be because of the high percentages of farmers.

The average household for all OVC caregivers in the sample was 5.38 people. Wonchi had larger average households (5.78) than Guraghe (5.08). Guraghe households had slightly more adult females and Wonchi had a higher average of children (3.50) than Guraghe (2.78).

Paternal orphans are the highest proportion of orphans at 66.7%. As stated earlier, there were higher proportions of maternal orphans (25.9%) and lower proportions of paternal orphans (60.3%) in Wonchi than Guraghe (11.9% and 69.4% respectively). Guraghe had higher percentages of OVCs that had lost both parents however at 18.7%. In addition, it had almost double the rate of OVC's whose mother was chronically ill<sup>3</sup> at 31.2%.



*Overall, OVC caregivers tended to be in between the ages of 25 and 49 years old. In Guraghe, OVC caregivers were more likely to be widowed while OVC caregivers were more likely to be married in Wonchi. The most common occupation was farmer while Guraghe had a greater diversity of occupations than Wonchi. The average household size was 5.38 and paternal orphans were the highest proportion of OVCs.*

<sup>3</sup> Chronic illness was defined as sick for longer than 3 months in the past year.

## OVC Caregivers Participating in Microfinance

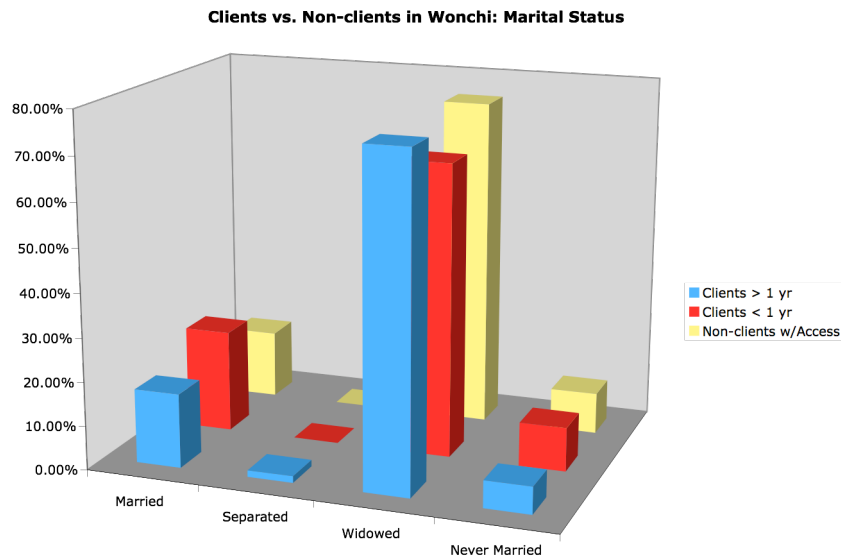
Interviews with both WVE community workers (CWs) and WISDOM staff members indicated the common belief that few OVC caregivers would participate in WISDOM services for mainly two reasons. First, because community banks are self-selected groups, other community members were reluctant to allow OVC caregivers to join their groups because of a perceived lack of capital. Second, OVC caregivers themselves were reluctant to join community banks because they feared the consequences of not being able to pay back the loan.

**TABLE 2: WISDOM Clients Who Are Caregivers for OVC**

<u>Kebele (KA)</u>	<u>% of Clients w/OVC</u>
Agena	20.4%
Desene	36.0%
Shebraden	9.7%
Sheremo	17.0%
Wadiye	15.2%
Wasamer	20.0%
Yegobet	30.1%
<b>Total of 8 KAs</b>	<b>20.8%</b>

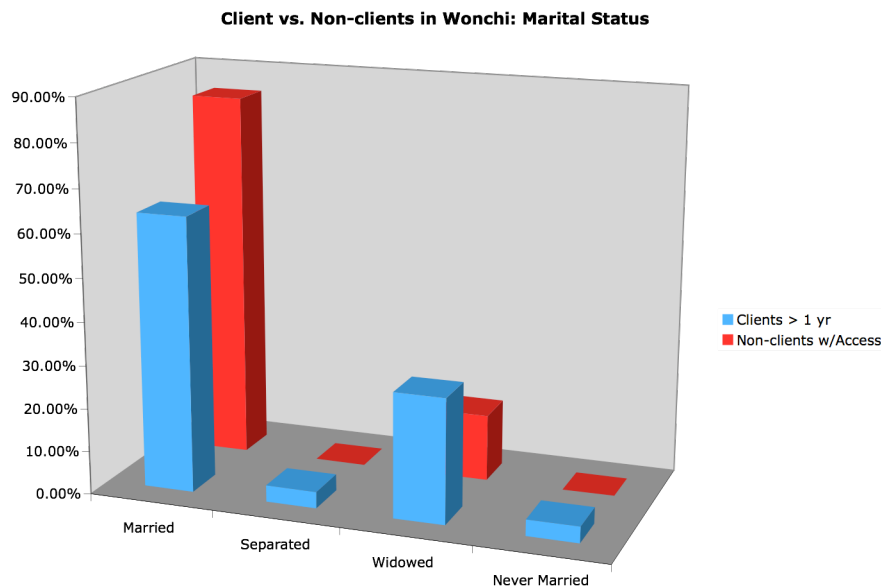
*Note:* Data taken from selected KAs in Guraghe ADP. Provided by cross-checking client lists between WVE Community Workers and WISDOM Staff.

Nevertheless, whether this is true or not for the majority of OVC caregivers, data from the first round of collection indicates that there is a population of OVC caregivers that are already participating in microfinance. Table 2 shows an average of 20.8% of the WISDOM clients in eight KAs that were researched in Guraghe were OVC caregivers.



Overall, caregivers who were clients of WISDOM tended to be older than caregivers who were not clients. In Guraghe, the average age of OVC caregivers who were WISDOM clients (clients less than one year was 26.33 yrs and clients greater than one year was 27.14) was higher than both non-clients who had access to WISDOM (24.41 yrs). Clients in Guraghe had greater percentages of caregivers who were both 15 to 24 yrs old and caregivers who were greater than 50 yrs old. In Wonchi, OVC caregivers who were WISDOM clients had a higher average age (21.54 yrs) than non-clients with access to WISDOM.

Overall, clients of microfinance are more likely to be married than non-clients. Similarly, clients of microfinance are less likely to have been widowed than non-clients. 84.6% of Wonchi clients were married compared to non-clients with access at 63.5%. 15.4% of Wonchi clients were widowed compared to 28.8%. In Guraghe, clients more than 1 year were at similar percentages as non-clients with access in proportions of caregivers who were married and widowed. Clients less than one year, however, were more likely to be married and less likely to be widowed than the other two groups.



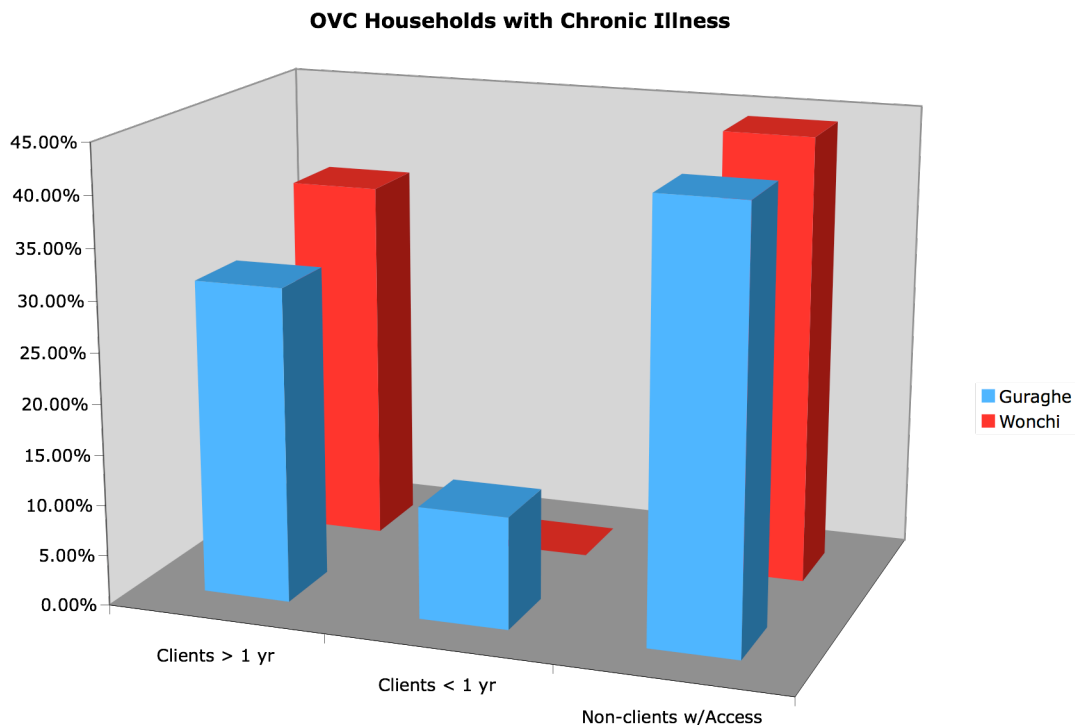
With regards to education, results from the two ADPs were more mixed with Wonchi clients being less likely to have gone to school compared to non-client while Guraghe clients were more likely. In terms of occupation, Wonchi clients showed similar patterns of high percentages of farmers as non-clients. In Guraghe, however, clients were more likely to be farmers (less than one yr: 62.1% and more than one yr: 50.0%) than non-clients with access (36.5%). In addition, Guraghe clients had higher percentages of caregivers who were professional/civil servants than non-clients in Guraghe. The differences with regards to occupation is likely to be because the rates of caregivers not working among non-clients with access in Guraghe was so high at 31.7%.

Clients also had smaller household sizes compared to non-clients in both ADPs. In Guraghe, the total household was 4.93 and 4.31 for clients less than a year and clients greater than a year respectively and 5.39 for non-clients with access. In Wonchi, clients

had an average of 5.69 while non-clients with access had 5.98. The differences in both ADPs are largely seen in the numbers of children.

With regards to orphan status, results were more mixed. Guraghe clients were less likely to have a maternal orphan while Wonchi clients were more likely to have a maternal orphan than their respective non-clients with access groups. Furthermore, in Guraghe, clients were less likely to have an OVC whose mother was chronically ill at 14.3% for clients less than a year and 30.0% for clients over a year compared to non-clients with access (53.5%). In Wonchi, the results were more mixed with OVCs with mothers who are chronically ill about even between the two groups.

Overall, clients were less likely to have someone in their household who was chronically ill. In Guraghe, 42.6% of all non-clients with access had someone who was chronically ill in the household compared to 11.1% of clients less than a year and 31.0% of clients longer than a year. In Wonchi, clients were also less likely to have someone in their household who was chronically ill (47.1%) than non-clients with access (44.2%)



In both ADPs, however, clients were less likely to have paternal orphans and more likely to have orphans who have lost both parents. This likely is accounted for by the fact that overall clients are more likely to be married. (See chart of orphan and sickness status).

*Data shows evidence of high numbers of OVC caregivers that are already participating in WISDOM without any special targeting by either organization. Clients more likely to be older and married and less likely to be widowed when compared to non-clients among OVC caregivers. In Guraghe, clients tended to have lower percentages of OVC caregivers who were 'Not currently working'. In both ADPs, clients tended to have*

*smaller households and fewer children. Clients were also less likely to have someone who was chronically ill in their household. Finally, clients were also less likely to have paternal orphans and more likely to have an orphan who had lost both of their parents.*

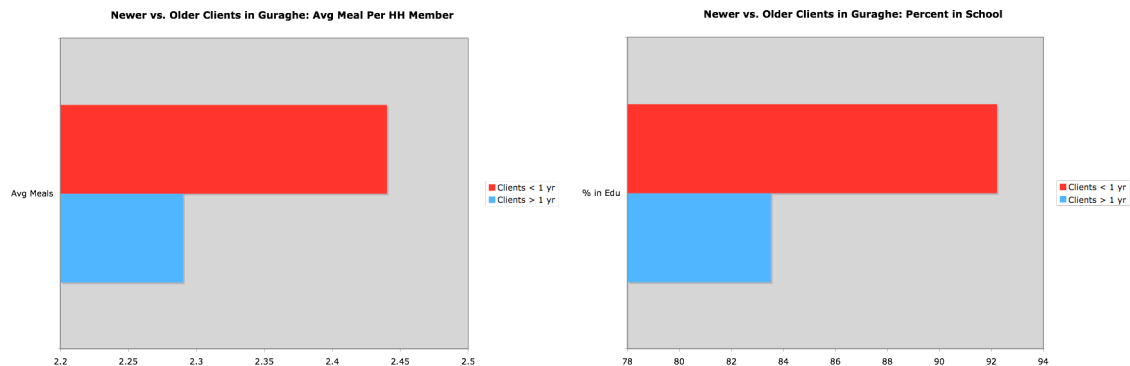
### What Difference Does Microfinance Make?

Because Wonchi did not have OVC caregivers who were also WISDOM clients participating less than a year, this section will examine only the Guraghe data. Because there have been criticisms of impact assessment of microfinance due to selection bias that may occur, this report compares outcomes among newer clients to older clients. Comparing newer clients to older clients eliminates the bias that may occur due to the fact the clients are self-selected and may have an “entrepreneurial factor” that is not accounted for in many impact assessments. Although there may still be an attrition bias of clients who drop out of the program after a year, it is likely less of a factor than the self-selection of clients.

### Household Expenditures

When examining household expenditures, the results are mixed in terms of if clients who have participating in microfinance longer than a year are better off than clients who have participated for less than a year.

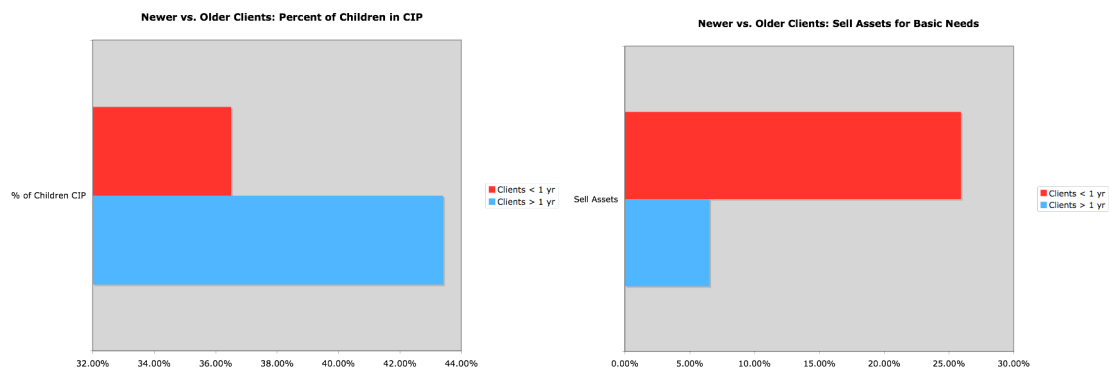
With regards to meals, the results strongly support that clients longer than a year are eating more than client less than a year. Clients more than year have an average of 2.44 meals per household member per day while clients less than one year have an average of 2.29. Similarly, clients who have participated in WISDOM longer than a year have higher averages of percentages of school-aged children who attend school at 92.2% compared to newer clients at 83.5%



Nevertheless, with regards to assets, both livestock and household asset scores show that clients longer than a year have less than clients less than a year. Clients longer than a year have an average of 3286.22 Birr of livestock assets while clients less than a year have an average of 3676.47 Birr. Similarly, household asset scores are lower for clients longer than a year than clients less than a year.

## Vulnerability and Assistance

One reason that assets scores are lower among clients longer than a year is because the levels of assistance can vary from household to household. Results from Guraghe indicate that clients longer than a year receive and rely on less support than clients who have participated in microfinance for less than a year. The average percentage of school-aged children who were identified as WVE's Children in Program (CIP) was lower for clients longer than a year (36.5%) than clients less than a year (43.4%). In addition, Guraghe clients longer than a year also were more likely to have paid their last medical bill themselves (83.3%) than with other forms of assistance than newer clients (73.3%).



Moreover, not only were there greater percentages of newer clients relying on these forms of assistance, but newer clients also seemed more susceptible to unexpected events. Greater proportions of newer clients had to sell their assets to provide for basic needs (25.9%), such as food and education, than clients longer than a year (6.5%) in Guraghe. Nevertheless, clients longer than a year were slightly more likely to have not sought medical services for the caregiver in the past year for some reason or another (29.4%) than newer clients (25.0%). The lower percentage among newer clients, however, may be because they are also less likely to pay for the medical services themselves.

## Community Involvement

Clients who had participated in microfinance for longer than a year were also more likely to attend a meeting to discuss community concerns, such as education or health problems, than non-clients. In Guraghe, 72.4% of all clients longer than a year attended community meetings compared to 39.3% of all clients less than a year. Clients longer than a year were also more likely to have someone they could turn to for advice at 18.5% compared to 11.1% of clients less than a year.

## OVC Psychosocial Factors

Perhaps one of the strongest cases for microfinance participation among caregivers of OVCs is the impact it has on the psychosocial well-being of the OVC. Regressions were

performed modeling various dimensions of OVC psychosocial well-being as a function of how long a caregiver had been a WISDOM client (0 = less than a year, 1 = longer than a year) in addition to other control variables. All regressions are ordinary least squares (OLS) and used the following equation:

$$\text{Psychosocial Outcome} = \alpha * \text{Length of WISDOM Participation} + \beta * \text{Other Controls} + \varepsilon$$

The four outcomes that were tested were: 1) adolescent low self-esteem, 2) adolescent overburden/responsibility, 3) child worry/stress, and 4) child overburden/responsibility. The outcomes were a result of a series of questions that were organized into various groupings and tested for internal consistency. The occurrences of when a respondent agreed with a question were totaled within each grouping and assigned as the score. Lower scores represent greater psychosocial well-being as higher scores indicate more agreement with questions concerning distress, burden, etc. A list of questions included in each of the groupings can be found in the Appendix. A fifth grouping for adolescent locus of control was also tested but did not pass internal consistency tests.

Table 3 shows the results of the regressions. Each model performed was able to explain high percentages of variance (adjusted R<sup>2</sup>) in dependent variable (psychosocial outcomes) ranging from 0.374 to 0.467.

Among adolescents, the length of WISDOM participation showed to be a significant at the 5% level and had the effect of decreasing low self-esteem measures (-0.403). Other significant factors on adolescent low self-esteem were the presence of female adults in the household (-0.597) and whether the caregiver was a trader by occupation (0.537). Because traders tend to spend time away from the household, the occupation had an effect of increasing adolescent low self-esteem.

Concerning adolescent overburden and responsibility, the length of WISDOM participation had a similar effect and was significant at the 5% level as well. Longer participation in WISDOM had the impact of lowering adolescent overburden/responsibility measures (-0.503). The numbers of children in the household were also significant factors with increasing numbers of male children lowering overburden measures while female children tended to increase it.

The results for children psychosocial well-being tended to be less significant but nevertheless are notable with significant F statistics and high adjusted R<sup>2</sup>s.

*Overall, clients who had participated in WISDOM longer than a year tended to eat more and were more likely to send the children in the household to school than clients less than a year. Livestock and household assets scores tended to be worse among clients longer than a year, however. This may be in part due to levels of assistance on which household are relying.*

*Clients who have participated in WISDOM longer than a year tend to rely less on CIP and health assistance than newer clients. In addition, comparisons showed that clients longer than a year were less likely to sell their assets for basic needs in the past year*



**TABLE 3: Regressions for Psychosocial Outcomes in Guraghe ADP**

	Adol Low Self-Esteem	Adol Overburden	Child Worry/Stress	Child Overburden
Client Longer Than 1 Yr (0 = No, 1 = Yes)	-0.403**	-0.503**	-0.219	-0.206
# M Adults in HH	-0.231	-0.210	0.126	0.303*
# F Adults in HH	-0.597***	-0.293	0.047	-0.206
# M Children in HH	0.050	-0.473**	0.087	0.051
# F Children in HH	0.026	0.530***	0.117	-0.050
Occupation: (0 = Not Working)				
Artisan	-----	-----	0.040	0.211
Farmer	-----	-----	0.089	0.483
Trader	0.537**	0.386*	0.265	0.759***
Professional/Civil Servant	0.388*	0.043	-0.310	-0.112
Other	-0.242	-0.268	-0.109	0.149
Marital Status (0 = Married)				
Widowed	-0.114	0.235	0.238	0.125
Never Married	-0.436*	-0.402*	-0.126	-0.236
% of Children in CIP	-0.177	-0.050	-0.268*	-0.100
Chronic Illness in HH	0.189	0.075	-0.020	0.053
Has Someone to Go to for Advice	-0.088	0.364*	-----	-----
Has Attended School	0.132	0.036	-----	-----
Regular Place to Sleep at Night	-----	-----	0.653***	0.491***
Total Meals a Day	-----	-----	-0.282	-0.470**
F-stat	2.663**	2.815**	2.456**	3.045***
Adjusted R <sup>2</sup>	0.445	0.467	0.374	0.456
N	30	30	40	40

Note: Standardized coefficients given. \*\*\* p < 0.01; \*\* p < 0.05; \* p < 0.10.

*than newer clients. In addition, clients longer than a year were also more likely to have attended a meeting to discuss community concerns in the past year than newer clients.*

*Finally, the strongest results showed a positive impact of microfinance participation on psychosocial well-being for adolescent OVCs. Regressions showed significant and positive impacts of the length of participation in WISDOM on OVC psychosocial well-being.*

## **COORDINATION BETWEEN WVE AND WISDOM**

### **Credit+Edu Program**

The Credit+Edu program was implemented in late-2005 in a small number of KAs and combined microfinance services with HIV/AIDS awareness education for WISDOM community banks. In both ADPs, WVE's HIV/AIDS focal staff member held a one day training session for WISDOM loan officers on HIV/AIDS education. The content of the training covered transmission, prevention, and educating others. Following this training, WISDOM loan officers chose a select number of KAs to introduce HIV/AIDS education into the community banks. A meeting with held with community bank leaders where they were educated on the same topics of HIV/AIDS transmission, prevention, and education. Leaders were then instructed by the loan officers to bring this information back to their community banks and allot time at the beginning of each meeting for questions concerning HIV/AIDS topics. Brochures and posters were also given to the leaders to distribute to their community banks and KAs. There was no follow-up, however, on the implementation of this program and WISDOM staff were unaware of whether community banks continued with their discussion of HIV/AIDS topics beyond initial trainings.

### **Role of Community Workers (CWs)**

Because both WVE ADP staff and WISDOM staff operate on the ADP or district level, the WVE community worker (CW) is the closest staff member to the frontlines operating on the KA level. CWs often have the most recent and accurate information concerning status of households and OVCs. Thus, CWs can be important sources of information for both ADP and WISDOM staff members.

Both WVE and WISDOM noted that there was more coordination between organizations two years earlier (2005) and that a communication gap had emerged since then. In prior collaboration, WVE CWs would mobilize solidarity groups and refer them to WISDOM for microfinance services. Since then, however, CWs were mobilizing less and less groups for WISDOM. Interview respondents had various reasons for why this had occurred, which ranged from WISDOM not wanting to be associated as much with a non-profit charity that gave direct aid to changes in management and policies to simply overburdened workloads on both sides.

At the time of the interviews, coordination between CWs and WISDOM staff involved consultation concerning certain clients or community issues arose from time to time. No regular or frequent interaction was occurring, however. Relationships between CWs and WISDOM were described as either good or medium depending on the CW.

Nevertheless, the relationship of WISDOM with a KA's CW may have an impact on the performance of the client. Regressions were performed modeling several household outcomes as a function of the quality of the relationship between the CW and WISDOM staff in the following question:

$$\text{Household Outcome} = \alpha * \text{Relationship with CW} + \beta * \text{Other Controls} + \varepsilon$$

Only clients who lived in KAs whose CW had been interviewed were included in the sample. Based on interviews, the relationship between the CW and the WISDOM branch office was assessed (0 = Neutral or Negative, 1 = Positive). Assessments were based on CWs responses concerning how they assessed their relationship with WISDOM, especially in regards to communication between the two, implementation processes for WISDOM, and the impact of microfinance for the communities.

The results of the regressions can be found in the Appendix. Overall, the models were able to explain high proportions of variance in the outcomes (adjusted  $R^2$ ), ranging from 0.379 to 0.692. F-stats were also significant at the 5% level or lower. For household outcomes including loan growth, livestock assets, and average meals per day per household member, the relationship with the CW was significant at the 5% level or lower. In addition, the relationship with the CW has a positive impact on the outcomes, ranging in standardized coefficients of 0.249 to 0.504.

### **Targeting OVC Households for WISDOM**

Nevertheless, if coordination is to continue and increase between WVE and WISDOM concerning OVC households, differences in how each views the other with regards to purpose and role may need to be addressed. When questioned about the roles and mission of WVE and WISDOM, both organizations showed evidence of potential obstacles to coordination with regards to OVC households.

Staff members for both WVE and WISDOM responded in interviews that the target populations of each organization were different. WVE targeted the very poor while WISDOM targeted the able poor. Other respondents noted the similar missions of the two organizations but noted that there were differences in implementation that made collaboration difficult with regards to OVC households.

Thus, it seemed that there was an understanding of how microfinance related and facilitated general community development. Nevertheless, there were two assumptions that seemed to deter staff members from both organizations from coordinating naturally concerning OVC households. First, there was an assumption that microfinance was designed to benefit the able poor and not the very poor. Second, there was an assumption that OVC households were predominantly very poor.

Nevertheless, where the two groups of respondents did agree were in the areas of change that could facilitate OVC caregivers participation in WISDOM services. Several respondents noted the increase in the minimum loans for clients and noted how community members had asked for it to be lowered. In addition, many noted how collateral was an issue for OVC households both in regards to other community members allowing them to join their solidarity group and in regards to OVC caregivers themselves wanting to participate in microfinance.

Whether these assumptions are true for the majority of OVC caregivers has yet to be shown. Data does show that there are already high percentages of WISDOM clients that are caring for OVCs. Nevertheless, whether WISDOM can expand and reach the very poor OVC households remains in question. One major hurdle for this to occur seems to be the high minimum loans in WISDOM policies and the lack of savings among very poor households.

However, if an OVC caregiver can remain and participate in microfinance for over a year, data suggests that they are less likely to rely on assistance, more resistant to unexpected events, more involved in community meetings, and more likely to have OVCs with healthier psychosocial well-beings.

## Appendix

### MEASURES OF PSYCHOSOCIAL WELL-BEING

#### For children 6–12 years:

How often have you....? Would you say “often,” “sometimes,” or “never”?

- Felt worried
- Felt happy
- Refused to eat at mealtimes
- Felt frustrated
- Felt like running away from home
- Have nightmares

I am going to ask you some questions about some things that may or may not bother you. I want you to tell me for each of the following things that I read if it bothers you a lot, a little, or if doesn't bother you at all.

- Having too many responsibilities (e.g., chores)
- Taking care of family members
- Not having enough money for things, such as clothing and food
- Having problems with friends and neighbors
- Having problems getting along with your family
- Feeling unsafe in your neighborhood
- Feeling unsafe in your home

#### For adolescents 13–19 years:

How often have you....? Would you say “often,” “sometimes,” or “never”?

- You are a good person
- You feel happy
- You feel worried
- You refuse to eat at mealtimes
- You feel frustrated when something does not go your way
- You have difficulty making friends
- You feel like running away from home

I am going to ask you some questions about some things that may or may not bother you. I want you to tell me for each of the following things that I read if it bothers you a lot, a little, or if doesn't bother you at all.

- Having too many responsibilities (e.g., chores)
- Taking care of family members
- Not having enough money for things, such as clothing and food
- Having concerns about the health of a family member.
- Having problems with friends and neighbors
- Having problems getting along with your family

Feeling unsafe in your neighborhood  
Feeling unsafe in your home

### Descriptive Statistics of Caregivers ALL

	Total Sample	Non-Clients w/o Access	Non-Clients w/ Access	Clients < 1 yr	Clients > 1yr
<b>AGE (123)</b>					
15 to 24 years	20.3%	20.8%	17.5%	33.3%	24.2%
25 to 49 years	55.3%	54.2%	58.7%	33.3%	51.5%
50+ years	24.4%	25.0%	23.8%	33.3%	24.2%
Total	100%	100%	100%	100%	100%
<b>MARITAL STATUS (276)</b>					
Married	39.1%	31.6%	37.6%	25.8%	53.5%
Separated/Divorced	1.4%	1.8%	2.6%	-----	-----
Widowed	54.3%	63.2%	54.7%	64.5%	42.3%
Never Married	5.1%	3.5%	5.1%	9.7%	4.2%
Total (276)	100%	100%	100%	100%	100%
<b>SCHOOL (269)</b>					
Yes	24.5%	21.8%	25.4%	17.9%	27.9%
<b>OCCUPATION (271)</b>					
Not Working	8.9%	1.8%	17.4%	-----	4.2%
Farmer	68.3%	69.1%	64.3%	63.3%	76.1%
Petty Trading	1.5%	3.6%	1.7%	-----	-----
Trader	3.0%	9.1%	0.9%	3.3%	1.4%
Artisan	1.1%	-----	0.9%	-----	2.8%
Professional/Civil Servant	10.0%	7.3%	7.8%	26.7%	8.5%
Retiree	0.4%	-----	0.9%	-----	-----
Other	7.0%	9.1%	6.1%	6.7%	7.0%
TOTAL (271)					
<b>IGA TRAINING (267)</b>					
Yes	6.5%	5.5%	6.9%	-----	10.4%
<b>AVG HH SIZE (279)</b>					
# of M Adults	1.04	0.96	1.08	1.03	1.04
# of F Adults	1.16	1.14	1.16	1.23	1.14
# of M Children	1.70	1.96	1.74	1.48	1.51
# of F Children	1.39	1.34	1.48	1.23	1.26

*Note:* Total number of subjects who answered the question is given in parentheses next to subheadings.

### Descriptive Statistics of Caregiver in Guraghe ADP

	Total Sample	Non-Clients w/o Access	Non-Clients w/ Access	Clients < 1 yr	Clients > 1yr
<b>AGE (162)</b>	24.93	22.62	24.41	26.33	27.14
15 to 24 years (46)	21.7%	14.3%	18.5%	33.3%	33.3%
25 to 49 years	58.7%	71.4%	63.0%	33.3%	44.4%
50+ years	19.6%	14.3%	18.5%	33.3%	22.2%
Total	100%	100%	100%	100% (3)	100%
<b>MARITAL STATUS (160)</b>					
Married	16.9%	12.1%	16.9%	23.3%	15.6%
Separated/Divorced	1.3%	3.0%	1.5%	-----	-----
Widowed	75.6%	84.8%	75.4%	66.7%	75.0%
Never Married	6.3%	-----	6.2%	10.0%	9.4%
Total	100%	100%	100%	100%	100%
<b>SCHOOL (154)</b>					
Yes	13.0%	9.7%	12.3%	14.8%	16.1%
<b>OCCUPATION (155)</b>					
Not Working	15.5%	3.2%	31.7%	-----	9.4%
Farmer	47.1%	51.6%	36.5%	62.1%	50.0%
Petty Trading	2.6%	6.5%	3.2%	-----	-----
Trader	3.9%	9.7%	1.6%	3.4%	3.1%
Artisan	1.9%	-----	1.6%	-----	6.3%
Professional/Civil Servant	17.4%	12.9%	14.3%	27.6%	18.8%
Other	11.6%	16.1%	11.1%	6.9%	12.5%
TOTAL	100%	100%	100%	100%	100%
<b>IGA TRAINING (153)</b>					
Yes	3.3%	9.7%	1.6%	-----	3.3%
<b>AVG HH SIZE (162)</b>	5.08	5.32	5.39	4.93	4.31
# of M Adults (157)	1.01	0.79	1.10	1.03	1.03
# of F Adults	1.20	1.12	1.24	1.23	1.19
# of M Children (158)	1.55	2.15	1.52	1.47	1.06
# of F Children	1.23	1.33	1.33	1.20	0.97

*Note:* Total number of subjects who answered the question is given in parentheses next to subheadings.



### Descriptive Statistics of Caregivers in Wonchi ADP

	Total Sample	Non-Clients w/o Access	Non-Clients w/ Access	Clients > 1yr
<b>AGE (116)</b>	21.59	24.29	20.40	21.54
15 to 24 years (77)	19.5%	23.5%	16.7%	20.8%
25 to 49 years	53.2%	47.1%	55.6%	54.2%
50+ years	27.3%	29.4%	27.8%	25.0%
Total	100%	100%	100%	100%
<b>MARITAL STATUS (115)</b>				
Married	69.9%	58.3%	63.5%	84.6%
Separated/Divorced	1.7%	----	3.8%	----
Widowed	25.2%	33.3%	28.8%	15.4%
Never Married	3.5%	8.3%	3.8%	----
Total	100%	100%	100%	100%
<b>SCHOOL (114)</b>				
Yes	39.5%	37.5%	41.5%	37.8%
<b>OCCUPATION (115)</b>				
Farmer	96.5%	91.7%	98.1%	97.4%
Trader	1.7%	8.3%	----	----
Retiree	0.9%	----	1.9%	----
Other	0.9%	----	----	2.6%
TOTAL	100%	100%	100%	100%
<b>IGA TRAINING (113)</b>				
Yes	11.5%	----	13.5%	16.2%
<b>AVG HH SIZE (116)</b>	5.78	5.50	5.98	5.69
# of M Adults (113)	1.09	1.22	1.06	1.05
# of F Adults	1.10	1.17	1.06	1.10
# of M Children	1.90	1.70	2.02	1.87
# of F Children	1.60	1.35	1.67	1.67

*Note:* Total number of subjects who answered the question is given in parentheses next to subheadings.

### Descriptive Statistics of OVCs in Guraghe ADP

	Total Sample	Non-Clients w/o Access	Non-Clients w/ Access	Clients < 1 yr	Clients > 1yr
<b>Orphan Status (134)</b>					
HHs w/Maternal Orphans	11.9%	18.5%	10.9%	7.1%	12.5%
HHs w/Paternal Orphans	69.4%	63.0%	72.7%	67.9%	70.8%
HHs w/Both Orphans	18.7%	18.5%	16.4%	25.0%	16.7%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Sickness Status (109)</b>					
Mother Chronically Ill	31.2%	8.0%	53.5%	14.3%	30.0%
Father Chronically Ill	0.9%	4.0%	----	----	----
Both Chronically Ill	1.8%	4.0%	2.3%	----	----
<b>Adolescents</b>					
Have Regular Place to Sleep at Night (94)	73.4%	88.2%	60.0%	79.2%	77.8%
Attending School (86)	93.0%	93.3%	91.4%	90.9%	100.0%
Self Esteem Score (162)	0.65	0.85	0.35	1.23	0.53
Buren Score (162)	1.42	1.53	1.09	2.10	1.34
HIV edu (93)	88.2%	82.4%	100.0%	75.0%	88.2%
HIV edu in last 3mo? (78)	59.0%	46.7%	68.8%	47.4%	66.7%
Test availability (68)	80.9%	66.7%	80.0%	93.8%	83.3%
Tested (84)	23.8%	7.1%	18.2%	41.7%	23.1%
<b>Children</b>					
Have Regular Place to Sleep at Night (129)	51.9%	63.3%	41.8%	65.2%	47.6%
Attending School (112)	99.1%	100.0%	97.9%	100.0%	100.0%
Worry Factor Score (162)	0.49	0.68	0.38	0.70	0.34
Buren Factor Score (162)	1.20	1.24	1.11	1.53	1.06

*Note:* Total number of subjects who answered the question is given in parentheses next to subheadings.

### Descriptive Statistics of OVCs in Wonchi ADP

	Total Sample	Non-Clients w/o Access	Non-Clients w/ Access	Clients > 1yr
<b>Orphan Status (58)</b>				
HHs w/Maternal Orphans	25.9%	21.1%	25.0%	33.3%
HHs w/Paternal Orphans	60.3%	57.9%	70.8%	46.7%
HHs w/Both Orphans	13.8%	21.1%	4.2%	20.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Sickness Status (68)</b>				
Mother Chronically Ill	16.2%	5.3%	20.0%	21.1%
Father Chronically Ill	16.2%	15.8%	13.3%	21.1%
<b>Adolescents</b>				
Have Regular Place to Sleep at Night (79)	74.9%	76.5%	78.9%	66.7%
Attending School (74)	87.8%	86.7%	86.5%	90.9%
Self Esteem Score (116)	0.40	0.33	0.43	0.38
Burden Score (116)	1.21	1.29	1.40	0.90
HIV edu (73)	89.0%	93.3%	86.1%	90.9%
HIV edu in last 3 mo? (72)	43.1%	46.7%	40.0%	45.5%
Test availability (51)	58.8%	53.8%	47.6%	76.5%
Tested (66)	7.6%	6.7%	6.3%	10.5%
<b>Children</b>				
Have Regular Place to Sleep at Night (91)	71.4%	58.8%	71.1%	79.3%
Attending School (63)	90.5%	90.9%	97.1%	77.8%
Worry Score (116)	0.52	0.46	0.66	0.36
Buren Score (116)	1.28	1.00	1.62	1.00

*Note:* Total number of subjects who answered the question is given in parentheses next to subheadings.

## Newer Clients vs. Older Clients in Gurghe: Household Outcomes

	Clients < 1 yr	Clients > 1yr
<b>AVG MEALS PER DAY PER HH MEMBER (271) (Welch stat: 4.956)</b>	2.21	2.24
Guraghe (159) (Welch stat: 5.664)	2.29	2.44
<b>LIVESTOCKS ASSESTS (279) (F-stat: 3.577)</b>	3557.78	3122.65
Guraghe (162) (F-stat: 6.199)	3676.47	3286.22
<b>HH ASSEST FACTOR SCORES (103)</b>	-0.686	-0.976
Guraghe (54) (F-stat: 3.534)	-0.509	-2.582
<b>HAD TO SELL ASSETS FOR BASIC NEEDS IN PAST YR (268)</b>	28.6%	41.4%
Guraghe (152) (Chi-square: 7.356)	25.9%	6.5%
<b>AVG % OF CHILDREN IN HH CIP** (270) (Welch: 2.898)</b>	42.2%	40.4%
Guraghe (158)	43.4%	36.5%
<b>AVG % OF CHILDREN IN HH ATTENDING SCHOOL (279) (F-stat: 3.653)</b>	81.3%	74.7%
Guraghe (162) (F-stat: 2.124)	83.5%	92.2%
<b>ATTEND COMM MEETINGS? (268) (Chi-square: 14.465)</b>	41.4%	77.6%
Guraghe (153) (Chi-square: 7.585)	39.3%	72.4%
<b>SOMEONE ADVICE? (263)</b>	14.3%	30.8%
Guraghe (149) (Chi-square: 10.240)	11.1%	18.5%

### Impact of Community Worker Relationship on Performance

	Loan Growth	Livestock Assets	Avg Meals
Good Relationship with CW?	0.249**	0.472***	0.504***
Yrs in Microfinance	0.552***	-0.027	0.134
Current Loan Amt	0.493***	-0.041	0.005
Training in IGA	0.063	0.320**	-0.142
# of M Adults	0.213*	0.201	-0.333**
# of F Adults	-0.139	0.162	-0.171
# of M Children	0.018	-0.188	-0.047
# of F Children	-0.052	0.284*	0.039
Marital Status: Widowed	0.232	0.363*	-0.011
Marital Status: Never Married	0.033	0.346*	0.092
Caregiver Educated?	0.054	0.053	-0.067
Receives Money?	-0.040	0.033	----
Sell Assets in Past Yr?	-0.024	----	----
Chronic Illness in HH?	----	0.200	----
Percent of School Aged Children in CIP	----	----	-0.504***
Solidarity Group: Close-knit?	-0.046	-0.066	-0.376***
Solidarity Group: Can be trusted?	-0.015	0.144	0.121
Solidarity Group: Do not share same values?	0.022	-0.165	0.179
Solidarity Group: Do not generally get along?	0.006	0.165	0.149
F-stat	6.681***	2.51**	3.559***
Adjusted R <sup>2</sup>	0.692	0.379	0.488
Observations	44	44	44

*Note:* All entries are standardized coefficients. Sample is taken from clients who were part of KAs where community workers were interviewed and their relationship with WISDOM was assessed as positive or negative. All VIF scores tested below 2.973.

\*\*\* p < 0.01; \*\* p < 0.05; \* p < 0.10.

## References

- A Generation At Risk: The Global Impact of HIV/AIDS on Orphans and Vulnerable Children.* (2005). Cambridge: Cambridge University Press.
- Andrews, G., Skinner, D., & Zuma, K. (2006). Epidemiology of health and vulnerability among children orphaned and made vulnerable by HIV/AIDS in sub-Saharan Africa. *AIDS Care*, 18(3), 269-276.
- Bhatt, N., & Tang, S.-Y. (2001a). Delivering microfinance in developing countries: Controversies and policy perspectives. *Policy Studies Journal*, 29, 319-333.
- Borzel, T. A., & Risse, T. (2003). Public-Private Partnerships: Effective and Legitimate Tools of International Governance? In Grande, E. & Pauly, L. W. (Eds.), *Complex Sovereignty: On the Reconstruction of Political Authority in the 21st Century*. Baltimore: Johns Hopkins University Press.
- Bozeman, B. (1987). *All Organizations are Public*. San Francisco: Jossey-Bass Publishers.
- Buse, K. (2004). Governing Public- Private Infectious Disease Partnerships. *Brown Journal of World Affairs*, 10(2), 225-242.
- Campbell, D. T., & Stanley, J. C. Experimental and Quasi-Experimental Designs for Research. In Campbell, D. T. & Stanley, J. C. (Eds.), *Quasi-Experimental Designs for Research*. Chicago: Rand McNally.
- Carr, J. H., & Tong, Z. T. (2002). Introduction: Replicating Microfinance in the United States - An Overview. In *Replicating Microfinance in the United States*. Washington DC: Woodrow Wilson Center Press.
- Castells, M. (2000). *The Rise of the Network Society*. Oxford: Blackwell.
- Chatterji, M., Dougherty, L., Ventimiglia, T., Mulenga, Y., Jones, A., Mukaneza, A., Murray, N., Buek, K., Winfrey, W., & Amon, J. (2005). *The Well-Being of Children Affected by HIV/AIDS in Lusaka, Zambia, and Gitarama Province, Rwanda: Findings from a Study*. Washington DC: Community REACH Program, Pact.
- Cheston, S., & Kuhn, L. (2002). Empowering Women Through Microfinance. In Harris, S. D. (Ed.), *Pathways Out of Poverty: Innovations in Microfinance for the Poorest Families*. Bloomfield: Kumarian Press.
- Coady, D. P. (2004). *Designing and Evaluating Social Safety Nets: Theory, Evidence, and Policy Conclusions*: International Food Policy Research Institute.
- Cooper, T. L. (1985). The Public-Private Continuum. *Public Budgeting and Finance*, 5(3), 99-115.
- Daley-Harris, S. (2005). *State of the Microcredit Summit Campaign Report 2005*.

- Washington, DC: Microcredit Summit Campaign.
- Donahue, J. (2005). *Forward-Looking Review: World Vision's Approaches to Integrating Microenterprise Development and HIV/AIDS Response*: World Vision.
- Donahue, J., Wamimbi, R., & Kiyaga, E. (2005). *End of Pilot Program Evaluation Microenterprise Development and HIV/AIDS (MEDHA) - May 23rd to June 2nd, 2005: A Collaborative Initiative of Microenterprise Development Network and World Vision Uganda*: World Vision.
- Doocy, S., Norell, D., Teffera, S., & Burnham, G. (2006?). Outcomes of an Ethiopian Microfinance Program and Management Actions to Improve Services. *Journal of Microfinance*, 7(1), 79-95.
- Fikkert, B. (2003, 2003/1/5-6/). *Christian Microfinance: Which Way Now?* Paper presented at the Association of Christian Economists 20th Anniversary Conference: "Economists, Practitioners, and the Attack on Poverty: Toward Christian Collaboration".
- Foster, G., & Williamson, J. (2000). A Review of Current Literature of the Impact of HIV/AIDS on Children in Sub-Saharan Africa. *AIDS*, 14, 275-284.
- Frederickson, H. G. (2004). *Whatever Happened to Public Administration?: Governance, Governance Everywhere*. Belfast: Institute of Governance Public Policy and Social Research.
- Fukuyama, F. (2002). Social Capital and Development: The Coming Agenda. *SAIS Review*, 22(1).
- Gebbie, K. (2005). Ch12: Public Health. In *The Limits of Market Organization*. New York: Russell Sage Foundation.
- Haque, M. S. (2001). The Diminishing Publicness of Public Service under the Current Mode of Governance. *Public Administration Review*, 61(1), 65-83.
- Hodge, G. A. (2000). Reviewing the Effectiveness of Privatization as Contracting Out. In *Privatization: An International Review of Performance* (pp. 97-156): Westview Press.
- Initiative, H. A. H. (2005). *Guide to Mobilising and Strengthening Community-Led Care for Orphans and Vulnerable Children*: World Vision International.
- Kettl, D. (1995). Privatization as a Tool of Reform. *THE LaFOLLETTE POLICY REPORT*.
- Khandker, S., R. (1998). *Fighting Poverty with Microcredit: Experience in Bangladesh*. New York: Oxford University Press.
- Khandker, S., R. (2005). Microfinance and Poverty: Evidence Using Panel Data from Bangladesh. *World Bank Economic Review*, 19(2).

- Knott, J. (1993). Comparing Public and Private Management: Basic Management Functions and External Constraints. *Journal of Public Administration Research and Theory*, 3, 93-119.
- Levine, C., Foster, G., & Williamson, J. (2005). Introduction: HIV/AIDS and Its Long-Term Impact on Children. In Foster, G., Levine, C. & Williamson, J. (Eds.), *A Generation At Risk: The Global Impact of HIV/AIDS on Orphans and Vulnerable Children*. Cambridge: Cambridge University Press.
- Luippold, B., & Roden, P. (2006). *The Hope Initiative: World Vision's Global Response to HIV and AIDS, FY06 Annual Report*: World Vision International.
- Luippold, B., & Roden, P. (2006). *World Vision Core HIV and AIDS Response Monitoring System (CHARMS): Important Information and Practical Tips*: World Vision.
- Milward, H. B., & Provan, K. G. (2000). Governing the Hollow State. *Journal of Public Administration and Theory*, 10(2), 359-379.
- Moe, T. (1984). The New Economics of Organization. *American Journal of Political Science*, 28, 739-777.
- Morduch, J. (1999). The Microfinance Promise. *Journal of Economic Literature*, 37, 1569-1614.
- Mwaipopo, R. (2005). *Evaluation of Tahea Supported "Mama Mkubwa" Initiative in Makete District, Iringa Region*. Dar es Salaam, Tanzania: UNICEF.
- Ostrom, V., & Ostrom, E. (1991). Public Goods and Public Choices: The Emergence of Public Economies and Industry Structures. In *The Meaning of American Federalism* (pp. 163-197). San Francisco: ICS Press.
- Pattberg, P. (2005). The Institutionalization of Private Governance: How Business and Non-profits Agree on Transnational Rules. *Governance: An International Journal of Policy, Administration and Institutions*, 18(4), 589-610.
- Perry, J. L., & Rainey, H. G. (1988). The Public-Private Distinction in Organization Theory: A Critique and Research Strategy. *The Academy of Management Review*, 13(2), 182-201.
- Peters, B. G., & Pierre, J. Governance without Government? Rethinking Public Administration. *Journal of Public Administration Research and Theory: J-PART*, 8(2), 223-243.
- Peters, B. G., & Pierre, J. Governance without Government? Rethinking Public Administration. *Journal of Public Administration Research and Theory: J-PART*, 8(2), 223-243.
- Pronyk, P. M., Kim, J. C., Hargreaves, J. R., Makhubele, M. B., Morison, L. A., Watts, C., & Porter, J. D. H. (2005). Microfinance and HIV Prevention - Emerging Lessons from Rural South Africa. *Small Enterprise Development*, 16(3), 26-38.



- Richter, L. (2006). Ch2: The Impact of HIV/AIDS on the Development of Children. In Williamson, J., Levine, C. & Foster, G. (Eds.), *A Generation at Risk? HIV/AIDS, Vulnerable Children and Security in Southern Africa*. Cambridge: Cambridge University Press.
- Sengendo, J., & Nambi, J. (1997). The Psychological Effect of Orphanhood: A Study of Orphans in Rakai District. *Health Transition Review*, 7(S), 105-124.
- Shetty, A. K., & Powell, G. (2003). Children Orphaned by AIDS: A Global Perspective. *Seminars in Pediatric Diseases*, 14(1), 25-31.
- Stanczak, G. C., Miller, D. E., & Dyrness, G. R. (2006). *Spiritually Engaged Development: Faith and Community in Transforming Tanzania*. Los Angeles: USC Center for Religion and Civic Culture.
- Tegarden, K. (2006). *Integrating Microfinance with HIV/AIDS Care: Improving Income for East African Women in High-Prevalence Areas (A Proposal)*. Los Angeles: World Vision.
- UNAIDS. (2004). *2004 Report on the global AIDS epidemic*. Geneva: UNAIDS.
- UNAIDS. (2006). *2006 AIDS Epidemic Update*. Geneva.
- UNICEF. (2007). *Children and AIDS - A stocktaking report: Actions and progress during the first year of Unite for Children, Unite against AIDS*. Geneva.
- USAID. (2001). *Care for Orphans, Children Affected by HIV/AIDS and Other Vulnerable Children: A Strategic Framework*. Arlington: Family Health International.
- USAID, UNICEF, & UNAIDS. (2002). *Children on the Brink: A Joint Report on Orphan Estimates and Program Strategies*. New York: UNICEF.
- USAID, UNICEF, & UNAIDS. (2004). *Children on the Brink: A Joint Report on New Orphan Estimates and a Framework for Action*. New York: UNICEF.
- WHO. (2005). *HIV/AIDS Epidemiological Surveillance Report for the WHO African Region 2005 Update*. Geneva: WHO.
- Williamson, O. (1999). Public and Private Bureaucracies: A Transaction Cost Economics Perspectives. *Journal of Law, Economics, and Organization*, 15, 306-342.
- Williamson, O. E. (1981). The Economics of Organization: The Transaction Cost Approach. *American Journal of Sociology*, 87(November), 548-577.
- Williamson, O. E. (1988). The Logic of the Economic Organization. *Journal of Law, Economics, & Organization*, 4, 65-93.
- Williamson, O. E. (2002). The Theory of the Firm as Governance Structure: From Choice to Contract. *Journal of Economic Perspective*, 16(3), 171-195.
- WISDOM. (2006). *WISDOM Business Plan*.

Wright, G. A. N. (2000). *Microfinance Systems: Designing Quality Financial Services for the Poor*. London: Zed Books.