

# **Women's Access to Credit, Income Generation and Adult Education in Ethiopia**

## **Evaluating the Women's Self Help Group**



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## Acronyms

AFSR – Action for Self Reliance  
AIDS – Auto Immune Deficiency Syndrome  
CF – Community Facilitator  
DFT – Developing Family Together  
FGM – Female Genital Mutilation  
FNS – Food and Nutrition Security  
GNI – Gross National Income  
GDP – Gross Domestic Product  
HIV – Human Immunodeficiency Virus  
IGA – Income Generating Activities  
ISAPSO – Integrated Service for AIDS Prevention & Support Organization  
LCO – Loving Children Organization  
MDG – Millenium Development Goals  
PCI – Project Concern International  
PPP – Purchasing Power Parity  
SHG – Self Help Group  
SWDA – Siiqee Women’s Development Association  
UNDP – United National Development Programme  
UNICEF – United Nations Children’s Fund  
UNFPA – United Nations Population Fund  
WHO – World Health Organization  
WB – World Bank

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## Executive Summary

Globally, there are numerous projects that separately address the need for Adult Education about HIV and Nutrition and provide business skills and access to savings and credit for poor, vulnerable women. Either very few programs exist that combine the two disciplines, or the current projects are not adequately documented. There are only two similar projects in the public domain regarding this integrative approach: the Shakti model in India and the Women First Group in Mozambique. The purpose of this study is to add to the scarce literature on the topic and assess the success and challenges of such an innovative approach to public health and development.

Though the Better Education and Life Opportunities for Vulnerable Children through Networking and Organizational Growth (BELONG) project, Project Concern International (PCI) has developed and implemented the Self Help Group (SHG) in Ethiopia to improve the livelihood of orphans and vulnerable children and their caretakers. Through local implementing partners, PCI empowers these women caretakers through education on health, nutrition, and business skills with simultaneous provision of access to saving and loans. So far, the SHG approach directly benefits over 5,000 women in the Amharra, Tigray and Addis Ababa regions. Each group is composed of between 15 to 20 women who meet weekly to save, access their own money, and learn and share their experiences to learn from each other. PCI's implementing partners provide technical assistance to the groups on a weekly basis.

The research used a two pronged approach. Interviews were conducted with implementing partner staff and beneficiaries to assess the progress of the program to date and offer suggestions for improvement. Program staff interviews were conducted for five implementing partners: AFSR, DFT, ISAPSO, LCO and SWDA. Individual interviews reached 117 women from 25 groups. This was done to ensure a 95% confidence level with a 9% - 10% confidence interval for the 253 SHG groups that represent over 5,000 women.

The findings suggest that the combination of health and nutrition education with group saving and promotion of income generation activities has had a profound effect on the lives of the women who participate in the SHG program. The women's participation directly and indirectly benefits 3,300 (95% C.I. 3321 - 4059) children and over 1,550 (95% C.I. 1395 - 1705) orphans and vulnerable children. Women provide food, nutrition, and education materials to their school age children. PCI has also integrated its Give-A-Goat program with the SHG model in rural areas, whereby families are given one or two sheep or goats to improve their livelihood and jump start their IGA activities.

Women were overwhelmingly enthusiastic about the program. More than 95% of women relied solely on PCI's programs to improve their lives and had a vested interest to remain in the SHG. Eighty eight percent of current participants had never thought of quitting the program, while the remaining 12% had thought of quitting once or twice. Those who thought of quitting most often cited difficulty with repayment as an impediment to membership. The majority of them discussed their difficulty with group members and came to an agreeable solution. Women noted that the weekly meetings themselves had drastically improved their lives and given them an

outlet to share ideas and learn from each other. Before the program started, two thirds of women were engaged in some kind of income generating activity (IGA). After the program, nearly three quarters (73.3%) were engaged in IGA. The majority of those with existing IGA used the loan money to expand their petite trade and other businesses to supplement the household income.

While the program is successful in many respects, there are challenges that warrant attention. Eighty four percent of the groups sampled had drop outs, with 11% overall attrition. Training is an important component of the SHG. Ideally, members should gain several useful skills, including health, nutrition, financial, and business planning. Only half of women participated in any training offered by implementing partners, while a small percentage (3.3%) were not aware of trainings offered. Only one-third of women had participated in health training, while 16.3% took advantage of financial training, and only 12% were offered business training. Similarly, bookkeepers should be given adequate training or ensure that they already have the existing skill set to carry out their duties effectively. Only 10% of bookkeepers participated in training sessions on any topic, while half (52%) said training was not offered. Only one-fifth of them felt comfortable with their bookkeeping skills, with 80% interested in further training to increase their capacity.

More than two-thirds (70.8%) of women discuss health issues at the meetings. However, only 57.6% of SHG members report being sensitized on health, including nutrition, HIV, and hygiene. More than one-fourth (26.1%) of women do not discuss health issues with their families, while 70.6% of women openly talk about HIV, hygiene, and other health topics with their husbands and children. Sixty two percent of SHG women tested for HIV, while 35.9% of their husbands received a test. Since the SHG members do not receive the health knowledge from the implementing partners, it is unclear what the quality of the health messages is and the impact they have on the women.

In light of the findings from the research, the recommendations made to PCI fall under the following five categories.

- Conduct baseline assessment of new SHG sites and improve ongoing M&E efforts
- Expand provision of training to Community Facilitators, Bookkeepers, and SHG members
- Create a standard teaching manual that is provided to each SHG group
- Improve linkages of SHG groups to micro credit and training institutions
- Integrate IGA component early on in the SHG program

Overall, the findings of the research show that the SHG has been very successful in organizing the women and providing them with regular meetings. The women are committed to meeting and saving every week. They appreciate the access to loans and have largely used the money for income generating activities and household consumption. The SHG has great potential and should be conscientiously expanded to new areas after conducting thorough and careful assessments of communities.

## **Introduction and Background**

Ethiopia emerged in 1994 from a long civil war with numerous health and nutrition problems. While progress is apparent over the past 15 years, much more work is needed to significantly improve the livelihoods of Ethiopia's poor citizens. Ethiopia suffers from recurrent famines and is classified as one of the poorest countries by the World Bank. Women caretakers of orphans and vulnerable children are especially subject to the worst effect of famine, drought, and other adverse shocks. Without adequate knowledge about health and nutrition and sufficient income, women should not be expected to make the healthiest decisions regarding their family's food consumption.

The Self Help Group offer one promising approach to reducing poverty and providing women with the tools to improve their lives. PCI's implementing partners and local administrators decide which communities to target for new SHGs. Once the SHG groups are started, women meet every week to save money that is then available for low interest loans to the women. The women are encouraged to invest the loans into income generating activities rather than consumption, although ultimately it is up to the women to decide the spending pattern.

The program offers a weekly opportunity for women to receive health, nutrition, and business training. The goal is to combine access to savings and loans with the necessary life skills so that women use the loans to improve their lives and reduce their vulnerabilities.

## **Research Overview**

The Women's Empowerment Coordinator at PCI Ethiopia invited me in July 2008 to observe a Women's SHG meeting in Addis Ababa. After finding out a bit more about how the group operates and the approach employed by PCI, I decided that it would be worthwhile to study the SHG in more detail. Through discussions with PCI Ethiopia staff, I suggested a two-tiered research design that incorporated both an evaluation of the health and quality of life outcomes for women and families participating in the SHG, as well as an examination of the programmatic strengths and weaknesses for the technical approach the program uses.

To obtain the needed health and economic information, an independent data collector met with groups of participants that are representative of the Self Help Groups in Addis Ababa. In addition, the data collector conducted individual interviews with staff members working on the SHG.

I conducted interviews with the program staff of implementing organizations to assess the outcomes linked to the health, nutrition and business education components of the program. An independent data collector that PCI contracted conducted individual interviews with beneficiaries in Addis Ababa. Addisalem Tesfaye and Wasihun Eshetu assisted the data collector to conduct beneficiary interviews in Addis Ababa, while Kassaw Asmare and Adugna Tesfay helped the data collector conduct the beneficiary interviews in Debre Birhan. Additionally, the data collector



compiled the interview data and presented it in a Microsoft Word document format for analysis without any personally identifiable information.

The beneficiary interviews did not collect any personally identifiable information, such as names and addresses of beneficiaries. The results of the interviews were compiled, analyzed and recommendations are herewith provided to PCI staff.

The focus group and individual interviews have attempted to gauge the knowledge and behaviors of participants, as well as measure the retention and discernible impact of the health education provided for those women who received it. In addition, the surveys addressed how the money from the SHG is used by the women. This information is used to develop recommendations for field and office staff to improve and/or replicate the program in similar or new contexts.

## **Literature Review**

### **Population and Life Expectancy in Ethiopia**

By 2006, Ethiopia had reached a population of 81 million people (UNICEF 2006), a significant increase from 22 million in 1960. (World Bank 2006) The annual population growth rate has slowed from 3.3% in 1990 to 2.6% in 2005. The urban population increased from 13% in 1990 to 15% in 2000 (WHO 2009).

Life expectancy at birth gradually increased from 39 years in 1960 to 50 years in 2000. (World Bank 2006) The life expectancy at birth for both sexes increased from 49 in 1990 to 53 in 2000 (WHO 2009). Between 2000 and 2006, it actually decreased to 52 years (UNICEF 2006), indicating an erosion of progress. Women's life expectancy increased from 51 in 1990 to 55 in 2000, while men's life expectancy for the same period increased from 46 to 52 (WHO 2009).

Half of Ethiopia's population is under 18 years of age (41.3 million), while the under five population was 16.5% (13.4 million) of the total in 2006. The majority of people (84%) live in rural areas, with only 16% of the population urbanized. The average annual growth rate of the urban population between 1990-2006 was 4.4% (UNICEF 2006).

### **Economics and Poverty in Sub-Saharan Africa and Ethiopia**

Between 1990 and 2004, the world's share of population living on less than \$1 per day decreased from 28.6% to 18.0%. However, most of that progress was driven by East Asia and the Pacific region. Poverty reduction in Sub-Saharan Africa decreased at a much slower rate, from 48.6% to 41.1%. While the \$1 and \$2 per day statistics provide a snapshot of world poverty, the data can be disaggregated further to provide a much more dismal picture of the plight of the world's poor and where they are located. Three quarters of the world's 162 million ultra poor, defined as those living on less than \$0.50 per day, live in Sub-Saharan Africa. The common characteristics of the ultra poor include living in rural areas, exclusion as a result of gender, ethnicity or

disability, and lack of access to credit, education, and assets (IFPRI 2007).

Per capita gross national income (GNI) steadily increased from \$350 in 1990 to \$580 in 2005 (WHO 2009). Using the World Bank's Atlas method, per capita GNP decreased from 1990 to 2007. In 1990, it was \$250; by 1995, it had decreased to \$150. The situation deteriorated further by 2000, when it had reached \$130. Less than one quarter (23%) of the population still lives on less than \$1 per day (World Bank 2006). Recently, there has been improvement, though the 2007 figure of 220 is still below the high mark almost twenty years ago. This translates into deteriorating life quality for the people of Ethiopia. These trends in health and poverty indicators also make it difficult for Ethiopia to achieve the Millennium Development Goals.

With a decreasing per capita GNI, per capita private expenditure on health decreased from \$48 in 1995 to \$39 in 2005. Government spending did not offset this decrease in private health spending with an infusion of public expenditure on health. Per capita government expenditure on health in international purchasing power parity increased from \$7 in 1995 to \$12 in 2005 (WHO 2009). However, during the same year, the central government allocated 1% of its budget to health, 5% to education, and 17% to national defense. The skewed budget allocation toward national defense and internal security has severe repercussions on health. Nearly \$2 billion flowed into the country from donors in 2005, representing 17% of recipient Gross National Income (UNICEF 2006).

## **Education in Ethiopia**

According to the UNESCO 2006 Education for All Global Monitoring Report, three-quarters of the world's adult illiterates live in 12 countries, including Ethiopia. Severe poverty correlates strongly with low literacy rates in these countries. More than three quarters of the population in these countries live on less than US\$2 per day, with adult literacy rates below 63% and the number of illiterates exceeding 5 million (UNESCO 2005a).

As of 2006, two thirds of Ethiopian children of primary school age are in school. Primary school enrollment is 68% for boys and 62% for girls. The primary education completion rate increased from 22% in 2000 to 46% in 2007 (UNICEF 2006). Secondary school enrollment drops to 29% for boys and 19% for girls (UNESCO 2005b). The gender gap in education, though still unequal, has improved in the last decade (UNICEF 2006). The ratio of enrollment for girls to boys in primary and secondary education increased from 65% in 2000 to 83% in 2007. (World Bank 2006) While these education efforts are commendable, the momentum needs to continue to ensure eventual universal access to, and completion of, primary education.

School enrollment rates are important; however, it is imperative that children learn to read and write. The literacy rate for Ethiopians 15 years old and up was 36% in 2005 (UNICEF 2006). This figure does not compare favorably with the regional average of 69% (UNESCO 2009). However, the vast number of older Ethiopians who are illiterate masks the progress made with the younger generation. The literacy rate for 15-24 year olds was 62% for boys and 39% for girls (UNICEF 2006).

**Table 1: Adult Literacy in Ethiopia**

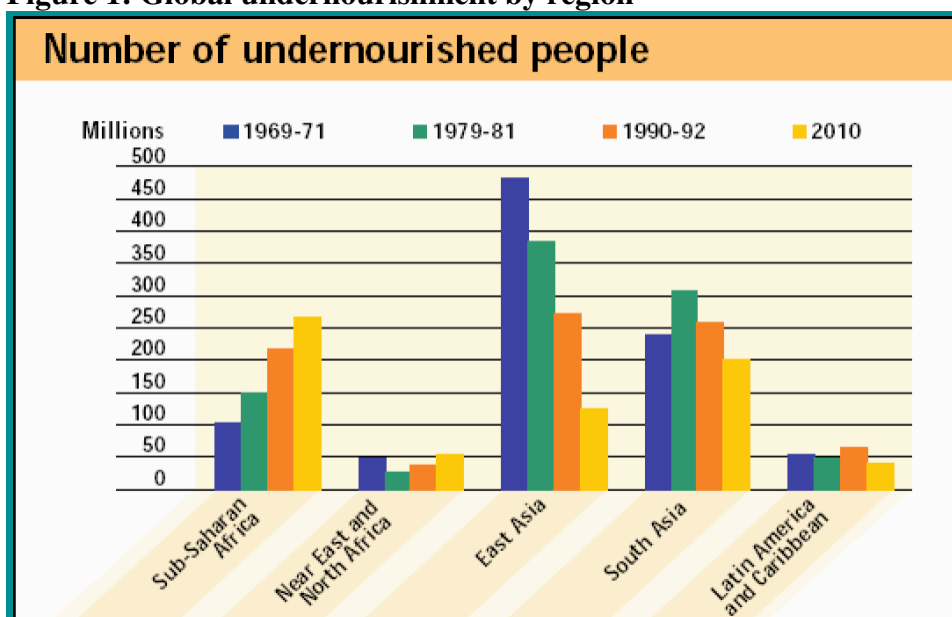
	Adult literacy rate (15 and over) % total		Adult literacy rate (15 and over) % male		Adults literacy rate (15 and over) % female	
	1994	2006	1994	2006	1994	2006
Ethiopia	27	35.9	36	50	18.5	22.8
Sub-Saharan Africa	53.4	61.7	62.7	70.7	44.7	53.2
World	76.1	83.6	82.4	88.3	69.9	78.9

Source: UNESCO Education for All Global Monitoring Report. 2008. Available at: <http://gmr.uis.unesco.org>. Accessed 16 February 2009.

## Sub-Saharan Africa Food Insecurity Overview

The International Food and Policy Research Institute estimates that more than 800 million people around the world are hungry (IFPRI 2007). One quarter of them live in Sub-Saharan Africa. Nutrition security remains Africa's most fundamental challenge (IFPRI 2004). Figure 1 below shows the number of undernourished people for the period of 1969-1992. Global food insecurity has decreased or remained constant from 1970 to 1990 in all regions of the world except for Sub-Saharan Africa. (FAO 2007)

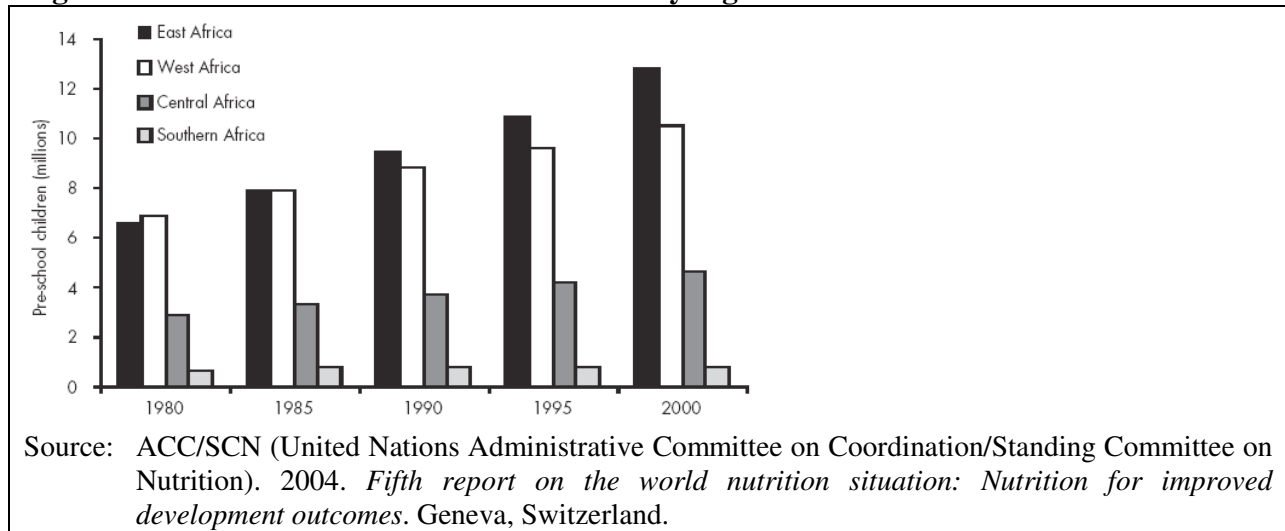
**Figure 1: Global undernourishment by region**



Adapted from World Food Summit, United Nations Food and Agriculture Organization, 2007

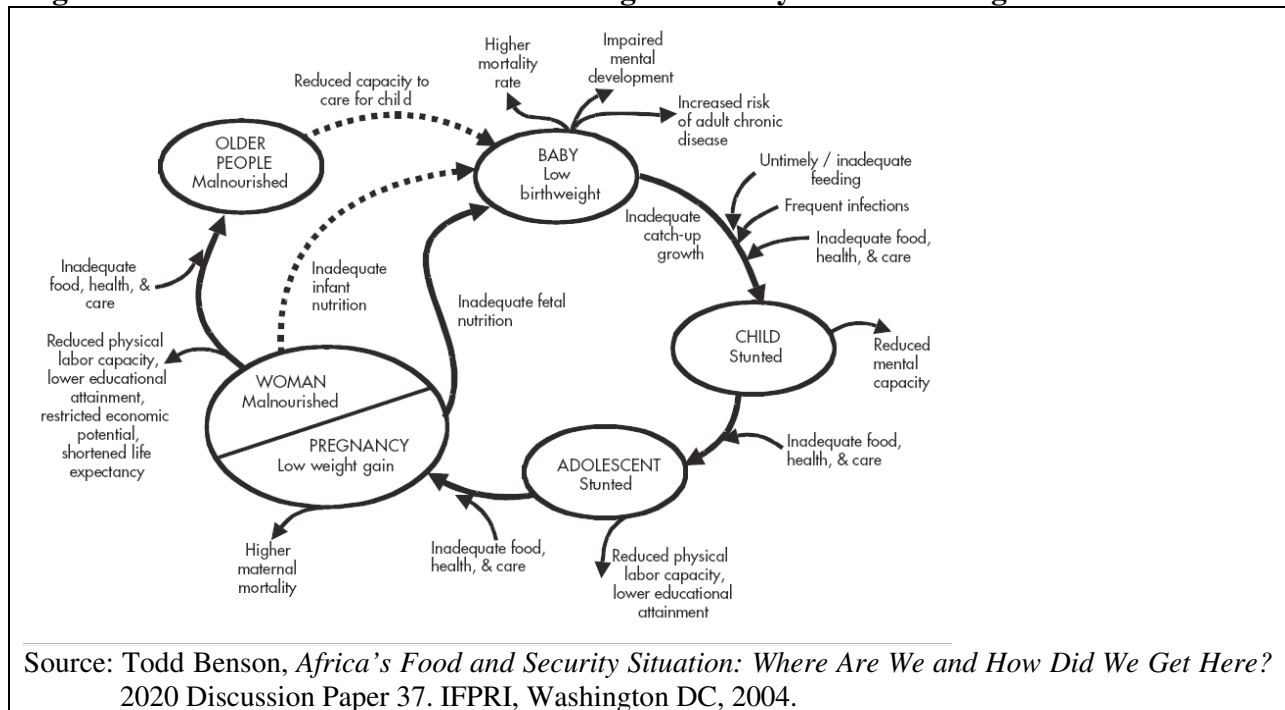
Specifically within Sub-Saharan Africa, East and West Africa have seen the largest increases in child undernourishment between 1980 and 2000. The number of undernourished children in central Africa has slightly increased, while southern Africa's rates have been fairly stable.

**Figure 2: Child Under-nourishment in Africa by region 1980-2000**



It is well understood that malnutrition affects people throughout their lives. A malnourished child will carry the biological damage imposed by lack of proper nutrition into adulthood, affecting the next generation. Malnourished girls who become pregnant either die during pregnancy or give birth to low birth weight children. The burden of malnutrition continues throughout people’s life cycles and vertically across generations. Malnutrition damage done in childhood is often not reversible in later years (Benson, 2004). Foods that meet nutritional requirements are too often expensive for poor households (World Bank 1998).

**Figure 3: The burden of malnutrition through the life cycle and across generations**



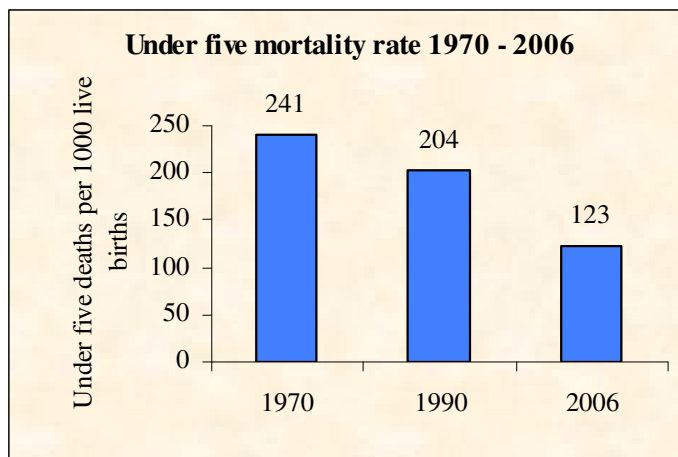
## Nutrition and Under Five Mortality in Ethiopia

Nutritional indicators in Ethiopia indicate the need to not only educate mothers on proper nutrition practices, but also provide adequate opportunities for people to improve their livelihoods, whether through agriculture or income generation. One fifth (20%) of infants had low birth weight in 1999-2006. A high 38% of under five children suffer from underweight, both moderate and severe, while 11% of under five children exhibit wasting (UNICEF 2006). Half (50.7%) of children under five still exhibit stunting (WHO 2009).

Interventions and proper child nutrition is not reaching all the children in need. Only 49% of children up to six months of age were breastfed during a UNICEF survey from 2000-2006. A little more than half (54%) of children were breastfed with complementary foods from six to nine months. (UNICEF 2006) In 2005 only 45.8% of children from 6 months to 5 years received Vitamin A supplementation (WHO 2009).

The under-five mortality rate in Ethiopia has improved markedly between 1970 to 2006. The rate declined from 241 per 1000 live births in 1970 to 204 per 1000 live births in 1990 and to 123 per 1000 live births in 2006 (See Figure 4 below). If this trend continues, Ethiopia could potentially reach the MDG role of halving the 1990 under five mortality rate by 2015 (UNICEF 2006). Marked inequalities between rural and urban areas persist. The under-five mortality rate for rural areas in 2005 was 135 per 1000 live births, while in urban areas for the same year it was 98 per 1000 live births. Seventeen percent (17.3%) of under five deaths were caused by diarrheal diseases, whereas 3.8% of under five deaths were caused by HIV/AIDS (WHO 2009).

**Figure 4**



Source: UNICEF Info by Country: Ethiopia Statistics: 2006.

The maternal mortality ratio per 100,000 live births was 720 in 2005 (WHO 2009). According to the UNFPA Report, Ethiopia has the fifth largest number of maternal deaths, with a 1 in 27 chances of lifetime maternal death.

## **Sanitation and Immunization Rates**

The number of people with access to an improved water source more than doubled from 1990 to 2000, but currently remains at 29% of the population (World Bank 2006). The figure does not reveal the vast differences between urban and rural areas. Only 11% of rural areas have an improved water source, while 81% of the urban population enjoys access to improved drinking water sources. Less than half (44%) of the urban population uses adequate sanitation facilities, while for rural populations, the figure drops to only seven percent (UNICEF 2006).

Immunization rates show a more positive picture, although not close to the WHO and UNICEF recommended rates. Immunization coverage rates for measles have improved drastically from a low of 4% in 1980 to 52% in 2000, though much work remains to be done to reach the rest of the population (World Bank 2006). Tuberculosis immunization (BCG vaccine) stood at 72% in 2006, while 80% of one year old children were immunized against DPT. Polio coverage through the DPT3β was 72%, while 79.9% of newborns were protected against tetanus. Only 15% of under five children suspected of having pneumonia were taken to an appropriate health care provider (UNICEF 2006). Just one third of children less than 5 years old with diarrhea received Oral Rehydration Therapy (WHO 2009).

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

The prevalence of HIV among 15-49 year olds in the total population was approximately 2% in 2007 (World Bank 2006). The 2005 HIV prevalence estimate ranged from 420,000 to 1.3 million. Prevention among young people with comprehensive knowledge of HIV was 33% for males and 21% for females. Sub-Saharan Africa has 46 million orphans (UNICEF 2008). Of these, it is estimated that 12 million are AIDS orphans. Ethiopia has 5 million orphans overall, with an estimated 1.5 million AIDS orphans (Abebe, Aase 2007). Ethiopia alone thus represents more than 10% of overall and AIDS specific orphans in Sub-Saharan Africa. It is therefore important to target health and development programs toward orphans. UNICEF estimates that only 60% of orphans attend school in Ethiopia (UNICEF 2006).

## **Gender Dynamics and Focus of SHG Program on Women**

The United Nations Development Programme (UNDP) notes in its 2008 World Development Report that Ethiopia ranks 84<sup>th</sup> out of 108 countries in the gender equity measure (UNDP 2007). Project Concern International created the Self Help Group to increase the livelihood opportunities for poor, vulnerable women. It is important to discuss the rationale for PCI's focus on women empowerment through the program.

The literature is replete with examples that show improved health and nutrition outcomes in households where women generate income and/or control the spending patterns because women place a higher priority on child welfare than men. (Simister 2003, IFPRI 1995, Manuh 1998). By increasing women's share of household income, it has been shown that there are corresponding increases of food consumption and a reduction in the purchase of alcohol, cigarettes, eating

outside the home, and adult clothing (Hoddinott 1995). Furthermore, women's income is positively related to the wellbeing of female members of the household, improving daughter survival and growth and maternal nutritional status (Gibson 2008).

A Demographic and Health Survey study in 44 countries found that household wealth and income interacts with gender to exacerbate the gap in educational outcomes (Filmer 2005). A recent study in South Africa found a significant difference in the enrollment rates of girls if they lived with a pensioner compared to an unemployed retired person. A program targeted toward income generation for female pensioners had a significant positive effect on children's health and development. The effect was almost entirely driven by living with a female pensioner rather than a male pensioner. (Case, Menendez 2007).

The impact of widowhood or divorce is devastating in all societies, and the struggle to survive without the husband's income is harsh. Many women lack income after the loss of their husband. The problems are exacerbated by deteriorating livelihoods. The vulnerability of these women and their children stems in part from lack of health and education services and income generating opportunities (Huisman 2005).

Violence toward women is still a major challenge in Ethiopia. Domestic violence and female genital mutilation (FGM) continue; 74% of women 15-49 years experienced female genital mutilation. Rural areas had higher (76%) rates than urban areas (69%), though much work still needs to be done to address this important issue (UNICEF 2006). An important part of the SHG education curriculum includes health education to reduce harmful traditional practices such as FGM.

## **Integrated Programming: Health and Nutrition Education and Micro Saving**

During preliminary literature research on income generation programs, health education, and micro credit and micro lending programs, there was little evidence of a similar program to PCI's Self Help Group model. Only two similar programs exist of which a record exists; both are implemented by International Relief and Development. The first is the Shakti program in India, which integrates income generation with health education. The second is the Women First Program in Mozambique. Though the Self Help Group program employs a slightly different approach than the IRD model, it is still among the few programs at the forefront of employing an integrative approach to development programming.

Integrated programming offers opportunities to harness the potential of individual programs and reap numerous benefits. Stand alone health education and income generation efforts are commendable in and of themselves. It is important for poor people to receive health messages. However, if they do not have the financial means to adhere to the messages, buy more fruits and vegetables, soap, etc., their noncompliance stems from a more fundamental economic vulnerability rather than poor message uptake. Conversely, if a project successfully increases the income of poor, vulnerable households without the accompanying health, nutrition and financial education, there is the risk that the family will spend the extra income on consumable household items rather than health, education, or long term income generating activities. While the

literature shows that women tend, on average, to allocate more money toward food for children it is presumptuous to believe that women without education will always allocate resources as efficiently as possible and toward the most beneficial purposes.

One of the strengths of the SHG model is that it integrates a savings scheme with education on health, nutrition, financial planning, and income generating activities. PCI addresses the gaps in stove piped programs by providing women with the health, nutrition and business knowledge to improve their lives along with the financial means to achieve the change.

Christiaensen and Alderman conducted a survey in Ethiopia and found a positive correlation between maternal and community nutritional knowledge and the health status of her child. An additionally significant improvement was noted when household incomes increased. The study authors estimate that coupling income growth with primary education and nutrition education could reduce chronic malnutrition in Ethiopia by up to 31% (Christiaensen, Alderman 2004).

A study in rural India regarding intake of nutritious food by pregnant women did not find a significant correlation with levels of general and health education. However, the consumption of fruits and green leafy vegetables increased when family income increased (Panwar, Punia 1998).

Anecdotal evidence suggests that women with increased income will be economically empowered and therefore less susceptible to risk of HIV infection. A study in Uganda of market women found that while they reported high levels of independence, mobility and social interaction, access to cash did not translate into control of how it was spent. Men still maintained their dominance over the money supply. Independence and income from market work make it easier for women to enter and exit new sexual relationships, although they do not ensure that women can protect themselves once in the partnership (Nyanzi et al. 2005). This draws attention to the importance of program implementers to strive to ensure that women and their children benefit from the increased amount of income.

With these observations in mind, it make sense to posit that programs that provide women with the opportunity to save money and generate income while simultaneously educating them on how best to use the money to positively improve the health and nutrition of their household have a greater chance to succeed than stand alone projects. There is a greater chance to achieve the long term goal of livelihood improvement when addressing the multiple needs of vulnerable women and their households.

## **Project Concern International Profile**

Project Concern International (PCI) is a U.S. non-profit organization that started in 1961. It currently operates in 13 countries and focuses on providing nutrition, maternal and child health, access to clean water, and essential medical services to vulnerable children and their families. PCI works in communities to address the underlying vulnerabilities of disease and poverty.



## PCI Ethiopia Profile

The organization began operations in Ethiopia in 2005 and its program portfolio has expanded quite rapidly since then.

In all its HIV and AIDS program, PCI Ethiopia emphasizes human rights, organizational capacity, and links among local organizations to work collaboratively to provide quality services to the largest number of people possible. PCI provides critical support services to orphans and vulnerable children (OVC). Through local implementing partners, PCI reaches OVCs to provide health care, psychosocial support, improved access to quality education, food and nutrition and livelihood security. The BELONG program, a five year, USAID funded project, works together with community based organizations, the Ethiopian government, and nearly 200 schools to reach more than 160,000 OVCs and over 7,300 caretakers. The Breedlove program provides vital supplemental food to 4,325 children and pregnant mothers affected by HIV/AIDS.

PCI also works to ensure sustainable development solutions for its beneficiaries. The economic strains imposed upon those in urban areas force many people to eat sub-optimally. The lack of regular intake of nutritious food is detrimental for those on antiretroviral medicine. PCI conducts urban agriculture training to beneficiaries to ensure those living with HIV/AIDS can grow their own supply of nutritious food.



The Give-A-Goat program provides OVCs with goats and sheep to improve livelihoods. The goats and sheep provide struggling families with protein-laden milk every day. By selling the offspring, they can also buy school supplies, medicine, and clothing for their children. Furthermore, the milk can be processed into cheese, which provides a value added food that can be sold in the marketplace. PCI also engages in Income Generating Activities through the Women's Self Help Group. The Self Help Group approach empowers more

than 5,000 women by providing them with health and nutrition training while simultaneously equipping them with important business skills.

PCI collaborates with numerous partners for various programming activities. The Links 4 Life Community of Practice initiative links NGO practitioners to meet on a monthly basis. They share best practices that integrate HIV/AIDS and Food and Nutrition Security programs in order to scale up what works. PCI, in partnership with the Ministry of Justice, is raising awareness about the issues surrounding human trafficking by holding workshops for judges, prosecutors, attorneys and police. A one year Avian Influenza Preparedness pilot project, in collaboration with the Ministry of Health, the International Rescue Committee and the Ethiopian Red Cross, aims to equip local communities with the necessary tools to effectively respond to an Avian Flu

outbreak. Simulation exercises will be conducted in three regions at the end of the project.

## The Self Help Group Approach

The objective of Project Concern International's Women Caretakers' Empowerment Self Help Group (SHG) is to strengthen the capacity of Orphan and Vulnerable Children (OVC) caretaking households to support themselves and their children through economic and social empowerment. The women contribute to a common fund that is then accessible to the members as a micro loan.

**Table 2: SHG Implementing Partner Statistics as of 30 September, 2008**

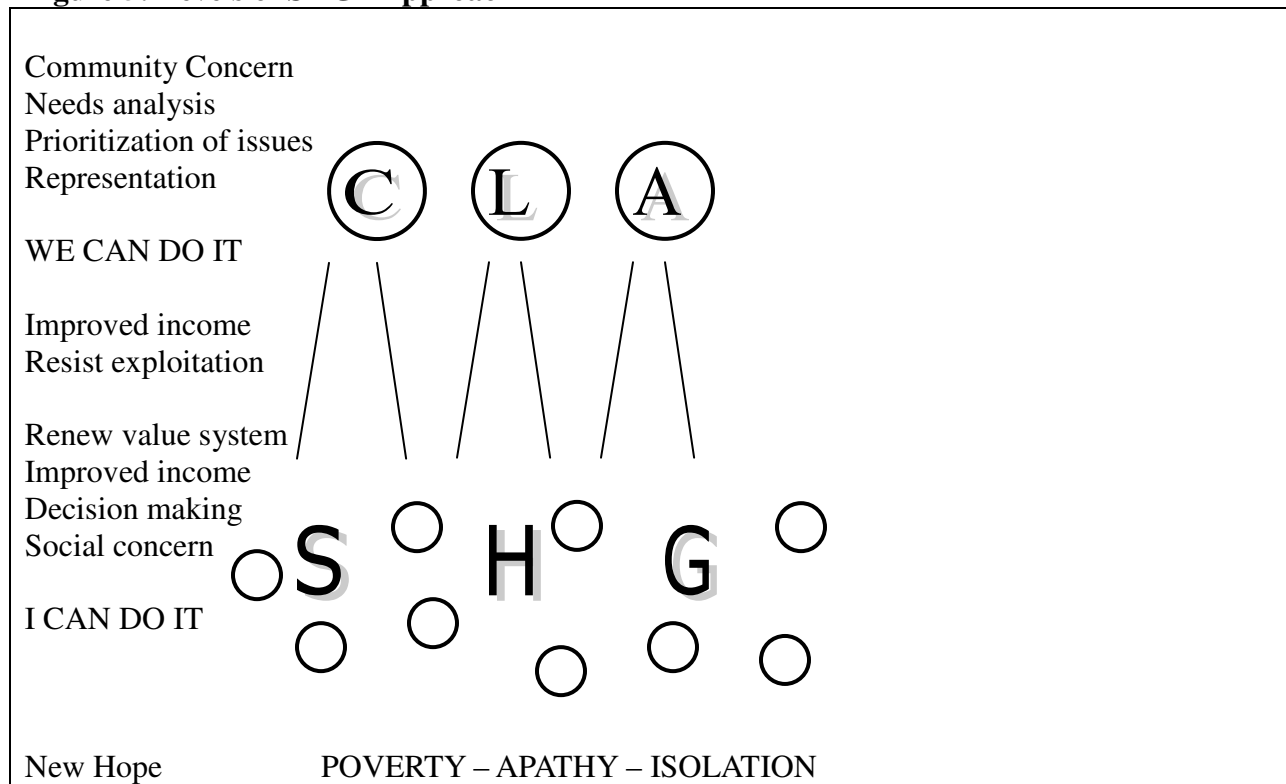
	NGO	Operational area	Number of SHG	Number of members	Total capital mobilized in ETB	Total loan disbursed in ETB
1	LCO	Addis Ababa	94	2,119	328,644	337,036
2	NPHHC	Tigray-Miachew	36	683	32,087	7,900
3	AFSR	Addis Ababa	30	568	9,952	4,083
4	ISAPSO	Addis Ababa	29	565	11,162	3,750
5	DFT	Amhara-Debre Berhan	39	739	14,476	7,750
6	SWDA	Addis Ababa	25	595	32,036	5,607
		TOTAL	253	5,269	428,356	366,126

The overall goal of the self help approach is to build poor women's capacity to bring change both to individual lives and also to the overall community in which they live. This is done by organizing poor community members through people's organizations which include the Self Help Group (SHG) and Cluster Level Associations (CLA). The whole process enables the women to learn about their rights and demand that their rights to met. The people's institution leads to economic, social and political empowerment process.

The SHG-approach offers an alternative to the development approach implemented by NGOs in general. The whole concept is to harness human potential and bring attitudinal change that leads to social, economic and political empowerment.

The first level of the self help approach is the SHG. It is a group formed by 15 to 20 poor and vulnerable women with the same socio-economic background. The group engages in weekly meetings to receive health, nutrition, and business skills education. The meetings provide a forum where the members open up and share common issues, which helps establish trust and a sense of belonging. The women also contribute to a common savings account. When the savings account grows, members are encouraged to take a loan from their own fund and engage in different business activities. Various mechanisms exist for the women to develop the SGH's capacity. Women have access to education on numerous topics, including business activities, savings and loan management, record keeping, leadership and communication, HIV/AIDS, and women's and children's rights.

**Figure 5: Levels of SHG - Approach**



The second level of the self help approach is the Cluster Level Association (CLA), which is formed by the SHGs for their own benefit. The CLA is a people’s institution composed of six to ten SHGs in the same geographical area. Two members from each SHG (a total of 12 to 20) are represented at the CLA level. The major role of the CLA is to ensure that SHGs are linked to the different service providers of financial, material and technical resources.

Individual lives improve as a result of participation in the SHG. Women access loans, engage in business activities and generate their own income to pay school fees and cover other household expenses. Members also learn about business and health including:

- Attitudinal change regarding culture of savings
- Business management
- Child rights
- Harmful traditional practices
- HIV/AIDS prevention
- OVC care and support
- Women’s rights

Furthermore, women develop numerous useful skills, such as:

- Business
- Communication
- Group management

- Leadership
- Reading and writing
- Sense of self-worth

In its work with SHGs, PCI emphasizes the need for women to take responsibility for their own development. SHGs have been successful in gaining recognition from their local government (i.e. Kebele office, Women's desk, HIV/AIDS desk) and other authorities.

## **Research Goals**

Even before analyzing the data collected from the field interviews, I was impressed by how quickly PCI's efforts in Women Empowerment grew over such a short period of time. After five years of operation, there are over 5,000 women who participate in the SHG. Considering that most of the women have at least one child and/or are married, the program indirectly impacts over 10,000 people.

While there are numerous micro credit and micro lending worldwide, either very few integrate the health and nutrition education component with the income generation component, or very few studies have been published about the efforts that exist. One of the major reasons to undertake this study was to add to the scant literature that is publicly available in this area of integrated programming. The vast literature on the benefits of income generation for women does not need to be replicated. However, what is needed is research to elucidate the benefits and challenges of incorporating an income generation scheme with health, nutrition and business skills education.

Since the program has grown so quickly, I was interested to assess the impact on women's lives and how they used the loans generated from the group saving model to improve their health, nutrition, and livelihood status. The research goals for data collection were therefore as follows:

- Contribute meaningfully to the existing literature that assesses similar programs
- Identify the purposes for which the women utilize the money (i.e. health, child education, household items, business expansion, etc.)
- Identify the programmatic strategies used to ensure the program's success
- Identify how the program integrates access to credit and adult education
- Evaluate the extent to which the program has achieved its intended health, nutrition and business skills knowledge outcomes
- Identify critical factors necessary for successful scale-up of the model

## **Research Hypotheses**

It would have been ideal to have a baseline survey of the women's groups. However, the research findings can still be used to assess the extent to which the program has achieved its strategic goals on health and nutrition knowledge and business skills acquisition and improved

the livelihood of these vulnerable women and children.

It is encouraging to see the integration of health and nutrition education with improved access to micro credit. This multi-sectoral development approach needs effective integration. It is important to analyze the extent to which this integration is carried out at the beneficiary level to identify potential improvements to the strategy.

Through the interviews with program staff, I intended to identify the most effective strategies used to scale up the program. The goal was to identify the challenges and shortcomings in carrying out the program activities and evaluate potential improvements in the program design, tools, and strategies.

The research hypotheses were formulated as follows:

1. Women who start off “better” (i.e. more education, more money, etc.) will reap more benefits from the program and exhibit improved health, nutrition and livelihood outcomes compared to other women in the group and across the SHG
2. The SHG program strategies utilized by PCI program implementers are effective to achieve the SHG goals; any gaps in program operations can be identified and addressed before the program ends and/or the CSO law takes effect.
3. The SHG program is a successful model that incorporates an adult education program with access to credit.
4. PCI’s Self Help Group offers a best practice for microcredit programs that target poor women without formal education or marketable skills who are at risk of HIV and food and nutrition insecurity.

This current research offers a glimpse of the best practices exhibited by an integrated program.

## **Methodology**

The interviewers conducted the individual interviews with the women. They started the discussions by affirming the anonymity and confidentiality of the women’s answers, unless the women specifically wished to attribute answers to them [See *Privacy Considerations to Research Participants* section below]. Additionally, they emphasized that they were independent consultants without an interest in any of the organizations involved with the program. Understanding that some of the women might have felt hesitant to discuss any criticisms of the program, the interviewers began the sessions by affirming the purpose of the study, which was not only to evaluate the success of the program, but also to offer suggestions for improvement that will benefit other women and communities. They emphasized that the women’s answers would help improve their program, and could potentially help impact many more women’s lives through expansion of the program. This gave the participants an active role in the evaluation and

improvement of the program.

The qualitative assessment of health outcomes gauged how participants' health knowledge and behaviors were impacted by the program. Specifically, I sought to verify if messages from the nutrition, health and business education have been retained, utilized and contributed to a discernible impact on the self-assessed health of the women and their families. All of the health related questions were asked in an individual interview, using standardized questionnaires for all groups in order to more accurately compare responses across groups.

Since a baseline assessment was not done for the SHG groups, the research findings can serve as baseline data for future studies.

The number of the participants in the SHG program is over 5,000 women divided in 253 groups of approximately 15 to 20 women per group. Twenty five groups were interviewed in order to reach ten percent of the total groups. Within each group, four to five women were interviewed, including the bookkeeper. The groups were randomly chosen from those operating in Addis Ababa and Debre Birhan. Due to the logistical and budget limitations of this project, SHG groups in the Tigray region were not reached. The data collectors were able to interview 117 women through individual interviews. According to sample size calculations, for a population of 5,000, a sample size between 94 and 116 will ensure a 95% confidence level with a 9% - 10% confidence interval.

The main consideration in designing the interview and focus group questions dealt with ensuring that women were comfortable with providing unscripted answers. Because of this, several of the programmatic questions were categorized as "individual" and included on the individual interview sets. Some of these were questions that involved the women's relationships with each other and whether they took an HIV test.

I spoke with current staff implementing the Self Help Group through PCI. Staff was interviewed about what they consider the strengths and weaknesses of the program, how their jobs could be made easier with implementing the program, and suggestions and assessments for approaches, tools and systems they found useful so far. Their feedback provided the framework to use as a tool in possible future expansion of the program. The program staff interviews were straightforward dialogues guided by a basic and flexible questionnaire [See Appendix I for the *Program Staff Interview Questionnaire*].

## **Privacy Considerations to Research Participants**

No personally identifiable information was collected from the women. The only identifier is the group name. However, individual answers cannot be traced back to a particular individual. Only program staff has access to the amount of money each group has saved. If PCI or its implementing partners want more detailed information about a particular group, they will need to revisit that group and interview individual women.

In order to ensure the privacy and security of the research participants, I instructed the

interviewers to create a security system on their computer so that nobody has access to the information until it is compiled, analyzed in aggregate, and distributed. I recommended that they add a different password to the working documents than the password to the computer. I believe this system is secure enough to avoid any information being disclosed without permission.

The two primary considerations for the health survey were privacy and relevance. The first, privacy, was addressed by making all the health questions part of the individual interview. Though I recognize that some of the topics, such as HIV testing status of the SHG member and her husband, may still have been too sensitive for the individuals to answer, I expected that PCI and field staff of implementing partners would provide critical feedback on the survey questions and help to refine them before, or immediately after, the interview process began. Another critical consideration was to make the questions relevant. This was accomplished by the input received from PCI and the GW Global Health Department.

## **Logistics**

Walleigne Beriye and Addisalem Tesfaye arranged all logistical details. PCI provided transport to and from the project sites and English speaking data collectors to facilitate the translation of interview questions from English to Amharic and back to English. The data collectors provided English transcripts of their interviews and are available upon request.

## **Uses of Research Findings**

Before my departure from Ethiopia, I had hoped to debrief the PCI staff in Addis Ababa regarding my preliminary findings and any analysis completed while in country. However, due to unforeseen circumstances, the data collection effort took longer than expected and I left before that process was completed. The presentation of the findings in this report will be presented to PCI Washington DC staff and The George Washington University Department of Global Health. I will also present the findings to the PCI headquarters in San Diego, California in May 2009.

## **Important Research Considerations**

It is important to note that the gender dynamic of male interviewers might have limited how candid and comfortable the women were to give private information to a male interlocutor (i.e. HIV testing status of woman or her husband). Since the research scope of this paper is limited, it would be helpful to conduct a larger wealth, health, and nutrition survey of the women, before, during and after a certain period of time participating in the program. This would provide a more comprehensive and objective look at the impact of the program on the women. One of the limitations inherent in qualitative recall interviews is that the researcher relies on the memory of participants and their willingness to provide subjective information such as livelihood improvement. Furthermore, the findings are based on active participants and their assessment of the program. Drop outs could not be easily located due to budgetary and time constraints.

## Research Findings

### Demographic Information

The interviews reached 117 women who currently participate in SHG groups. Twenty five bookkeepers were interviewed, while 92 group members were reached through individual interviews. The women have a total of 369 biological children and take care of 79 orphans and vulnerable children. Each woman therefore has an average of 3.2 children. There are seven orphans and vulnerable children for every 10 SHG members. The SHG groups as a whole therefore serve or benefit between 3,321 and 4,059<sup>1</sup> children and between 1,395 and 1705<sup>2</sup> orphans and vulnerable children.

Ethiopia as a whole lags behind in education compared to the rest of the world and the Sub-Saharan Africa region. Table 3 below compares key data and rates of improvement between 1994 and 2006.

**Table 3: Adult Literacy in Ethiopia**

	Adult literacy rate (15 and over) % total		Adult literacy rate (15 and over) % male		Adults literacy rate (15 and over) % female	
	1994	2006	1994	2006	1994	2006
Ethiopia	27	35.9	36	50	18.5	22.8
Sub-Saharan Africa	53.4	61.7	62.7	70.7	44.7	53.2
World	76.1	83.6	82.4	88.3	69.9	78.9

Source: UNESCO Education for All Global Monitoring Report. 2008. Available at: <http://gmr.uis.unesco.org>

Of the women interviewed, 43.5% are literate. This compares favorably with the 22.8% of Ethiopian women who were literate in 2006 (UNESCO 2008). SHG members seem to benefit from more years of education compared to the general population. SHG members averaged 3.2 years of education, while bookkeepers averaged 7.6 years of education. Six SHG members are currently attending a literacy program.

Although education is a factor normally associated with improved livelihood, it is important to see how their circumstances make them vulnerable despite their higher levels of education.

<sup>1</sup> This figure was calculated as follows: Since 10% of the SHG groups were reached, the number of children and OVCs was multiplied by 10 to give a reasonable estimate of 100% of children in the entire SHG system. Since there is a 9-10% confidence interval, a range of plus or minus 10% of the estimate was subtracted and added, respectively, from the calculated total number. In this case, 369 children was multiplied by 10 to yield 3690 children. Then, 10%, or 369, was subtracted and added, respectively, to give the estimated range of children benefiting from the program.

<sup>2</sup> This figure includes the 79 orphans in the sample and 24 widows with 76 biological children. Since these latter children are single orphans, they are also considered vulnerable.



More than half of SHG members remain illiterate. Worryingly, one bookkeeper in the rural area of Debre Birhan is illiterate and has another SHG member help her with filling out the weekly paperwork.

Forty percent are single, widowed, or divorced, and therefore rely solely on their income for their livelihoods. While the remaining 60% of women in the SHG groups are married, it is important to disaggregate their husband's employment status and find out how many can rely on a steady source of income from their husband.

**Figure 6**

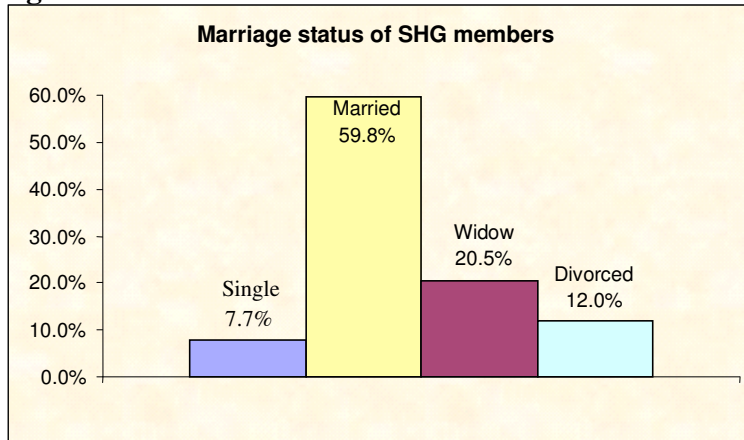
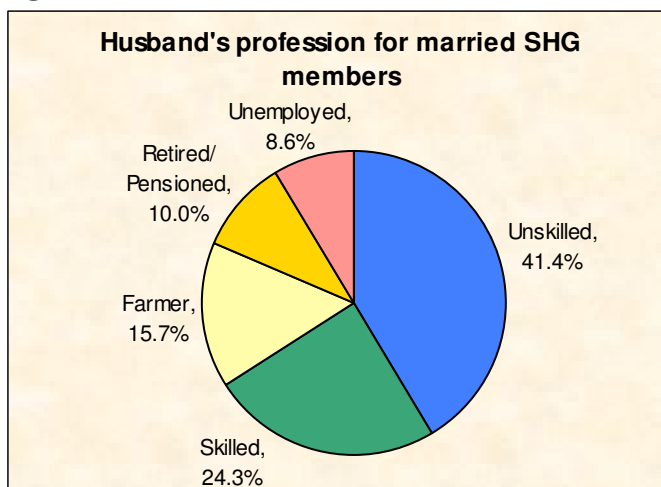


Figure 7 below shows the breakdown of husband's occupation for the 70 women in the sample who are married. As can be seen, nearly one quarter of married women's husbands have a skilled job, which brings in more income than an unskilled job, though still not enough to ensure an adequate level of livelihood. The rest of the women must rely on income that varies with their husband's day laborer contracts, or no other income at all.

**Figure 7**



## Group Saving

SHG members meet and save money on a weekly basis. Each woman is issued an individual saving passbook when she joins the SHG. The bookkeeper collects the money from the women and records the amount in the individual passbook and the bookkeeping journal she keeps.

It is logically expected that SHG groups that have been active for a longer period will have saved more. While there is a general trend toward more money saved with more months of membership, regression analysis did not reveal a statistically significant relationship.<sup>3</sup> LCO has the highest amount saved because they have 94 SHG groups, nearly three times as many as any of the other implementing partners. SWDA has the least number of SHG groups but has surprisingly managed to “outsave” the remaining three NGOs. The trend seen in figure 8 below can be explained not only by the number of SHG groups that an implementing partner has, but also by the characteristics of the area in which the SHGs are located.

While the aggregate amount saved provides an indicator of SHG member commitment to the savings scheme, it is important to note that some SHGs have been operational longer than other groups. It is therefore logical to assume that newer groups have not saved as much. In order to control for the length each SHG group has been active, the average monthly saving amount is shown in figure 9 below. It is noteworthy that with this methodology SWDA outperforms all other NGOs and is slightly higher than LCO, especially considering that LCO manages almost four times as many SHG groups as SWDA.

**Figure 8<sup>4</sup>**

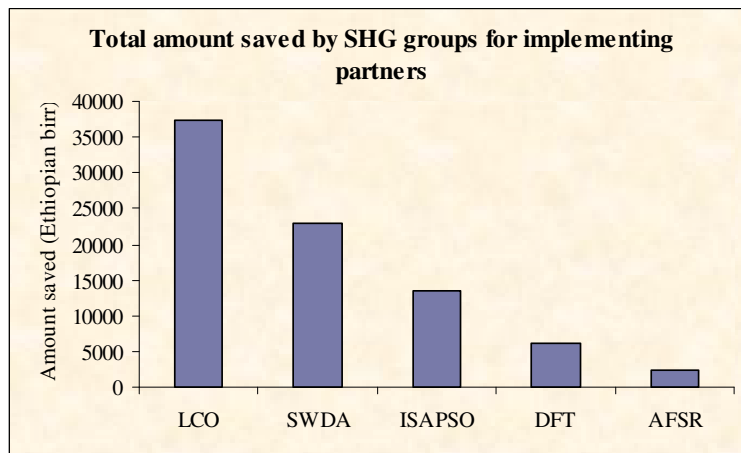


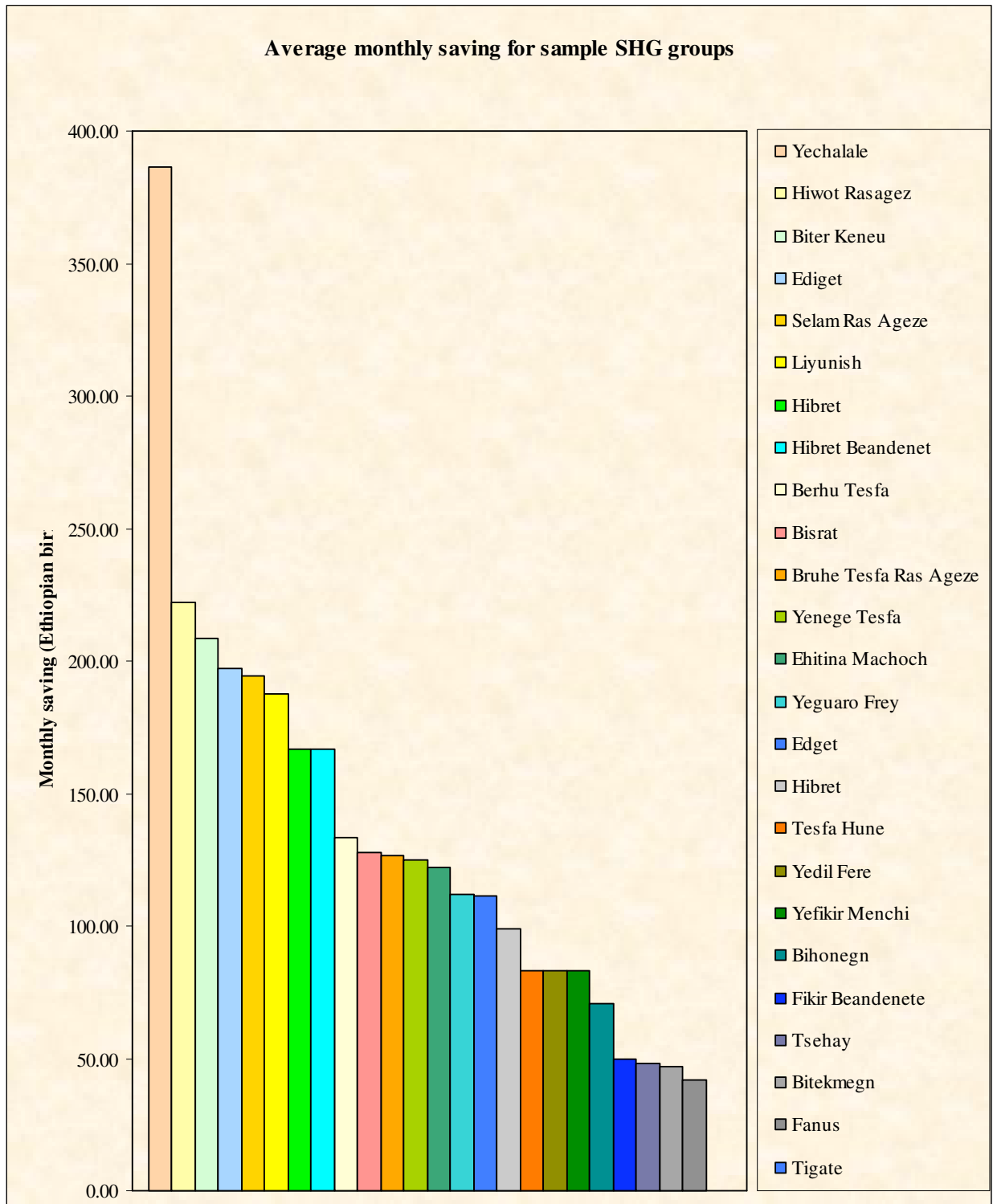
Figure 9 below shows the average monthly saving for all the groups interviewed. The top five performing groups as measured by average monthly saving are SHGs from LCO and SWDA.

<sup>3</sup> Before starting the “heavy” analysis of the dataset, a simple correlation analysis was performed to ensure that the data set had not only internal validity, but also external validity as well. As expected by conventional wisdom, the literature, and numerous studies on the subject, there was a strong correlation (4.49) between years of school and literacy rates of the groups. People who go to school for longer periods of time tend to learn how to read.

<sup>4</sup> To calculate the total amount saved, the total for each implementing partner was multiplied by ten because ten percent of each implementing partner number of SHG groups were interviewed.

Using the same measurement standard, AFSR does not have any group in the top 50% of SHGs.

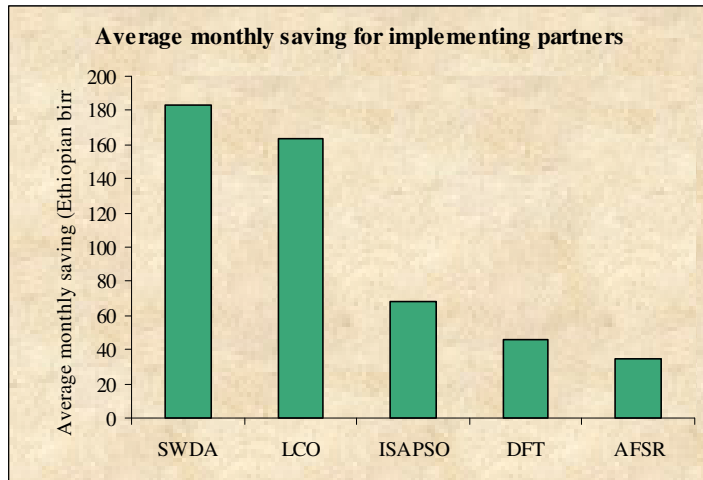
**Figure 9**



Another important observation to note is that ISAPSO and AFSR have virtually the same number

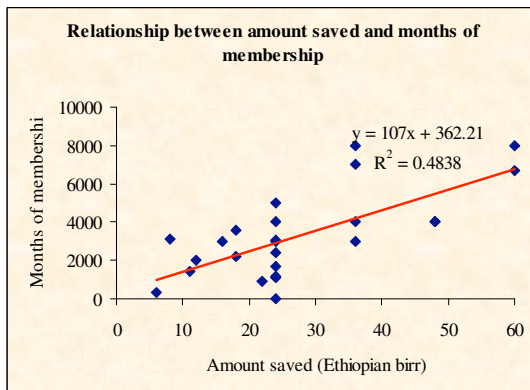
of SHG groups (29 and 30, respectively), yet the former NGO has managed to get the members to save, on average, double the amount that AFSR members save.

**Figure 10**

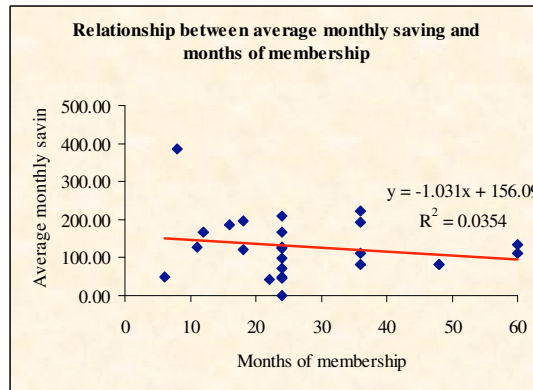


A slight positive relationship was found between average monthly saving and length of SHG membership. This is apparent in figure 11. When the two outliers were removed from the analysis sample, a flat, though slightly negative, relationship is seen in figure 12 between average monthly saving and months of membership.

**Figure 11**



**Figure 12**

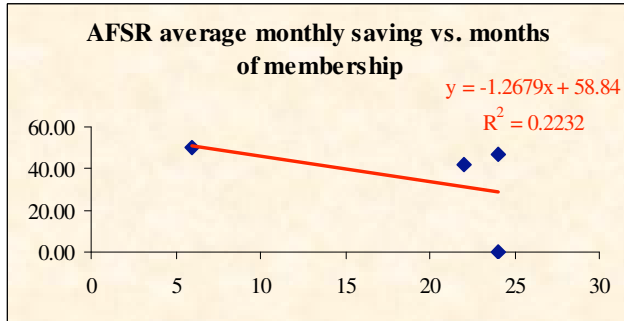


Correlation analysis for all SHG groups in the sample reveals that older groups save less than newer groups each month<sup>5</sup>. Although it is not apparently clear why this is the case, several explanations can be hypothesized. The first groups targeted with the SHG intervention were “poorer” than newer ones and have generally saved less than newer groups that are “richer.” Because there is no baseline data, this explanation unfortunately cannot be proven. Another plausible explanation is that over the four years in which the SHG model has been implemented, the Community Facilitators have “learned by doing” and have been able to hone their skills to offer more appropriate technical assistance to the groups during their start-up phase. This

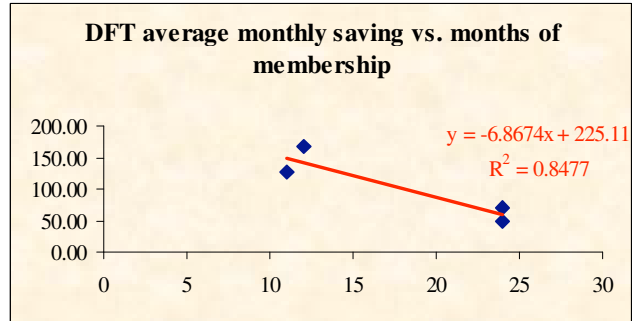
<sup>5</sup> The correlation between monthly saving and months of membership is -0.19856, which shows a decrease of 0.19 birr in the saving rate for every month of membership.

ensures that new SHG groups and members see the value of saving and are encouraged to save more than older groups. Furthermore, newer groups are able to see the progress of existing groups in their neighborhood. This motivates them to save more money in order to “catch up” with the progress attained by existing SHG members. The findings are seen below in Figures 13 – 17. All implementing partners except AFSR have a statistically significant negative relationship ( $p=0.01143$ ) between average monthly saved and months of membership. Older groups tend to save, on average, 0.10 birr less per month than newer groups.

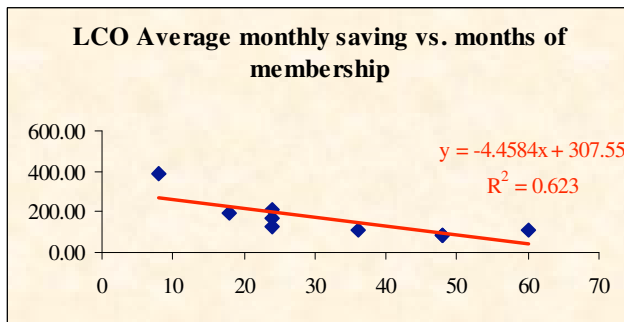
**Figure 13**



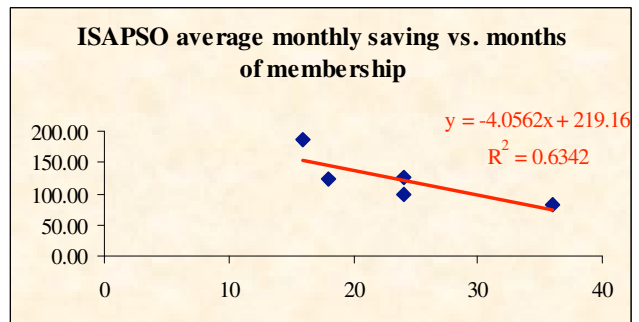
**Figure 14**



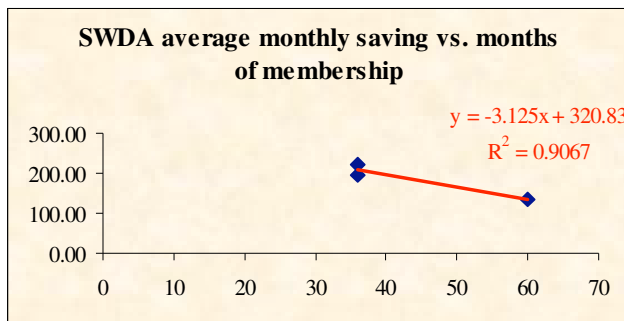
**Figure 15**



**Figure 16**



**Figure 17**

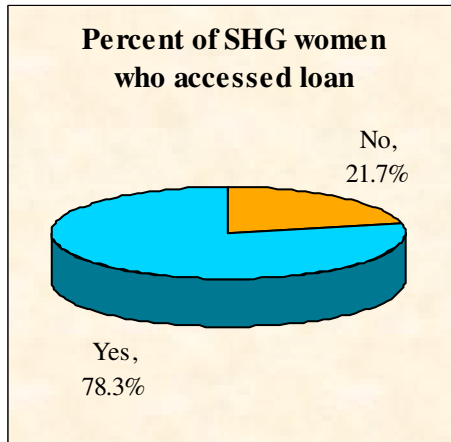


## Loan Access

Once the common pool of funds grows sufficiently, women can take out a loan. They decide the repayment terms and who gets the loans. The repayment period ranges from two to five months.

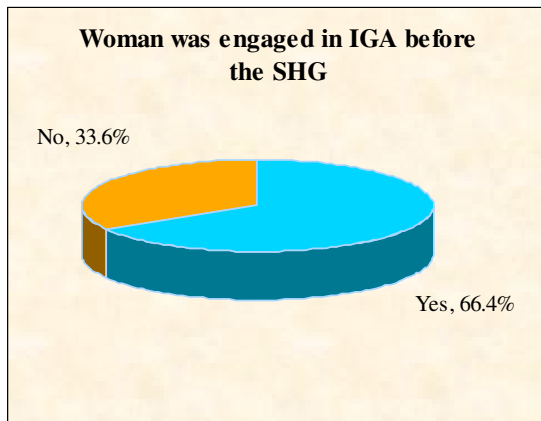
The amount of money borrowed ranges from 50 birr to 1000 birr. The average loan for all groups is 260 birr. The average interest rate is 5.6 percent, ranging from 3% to 15%. The majority of groups (78.3%) charge between 3% and 5% interest on loans. Five groups charge ten percent or more on the loans taken out by the women.

**Figure 18**

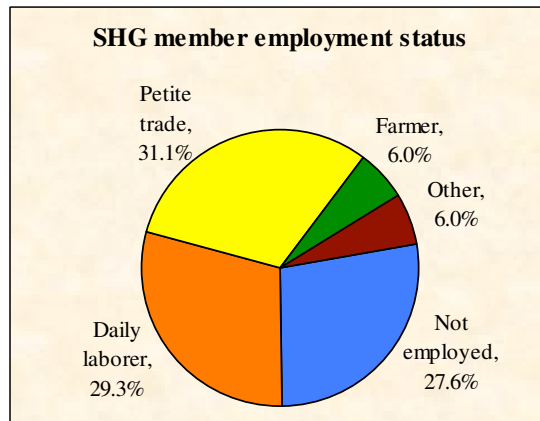


Sixty percent of women were engaged in some kind of income generating activity before participating in the Self Help Group, divided fairly equally between daily laborers and those engaged in petite trade. More than one quarter were unemployed.

**Figure 19**

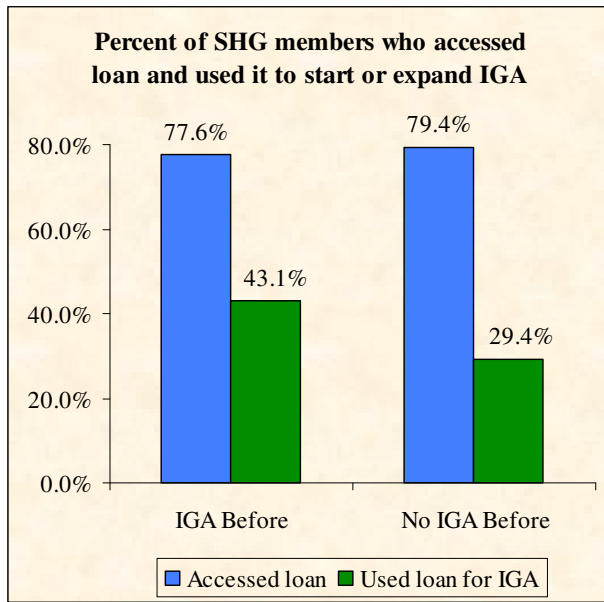


**Figure 20**



As seen in figure 18 above, over three quarters of SHG members have accessed a loan an average of 2.2 times each. When access to loan is disaggregated by whether a woman had experience with IGA before the SHG or not in figure 21 below, it is interesting that women without prior IGA experience were more likely to access a loan. Nearly four fifths (79.4%) of women without prior IGA experience started IGA with their loan money while three quarters (75.9%) of women with existing IGA used the loan to expand their business. Women without prior IGA experience were one-third less likely to use the loan for IGA purposes than women with prior IGA experience.

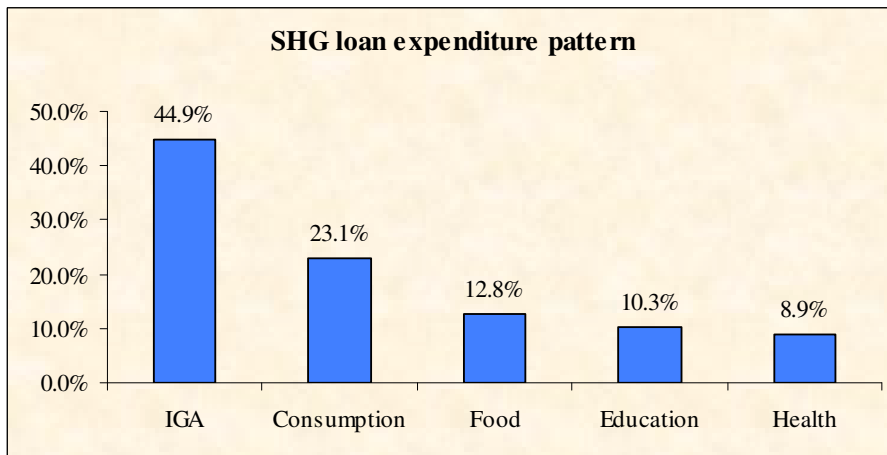
**Figure 21**



## Loan Expenditure

Figure 22 below shows the main purposes of SHG loans. A high number of the loans were spent on income generating activities, followed by consumption. The former includes petite trade, retail and kitchen equipment to cook and sell injera and shiro (traditional Ethiopian foods) while the latter includes food and household items. Nearly half (44.9%) of loans were used to start or improve income generating activities. Almost one quarter (23.1%) of loans went to household consumption, while 12.8% went to buy food, 10.3% to education support, and 8.9% was spent on health.

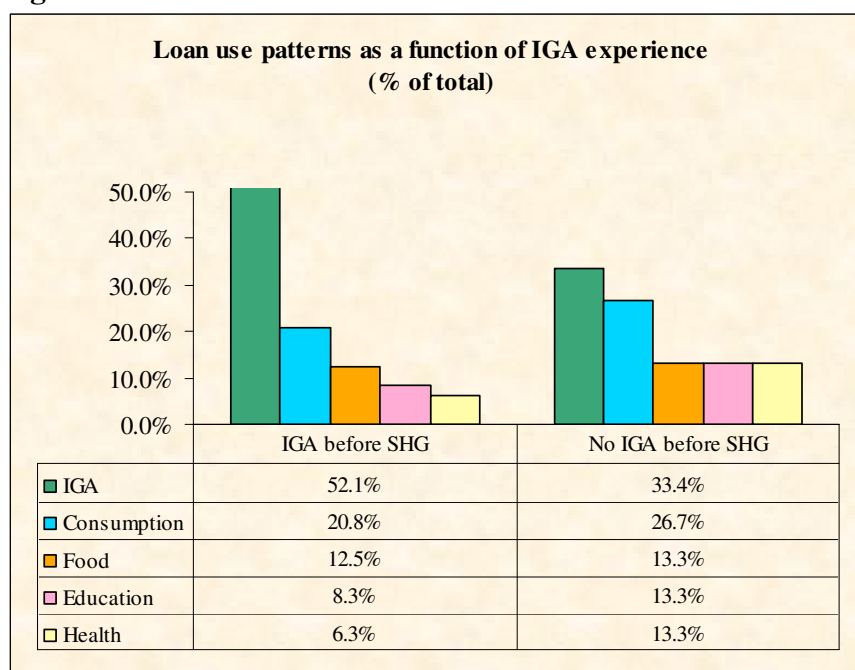
**Figure 22**



When loan expenditure patterns are disaggregated by women's experience with IGA, it is clear that women who were engaged in IGA before the SHG are more likely to expand their IGA with

the loan they borrow (52.1% versus 33.4%, respectively). These women still spend one fifth (20.8%) of their loans on consumption. Similarly, women with no prior IGA experience tend to spend one quarter (26.7%) of their loans on consumption, though one third of them engage in income generating activities with the loan money. It is surprising that women with IGA experience, and presumably a higher cash flow than those without IGA, spend less than half the loan money on health expenditures than women without IGA experience. One plausible explanation suggests that women with IGA experience know that investment in IGA will generate more money that can subsequently be spent on health, education, and other household expenses.

**Figure 23**



## Enthusiasm for the Program

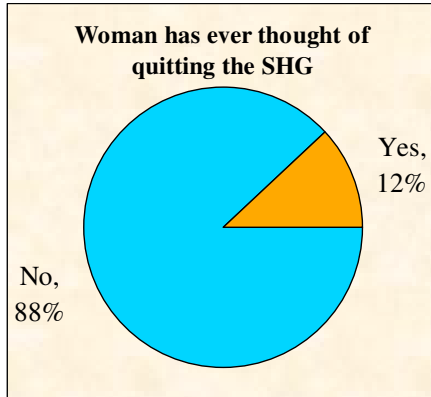
Enthusiasm for SHG participation among the women is very high. Almost 90% of respondents said emphatically that they has never thought of quitting the program. The most often cited reasons for staying in the program include:

- Can now buy food in bulk and pay back over several months
- The SHG is the woman's only hope for a better life
- The women are using their own resources instead of borrowing other people's money
- She does not have to see moneylender's face again
- The women discuss things together and interact on a weekly basis
- The SHG is "my" group and I access "my money"
- They receive education
- Some women receive sheep
- The group helps her expand her business



- The women are like sisters
- Can now “think in time” and appreciate the value of saving money diligently over a period of time because small sums eventually add up to a significant amount

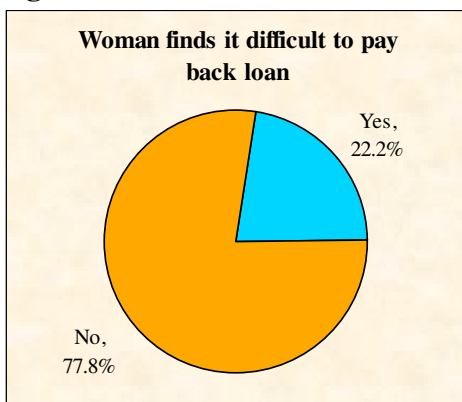
**Figure 24**



The 12% of women who had thought of quitting had mostly done so once or twice. Nearly all of them cited difficulty with weekly saving as an impediment to continued participation in the group. They spoke openly with their SHG group about the difficulties and appreciated the support of other women, who often waived the penalty for not saving during a particular week. Most of the time, women would make up the saving deficit the following week or month. Other reasons for mentioned as reasons to contemplate quitting include:

- Member disputes
- Woman not in a position to pay back a loan
- Inconvenient meeting time
- Family is not supportive

**Figure 25**



Another difficulty encountered by women is paying back the loan. As seen in figure 25 above, nearly one quarter of women reported that it is hard to pay back a loan. Most often cited reasons include:

- Cost of living increasing

- Poverty
- Large payment in relation to income
- No steady source of income

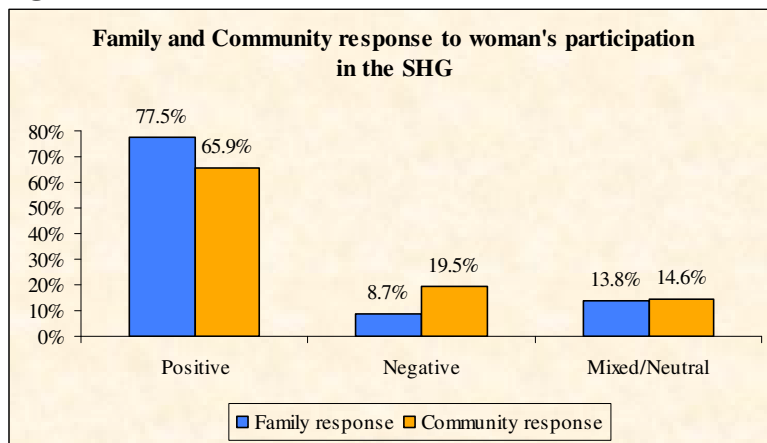
On the other hand, the women who paid on time and did not report difficulty with repayment noted that:

- She used the loan money for IGA and now generates the money to pay back the loan
- The payment is spread out over several months so there is enough time to repay
- She benefits from the loan and does not want to deprive other women of the opportunity
- Her family works and helps with payment
- The SHG is "her" group and feels responsible for it
- She borrowed the amount she knew she could pay back

While the program is targeted toward women empowerment, it is important to acknowledge the practical realities of the beneficiaries. Sixty percent of women are married. The vast majority of them must consult with their husband on whether to participate in the group. Fortunately, nearly 80% (77.5%) of women reported a very supportive family, including the husband. A small, but significant, percentage of women (8.7%) noted that their husband or other family member disapproved of their participation in the SHG.

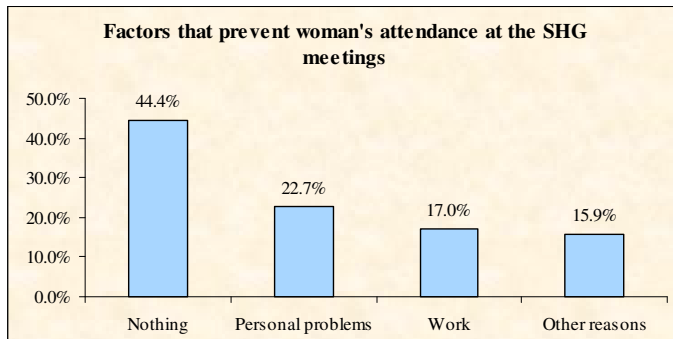
Communities were less enthusiastic of the women’s participation in the program than families. Still, two-thirds (65.9%) of women report a positive outlook from their neighbors toward their participation in the SHG, while one-fifth (19.5%) of members reported a negative outlook from their neighbors.

**Figure 26**



Because women were overwhelmingly enthusiastic about the program, most of them did not want to miss any of the weekly meetings. While 44% of women reported that nothing prevented their attendance, 22.7% cited personal problems and 17% the need to work as impediments to regular attendance. The remaining 16% cited various social functions such as funerals, trips out of town, and kebele meetings.

**Figure 27**



Group members were universally considerate and understanding of women who kept an open line of communication and discussed any planned absence. They did not appreciate women who left without an explanation and came back weeks or months later. In this case, the SHG members normally told those who left and came back to form their own group.

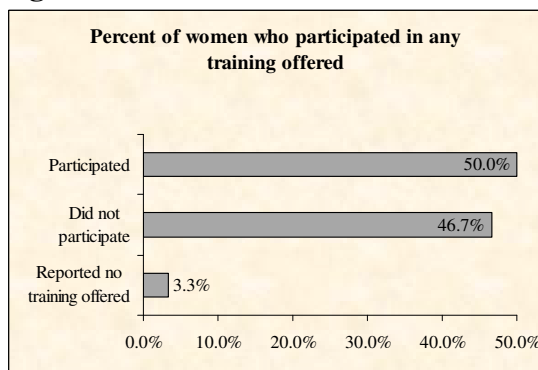
One of the most striking externalities of the SHG program and its positive impact on their community is that neighbors formed eight new SHGs in response to existing groups. Six of the new groups are in communities where LCO operates. All the spontaneously-formed groups have requested technical assistance from the implementing partners in their community.

## Training Component

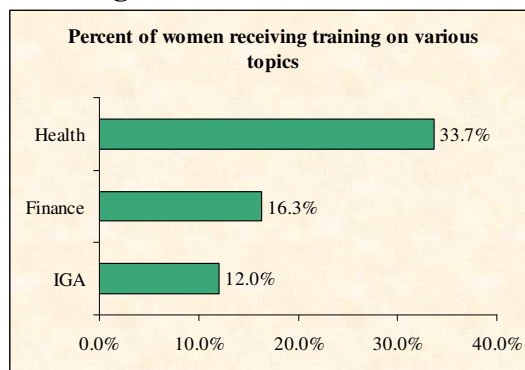
Training is an essential component of the SHG strategy. The goal is to educate women on relevant health, nutrition, and IGA issues. When women are trained to care for their children, to protect themselves from HIV/AIDS, and to manage household finances, they are expected to use the loans toward the betterment of their household.

While some women in the program have benefited from training, the majority of SHG members have not. Only 50% of SHG women participated in any training offered by implementing partners. Three percent of women were not even aware that training on various topics was available from the local NGO (See Figure 28 below).

**Figure 28**

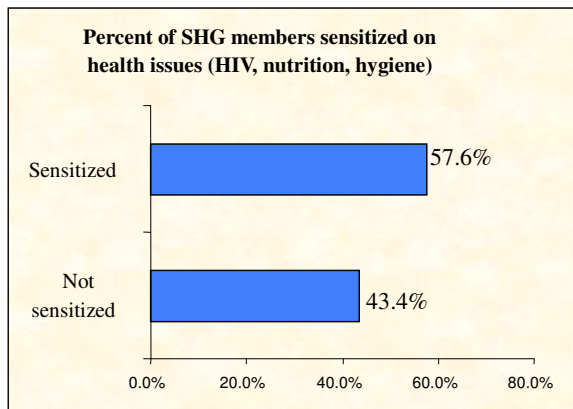


**Figure 29**



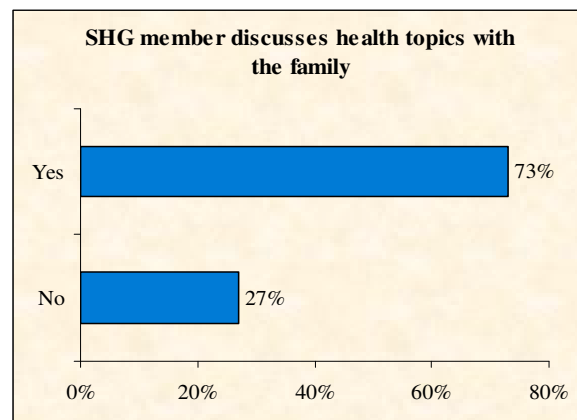
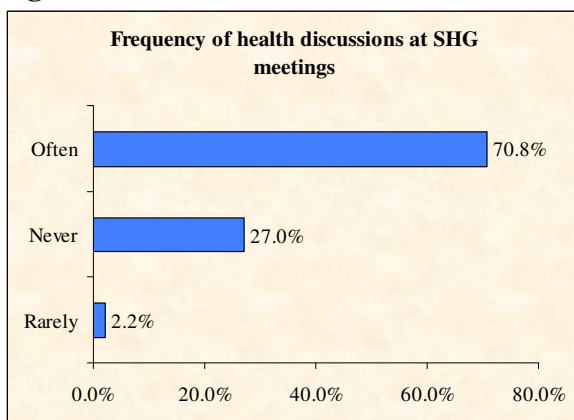
One third of women have received any kind of health training from the implementing partner, while 16% received finance training and only 12% received IGA training. (See Figure 29 below) A higher percentage (57.6%) of women reported sensitization sessions on certain topics such as HIV, nutrition, and hygiene (See Figure 30 below). The discrepancy between sensitization and training on health topics points to another source of health knowledge acquisition by the women, although it is unclear where the women are sensitized on health.

**Figure 30**



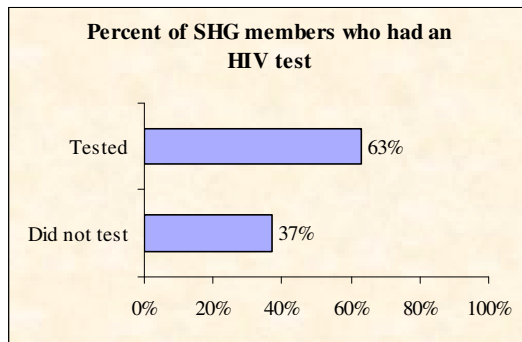
Seven out of ten SHG members noted that women frequently discussed health topics at the weekly meetings (Figure 33), while nearly three quarters (Figure 32) of women reported health discussions with their families (Figure 32). It is conceivable that women receive health training from other sources, although the more likely explanation is that women learn from each other and discuss the trainings they receive at the meetings.

**Figure 31 and 32<sup>6</sup>**

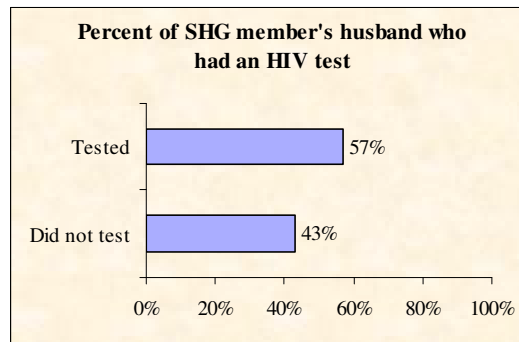


<sup>6</sup> There were three women who responded to this question who did not have a family with whom to discuss health issues. If they are included in the calculations, the percentages decrease slightly for women who speak with their family about health issues (from 73% to 70.6%) and also for women who do not speak with their family about health issues (from 27% to 26.1%). The relationship remains the same regardless of the inclusion, with more women speaking to their family than not.

**Figure 33**



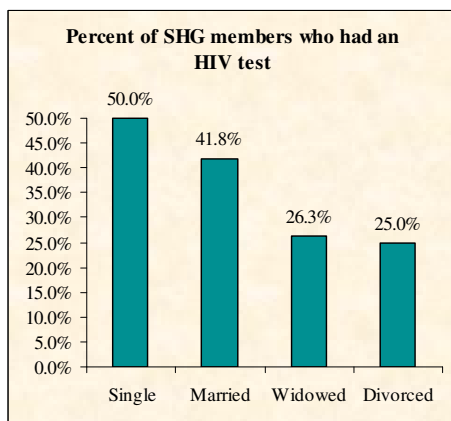
**Figure 34**



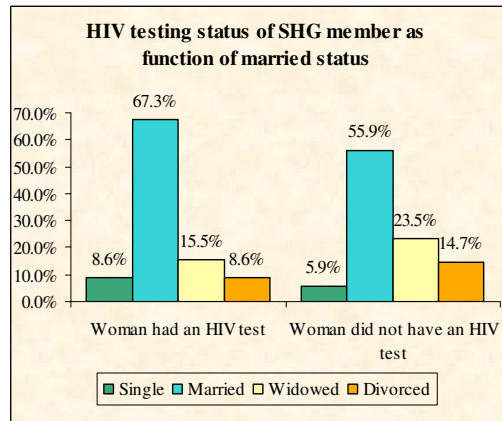
One way to gauge whether health and HIV/AIDS education is having an impact is to look at the HIV testing rates of the SHG groups and compare to national averages. Sixty three percent of women in the sample had an HIV test. The overall percentage of husbands who had an HIV test was comparable, though slightly lower (57%), to that of women (Figure 34). This compares favorably to the national HIV testing rates in Ethiopia, where only 4% of men and 3% of women take an HIV test and receive the results. Urban areas have higher HIV testing rates; 15% for men and 12% for women (USAID 2006).

In order to target HIV education effectively, it is important to know the demographic profile of the SHG members that have an HIV test. Looking at marriage status and HIV testing status reveals that single SHG members had the highest testing proportion compared to other groups. Men and single women are at highest risk and most often do not know their status (Bassett et al 2008). However, progress still needs to be made to educate the women about the importance of getting an HIV test along with other health messages. Divorced women were least likely to have an HIV test.

**Figure 35**



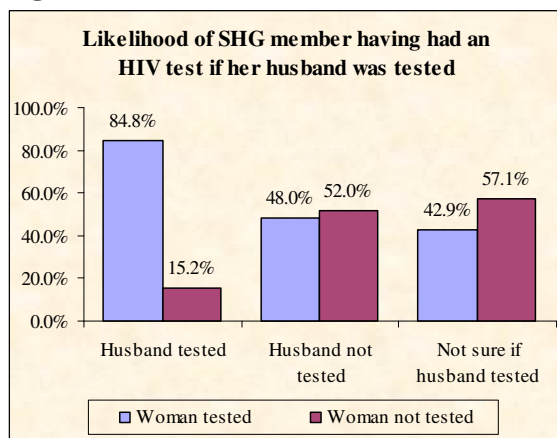
**Figure 36**



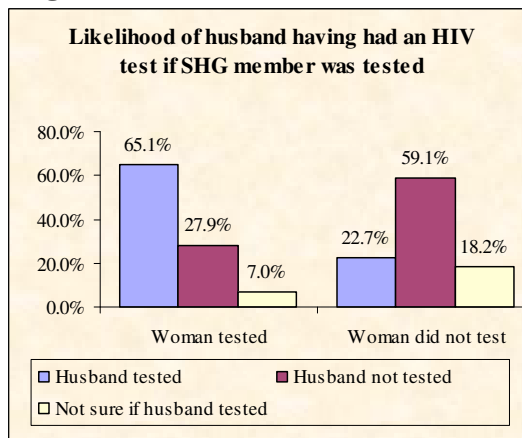
Further disaggregating the data within the SHG groups confirms that some expected trends hold for the members. For both the members who had an HIV test and those who did not, the majority (67% and 55% respectively) were married. This finding points to the importance of the husband on a woman's likelihood to get tested.

As the literature points out, the likelihood of a married woman taking an HIV test increases significantly if her husband has had an HIV test (Kranzer 2008). As seen in figure 37 below, if the husband of an SHG member has had an HIV test, the likelihood of his wife also having had an HIV test is 80%. Similarly, figure 38 shows that for the women in the sample who had an HIV test, two thirds (65.1%) of husbands also had an HIV test, whereas for the women who did not have an HIV test, less than one quarter (22.7%) of husbands had had an HIV test.

**Figure 37**



**Figure 38**



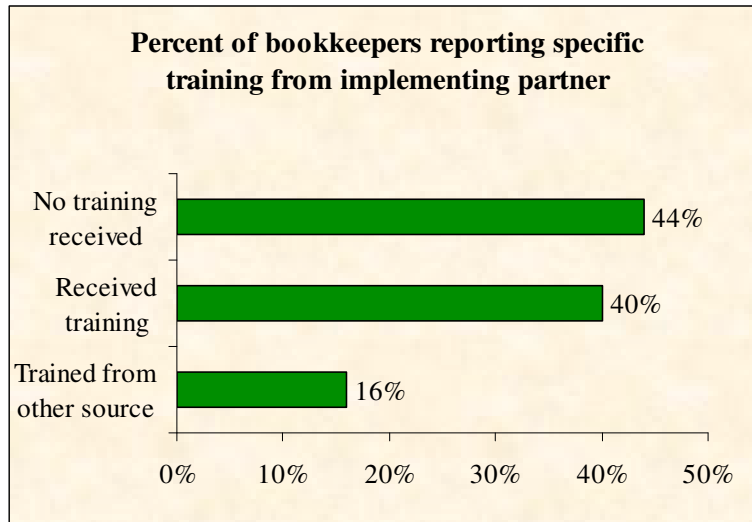
## SHG Bookkeeper

The bookkeeper is an integral part of the SHG model. She must be familiar with the banking system and is responsible for handling weekly cash transactions. She balances the accounting books and ensures that individual members' savings books are kept up to date. She therefore has to be literate. The SHG strategy requires that bookkeepers have at least an eighth grade education. The bookkeepers in the sample averaged 7.6 years of education. Worryingly, one bookkeeper had never gone to school and was illiterate. This was the case with DFT's Bitekmegn SHG group in Debre Birhan. In this case, the bookkeeper relies on another SHG member who is literate. She worries that the literate SHG member might leave one day because the latter fears making bookkeeping errors as the amount of saving increases.

When a new SHG is started, the implementing partner ideally should provide training to the bookkeeper regarding bank accounts, how to keep the accounting books, and other requirements for the position. Unfortunately, PCI's implementing partners have only provided training to 40% of bookkeepers. Although an additional 16% of bookkeepers received training from the previous bookkeeper or another source<sup>7</sup>, 44% still remain without any formal training for the position. Some of these women without formal training learned how to fill out the books from the previous bookkeeper, although it is unclear how the rest learned bookkeeping skills.

<sup>7</sup> These are women who worked in accounting before becoming SHG members

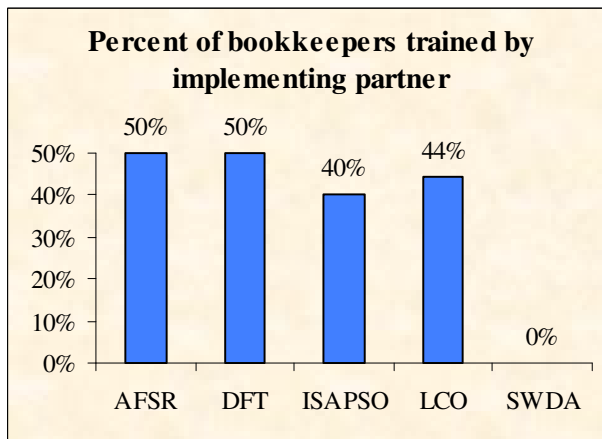
**Figure 39**



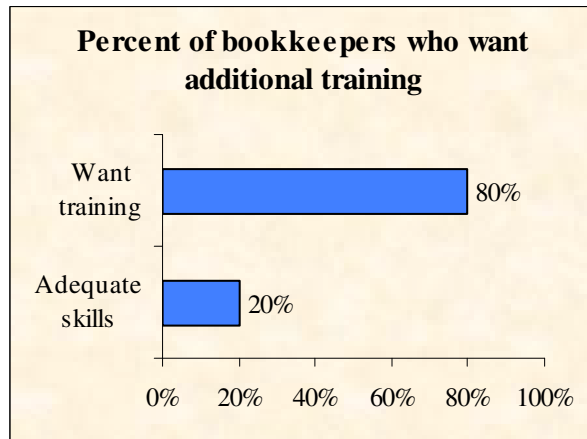
One group has implemented a system of a backup bookkeeper. LCO’s Hiwot Rasagez group has two women in charge of bookkeeping in case one of them is sick or leaves the group. Both are literate and learned bookkeeping procedures from the previous bookkeeper.

Figure 40 below shows that none of the implementing partners provided adequate training to the bookkeepers. AFSR and DFT trained half of their bookkeepers, while the rest trained less than that. Worryingly, SWDA did not provide direct training to any of its bookkeepers.

**Figure 40**



**Figure 41**



Nearly all bookkeepers wanted additional training from the implementing partner. Eighty percent wanted any form of training, while the remaining 20% only wanted training if their responsibilities changed in the future.

## Program Staff Feedback

Part of the evaluation of the Self Help Group was to conduct interviews with Program Officers and Community Facilitators of PCI's implementing partners. These discussions were based on the questionnaire in Appendix I, but remained flexible enough to allow for the implementing staff to discuss achievements, challenges and opportunities relevant to their SHG groups. Their responses are synthesized below to reveal observations regarding progress to date and the future of SHG groups. Where appropriate, responses that only apply to one implementing partner are identified as such; for example, DFT is the only NGO that works in rural areas, whereas the other NGOs surveyed all operate in Addis Ababa. The following represents a compilation of the observations that seem most salient to the SHG and warrant closer attention by PCI staff.

- Nearly all implementing partners have similar experiences when introducing the SHG to a new community without prior experience with saving. A meeting is initially held with the women of the community to explain the SHG concept. Most women are skeptical of the program and initially expect direct financial support because they cannot fathom saving money from their meager resources. A few women decide to remain and form a group. As they start to save and see the common pool of funds grow, they access the loans and use them to improve their lives. They then tell their neighbors and more women join. The other women see that the SHG members prosper and benefit from the program. Eventually, the community becomes convinced that the SHG is a good model and wants to replicate and expand it to the rest of the area. It is noteworthy that the initial women are also viewed as leading pioneers in their communities and the groups.
- When forming new groups, it is useful to choose women who are in physical proximity to each other. This helps ensure that women do not travel long distances for weekly meetings and strengthens the local community in which the SHG operates.
- When the SHG started five years ago, it took some time for the implementing organizations to internalize the concept and incorporate the approach into their programming. Now that the implementing organizations have seen successful groups flourish in their communities and have come to realize the advantage of the SHG to empower women, it is much easier to promote the SHG concept.
- Some of the groups use the loan money to purchase food items in bulk during harvest season when the price is low. The women are then able to pay for the lower priced food over several months, easing the burden of food purchase. This model has been noted by many women in the program for its potential for scale-up.
- There is now more demand for new SHG groups and request for technical guidance from Community Facilitators than can be met with current staff levels and funding constraints.
- In rural areas, the women greatly appreciate and benefit from receiving sheep from the Give-A-Goat program. The integrated approach of health education and livelihood improvement helps reduce the vulnerability of families in rural areas.



- Women are interested in obtaining land for meeting space, IGA activities, and to expand their SHG efforts. To do this, the SHG groups need legal recognition from the local kebele, woreda, and federal administrators. One promising approach that DFT identified is to link the SHG groups with kebele and woreda officials for training of the women. This approach acknowledges the government officials as knowledgeable sources who can help the SHG in a technical capacity. Relevant government partners include the Women's Affairs Office, the Small Scale Enterprise Office, and the Cooperative Office. With increased interaction between the government and the SHG, the government officials begin to see the SHG as an important and integral part of the community. This approach helps ensure the long term sustainability of the program.
- Some groups rotate the meeting place so that every member has a chance to host the meetings. This builds cohesion and allows members to be familiar with each other's living situation, etc. That way, there are no assumptions about a woman's living conditions, whether positive or negative.
- It is widely acknowledged that a strong bookkeeper is essential for group success. The bookkeeper needs the necessary skills to carry out her duties. Most of the time, she also acts as the chairman of the meetings and women generally treat her as a trustful leader of the group.
- It is a challenge in rural areas to find a literate bookkeeper who is trusted by the community and SHG members. The SHGs would benefit from adult literacy classes.
- Retraining of bookkeepers and members rarely happens in any of the groups. There should be an initial training when women join the SHG and a subsequent retraining session toward the end of the program life cycle.
- When the subject of male involvement in the program was brought up, implementing organizations generally agreed that there should be a role for men in the SHG, although project officers advocated an indirect approach to engaging the husbands and male family members of SHG members. Most of them said that they had viewed the SHG solely as a women's project before the interview.
- The implementing partner staff operates on a lean budget. Community Facilitators are not necessarily looking for higher salaries, and would be motivated by additional training that increases their professional capacity. Women receive a patchwork of health education, and training is limited by the level of knowledge and technical expertise of Community Facilitators. The following topics were identified as areas in which Community Facilitators would like additional training:
  - Business skills
    - Monitoring and Evaluation (M&E)
    - Report writing
    - Appraisal of markets
    - Income generating activities (IGA)

- Basic business skills (BBS)
  - Health
    - Reproductive health
    - Good parenting skills
    - Harmful traditional practices (HTP)
    - Hygiene and sanitation
    - Nutrition
  - HIV/AIDS
    - Male circumcision
    - Prevention
    - Prevention of Mother to Child Transmission (PMTCT)
    - Gender issues
  - Orphans and Vulnerable Children
    - Good parenting
    - Child protection
- The Cluster Level Association serves to link six to ten SHGs to share experiences and promote sustainability of groups. The CLAs should be formed at the kebele level. If one CLA spans multiple kebeles or woredas, it is difficult for the women to attend the meetings regularly. Further, different SHG groups in the same kebele are intimately familiar with the local context and can offer a different perspective about similar challenges.
  - There is the potential that those who start their own SHG without proper training will be easily discouraged to stop and dissolve their group because they do not have the technical assistance and do not fully understand the SHG concept that small savings add up over time. It is also important that new groups do not distort the essential quality that makes the SHG successful: focus on empowering the economic status of women caretakers by encouraging them to save their own money rather than rely on seed money.
  - DFT conducted a baseline survey of IGA opportunities in Debre Birhan and can direct the women to more profitable activities. While the Project Officer at DFT claimed that they train the women on inputs, profits and inventory of IGA activities, few women noted this in their interviews.

## **Role of Men in the SHG**

A recent study in rural KwaZulu Natal, South Africa finds that men are positively involved with their families in HIV/AIDS settings. They care for patients and children and work to financially support the household. Unfortunately, the dominant perception continues to be that men do not care for their families but are instead irresponsible and profligate. (Montgomery et al. 2006) Understandably, these men become resentful when their goodwill efforts are not acknowledged or even excluded from programs that aim to empower their wives.

As noted in the *Research Findings* section above, the health and nutrition status of households improve faster if women control the money supply and decide spending patterns. In light of this, development projects should aim not to isolate and ignore men and solely focus on women. This approach breeds resentment among the men that the progress of women comes at their own expense. Rather than analyzing the gender dynamic in zero-sum terms in which the empowerment of men and women have an inverse relationship, SHG implementers should engage men where possible to ensure their support of the program. As already mentioned above in the section on *Enthusiasm for the Program*, nearly 80% of husbands and family members now support the woman's participation in the SHG. This observation points to the willingness of the majority of husbands to support their wives. There are, however, almost ten percent of men who have responded negatively to their wife's membership in the SHG.

Some SHG groups have male members. They fall under two categories. The first is OVC boys and the second comprises of men who took over the membership duties of their wife when she died. ISAPSO currently has 750 SHG members; of those, 18 are male caretakers of OVCs. DFT has one SHG group that is composed entirely of OVCs; 12 boys and 11 girls. In some of its groups in which SHG members have died, LCO notes that husbands assumed their wife's role, coming to weekly meeting to save and participate in the discussions.

LCO has noted that it is sometimes beneficial to engage the men in the SHG. Men are usually better educated and can help with bookkeeping and auditing roles. Furthermore, male attendance so far has not drastically altered group dynamics or compromised the women empowerment role of the SHG, especially in groups that have been established for a longer period of time. The women freely discuss agenda items without reservation or inhibition when their husbands are present. Importantly, LCO noted that men who attend the meetings receive training on women's rights from LCO's Project Officer. Despite the women's openness if men are present, implementing partners all agreed that male involvement in the SHGs should be indirect rather than direct membership. Indirect participation can take the form of attending regular gender sensitivity training and gender based violence sessions.

## **Challenges to SHG Groups**

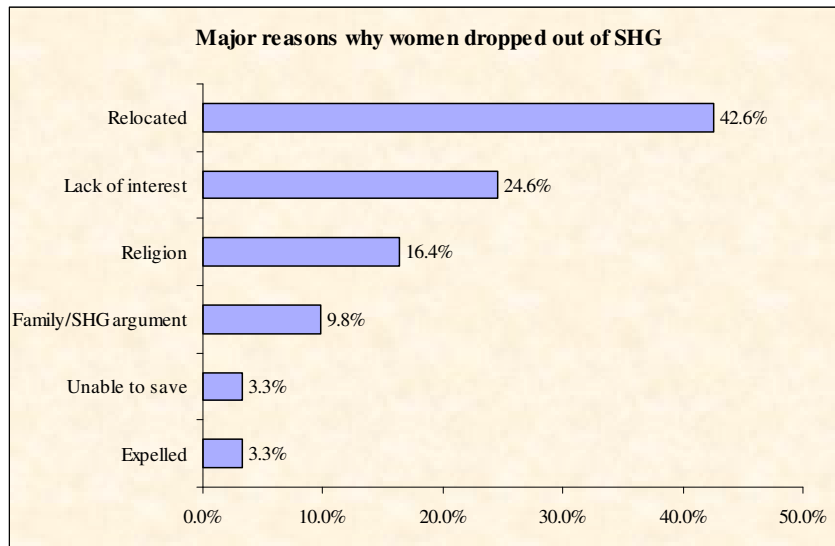
### **Dropouts**

More than 95% of SHG members rely solely on PCI's program to improve their lives. Only 4.5% of women benefit from another program in the area, including a church, a youth association, and the Women's Affairs Bureau at the Woreda level. The rest are members of Idir and Iqub, which provide cultural funeral and traditional informal saving services. They therefore have a vested interest to remain in the program, because very few alternatives exist.

In any long term group endeavor, attrition is a practical reality. It is acceptable in certain cases, such as when people move out of the area for better opportunities. Out of the 25 SHG groups in the sample, 84% had dropouts. The total number of original SHG members in the 25 groups that were interviewed is 540. Sixty one women dropped out of these groups over the past five years,

resulting in an attrition rate of 11.3%. As seen in the figure below, nearly half the women who dropped out did so because they moved out of the area in which the SHG was operating. One quarter of women lost interest in the SHG. Less than five percent of dropouts were no longer able to save<sup>8</sup> and a similar percent were expelled for non-payment of their weekly savings<sup>9</sup>.

**Figure 42**<sup>10</sup>



Dropouts are worrying if women have fundamental disagreements with the SHG model. One such case occurred with AFSR’s Fikir Beandenete, where half the members quit. When asked why such a high number of women quit, they noted that they were Muslim and their faith does not allow them to charge interest. Sharia (Islamic Law) dictates what is Halal (lawful) and what qualifies as Haram (unlawful). Sharia prohibits charging Riba (usury) on any loan.

A number of groups dissolved completely. One of ISAPSO’s SHG groups dissolved. It had ten members; six left the area and the remaining four tried to get other women to join, but could not muster enough support in their communities. There is now an effort to integrate the four members into existing SHGs. AFSR has experienced four group dissolutions. They have been unsuccessful at tracking dissolved groups either because the women moved out of the area or do not wish to speak with AFSR.

## CSO Law

The Ethiopian government spent the latter half of 2008 discussing a proposed Civil Society Organization law; the Ethiopian parliament recently passed the law on January 6, 2009. The

<sup>8</sup> One woman in each of LCO’s Selam Ras Ageze and Berhu Tesfa was unable to save and thus dropped out.

<sup>9</sup> Both cases of expulsion were in LCO’s Yedil group.

<sup>10</sup> It is important to note that the reasons for dropouts were obtained from interviews with existing members, not the dropouts. Due to research limitations, it was not possible to track and interview the dropouts to find out the exact reasons why they left. However, responses to this question were consistent for both beneficiary and program staff interviews, adding credibility to the answers.

government has stated that the new law will allow for increased transparency of NGO operations and ensure financial accountability by allowing a “proper” administration and regulation of civil society.

Critics, however, see a more sinister reason for the law. A recent Human Rights Watch analysis (Human Rights Watch 2008) of the Civil Society Organization (CSO) law pointed out that,

the [CSO] law is ostensibly a tool for enhancing the transparency and accountability of civil society organizations. But in fact, its provisions would create a complex web of arbitrary restrictions on the work civil society groups can engage in, onerous bureaucratic hurdles, draconian criminal penalties, and intrusive powers of surveillance.

The law stipulates that any NGO that receives more than 10% of its funding from a foreign source does not qualify to be considered an Ethiopian NGO but rather a foreign NGO. As noted in the Human Rights Watch report, the CSO law severely curtails the ability of foreign NGOs to work in the area of human rights or political empowerment of a community. This law can have detrimental effects on projects such as the SHG, whose aim is to sensitize people about their basic economic, social, and political rights, both as enshrined in the United Nations Declaration of Human Rights and the Ethiopian Constitution.

The Ethiopian Parliament backed away from several draconian measures in the original law; yet in other respects, the penalties for working in areas forbidden by the government were increased. The new version of the law, which was passed on January 8, 2009, drew intense criticism from Amnesty International. (Amnesty International 2009)

Amnesty International further notes that,

the law will also [criminalize] human rights activities by foreign and foreign-funded organizations, including campaigning for gender equality, children's rights, disabled persons' rights and conflict resolution.

Foreign NGOs must register with a newly established Charities and Societies Agency, which has broad discretionary power over civil society organizations. The new agency allows closer government surveillance of the operations and management of civil society organizations. The Ethiopian government's human rights record was increasingly criticized after the disputed 2005 elections, when hundreds of demonstrators were killed and thousands were arrested, including opposition parliamentarians and journalists. Critics of the law strongly suspect that the Ethiopian regime is strategically limiting the ability of any opposition party to take hold for 2010 elections.

Multilateral efforts to modify the CSO law have been unsuccessful. Western donor government have so far “expressed their concern” with the law. Some donors have signed bilateral agreements with the Ethiopian government to avoid expulsion of their NGOs from the country. The United States has not yet signed a bilateral agreement with Ethiopia and is reviewing available options for American NGOs to continue operating under existing agreements.

In 2007, the U.S. House of Representatives passed H.R. 2003, the Ethiopia Democracy and Accountability Act of 2007. In response, the Ethiopian government stepped up diplomatic and

public relations efforts to combat the bill as an affront to Ethiopia's sovereign right in its internal affairs. (Ministry of Foreign Affairs, 2008a) The Ethiopian Ambassador to the United States strongly criticized Senator Feingold and Congressman Payne for "lack of knowledge" (Ministry of Foreign Affairs, 2008b). The Ambassador stated in the open letter on the Ethiopian embassy's website that,

Senator Feingold's comments suggest he has been listening far too much to the more extreme elements of the US-based Ethiopian opposition, some of whom are in cahoots with Eritrea actively determined to destabilize the Government of the Federal Democratic Republic of Ethiopia.

Human Rights Watch notes the similarities between the Ethiopian CSO law and Zimbabwe's NGO law of 2004. When the Zimbabwean parliament passed the law, the U.S. State Department condemned it as "an assault on civil society and an attempt to curtail political discussion in Zimbabwe" and said that the law would "set up a mechanism for government oversight of nongovernmental organizations that would be highly intrusive and subject to political manipulation."

Needless to say, the recently passed Ethiopian Civil Society Organization law severely limits the potential for scale up of development projects such as the SHG in the Ethiopian context.

## **Inflation**

A significant number of women interviewed noted that inflation is currently eroding the value of the small contribution they make to the common fund. Although the common pool of funds has grown over the years, the value of that money has decreased and they still have limited purchasing power. Some noted that the ability to purchase food in bulk has been counteracted by the bulk prices that are now on par with retail prices when the SHG started. The women do not see the buffering effects of bulk purchasing against eroding living standards, but rather as a stagnant economic life.

## Discussion and Recommendations

To begin offering some preliminary recommendations, the initial hypotheses are reviewed here. Below is a summary of the findings relative to the hypotheses. Where appropriate, recommendations are offered when the findings warrant a change in the programmatic approach.

**Hypothesis 1: Women who start off “better” (i.e. more education, more money, etc.) will reap more benefits from the program and exhibit improved health, nutrition and livelihood outcomes compared to other women in the group and across the SHG with lower socioeconomic characteristics.**

Using literacy levels of women and prior IGA experience before the SHG as proxy indicators of higher socioeconomic status for women, it is not clear that literate women and those with existing IGA before SHG membership reap more benefits from the program. If a woman was literate, she was 1.7 times, or 57%, more likely to access a loan than an illiterate woman, although there was an insignificant difference in the likelihood of using the loan for IGA purposes between the two groups. Literate women were also 0.47 times, or 53%, more likely to attend a training session than illiterate women. However, illiterate women were 0.96 times, or 74%, more likely to have IGA before the SHG. Interestingly, women without prior IGA experience before the SHG accessed a loan 0.4 times, or 11%, more than women with IGA experience. This latter finding suggests that either women are excited to access the loan money or that other members with an existing source of income give loan access priority for the more vulnerable SHG members, or both. Some groups provide loans on a first-come, first-served basis, while other groups engage in dialogue and decide loan recipients after group discussions.

- **Recommendation: Conduct baseline assessments at new SHG sites**

One of the biggest difficulties of this research is that the impact of livelihood improvement is difficult to measure against a baseline survey of every group. While implementing partners noted community studies when starting a new group, these efforts were not formalized in documented profiles of the groups. Initial assessments and ongoing surveys will allow PCI to more carefully gauge the progress of individual groups and which aspects of health, nutrition and business training are having an impact. This will allow for more flexible reorientations of resources throughout the life of the project in order to have a greater impact on groups.

- **Recommendation: Improve M&E efforts of individual group progress**

While the current research provides a snapshot of the trends of SHGs so far, it is important to note that ongoing monitoring and evaluation efforts will yield a much clearer picture about the progress of the SHG. Ongoing M&E efforts will provide a more accurate portrayal of annual and seasonal variation in loan use patterns and which members could benefit from the program. An important consideration when collecting data is to avoid the creation of expectations from the program beneficiaries. ISAPSO noted that its data collection efforts of OVC profiles sometimes create expectations from the caretakers. The mothers assume that because ISAPSO collects information about their children, the organization plans to provide assistance in the future.

Also, because the research scope of this project was limited, a broader wealth assessment was not conducted before and during the program implementation phases to note any changes in the living conditions and durable assets of SHG members. It is possible that women with existing IGA that used loan money to expand their IGA were able to buy more food, send more children to school, and other benefits derived from a higher source of income. The current data does provide sufficient evidence to show that women who started with a higher SES status were able to reap more benefits than women of lower SES status.

**Hypothesis 2: The SHG program strategies utilized by PCI staff implementers are effective to achieve the SHG goals; any gaps in program operations can be identified and addressed before the program ends and/or the CSO law takes effect.**

The rapid growth of the SHG model in the past five years attests to the effectiveness of the Community Facilitators to gain support from communities to start SHGs. Implementers have made progress toward achieving the SHG goals. Despite this, some gaps exist that should be addressed to ensure the SHGs achieves their goals when funding terminates in September 2009.

- **Recommendation: Expand the provision of training to Community Facilitators**

Currently, the largest share of the SHG implementing partner budget is the salary of Community Facilitators. Implementing staff noted that Community Facilitators are interested not just in a higher salary, but also in further training to increase their capacity to serve the SHGs. They noted limited capacity in business skills and health knowledge. Please see *Program Staff Feedback* section above for specific topics in which the CFs would like additional training. The limitations of Community Facilitators restrict the potential for SHGs to learn about and begin income generating activities. PCI should hold periodic training sessions for the Community Facilitators to train them on various issues. As a member of CRDA, PCI is entitled to various training sessions on numerous topics throughout the year. PCI could explore the possibility to use CRDA to host trainings for the Community Facilitators of implementing partners.

- **Recommendation: Ensure provision of sufficient training to all bookkeepers**

Bookkeepers play a critical role in the functioning of the SHG. Less than half of bookkeepers interviewed had received formal training for their position from the implementing partners. Since bookkeepers are informally the leader of the group, their limited capacity might be a limiting factor of group saving and growth. It is important to ensure a standard body of knowledge is imparted to the bookkeepers to streamline the SHG saving and lending process.

DFT's Bitekmegn group has an illiterate bookkeeper. While it is understandable that in a rural area, the pool of literate candidates for the position of bookkeeper diminishes, it is important to ensure that the bookkeeper has the skills required to do her job. The implementing partner should respect the choice of SHG group in selecting the bookkeeper and provide literacy classes so that illiterate women can perform their duties. It is important to note that implementing partner staff mentioned that SHG members and bookkeepers sometimes regard training as such



when it involves formal workshops. Some of them do not consider onsite training as “training.” However, the women who reported lack of training opportunities also mentioned getting trained “onsite” by the previous bookkeeper. It is important to study whether women actually receive training or not. The most important thing is to provide bookkeepers with the necessary training so they feel adequately prepared for the tasks. Eighty percent wanted any form of training, which suggests that training does not happen as frequently as implementing partners claim.

When feasible, PCI should ask the implementing partner to train a backup bookkeeper to ease the burden of transition if the bookkeeper leaves. LCO’s Hiwot Rasagez group currently has two women in charge of bookkeeping. The previous bookkeeper left and the group decided to have two bookkeepers in case one of them leaves. The backup bookkeeper can also help write meeting notes and relieves the bookkeeping burden.

- **Recommendation: Improve linkages of SHGs to microcredit and training institutions**

Currently, SHGs rely on PCI’s implementing partners for technical assistance. Before the program ends, group members should have knowledge of how to access training on various topics from other sources, including alternate NGOs and government institutions. Furthermore, groups that wish to engage in larger IGA projects should have access to finance institutions. This will enable the women to access larger loans than possible through SHG loans.

A large percentage of SHG members are illiterate. The majority of rural participants noted their interest in adult literacy classes. PCI and implementing partners should work with schools and other relevant actors in the region to offer adult literacy classes to the women.

### **Hypothesis 3: The SHG program is a successful model that incorporates an adult education program with access to credit.**

The data collected and discussions with beneficiaries and project staff confirm that the SHG model is an innovative way to approach development challenges. Program staff and SHG members were overwhelmingly enthusiastic about the program. By integrating an education program with access to credit, the program addresses both education and adherence to the messages. The following recommendations are ones that deserve particular attention, although PCI Ethiopia staff understand these issues well.

- **Recommendation : Ensure full and clear understanding of the SHG approach among implementing partners and staff and provide training where necessary**

In Debre Birhan, before PCI’s SHG was introduced, another organization had come to the area to implement a savings model. After the project ended, the women who had saved their money could not take back their savings because the bookkeeper disappeared. Furthermore, the NGO had chosen the bookkeeper. It is important for PCI and its implementing partners to clearly explain how this approach is different than other organizations. It is crucial to explain to potential SHG members that they have autonomy within their group and ultimate authority to

decide their bylaws and who their bookkeeper will be.

Although Community Facilitators have been trained on how the SHG model works, staff turnover in implementing organizations and changes of Project Officers provide an opportunity for the SHG approach to be modified through improper understanding of the model's difference with other microlending and microcredit programs.

PCI's SHG approach is different than a micro lending scheme. The main rationale against providing initial seed money to the SHG members is because that approach breeds dependency. Any injection of cash into the program's beneficiaries is contrary to the principle of the SHG. From the outset, the SHG model aims to empower women through the realization of self sufficiency. Once women begin to save from their meager incomes, they realize that despite their adverse living conditions, they can improve their lives by committing themselves to saving in the group. It is crucial for implementing staff to understand this. Initially, even implementing organizations were skeptical about the model. Some of the implementing partners have now integrated the SHG approach into their other programs because they have seen its potential to bring women together and empower individuals. The goal now is to ensure continued commitment to the model and that it does not get confused with other micro lending models, whose approach is different.

- **Recommendation: Expand sufficient training to all SHG members**

While in aggregate, the women receive training on a wide variety of education topics, individual women have not benefited equally from individual training sessions. Currently, only 33% of women report receiving health, education, or finance training. Training is rare and health sessions focus predominantly on HIV, family planning, and personal hygiene, while financial planning focuses mostly on the SHG model and teaching the women about the importance of saving. While these topics are relevant and training should be continued, it is important to expand the list of topics offered to include health and nutrition messages based on the latest Demographic and Health Surveys. Since 71% and 73% of women reported discussions about health topics during the meetings and with their families, respectively, it is important to find out where the women receive the health messages, the accuracy of the content, and whether the knowledge translates into improved health for the family. Financial planning training should incorporate basic management of household expenditures and IGA training opportunities. Some of the women who paid their loans on time noted that they knew they could repay the amount of money borrowed. Financial responsibility and debt management should be included in the training sessions.

When addressing the topic of having an HIV test within SHG groups, it is important to keep the gender dynamic in mind when discussing voluntary counseling and testing. Although the issue of stigma is quite real among SHG members, and some of them mentioned that they never speak about HIV or even health in general to their family or husbands, it is important to at least start the dialogue regarding HIV testing. The training sessions is a great avenue for general health discussions and the importance of HIV testing.

- **Recommendation: PCI should endeavor to create a standard training manual that is provided to each SHG**

PCI should endeavor to standardize the trainings offered to the women and create a standard training manual that is provided to each SHG. The Community Facilitator could cover the topics in the manual for the first year and then transfer the manual to the group. The manual should be easy to read and include concepts easily understood and internalized by the women. A similar manual is already in use by the Women's First Group in Mozambique, a project funded by World Vision and implemented by International Relief and Development. Within the Ethiopian context, the Academic for Educational Development (AED) has created many laminated pamphlets and teaching tools to disseminate health messages to illiterate populations.

**Hypothesis 4: PCI's Self Help Group offers a promising practice for microcredit programs that target poor women without formal education or marketable skills who are at risk of HIV and food and nutrition insecurity.**

PCI can potentially take a leadership role in the field of integrated microcredit and adult education programs for poor women. As previously mentioned, integrated programming offers the potential to reap more benefits than individual programming approaches. Encouraging poor women to save their own money has had a paradigmatic shift in the communities in which the SHG is implemented. Women have, over time, understood that even though they are poor, they can save money and use it to improve their lives. The saving component is critical to the success of the SHG model. To build on this success, the following recommendations are presented for both PCI and implementing partners.

- **Recommendation: Encourage higher saving rates**

Smaller group savings mean that fewer women can access loans simultaneously and thus limits the growth of individual SHG members. While the emphasis of the SHG should not be solely on maximizing the saving rate, women must be able to access an adequately sized loan and use it to improve their lives to see a discernible impact of the SHG on their household's welfare. The implementing partners should strive to more actively educate women on the importance of saving and its role in IGA formation. It is understood that SHG beneficiaries are normally poor and the program should not place an undue burden on the women to save money to the detriment of their livelihood.

- **Recommendation: Address the concerns of Muslim SHG members to ensure acceptance of the model when scaled up in Muslim regions**

It is important to mould the SHG to fit the circumstances of the community in which it operates. Since the women are the ones who decide the terms of their SHG, the Community Facilitator should work with them to find workable solutions to context-specific challenges. Where appropriate, an Imam or other religious leader in the community should be engaged to discuss with the women the terms under which the SHG conforms to Sharia.

Two alternatives to interest loans from the SHG are hereby proposed that conform to Sharia. (MEED 2007). The first is *qardh hasan*, which is an interest-free loan, made for welfare purposes or to bridge short-term funding shortfalls. The borrower only repays the principal. The second option is the *istisnaa*, which is a contract of acquisition of goods, currently used by Middle Eastern bank customers to finance the building of their house. The bank buys the house and resells it to customers for a profit. The profit is capitalized and the new amount of the house is then financed interest free to the customer in installments. This means that Muslim SHG members can buy food items such cooking oil in bulk from the loan money and pay back in installments. Modern Islamic banks have also instituted user and administrative fees.

Furthermore, the SHG as an entity could buy the food in bulk and resell it to the women at a slightly higher price that is still lower than the market price to take advantage of bulk purchases. The profit could then be added to benefit the SHG. It is unclear whether Muslim women feel comfortable to engage in IGA activities with the food purchased in bulk. Sharia does not seem to prohibit income generating activities. Since various interpretations exist on the legality of user fees within the Muslim faith, it is important for PCI and implementing partners to engage the Muslim SHG members and consult local religious leaders in Muslim communities to discuss these alternative financing options to ensure acceptance of these principles and their conformity to Islamic law.

- **Recommendation: Integrate IGA component early on in the SHG program**

Some of the groups appreciated that with the SHG loan money, they could buy cooking oil and other food items in bulk during harvest season when the price was low. As one woman noted, “[The loan] allows [women] to bridge the gap between the have period and have not period in life.” While the purchase of food items in bulk is great because it saves women money with their annual food costs, this approach is currently limited to reducing household consumption expenses. The model can be adopted as an IGA activity. Women noted an interest to buy food items in bulk during harvest season and sell on the market for a profit the rest of the year. The feasibility of this endeavor, including market conditions, saturation of markets, warehousing of food, and other aspects should be studied by PCI and the implementing partners.



- **Recommendation: Provide SHG members with marketable skills**

While women should be provided with health and nutrition education, marketable skills such as cooking, sewing, and leatherwork will enable the SHG members to engage in IGA with loan money. PCI and implementing partners should conduct a preliminary assessment regarding the mix of skill sets in groups and opportunities for members to learn valuable trades from each

other. Further, project implementers should assess the market saturation of certain IGA activities before beginning skills training sessions or referring women to organizations that conduct specialized training such as sewing.

As already mentioned, some SHG members currently purchase food in bulk at low cost during harvest season. Bulk purchasing could also become a group activity to generate income. One woman washes clothing for a private company to make money. As an example, SHG groups could try to partner with local motels and hotels to offer two- and three-day laundry services to guests and tourists.

- **Recommendation: Work toward group autonomy early on in SHG formation to ensure sustainability**

The technical assistance provided by the implementing partner is invaluable to the SHG groups. The Community Facilitators help women with numerous aspects of starting and maintaining an SHG. They teach the women how the banking system works, how to make deposits and withdrawals, and the various day to day operations of the group. A majority of groups noted that the Community Facilitator also helps with conflict resolution within the groups. As groups gain experience, they should be equipped with the tools necessary to operate independently of the implementing partner.

DFT seems to have made the greatest progress in this regard. It has worked closely with kebele administration officials to ensure the SHG groups have access to any training and/or technical assistance the kebele has to offer. Discussions with the kebele administrator show that the local administration is aware of the SHG and appreciates the extent to which the SHG has helped the women in the community. However, the kebele administration does not offer an exhaustive array of training topics. It is therefore advisable to carefully assess the capacity of the kebele to adequately train the women before transferring the responsibility of training fully on the kebele.

The Cluster Level Association aims to group SHGs together to share successes stories and to link groups to service providers of financial and technical resources. The interviews and discussions with program staff did not indicate that individual SHGs are aware of the CLA in the formative months of the SHG. Rather, it seems the CLA is implemented as an afterthought when the program approaches its termination period. PCI should work with implementing partners to lay the foundation for the CLA early on and openly discuss the association with SHG members.

## **Sustainability of the Program**

One of the main strengths of the program is that throughout the life of the project, neither PCI nor the implementing partners provide seed money to the SHG groups. Instead, technical assistance is provided to the groups and emphasis is placed on women saving and managing their own money.

A second source of strength for the SHG approach to development is that it integrates access to microcredit with adult education on health, nutrition, and business topics. As decades of

development efforts have shown, individual silo approaches to reducing disease burden or increasing the income of individuals have not by themselves been effective in reducing vulnerabilities in the long term. PCI looks at the various reasons for the underlying causes of poverty in the areas in which it operates. The Give-A-Goat project is integrated into the SHG model in rural areas such as Debre Birhan. Beneficiaries noted the importance of the sheep in improving their livelihoods and allowing them to save money.

Out of the 108 SHG groups that LCO currently runs, program officers and community facilitators have full confidence in 20. All 20 groups are older than 18 months, generally accepted as the minimum time necessary to fully train a group. It is important that successful groups are linked with those that still need technical assistance. LCO should aim to provide the rest of the groups with the necessary skills to ensure they continue after the program is phased out. The Community Facilitators at ISAPSO estimate that 75% of their groups are currently self sustaining. They note that many groups hold meetings and resolve disputes without waiting for the Community Facilitator to come to their group.

- **Recommendation: Garner the support of woman’s family before SHG formation**

A large percentage of the women interviewed reported supportive families. Although a small percent of women reported unsupportive families for the SHG membership, it is important to work at the beginning of the project to educate the men and children. While there are valid reasons for not directly involving the husbands in the program, the initial sensitization sessions of a community to the SHG concept should involve the husbands to ensure greater buy-in and support for the women. [See Role of Men in SHG in the Program Feedback section]. This can be done by hosting “family days” whereby the women’s families are invited to a coffee ceremony to explain the SHG concept and the benefits to the women and their families. By indirectly involving the men from the outset of the project, implementing partners reduce the likelihood of dropouts. Involving men also increases the long term sustainability of the project after Community Facilitators phase out their visits and women must contend with unsupportive families.

PCI and partners should consider ways to engage the men as active partners to maintain and expand the gains achieved by the SHG approach. Rather than view the SHG as a “women’s development project,” a more inclusive view of the approach that broadens its capacity to effect positive change in the lives of women is needed. Various other options can be exercised to engage and educate the men about how their wife’s participation in the SHG will also benefit the husband. One option is to host “family days” during initial SHG meetings, whereby the women’s families are invited to a coffee ceremony to explain the SHG concept and promote the benefits to the women’s families. If well established SHG groups have supportive husbands actively engaged in the SHG, they can act as witnesses to the positive impact the SHG can have on their lives.

- **Recommendation: When expanding the SHG model in a community, use existing SHG members as Community Facilitators as much as possible**

Current members offer great witness testimony to the strengths of the SHG model. LCO has

hired a former SHG member to act as the Community Facilitator. This approach also reduces the training costs of a new Community Facilitator. Existing SHG members can more convincingly speak about the impact of the group on their lives. They also know firsthand the challenges of implementing the program and understand the viewpoint of the women. This strategy should be used when feasible and if the women are willing and able to work as Community Facilitators.

## **Suggestions for Future Research**

This research has provided some preliminary insight into the way the SHG model is implemented in Ethiopia. However, the research is based on recall and self-assessed livelihood improvement. It did not measure any objectively verifiable information, such as household wealth. Ideally, the research should have included a control group of women in SHG communities; due to research constraints, this was not possible. Looking forward, the following areas of research warrant closer attention:

### **Income Generating Activities**

With one year remaining before the project ends in 2009, nearly three quarters of the SHG members participate in some kind of income generating activity. Since one of the stated objectives of the SHG is that women begin IGA, more effort should be devoted to the feasibility of using the SHG model as a platform for group and individual IGA activities. Some of the women started buying food items such as shiro and beurbeure in bulk during harvest season. The potential to scale this up to every SHG group and eventually to turn it into an income generating project for the group should be studied.

### **Role of Social Capital in Self Help Groups**

The social capital that is generated by the Self Help Group can be harnessed to benefit the group members in numerous ways. Women themselves are often the best resource regarding the level of trust among the members. The SHG generates numerous networks whose avenues are not yet fully explored. This aspect of the group, as well as the social cohesion among the women, should be further studied.

### **Uptake of Training Messages**

Currently, very few women benefit from health, nutrition and business training. Bookkeepers also do not receive the necessary training. While at this point the emphasis of training is to ensure many more women are trained, the goal should also be for the training to have a discernible impact on the women's lives. It is especially important to study the uptake and quality of training messages and their application for SHG groups to see which messages have the greatest impact.

## **Conclusion**

The research findings show that the PCI's SHG program implementers have not provided sufficient training to the women. With less than one year remaining in the program, it is critical to scale up health, nutrition and business training to the women. However, this deficiency should not detract attention from the dramatic change the program has had in the lives of its members. At this point, it is clear that the SHG has achieved some impressive results and women greatly appreciate the extent to which membership in the group has improved their lives. Women are overwhelmingly enthusiastic about the program and neighboring communities in which the SHGs operate have spontaneously created eight new groups. The SHG approach has restored hope in the lives of these women and they have begun to think about their family's future. The positive externalities of existing SHG groups should not be underestimated when considering the wider stabilizing effects of this innovative and integrated development approach in the communities in which groups are established. It is important to continue the momentum that has propelled the endeavor so far and appropriately and conscientiously expand this model to other areas of need.



## **Appendix I. Program Staff Interview Questionnaire**

### A) Program Operations

- 1) When did the groups start? (Individual data on groups would be nice)
- 2) What is the process for selection of women in the group?
- 3) Are there groups in which women dropped out? Why did they drop out?
- 4) Can we talk to the women who dropped out?
- 5) What do you consider the major achievements and challenges of the SHG groups?

### B) Adult Education Components

- 1) What general topics are taught to the women? (i.e. business, health, nutrition, etc.)
- 2) How are those topics chosen?
- 3) How is the health, nutrition and business education disseminated to the women?
- 4) What is contained in the health messages? Is the focus exclusively on HIV/AIDS? Is there data on health message retention?
- 5) Are there linkages to other health messages? (i.e. hygiene)
- 6) What topics are taught to the women in the financial planning training sessions?
- 7) How often are the women retrained on health, nutrition and business skills training?
- 8) Is one group of women doing better than another?
- 9) What factors made the difference in performance?

### C) Sustainability of Program

- 1) What mechanisms are in place to continue the SHG after PCI and its partners terminate funding?
- 2) What is the structure of the program after PCI leaves? How does the funding mechanism for staff continue after PCI phases out its operations?
- 3) Who will conduct health, nutrition and business message training after PCI and partners leave?
- 4) What is the community response to your SHGs?
- 5) Is there a plan to engage the men in the program?

Is there anything else you want us to know?

## **Appendix II. Bookkeeper Interview Questionnaire**

Thank her for her willingness to help us with the research study. The research study is intended to help us find what works and what needs to be improved in the program so that the approach can benefit other women in similar situations. We need to confirm the anonymity of their responses unless they want a specific answer to be linked to them. If there is any question that they do not want to answer, they do not have to answer it.

### A) Demographic information

- 1) What is the group name?
- 2) How old are you?
- 3) Did you go to school? If yes, how many years did you complete?
- 4) Are you married? If yes, what does your husband do?
- 5) Do you have children? If yes, how many?
- 6) Do you care for any other children in your household? If yes, how many?
- 7) What do you do to support yourself and your family?

### B) Micro-Credit

- 1) How many members are in the group?
- 2) How often does your group meet?
- 3) What are the activities during group meetings? (i.e. savings, giving loan, discussions)
- 4) How are the activities chosen?
- 5) Has the group started lending?
- 6) How much money have the women saved so far?
- 7) What criteria do women use to determine who gets the loan?
- 8) How many women have accessed the loan so far?
- 9) What is the amount that women borrow? (i.e. what is the range)
- 10) How long does each borrower have to repay the money?
- 11) How much interest is charged for the loan?
- 12) What is the penalty if women do not pay back?
- 13) What is your experience with repayment?
- 14) How many women have paid on time?
- 15) How many women were charged a penalty but still paid back the money?
- 16) How many women have not paid back a loan given to them?
- 17) What recommendations do you have to maximize the efficiency of the loans?

### C) Programmatic Aspects

- 1) How long have you worked as a bookkeeper?
- 2) Have you received training to enable your capacity as a bookkeeper?
- 3) Do you want any further training to increase your capacity as a bookkeeper?
- 4) Are there any challenges in working as a bookkeeper in the program?
- 5) What were to coping mechanisms to address/reduce those challenges?

Is there anything else you want us to know about the position of bookkeeper?

## **Appendix III. Individual Interview Questionnaire**

### **A) Demographic information**

- 1) How old are you?
- 2) Can you read and write?
- 3) Did you go to school? If yes, how many years did you complete?
- 4) Are you married? If yes, what does your husband do?
- 5) Do you have children? If yes, how many?
- 6) Do you care for any other children in your household? If yes, how many?
- 7) What do you do now to support yourself and your family?

### **B) Participation and Assessment of Self Help Group**

- 1) How long have you been a member of the group?
- 2) What motivated you to join the group?
- 3) Have you accessed the Self Help Group money?
- 4) How many times have you accessed the money?
- 5) For what purpose did you use the money?
- 6) Was it difficult to pay back the money? Why or why not?
- 7) Were you engaged in Income Generating Activities (IGA) before participating in the group? What did you do? (Refer to Question A7 above and E1 below)
- 8) What is the community response to your SHG?
- 9) What is your family's response to you participating in the SHG?
- 10) Have you ever thought of quitting the SHG? If yes, why? If no, what kept you in the program?
- 11) What are the challenges of being a member of your group?
- 12) What have you done so far to overcome those challenges?
- 13) Are there any women who stopped participating in the program? If yes, why?

### **C) Education Aspects**

- 1) How does the implementing partner (i.e. LCO, SWDA) support your group? (i.e. trainings, organize women, experience sharing, etc.)
- 2) Have you participated in any of these trainings/discussions? (Try to find out the exact topics that are taught to the women)
- 3) Is there anything that prevents your attendance in the meetings?
- 4) What do you like about your group?
- 5) For your group to be successful, what do you recommend? (i.e. technical, material, and financial support, repayment terms, link to microfinance institutions, etc.)

### **D) Health Message Retention and Application**

- 1) Do group members discuss health issues? Give examples
- 2) Were you trained/sensitized on HIV, nutrition, or hygiene and sanitation?
- 3) If yes to Question 2, have you benefited from the training/sensitization?
- 4) Have you discussed health issues with your family? Give examples.
- 5) Have you been tested for HIV? Why or why not?
- 6) If married, has your husband been tested for HIV? Why or why not?

### **E) Livelihood Improvement**

(See A7 and B7 above)

- 1) Is your life different now than before participating in the program? Give examples.
- 2) How have your children benefited as a result of you joining the program?
- 3) Do you benefit from other programs in the area besides the SHG? Which one(s)?

Is there anything else you want us to know about your group?

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