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Even though half or more of US medical schools are involved in international collaborations, experts say the IUSM-MUCHS partnership is unique. "Other schools have not started what IU has in terms of fundraising and the comprehensive program of clinics—and a farm," says M. Brownell Anderson, MEd, senior associate vice president of the Association of American Medical Colleges.

Anderson agrees with Einterz and others that the partnership is reproducible. Officials at the University of Utah School of Medicine are talking with leaders at the medical school in Kumasi, Ghana, to do just that. "We've talked about mimicking what Indiana has done in Eldoret," says Devon Hale, MD, Utah's dean of international medical education who has spent time with Mamlin in Mosoriot.

Hale credits the longevity of the partnership to the fact that IUSM and MUCHS focused first on education rather than timebound research or financial benefits. He and others say that while US medical schools have good intentions, they sometimes come to developing countries with grants and a predetermined research agenda.

"They do research and leave," says Hale. By focusing on education, says Einterz, the medical community in Eldoret eventually can become self-sustaining.

The partnership's progress can be measured in many ways—numbers of patients treated with ARVs and prevention of mother-to-child HIV transmission, for example. But progress also is measured by the lessening of stigma and silence. Now, says Mamlin, "one can speak openly about HIV in the villages where we work . . . and hope abounds on our wards." □

Small Loans Yield Big Health Profits

Brian Vastag

IN COUNTRIES HARD HIT BY THE AIDS epidemic, basic needs often go unfulfilled, rendering medical care an unattainable dream. But one innovative program—a kind of public health perpetual-motion machine—is helping families cope with the epidemic by providing the means to allow them to help themselves.

Run by Project HOPE, a Norfolk, Va, nonprofit organization, the 11-year-old Village Health Bank offers small loans to collectives of 10 to 20 women in Malawi, Thailand, and 5 other developing countries. Women who receive loans attend twice-monthly health education sessions, tailored to local needs, while repaying the principal and small amounts of interest.

"The beauty of this model is that it takes this collective from a single village and then uses that as an instrument of health prevention and education," said Renslow Sherer, MD, director of the infectious diseases unit at Project HOPE. "You have to have the stuff of life, a home and a sustainable source of food. And then maybe you can begin to make gains against the disease."

The program has helped some 50000 women since its inception in 1993, dispensing $25 million in so-called microcredit. Each 4-month loan averages around $100, enough to launch small-scale trading, craft work, and animal husbandry. Along the coffee-heavy slopes in the highlands of Guatemala, village women buy goats and chickens to raise and sell at market, using part of the profits for Pap tests and other preventive health care, said Juan Carlos Lau, director of that country's health banks. Likewise, women in Malawi buy grain from neighboring Mozambique. During a recent drought, they hauled it home for a tidy profit, helping their families and their villages through tough times.

Three of the 7 countries served by the Village Health Bank program—Ecuador, Guatemala, and Peru—have programs that are now self-sufficient, said program director John Bronson, MA; they bring in enough interest to cover administrative costs and to pay local health educators. Project HOPE continues running the programs in Guatemala and Peru, but it spun off the Ecuador bank into an independent organization after it attracted more than 10000 women.

"In most public health programs, when the dollars stop, the intervention stops," said Bronson. "But a successful [Village Health Bank] program can become financially self-sustainable on a long-term basis."

MALAWI'S CHALLENGE

Bronson said that the Malawi bank, now in its fifth year, is approaching self-sufficiency, good news for village

Project HOPE Malawi

Women who are members of a Village Health Bank program in Malawi that provides small business loans and health education learn how the program and group should operate.

families hit by HIV/AIDS. Statistics cement the country as a key part of East Africa's epidemic; the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that more than 900 000 of the country's 11.6 million adults and children are living with the disease; nearly half a million children have lost one or both parents to it. The impact of the disease on the population of Malawi is profound; life expectancy of a newborn is just 38 years.

Sherer was acutely aware of the toll that HIV/AIDS can take on a community when he joined Project HOPE last year. During the previous 20 years, he had guided HIV/AIDS services at Cook County Hospital, model for the television program *ER*, and, as the only public hospital in Chicago, the center of that city's AIDS problem. The obvious parallels between the HIV/AIDS crises in Cook County, Illinois, and Malawi drew him into the project.

"Before you can address the disease and work on antiretroviral therapy, if it's available," he said, "you have to deal with the basic problems" of poverty and homelessness—both huge problems among Chicago's AIDS population. "They didn't know exactly where they were going to sleep or where their next meal would come from, so that was a much bigger priority than anything having to do with this disease."

Likewise, crushing poverty, feelings of helplessness, and the second-class status of women work together to deprive many families in Malawi of basic necessities, said Dorothy Namate, Project HOPE's country director. Since 1999, the Village Health Banks have helped approximately 7500 women in Malawi with all three. "Some have money to build a house, some have been able to upgrade their [food stalls] to a small grocery shop," she said during a telephone call from Blantyre, Malawi's largest city.

While the program works well in cities and some villages, the poorest, most remote areas remain out of reach. "There has to be some level of commerce," said Sherer.

Women, not men, receive the small loans because commercial banks generally shut them out and because women tend to be more responsible with their income, explained Namate.

Twice a month, the 10 to 20 women in each village bank meet to repay the loans, which are handed from Project HOPE to the collective as a whole. Local health educators, trained by Project HOPE, appear at these sessions with various preventive health modules. At first, the Malawi educators focused on prenatal, infant, and child health and nutrition.

But as the program evolved, organizers found that new participants were older and therefore had fewer young children. So they began reworking the curriculum into a "healthy woman" program aimed at preventing HIV/AIDS and other sexually transmitted diseases, as well as the prevention of cervical cancer. According to UNAIDS, the knowledge fills a crucial gap, as just 34% of young women in Malawi have comprehensive knowledge of HIV—including how it is transmitted and that apparently healthy men can carry the virus.

With knowledge in head and cash in hand—and a powerful dose of self-esteem and self-confidence, according to Bronson—village women can finally access private clinics and scarce pharmaceuticals. Namate said that many receive treatment for opportunistic infections that would otherwise rampage unchecked. She added that supplies of antiretroviral drugs remain severely limited.

This lack of needed drugs to treat HIV-infected individuals has directly led to Malawi's burgeoning orphan population. The country's relatively high birth rate, coupled with the fact that AIDS kills so many in their childbearing years, results in tens of thousands of orphans each year.

A recent Project HOPE survey found that in a convenience sample of 266 Village Health Bank members, 48% experienced at least one death in their household during the previous 12 months, and 67% housed at least one orphan. The average number of orphans per household was 2. The need to care for orphans, added to the tradition of intergenerational togetherness, has contributed to a growing burden on caregivers. Women in households receiving loans often care for 5 or 6 individuals, said Namate.

"It's a lot of pressure. If you have a sibling and your sibling dies, you are obligated to take care of the children," she said.

Last year Namate helped launch an insurance program to help collectives that experience the death of one of their members, a common occurrence with Malawi's high prevalence of HIV/AIDS. "We make sure that when a bank loses someone, the remaining members are not punished because they are not able to repay the loan of their colleague," said Namate.

MICRO HISTORY

Bronson said that he became intrigued with microcredit when people in developing countries learning about good health practices from Project HOPE staff complained that they could not follow through—they had no money for Pap tests, prenatal care, or the many other healthful practices they were hearing about.

The idea of providing small loans to working families earned its reputation as a viable development strategy in Bangladesh in the 1970s. Called the Grameen Bank, the concept was simple: Provide loans directly to people who rarely see $10, let alone $100. Remove collateral from the equation, and instead rely on community trust and mutual accountability. Grameen Bank has more than proven the concept: in September 2002, it boasted 2.4 million members (95% women) living in 41 000 villages.

And like Grameen, Project HOPE records an astounding payback rate of 99%. "They look after each other and if one defaults on the loan it hurts the others," said Sherer. "Helping households and families to be sustainable is, I think, step number one. Of course, all the other [health-related] things have to happen. It's not a panacea." □