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Brief abstract (description of project)	The BSY programme aims to provide high-quality and comprehensive prevention, treatment, care and support services to the children and their families (40,000 households, reaching 60,000 adults and 68,000 children) infected with or affected by HIV in 11 districts in Andhra Pradesh through a phased approach. It aims to improve the quality of life and well-being of these children and their families.
Comment	

Royal Tropical Institute
KIT Development Policy & Practice

"Are the children better off?"

Round 1 Evaluation Report on the concurrent evaluation and learning from the Balasahyoga programme

Development Policy & Practice

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Abbreviations and Acronyms

APSACS	Andhra Pradesh State Control Society
ART	Antiretroviral therapy
ARV	Antiretroviral
ASER	Annual Status of Education Report
BSY	Balasahyoga
CABA	Children Affected by AIDS
CCC	Community Care Centre
CHAI	Clinton HIV/AIDS Initiative
CIFF	Children's Investment Fund Foundation
CV	Community volunteer
DAPCU	District AIDS Prevention and Control Unit
DLC	Damien Leprosy Centre
ECG	Evaluation Core Group
EJAF	Elton John AIDS Foundation
FCM	Family Case Manager
FGD	Focus group discussion
FHI	Family Health International
ICDS	Integrated Child Development Services
ICTC	Integrated Counselling and Testing Centre
IHHT(S)	Intensified Household Tracking (Survey)
KII	Key informant interview
KIT	Royal Tropical Institute (abbreviation in Dutch)
LFU	Loss to follow-up
LSE	Life skills education
MIS	Management information system
MO	Medical Officer
MUAC	Mid-upper arm circumference
M&E	Monitoring and evaluation
NACO	National AIDS Control Organisation
NGO	Non-governmental organization
NPLHIV	Network of people living with HIV
OI	Opportunistic infection
PCC	Peer Care Coordinator
PLHIV	People living with HIV
PPTCT	Prevention of parent-to-child transmission
QoL	Quality of life
SWASTI	Health Resource Centre in Bangalore, India
TAP	Technical assistance partner
TNFCC	Tamil Nadu Family Continuum of Care
VWCS	Vimala Women Charitable Society
WHO	World Health Organization

Executive Summary

Executive Summary first round evaluation of Balasahyoga Programme

Between August 2009 and January 2010 the first round of evaluation of the Balasahyoga (BSY) programme in Andrah Pradesh in India took place. The evaluation was commissioned by CIFF and designed in close collaboration with all BSY partners (FHI, CHAI, CARE, EJAF and APSACS). Even though the evaluation was designed to provide baseline information, it started later than expected. Therefore the data in the report of the 1st round of the evaluation provide information on the status quo during the evaluation period (August 2009 until January 2010, except for sections where the annual progress report of BSY partners were used this period is extended to end of Q1, 2010). In the sample district for the intensified household tracking (IHHT) clients were enrolled in the BSY programme between 3 month and 2 and half years prior to the interviews. Key conclusions will only be elaborated after the End Line has been completed towards the end of project in the first quarter of 2012.

The BSY programme aims to provide high-quality and comprehensive prevention, treatment, care and support services to the children and their families (40,000 households, reaching 60,000 adults and 68,000 children) infected with or affected by HIV in 11 districts in Andhra Pradesh through a phased approach. It aims to improve the quality of life and well-being of these children and their families. The overall objective of the evaluation is to assess the contribution of the BSY programme to the quality of life and well-being of the children living with or affected by AIDS and their care-givers from 40,000 households in 11 districts of Andhra Pradesh.

The report is primarily an **internal document for the BSY partners** that can be used as information about how the different components are operating at **the point in time that the 1st round of the evaluation** took place and provide insights about where medium term adjustments could be made.

The design of the End Line evaluation will be adjusted to the findings of the 1st round as especially the QoL scores for children were found to be rather high. Discussions are ongoing between KIT/Swasti and CIFF and will be further elaborated with BSY partners.

The **evaluation methodology** uses a mix of quantitative and qualitative standardised and structured tools and instruments as described in the report. These include amongst others, perceptions on Quality of Life of children and their caregivers in West Godavari, self-assessments of the capacity of the family care providers and volunteers, waiting time and service time analysis in the ARV clinics in West Godavari, Medak and Kurnool and interviews with key stakeholders and informants in the same three districts.
The children in the IHHT sample were comparable with the other children in BSY in terms of age and sex, although they were tested for HIV more often, which could be an effect of being longer in the programme.

The selection criteria for the sample were based on inclusion of families that were comfortable enough to be visited at home by the BSY staff. Based on the above the evaluation team concludes that the findings can be generalised to children in families that were willing to be interviewed.

The extensive **validation exercise of the QoL IHHT tool** undertaken by the evaluation team showed that its internal consistency and ability to discriminate were high. Also the subgroup analyses of QoL and Hope Scale scores show that scores for QoL (all domains) were significantly higher for HIV-negative children than HIV-positive children (in both age groups). This indicates that the QoL IHHT tool (and the Hope Scale) can indeed discriminate between relatively healthy (HIV-negative) and infected (HIV-positive) children with respect to the QoL and Hope Scale domains that were assessed.

Part of the evaluation consisted of provision of technical support to the BSY partners (mainly FHI) for the redesign of the **Monitoring and Information System** as the data from this system should inform the evaluation. The rationale for this support included the necessity to compare IHHT data with the entire BSY population. Especially at End Line the MIS needs to provide reliable data on mortality, morbidity, physical health of children (OI), changes in CD4 counts over time, BMI, MUAC, number of OVCs prevented and provide information on the exposure of households and children to different BSY interventions. Over the course of the evaluation the KIT/Swasti team will continue to provide support to the MIS team.

1. Key findings about the quality of Life

Some key differences were found in terms of the more objective QoL indicators (BMI and MUAC) as well as on the perceived quality of Life indictors (QoL IHHT tool and Trait Hope scale).

Across the board **children living with HIV** (in both age groups) had significantly lower scores for QoL and Hope Agency and Pathways (for the 0-8 years group overall QoL was 86.2 for HIV positive groups versus 91.3 in HIV negative group; for the 9-16 years these figures were respectively 84.3 and 89%). Also the older age groups scored lower than the younger age groups (overall score 88.6 versus 90.4) where parents had provided the answers on behalf of their children. The MUAC and BMI scores for HIV positive children below 9 years were not significantly different from their health counterparts. For elder children however the BMI was significantly lower for the HIV positive children (14.0 versus 15.0, p=0.002).

QoL and Hope Scale scores for the children in the IHHT sample **were all relatively high**, but compared quite well with a similar study among a similar group of children done in Tamil Nadu. As a consequence of the relatively high QoL scores of the IHHT sample, the likelihood of improving these scores as a result of the BSY programme seems limited for the entire group of children, but not for certain sub groups, most notably for the children living with HIV. The reference group and end line design will address these specific concerns.

There was no clear relationship between **BSY exposure time** and QoL or Hope Scale scores for the younger age group. Previous studies have shown that improvements in QoL scores are most likely to occur in the first few months after exposure. For the elder children aged 9–16 years, the BMI was higher in children who had been exposed longer to the BSY programme, which could indicate an effect of the BSY programme.

There was a relationship between the **number of services mentioned and received** in terms of higher Hope Pathway scores for caregivers of the younger children (0-8 years). This means that caregivers are better able to devise workable routes to desired goals ("I will find a way to get this done"). This could be a measurable positive effect of the BSY programme toward creating families with more resilience.

With respect to the **actual linking services** accessed by the BSY families through the FCM/CV system, a similar finding as in the previous section was found for the younger age group whereby, for both the care givers assessing the Hope scale for their children aged 0–8 years as well as their own Hope Pathway scores, higher scores were seen with increasing number of services provided ($p=0.002$ (children) and $p<0.001$ (caregivers) although this was not seen for the children in the older age group.

Across all age groups **children living with HIV had the poorest QoL and Hope scores**, but at the same time when they were receiving anti- retroviral treatment the scores were better, especially for the younger children.

The analysis shows that **some children are more vulnerable** to the adverse effects of living in families affected by HIV. Children living with their grandparents of 9-16 years showed poorer QoL scores across all domains than those living with their parents. In households with a female care giver the scores for attending school (o-8 years group) and also the female caregivers themselves scored higher on the Hope Agency scales than in male headed households. Younger Children in male-headed households, on the other hand, had higher BMI scores. For the older age groups there were no differences.

Girls in general had better scores on their QoL scale for social behaviour and for the Hope Agency score. Also the BMI for girls was higher than for boys.

2. Key findings and recommendations about quality of Care

BSY addresses most of the **areas seen as critical for the wellbeing of children affected by AIDSV** in the "National Operational Guidelines for the Protection, Care and Support for Children affected by AIDS". For the children that are enrolled in BSY, the programme has placed **a stronger focus on children** in relation to the treatment cascade resulting in more children having been tested for HIV and CD-4 cells, more children being on ARV treatment, and fewer children being lost to follow-up since the beginning of the programme. Some mentioning was made of children finding it hard to take ART drugs because of the taste, exploration on how this affects adherence might be required. This first round of evaluation also found that there is **scope to expand the number of children enrolled** in the programme even in districts were the programme has first been rolled out. In West Godavari for instance, 6 out of 10 families

eligible for BSY support interviewed in an ART clinic were not aware that the programme existed.

BSY's assistance to **access facility-based health services** was found to have a positive impact on the overall QoL score and the Hope Pathways of children between 0 – 8 year and the Hope Pathway for their care-providers. BSY has also contributed to providing families with skills and know-how on how to provide care to children living with HIV. Collaboration in general between ICTC and ART centres and BSY has become stronger over time, but clarification on the role of FCMs and CVs could help further improve this collaboration. The waiting and service time in ART centres differ by district, including for children. Travel time to ART centres is considerable and time and resources people have to spend on accessing ART centres are among the most important reasons for LFU. BSY could contribute to addressing this problem by working out more common formats for service time and advocate for alternative more client friendly ways for ART service provision. Overall high patient satisfaction was measured, in spite of counselling within the health facilities being minimal. There is a strong need to improve the counselling services, especially towards children.

Children aged 9 – 16 years of families having received **psycho-social support services** through BSY were found to know better how to achieve their goals in life. Parents and care-givers were found to talk very little, if at all, with their children about HIV. Improving the scope of disclosure would help to address unmet psychosocial needs of children infected with or affected by HIV. This could be supported by developing strategies through which LSE would be feasible in the BSY context as well as implementing already scheduled counselling and communication training for FCMs and CVs.

Stigma and discrimination are still very much present and **prevent people from accessing services**. Community sensitization meetings were found to be an important route to contribute to stigma and discrimination reduction. Strengthening the skills of FCMs and CVs to conduct such meetings could potentially contribute to enabling more families affected by HIV to access services.

Stigma and discrimination are **also prominent in schools**. There is currently no specific strategy to address this issue. While FCMs and CVs provide strong follow-up on school drop outs during home visits, the IHHT data demonstrated that in spite of these efforts a number of children drop out of school for economic reasons. More than one in four children had missed school in the last month because of visits to medical facilities for them-selves or care-givers. Reducing the time BSY families have to spend on testing and treatment could therefore also have a positive impact on school attendance.

BSY has helped children to access the ICDS scheme. Better **tracking of the impact of nutrition on children** through pre- and post-exposure measurement of MUAC or BMI could help to document the impact of the programme. Working towards improving the nutritional value of the ICDS double ration, thereby building upon the experiences with the nutrition

programme in the ART centres, could help to provide added value to this government scheme for children infected with HIV.

No significant differences in QoL, MUAC and Hope Scales were found between the different groups who were classified as severely food insecure, moderately food insecure and food secure. A higher percentage of moderately food insecure than severely food insecure households were found to have received **safety net services**, leaving quite a number of food insecure households uncovered. Something that might be taken into account while rolling out the in 2009 revised food security strategy. While FCMs and CVs are offering assistance in relation to a range of government schemes to BSY families, further training on these schemes is required, especially on eligibility criteria. MIS data show varying results in accessing these schemes.

Capacities of FCMs and CVs have increased over time, in spite of CVs not having had any formal training. Turn-over of FCMs and CVs is however negatively affecting this capacity. Specific priority training needs are counselling, LSE, community sensitization, and safety net training. Better planning, role clarification, hand in hand with work load reduction was requested by FCMs and CVs.

Government health and HIV services did not acknowledge BSY's role related to capacity-building, however they did **acknowledge that BSY had contributed to increasing access to services to some extent**. Advocacy to ensure greater visibility of BSY, including in relation to issue like tracing LFU, would be recommended.

3. Key findings and recommendations about the Balasahyoga model and its effectiveness

One of the conclusions of the first round of evaluation is that there is a **clear need for models that help to operationalize the CABA guidelines**. BSY is covering five of the seven components seen as critical and necessary in these guidelines to "ensure the immediate well-being and holistic development of children affected by HIV", using a family-centred approach.

One of the **underlying assumptions of the BSY programme is that when building resilience** in families they can eventually access services as and when required themselves, and this is essential for sustainability. The 1st round of the evaluation used the Hope Trait Scale, specifically the Pathways[1] dimension for adults, as a proxy indicator for family resilience. Even though real conclusions can only be made after completion of the End line there are indications that resilience of families is influenced by a number of factors. In female-headed households caregivers had higher Pathway scales than male headed. Households headed by grand parents and those with more members infected by HIV scored significantly lower on the scale. Resilience also increased with the number of services received by families, providing initial evidence about the effectiveness of the linkages established by the FCM/CVs.

[1] Pathways are a person's perceived ability to generate workable routes to desired goals and are seen in internal speech such as "I'll find a way to get this done".

Increasing access and coverage should be the key priority for the coming years. Even though good progress has made for children that have been enrolled in the programme, on a population basis, the BSY programme seems to be able to test only 48 per cent of the programme target for eligible children for HIV, and the trend shows a downward inclination. The number of children testing HIV-positive is also much lower than anticipated in the targets. The BSY programme is also underperforming in terms of getting the forecasted numbers of children onto ART (reaching 51 per cent of those expected in the 11 districts). In terms of performance against the BSY target the programme seems to reach only 26 per cent of the children for ART.

The evaluation found that **stigma and discrimination** are highly prevalent in the three districts at all levels in the system: government services and departments, service providers, communities, neighbourhoods, schools and also within families. It may be one of the reasons why the programme is reaching only 50 per cent of its intended target.

There are two ways possible to look at **the BSY model**: one as the sum of different domains of services reaching families and the second as the creation of a bridging function between HIV affected and vulnerable households to services and vice versa. The BSY seem to be more inclined to view the model as the former. The evaluation team sees the value more in the bridging function. This evaluation team would like to challenge the BSY partners to look at the model as an implementation mechanism rather than looking at the model as the sum of five domains addressed by three strong NGOs. The following questions could support a discussion amongst the partners including APSACS and could help in defining the model and its replicability:

- What are the key bridging functions that the FCM/CVs address in the five domains of the programme and which cadres are in place that could take this function?
- Which skills are needed at various levels in the system (both at FCM/CV level and in the different domains that families are linked to)?
- What minimum support system is needed to operate the model, leveraging existing efforts such as UNICEF, networks of people living with HIV and others (for supervision, coordination, capacity development and continuous education, financial management system, structure and a simplified M&E system)?

Even though the team feels that the FCMs and CVs are the essential bridging cadres in the BSY programme, we also note that **there might be other cadres** that are already performing community functions that might be well placed to take on the functions of the FCMs (paid) and CVs (not paid) – among others, the 'link worker' as advocated by the NACO and APSACS strategic plans. As such the FCM/CV model does not seem to be sustainable at this point in time. The 1st round findings provide early evidence that the "linking function" requires well trained cadres, especially in addressing the needs of children/families infected with or affected by HIV, have the ability to link families to schemes and services, and have a support system that enables them to do their work.

Whatever the outcome of the above discussions, there is a need to **strengthen the linkages and institutionalise** them at both mandal and district levels for referring the registered families to access the other services/social welfare schemes and social entitlements. The linkage environment needs to be focused on bringing about an environment of readiness for transition and, ultimately, sustainability.

Simplification of the programme could be one of the issues to be discussed also in view of sustainability and replicability. This could focus on defining a time path for which families need intensified support (when are they resilient enough that they can graduate from intensive support, which milestones?) and what should a leaner support system offer, once families move out of the more intensive phase. In view of this the BSY partners could also reflect on how they can best target the neediest for which some pointers come out of the 1st assessments of QoL and Hope scales.

The BSY partners should engage in discussions with the APSACS about getting the **denominators right for the target group of children living in HIV affected households** (through appropriate methods – a possible key contribution to the sector), also in view of potential effects of the PPTCT programme, which should result in fewer children becoming infected with HIV. This will also allow the programme to review if the targets are realistic. This could potentially greatly impact on the effectiveness indicators as the KPI's are based on assumptions.

One overall concern the evaluation team would like to raise at this point relates to the fact that BSY programme is very ambitious and complex and in view of the reprogramming exercise, the five years duration of the programme as initially foreseen, has been reduced by over a year. This meant that a lot of activities had to be implemented at the same time and in a very short timeframe. The evaluation team **questions whether the BSY project has sufficient implementation time** to demonstrate a real impact on the lives of the affected families and households. Many BSY partners felt it would be difficult to achieve the targets.

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Part 2

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1 Introduction

1.1. Background of the evaluation

The Balasahyoga (BSY) programme, funded by the Children's Investment Fund Foundation (CIFF) and Elton John AIDS Foundation (EJAF) and implemented by Family Health International (FHI) (lead partner), the Clinton HIV/AIDS Initiative (CHAI) and CARE, was launched in April 2007 for a period of five years. Under the overall coordination of Andhra Pradesh State Control Society (APSACS), the programme aims to provide high-quality and comprehensive prevention, treatment, care and support services to the children and their families (40,000 households, reaching 60,000 adults and 68,000 children) infected with or affected by HIV in 11 districts in Andhra Pradesh through a phased approach. It aims to improve the quality of life and well-being of these children and their families. The programme components are implemented through three key components:

- community-based services;
- facility-based services; and
- safety net and food security.

The project seeks to provide a comprehensive continuum of care through a family case management approach by strengthening operational linkages between community-based services, facility-based services and nutrition, food security and safety net components.

A team from the Royal Tropical Institute (KIT) in Amsterdam and SWASTI were subsequently contracted by CIFF to design and implement the evaluation component.

1.2. Concurrent evaluation objectives

Overall objective

To assess the contribution of the BSY programme to the quality of life and well-being of the children living with or affected by AIDS and their care-givers from 40,000 households in 11 districts of Andhra Pradesh.[2]

Specific evaluation questions

1. **Has the quality of life of children infected with or affected by HIV, and their households, been improved?**

For the purposes of this evaluation, the quality of life consists of a number of different elements, namely: education, health, psychosocial and nutritional status, and the use of safety nets – all areas that BSY aims to address holistically. For the younger children the perspectives of the primary care givers on QoL and Hope scale were included.

[2] The 11 districts are: Adilabad, Anantapur, Chittoor, East Godavari, Guntur, Kadapa, Kurnool, Mahabubnagar, Medak, Vizianagaram, and West Godavari.

The evaluation also looks into the attribution of improvements to BSY, by linking the quality of life with the level of exposure to BSY. To the extent possible, the evaluation will also compare the QoL scores with other studies in India and some of the QoL indicators with data from other programmes in AP/India.

2. How has the quality of care of children infected with or affected by HIV, and their households, been improved as a result of capacity strengthening of service delivery by the programme?

- Has the perceived quality of care for children infected with or affected by HIV been enhanced by BSY, and how?
- Has the BSY project contributed to improving access to services for children and their care-givers (linkages)?

As these questions relates to perceptions of entire households the primary care giver for each child was also interviewed.

3. Is the proposed model implementable, effective, sustainable and replicable?

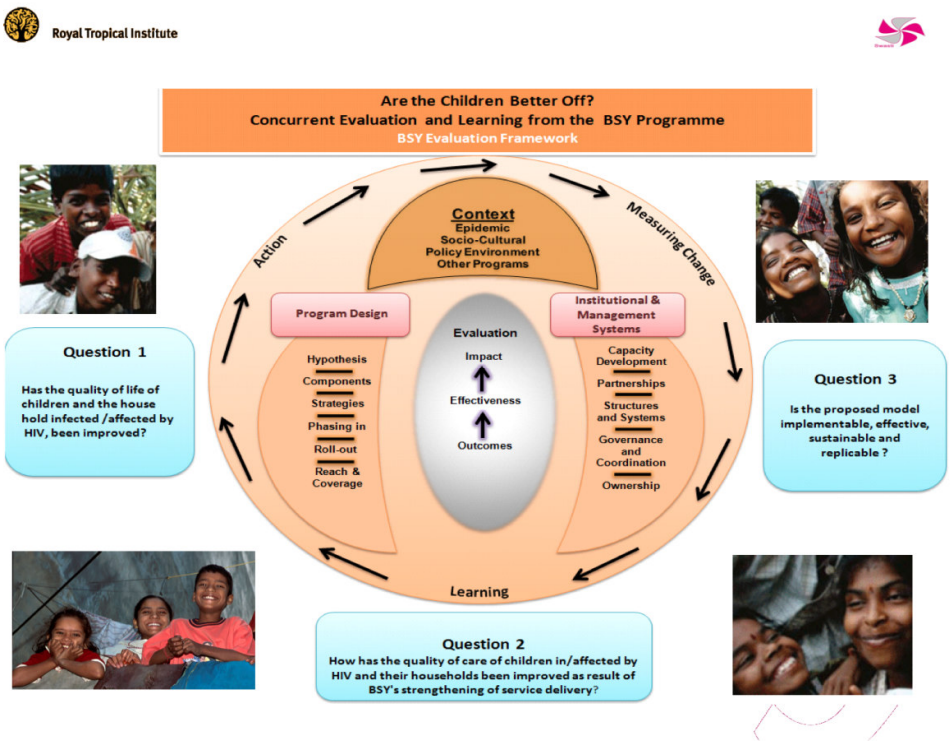
- How was the model conceived, based on which assumptions and hypotheses?
- What are the contexts in which the model operates?
- How effective is the model in achieving its primary objective (improving quality of life)? Contextual factors, such as other programmes in place, are also being looked at in this context, as it is understood that BSY is not operating in a vacuum.
- What is the cost of this model and the different components?
- Under what circumstances is the model replicable, and why?
    - Review how the model can be replicated through existing government systems where partnerships are established with non-governmental organizations (NGOs).
- Minimum requirements (quality, components, coverage) for running the programme, and at what cost?
- How sustainable is the model likely to be?
    - Are households in need better able to demand and access the services they are eligible for after exposure to BSY?
- How have institutional arrangements and management systems influenced the results?

It was expected that this first round of the evaluation would provide a true Baseline against which at End-line conclusions were to be drawn on the effectiveness of the BSY programme across the above key questions. Due to a number of reasons, related to contracting issues and the design of the evaluation, the evaluation took off much later than was initially foreseen. After discussing this issue with CIFF and BSY it was decided that the 1st round could not provide a true baseline and therefore it was agreed that we now talk about the **first round of the evaluation**. We consider therefore that the 1st round provides a snapshot of the situation at the point in time of the evaluation. Final conclusions about the BSY programme will only be made after the End Line has been completed.

Data collection for answering question 1 and 2 took place between October 2009 and January 2010. For Question 3 the evaluation timeframe included the first quarter of 2010 as the annual BSY report provides important information and therefore the 2 additional months were included for analysis of question 3. At the time of data collection for this round the BSY programme had already been implemented since April 2007 in the Coastal Andhra and Rayalseema and was being rolled out in Telangana.

The evaluation team provided technical support to BSY partners (mainly FHI) for strengthening its Monitoring and Information System (MIS), as the system is place was not yet able to provide key data for evaluation purposes at the time KIT. A data base was set-up capturing key information for the BSY programme across all domains and key staff was trained in the operational aspects of the system. The MIS provides an essential element for comparing the sample population (West Godavari) to the overall BSY programme at End Line. Evaluation methodology

1.3. Evaluation methodology



For perceived quality of life (QoL), the evaluators used a combination of the PedsQL4 self-assessment scale for children, the Child Status Index, the Trait Hope Scale both for children and for adults. Other more objective quality of life indicators included body mass index (BMI) and the mid-upper arm circumference (MUAC), and an index for BSY exposure

developed by the evaluation team in consultation with members of the Evaluation Core Group (ECG).

For the other evaluation questions a set of specific tools were developed and pretested by the KIT-Swasti team as per evaluation protocol agreed upon between CIFF, BSY partners, ECG and KIT-Swasti.

1.3.1 Sample and respondents for the first round of evaluation

The Intensified Household Tracking Survey (IHHTS) sample was drawn from children living in West Godavari to minimize confounding factors. A random sample of 2694 children between 0 and 16 years of age as of August 2009 was drawn from the MIS with assistance from FHI. Due to the low response rate, a second random sample was drawn in November 2009 of another 750 children between 0 and 16 years of age, also with assistance from FHI. Parents responded to questions for children 0-8 years while children 9-16 years reported on their own QoL.

The matrix below provides an overview of the original and the replacement samples. Due to time pressure it was decided in collaboration with CIFF to stop data collection for the IHHT at the end of 2009, during which time approximately 50 per cent of the replacement sample had been visited. By this time 2072 of the originally proposed number of 2694 children had been successfully interviewed.

Table 1.1. Overview IHTT sample West Godavari

	Original sample of 2694	Replacement sample of 750	Total
No. of children/households not visited	43	371	414
No. of children/households visited	2651	379	3030
No. of children successfully interviewed	**1745**	**327**	**2072 (68%)**
No. of non-responses	906	52	958

The main reasons for not responding were related to the following: child above the age limit (26%); not willing (18%); living in a hostel (16%) and migrated permanently (13%). Please see the annex to Chapter 1, Table 1.1 for more details.

Three districts were purposefully selected for testing the BSY model: West Godavari, Kurnool and Medak. Interviews with key informants at all levels were conducted as shown in the table below. In addition to these interviews, contextual information was also collected, bringing together demographic, health and HIV infrastructure, and epidemiological data to better understand the commonalities and differences between these three districts (see the annex to Chapter 1, Section 1.2).

An overview of the respondents interviewed for answering question 2 and 3 (called institutional analysis) is provided in the matrix below. Please see the annex to Chapter 1, Table 1.2 for a more detailed breakdown.

Table 1.2. Institutional analysis of the respondents

Level	Number

Technical Assistance Partner level (including Family Case Managers) (including Community Volunteers)	**329** (55) (192)
Government health facilities (including clients) (health staff)	**848** (705) (143)
Key informants	**39**
BSY partners	**27**
Total	**1243**

1.3.2 Limitations of Round 1 of the concurrent evaluation

The perceived QoL tool used for the evaluation was a combination of children's Trait Hope Scale and adult Hope Scales, the PedsQL4 self-assessment scale for children and the Child Status Index. The tool was adapted in collaboration with partners to suit the local context, subsequently piloted and validated. The tool showed to be valid for the group of children whose parents are willing to receive outsiders (BSY and others) in their homes. The tools also seem to compare well with the tools used in Tamil Nadu amongst a similar group of HIV infected and affected children.

The findings from the children's Trait Hope Scale and adult Hope Scales are comparable with other studies, as they were used without any changes. For interpretation purposes the country context should be taken into account.

As all children and their care-givers interviewed in the IHHT had already been registered with BSY for between three months and two and a half years, the evaluation is not able to provide a true baseline for the QoL. To compensate for this, it is proposed to establish in the next few months a reference group of children infected with or affected by HIV who have not yet been exposed to BSY. This reference group would help to differentiate programme effects from other factors that could potentially have influenced the high QoL outcome scores found in the 1st round.

Households that were registered in MIS that they were not willing to be visited by BSY and external staff were excluded from the sample. Therefore the findings are applicable to children living in families who were willing to participate in the interviews.

Furthermore, the high non-response rate (32%) is likely to have resulted in an inclusion bias, as 16 per cent of the non-responders, for instance, were living in hostels. While no differences were found in age and sex, the proportion of children tested for HIV was higher in the IHHT sample than in the MIS. There are a number of possible explanations for this such as the possibility that not all data fields are yet fully completed in the entire MIS as West Godavari was prioritised for data entry and quality control. As the KIT team will continue to provide assistance to BSY MIS until End Line we foresee that by End Line comparisons between sample and MIS are levelled off. Another explanation could be related to BSY programme effects (related to exposure time) as one of the first activities focus on

ensuring that children in affected households get tested for HIV. Both HIV testing and the willingness to participate in interviews are likely a proxy for stigma. It is likely that there will be many households/children in BSY with these characteristics - so the findings can be generalized. At End Line the evaluation team will again assess comparability of the sample.

The perceived QoL and Hope scales and self-assessments completed by Family Case Managers (FCMs), Community Volunteers (CVs) and counsellors are all self-reported measures. Intra- and inter-repeatability of findings were tested for the QoL and Hope Scale (validation report) and the tools were found to be valid. The self-capacity assessment of FCMs and Volunteers was to a certain extent validated by the role plays, where capacities to deal with typical BSY situations were played out and observed.

Measuring BSY programme exposure in terms of the number of visits a household received proved to be difficult because of definition problems, so an index for BSY exposure was constructed in consultation with partners (see chapter 2).

The required sample size of 2700 (to ensure a sample size of 2000 at end line) was not achieved due to high refusal rates and time pressure. A 10 per cent change in QoL and Trait Hope scale can still be measured over time. As the evaluation team is discussing an alternative design for the End Line that will include children that have the lowest QoL scores (those that are HIV positive) combined with the data from the Reference Group, the team is confident that there is enough power in the sample to find significant changes in perceived QoL measures. These will be coupled with more objective measures such as changes over time in BMI/MUAC and CD4 counts.

2 How has the quality of life of children infected with and affected by HIV been improved?

This chapter focuses on the findings related to the perceived QoL of the 2072 children and or their care-providers interviewed in West Godavari in the period October–December 2009, and starts by comparing this sample with all other children enrolled in BSY (data are presented Tables 2.7 and 2.8 in the annex to Chapter 2, Tables 2.7 and 2.8). Findings about more objective QoL indicators include analysis of the Body Mass Index (BMI) and Mid-Upper-Arm circumference (MUAC). Currently in the MIS of the BSY partners the data on mortality, morbidity, changes in CD4 counts and incidence of orphans are not yet reliable. Towards end line it is expected that these data can be analysed as proxy's for quality of life changes over time.

2.1. Comparing IHHT sample and all children enrolled in BSY

The comparison shows that in terms of the treatment cascade, the IHHT sample is doing better: 1) more children in the West Godavari IHHT sample have been tested for HIV, 2) more children went for a CD4 test, and 3) for the age group 9–16 years more children are on antiretroviral therapy (ART). The latter does not apply for the younger age group though. The comparison also shows substantially higher levels of HIV infection within the IHHT sample for both age groups and lower levels of BMI for the 0–8 years age group.

The main difference between the IHHT sample and both the total MIS sample and the West Godavari MIS sample is seen in the proportion of children who have been tested for HIV. This was much higher for the IHHT sample compared to the two other samples. This and the above statements are most likely the effect of programme interventions that have occurred in West Godavari, as in this district interventions started early on, and was anticipated in the design of the evaluation.

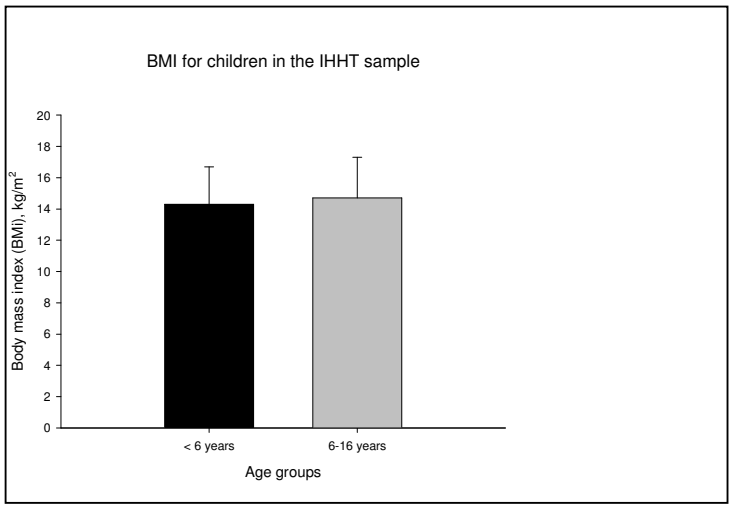
In terms of age and sex, which is the most important proxy for checking the similarity of the IHHT children compared to all the children, both groups are quite similar although the age is slightly higher in the 9–16 years age group than in the Management Information System (MIS) group of the entire BSY programme.

From the 3030 children who were eligible for inclusion in the IHHT sample, 958 children were non-responders (31.6%) and, therefore, not included in the sample. The main reasons for not responding were related to the following: child above the age limit (26%); not willing (18%); living in a hostel (16%) and migrated permanently (13%). This means that one quarter of the non –response was related to incorrect reports of the age of children in the sampling file, which was corrected in the replacement sample. Moreover the sample selection criteria were based on inclusions of families that were comfortable enough to be visited at home by the BSY staff. This could be a possible explanation for the differences between the IHHT sample and the total MIS sample. BSY families that had indicated that they did not want to be visited by the project – and, consequently therefore, were less exposed to BSY – were excluded from the sample. This could explain the differences in more children being tested for HIV in the sample. Based on the above the evaluation team concludes that the findings can be generalised to children in families that were willing to be interviewed.

2.2. Comparing IHHT sample (BMI and MUAC) with World Health Organization standards

Data on BMI and MUAC from the IHHT sample are presented for children aged 0–60 months and 60 months and over, respectively (Figure 2.1 and Table 2.1)

Figure 2.1. BMI for children in the IHHT sample



These data are compared with World Health Organization (WHO) scales for children in these age groups. The WHO Child Growth standards[3] show that the MUAC for the children aged 0–5 years in the IHHT is in general between 1 and 2 z-scores[4] lower than the WHO standard.

This shows that the children in the IHHT sample had a smaller MUAC compared to the WHO standard for children aged 0–5 years. Details on differences for boys and girls are found in the annex to this chapter (Table 2.9 and 2.10 and Figures 2.1 and 2.2).

However, these findings are not surprising, considering the relatively high SAM (severe acute malnutrition) rates in India in general and the fact that the children in BSY are in the programme because of their expected poorer health status and greater vulnerability.

Data on MUAC could not yet be analysed for all children in the BSY programme as MUAC and BMI were not measured for all children yet.

Table 2.1. IHHT - BMI and MUAC for children aged 0–5 years and 6–16 years

Characteristics	Children	
	Children 0–5 years	Children 6–16 years
Number	300	1601
BMI ± SD	14.3 ± 2.4	14.7 ± 2.6
MUAC* ± SD	14.8 ± 1.4	-

Data are means. SD = standard deviation
* MUAC data were available for 194 children.

[3] http://www.who.int/childgrowth /standards/en/

[4] Z-score is a standardized scores (Z-score = (individual score – mean population score)/SD population score

Data on BMI and MUAC from the IHHT were also stratified by HIV test result. Children with a negative HIV test had a larger MUAC or a higher BMI than those who tested positive in both age groups in the IHHT (Tables 2.11 and 2.12 in the annex to this chapter).

2.3. Perceived QoL and Hope Scale scores

2.3.1 Perceived QoL and Hope Scale scores for the IHHT sample

As described in the evaluation protocol, for measuring the perceived QoL, the evaluators used a combination of the PedsQL4 self-assessment scale for children, the Child Status Index, the Trait Hope Scale both for children and for adults and an index for BSY exposure developed by the evaluation team in consultation with members of the ECG. The Trait Hope Scale measures two distinct variable being the Hope Pathway score reflecting a person's ability to generate workable routes to desired goals ("I will find a way to get this done") and the Hope Agency score referring to the motivational component that reflects a person's cognition about the ability to begin and sustain goal-directed behavior ("I can do this").

Following discussions with the BSY partners on the preliminary results in March 2010, an extensive validation exercise took place to look at the internal consistency of the QoL IHHT tool and its ability to discriminate. Following this exercise, 4 items were removed from the tool to improve internal consistency. The items removed included the section on disclosure and did not affect the other domains in the score. This resulted in confirmation that the tool is a valid and reliable instrument for use in the current setting.

Table 2.2 shows the scores for children aged 0–8 years and 9–16 years, respectively, from the IHHT sample. The scores were transformed into proportions of the maximal score per QoL domain or Hope Scale domain to make our data comparable with previous studies on QoL measurements in children. This means that, for instance, a QoL Health score of 78.4 indicates that the score represents 78.4 per cent of the maximal score possible on this domain.

Table 2.2. QoL and Hope Scale scores for the IHHT sample

QoL score	Age groups	
	0–8 years (n =657)	9–16 years (n =1273)
Health	93.3 (10.0)	89.9 (10.9)
Food	93.1 (9.5)	91.4 (9.6)
Emotional health	91.3 (7.6)	88.4 (9.4)
Social behaviour	87.5 (11.0)	88.7 (8.8)
Education	94.1 (9.1)	85.5 (9.7)
School	70.2 (23.7)	-
QoL overall	90.4 (7.2)	88.6 (7.3)
Hope Agency children	77.7 (16.4)	83.3 (14.9)
Hope Path children	53.5 (24.2)	70.8 (19.1)
Hope Agency adults	77.3 (15.8)	-
Hope Path adults	80.8 (14.1)	-

Data are mean scores (SD). SD=standard deviation. The Food score indicates both food and intake of nutritious food; The Education score reflects school attendance; The School score reflects school performance.

These data indicate that QoL scores for both age groups are relatively high with mean scores on QoL of 90.4 per cent of the maximum score for 0–8 years and 88.6 per cent for 9–16 years.

Previous studies have assessed QoL in children from different countries, using scales that were comparable with the tool used in the BSY programme. Table 2.3 shows the QoL scores

for healthy children that were assessed in studies from China (Xu et al., 2010),[5] Japan (Kobayashi et al., 2010),[6] Korea (Hook et al., 2008),[7] the Netherlands (Engelen et al., 2009)[8] and India (Sreevidya et al., 2008).[9]

Table 2.3. QoL scores overview

Study	QoL score	Number	Age	Country	QoL tool
Xu et al. (2010)[a]	78.2 (12.2)	88	8–18	China	PedsQL
Kobayashi et al. (2010)[b]	74.1 (11.9)	31	2–5	Japan	PedsQL
Kobayashi et al. (2010)[b]	82.7 (11.6)	891	6–18	Japan	PedsQL
Hook et al. (2008)[c]	88.2 (10.7)	1341	8–18	Korea	PedsQL
Engelen et al. (2009)[d]	84.2 (9.0)	92	5–7	the Netherlands	PedsQL
Engelen et al. (2009)[d]	82.1 (8.9)	219	8–12	the Netherlands	PedsQL
Engelen et al. (2009)[d]	82.2 (9.2)	185	13–18	the Netherlands	PedsQL
Sreevidya et al. (2008)[e]	90.0 * (baseline) 93.5 ** (end line)	1022	0–18	India	PedsQL
BSY	89.5 (7.3)	1930	0–16	India	QoL IHHT tool

Data are mean scores (SD). SD=standard deviation.
* Estimated score at baseline of children infected with and affected by HIV combined
** Estimated score at the 18th month examination of children infected with and affected by HIV combined.

When QoL scores for healthy children from other study populations (China, Japan, Korea and the Netherlands) are compared with the QoL scores of children infected with and affected by HIV in India, the latter have the highest QoL scores. This also applies to both the baseline and end line scores of the Tamil Nadu Family Continuum of Care (TNFCC) programme in Tamil Nadu (Sreevidya et al.) and the BSY children in Andhra Pradesh, which included children that are comparable to the children in the BSY programme.

The high QoL scores of the BSY children may have been influenced by the high proportion of non-responders (31.6%) in the IHHT sample. A more likely explanation, however, is that the BSY families had already received services before QoL was measured, and therefore perceived a relatively high quality of life at the moment of examination. Furthermore, the baseline scores of TNFCC and BSY are both high, indicating that in the Indian context the perceptions on QoL may be higher than in other countries. The extensive validation exercise of the tool undertaken by the evaluation team showed that its internal consistency and ability to discriminate were high. As a consequence of the relatively high QoL scores of the IHHT sample, the likelihood of improving these scores as a result of the BSY programme seems limited for the entire group of children, but not for certain sub groups as described in the following sections. The reference group and end line design will address these specific concerns.

2.3.2 Perceived QoL and Hope Scale scores for subgroups of the IHHT sample

The score for QoL and Hope Scale were analysed for different subgroups of the IHHT study sample. Participating children were divided into groups based on:

- HIV status (positive/negative);
- ART (treatment/no treatment);
- Gender (male/female);
- Head of household (female/male); and

[5] Xu et al. *J Acquir Inmmune Defic Syndr* 2010;53:S111–S115.
[6] Kobayashi et al. *Pediatrics International* 2010;52:80–88.
[7] Hook et al. *Health and QoL Outcomes* 2008;6:41–56.
[8] Engelen et al. *BMC Pediatrics* 2009;9:68–76.
[9] J. Sreevidya et al. (2008) *Psychosocial Impact on Infected and Affected Children in the Tamil Nadu Family Continuum of Care (TNFCC) Program in India*. TANSACS, CIFF, Duke University, Saathi. (abstract).

- Head of household (grandparents/non-grandparents).

Analyses of covariance were used to compare QoL scores, Hope Scale scores, MUAC and BMI between different groups. All analyses were adjusted for age and sex.

HIV status

Scores for QoL (all domains) were significantly higher for children who tested HIV-negative than for those who tested HIV-positive in both age groups. The Hope Agency child scores (both age groups) and the Hope Pathway child scores (9–16 years only) were also significantly higher for HIV-negative children, as was the BMI for children aged 9–16 years only (see Tables 2.4 and 2.5). These results indicate that the QoL IHHT tool (and the Hope Scale) can indeed discriminate between relatively healthy (HIV-negative) and infected (HIV-positive) children with respect to the QoL and Hope Scale domains that were assessed.

Table 2.4. HIV test status and scores for children aged 0–8 years (n =532)

QoL score	HIV test status		
	HIV-positive (n =123)	HIV-negative (n =409)	p-value
Health	86.7 (12.1)	94.5 (9.2)	**<0.001**
Food	90.2 (11.9)	93.6 (8.90	**0.001**
Emotional health	88.3 (9.8)	91.7 (6.9)	**<0.001**
Social behaviour	83.7 (12.7)	88.6 (10.5)	**<0.001**
Education	89.8 (9.3)	95.0 (8.9)	**<0.001**
School	65.0 (23.9)	72.2 (23.5)	**0.008**
QoL overall	86.2 (9.3)	91.3 (6.5)	**<0.001**
Hope Agency children	73.3 (18.00	80.0 (15.2)	**<0.001**
Hope Path children	51.5 (24.1)	55.5 (23.8)	0.065
Hope Agency adults	75.2 (17.5)	78.1 (14.9)	0.081
Hope Path adults	79.6 (16.0)	81.4 (13.8)	0.183
MUAC, cm*	14.1 (3.2)	14.3 (2.8)	0.818
BMI, kg/m^2	13.6 (1.5)	13.8 (2.1)	0.490

* Data on MUAC were available for 153 children.
P-values reflect the difference between the two groups, adjusted for age and sex.

Table 2.5. HIV test status and scores for children aged 9–16 years (n =1006)

QoL score	HIV test status		
	HIV-positive (n =147)	HIV-negative (n =859)	p-value
Health	82.6 (14.2)	90.7 (10.2)	**<0.001**
Food	88.5 (10.8)	91.8 (9.3)	**<0.001**
Emotional health	86.8 (10.1)	88.6 (9.4)	**0.019**
Social behaviour	85.5 (10.1)	88.8 (8.6)	**<0.001**
Education	79.3 (10.1)	86.5 (9.4)	**<0.001**
QoL overall	84.3 (8.7)	89.0 (7.1)	**<0.001**
Hope Agency children	78.1 (16.5)	83.3 (14.7)	**<0.001**
Hope Path children	62.7 (19.4)	71.2 (19.2)	**<0.001**
BMI, kg/m^2	14.0 (2.0)	15.0 (2.7)	**0.002**

P-values reflect the difference between the two groups, adjusted for age and sex.

Anti Retroviral Treatment

Children who were on ART in the age group 0–8 years had higher QoL and Hope Scale scores than children who were not on ART. This difference was only significant for the QoL domains Health and Food. This means that the health and nutritional status of these younger improved significantly after receiving treatment for their HIV infections. For the

older children aged 9–16 years, there was no clear relationship between ART and QoL scores. BMI was higher for children who were receiving ART, although not to a statistically significant extent (Tables 2.13 and 2.14 in the annex to Chapter 2).

Differences in gender

When comparing QoL scores for boys and girls in the IHHT sample, no clear relationship was found between gender and QoL scores or MUAC and BMI for the younger age group (0-8). The Hope Agency score was slightly higher for girls. The gender analysis for children aged 9–16 showed a few differences. The QoL score for Social Behaviour was higher for girls (p=0.013), as was the Hope Agency score (p=0.032). Also the BMI for girls was slightly higher than for boys (p-value <0.001) (Tables 2.15 and 2.16 in the annex to Chapter 2). At this stage it is too early to make any inferences about this finding.

Head of household: female vs. male

For children aged 0–8 years, those living in female-headed households had a significantly higher QoL score for the domain School, and the care-giver in these families had a higher Hope Agency score than male-headed households. Children in male-headed households had a higher BMI than those in female-headed households (p=0.019). For children aged 9–16 years, there was no clear difference in QoL scores and Hope Scale scores between those living in male- and those in female-headed households (Tables 2.17 and 2.18 in the annex to Chapter 2).

Head of household: grandparents vs. non-grandparents

For children aged 0–8 years, there was no clear difference in QoL scores and Hope Scale scores between those living in households headed by a grandparent and those not headed by grandparents (Tables 2.19 in the annex to Chapter 2) except for children in non-grandparent-headed households who had a slightly better score in the Health domain of the QoL scale (p=0.031). For children the older children (9–16 years), however, the scores on all QoL domains were significantly higher for children who lived in non-grandparent-headed households (Table 2.6). This could indicate that it is might be easier for grand parents to care for younger children than for older ones and/or reflect that older children living with their grand parents have a stronger realization of the situation they are in (having possibly lost their parents with effects on their ability to access schooling, food and health).

Table 2.6. Head of household (grandparent vs. non-grandparent) and scores for children aged 9–16 years (n =1273)

QoL score	Head of household		
	Grandparent (n =160)	Non-grandparent (n =1112)	p-value
Health	85.3 (13.6)	90.6 (10.4)	**<0.001**
Food	88.3 (12.1)	91.8 (9.1)	**<0.001**
Emotional health	84.5 (12.4)	89.0 (8.7)	**<0.001**
Social behaviour	86.8 (9.8)	89.0 (8.6)	**0.005**
Education	83.0 (10.6)	85.9 (9.6)	**0.001**
QoL overall	85.4 (9.2)	89.1 (6.9)	**<0.001**
Hope Agency children	81.3 (16.8)	83.5 (14.6)	0.110
Hope Path children	69.1 (19.5)	71.0 (19.1)	0.372
BMI, kg/m^2	14.5 (2.4)	15.1 (2.7)	0.067

P-values reflect the difference between the two groups, adjusted for age and sex.

In conclusion, the QoL IHHT tool (and the Hope Scale) shows differences between some subgroups in the BSY programme (HIV test positive/negative; grandparent/non-grandparent head of household; male and female headed households) with respect to the QoL and the

Trait Hope Scale domains. These results indicate that some subgroups are more vulnerable than others and provide the BSY partners with an opportunity to better target more vulnerable children.

2.4. BSY exposure and QoL and Hope Scale scores

The relation between BSY exposure variables and QoL and Hope Scale scores was assessed by looking at: (1) BSY exposure time, (2) BSY services and linkages mentioned, and (3) BSY services and linkages provided.

2.4.1 BSY exposure time

BSY exposure time was defined as the time between date of entry in the BSY programme and date of interview. QoL and Hope Scale scores are presented for five groups of children, based on the length of BSY exposure: Group A (0–6 months), group B (6–12 months), group C (12–18 months), group D (18–24 months), and group E (24 months and over).

The results showed that for children aged 0–8 years, there was no clear relationship between BSY exposure time and QoL and Hope Scale scores. For the elder children aged 9–16 years, the BMI seemed to be higher in children who had been exposed longer to the BSY programme (Tables 2.20 and 2.21 in the annex to this chapter), which could indicate an effect of the BSY programme.

The evaluation team realises that it is possible that the time band of 0-6 months exposure time influences the possibility of finding a relationship between time of exposure and QoL and Hope Scale scores. Previous studies have shown that improvements in QoL scores are most likely to occur in the first few months after exposure. Below, the results of the TNFCC programme clearly illustrate that the biggest change in terms of QoL scores, especially for children infected with HIV but also to some extent for children affected by HIV, took place in the first three to six months of the programme.

Table 2.7. Psychosocial Impact on Infected and Affected Children in the Tamil Nadu Family Continuum Care (TNFCC) Programme in India[10]

Paediatric QoL scores of infected children

Domain	Base-line	6 Month	12 Month	18 Month
Physical	72	81 ***	84 ***	90 ***
Psychological	74	82 ***	84 ***	84 ***
Social	88	93 *	95 ***	94 **
School	74	83 **	84 ***	85 ***

Sample size for the analyses ranged from 71 to 127

Note: *p < 0.05, ** p < 0.01 & ***p < 0.001, Statistically different from baseline

Paediatric QoL scores of affected children

Domain	Base-line	6 Month	12 Month	18 Month
Physical	90	93 ***	94 ***	96 ***
Psychological	83	88 ***	87 ***	86 ***
Social	98	99 ***	99 ***	98
School	89	93 ***	93 ***	94 ***

Sample size for the analyses ranged from 1022 to 1974

Furthermore, the paediatric QoL scores in the TNFCC programme in India showed that scores were relatively high (84–98%) at the 18th month examination. These scores are in line with the QoL scores measured in the IHHT sample in the BSY programme. This supports the earlier finding that the IHHT QoL tool is valid for use in this population. The TNFCC scores were measured with a locally validated PedsQL tool.

[10] J. Sreevidya et al. (2008) *Psychosocial Impact on Infected and Affected Children in the Tamil Nadu Family Continuum Care (TNFCC) Program in India*. TANSACS, CIFF, Duke University, Saathi. (abstract)

2.4.2 BSY services and linkages

BSY exposure was defined by using two constructed exposure variables that were based on (1) BSY (linkage) services that were mentioned by respondents in the questionnaires (pages 25–28 of the questionnaire HH1B; pages 7–10 of the questionnaire HH1C); and (2) types of assistance provided by services, that were mentioned in the questionnaires (pages 29–34 of the questionnaire HH1B; pages 11–17 of the questionnaire HH1C). These two exposure variables were each divided into six groups based on the total number of services or types of assistance that were mentioned. Analyses of covariance were used to compare QoL scores, Hope Scale scores, MUAC and BMI between different groups. All analyses were adjusted for age and sex.

BSY services and linkages mentioned

QoL scores, Hope Scale scores, MUAC and BMI were analysed for children (or their care-givers) who had mentioned (either 'top of mind recall' or 'on probing') a certain number of areas of support/services (both BSY services and BSY linkage services) that were discussed during the visits.

The data showed that for the caregivers that responded to the questions for the children aged 0–8 years, the Hope Pathway score significantly increased with the more areas of support were mentioned ($p<0.001$) (see Tables 2.22 and 2.23 in the annex related to this chapter). This is further explored in chapter 4. There was no consistent relationship between the BSY services and linkages mentioned and QoL or Hope Scale scores, MUAC or BMI in the elder age group.

BSY services and linkages provided

QoL scores, Hope Scale scores, MUAC and BMI were analysed for children (or their care-givers) who mentioned whether they had received any kind of assistance (pages 29–34 of the questionnaire HH1B; pages 11–17 of the questionnaire HH1C) for each service (HIV test, prevention of parent-to-child transmission (PPTCT), TB etc.). For instance, for the 'HIV Test' service, participants were asked whether they had received one of the following types of assistance: 'provided information', 'motivated us to go for test', 'accompanied to the integrated counselling and testing centre (ICTC)', 'have taken the HIV test'.

Every single type of assistance was scored to calculate a sum-score for all the types of assistance that were provided by facility-based, household-based and linkage-based services taken together. A similar finding as in the previous section was found for the younger age group whereby, for both the care givers assessing the Hope scale for their children aged 0–8 years as well as their own Hope Pathway scores, higher scores were seen with increasing number of services provided ($p=0.002$ (children) and $p<0.001$ (caregivers)) (Tables 2.24 and 2.25 in the annex related to this chapter). There was no consistent relationship between BSY services and linkages provided and QoL or Hope Scale scores, MUAC or BMI in either age group.

2.4.3 Profile description of children with low QoL (lowest 5 per cent of children)

Identification of children with low QoL could help to direct the BSY programme to identify and focus on the most vulnerable children. For this purpose, the evaluators undertook an exercise to describe children with the lowest 5th percentile of QoL and compared this to children with high QoL. The full descriptive analysis has been included in Section 2 in the annex to this chapter.

Significantly more children with low QoL scores were found to be HIV-positive, and fewer children with high QoL were tested for HIV. Although more children with high QoL were on ART, this was not statistically significant. Having CD4 cell counts done was similar in both groups. For both age groups of children (0–8 years and 9–16 years) it was found that children falling into the lowest 5th percentile of QoL were not different in sex distribution and age (albeit a bit younger) than children

with higher QoL. This finding is commensurate with earlier findings that children that are HIV positive are amongst the most vulnerable children in Balasahyoga.

2.5. Key findings and conclusions about the quality of Life

2.5.1 Methodological

The children in the IHHT sample were comparable with the other children in BSY, although they were tested for HIV more often, which could be an effect of being longer in the programme.

The distribution of age and sex was similar for both the IHHT sample and the MIS sample, although age was slightly higher for children in the MIS sample (for both the 0–8 years and the 9–16 years age groups).

The sample selection criteria were based on inclusion of families that were comfortable enough to be visited at home by the BSY staff. This could be a possible explanation for the differences between the IHHT sample and the total MIS sample. BSY families that had indicated that they did not want to be visited by the project – and, consequently therefore, were less exposed to BSY – were excluded from the sample. This could explain the differences in more children being tested for HIV in the sample. Based on the above the evaluation team concludes that the findings can be generalised to children in families that were willing to be interviewed.

2.5.2 MUAC and BMI

Data on BMI and MUAC from the IHHT sample were compared to World Health Organization (WHO) scales for children in these age groups. The children in the IHHT sample had a smaller MUAC compared to the WHO standard for children aged 0–5 years. In view of the relatively high SAM rates in India and the fact that the BSY children are a selection of the more vulnerable population explain these data, but also show that improvements can be made by the BSY programme.
Children with a negative HIV test were having a larger MUAC and higher BMI as compared to those testing HIV positive in both age groups in the IHHT.

2.5.3 Perceived Quality of Life Scores

QoL and Hope Scale scores for the children in the IHHT sample were relatively high.
When QoL scores for healthy children from other previously performed studies in the world, were compared with the QoL scores of the children in the IHHT sample, the IHHT children had the highest scores. However, when comparing them to a similar group of infected and affected children in Tamil Nadu, the scores were quite comparable. The extensive validation exercise of the tool undertaken by the evaluation team showed that its internal consistency and ability to discriminate were high.

As a consequence of the relatively high QoL scores of the IHHT sample, the likelihood of improving these scores as a result of the BSY programme seems limited for the entire group of children, but not for certain sub groups, most notably for the children living with HIV. The reference group and end line design will address these specific concerns.

The subgroup analyses of QoL and Hope Scale scores showed that scores for QoL (all domains) were significantly higher for HIV-negative children than HIV-positive children (in both age groups). This indicates that the QoL IHHT tool (and the Hope Scale) can indeed discriminate between relatively healthy (HIV-negative) and infected (HIV-positive) children with respect to the QoL and Hope Scale domains that were assessed.

Balasahyoga exposure and Quality of Life and Hope scales

There was no clear relationship between **BSY exposure time** and QoL or Hope Scale scores for the younger age group. It is possible that the time band of 0-6 months exposure time influences the possibility of finding a relationship between time of exposure and QoL and Hope Scale scores. Previous studies have shown that improvements in QoL scores are most likely to occur in the first few months after exposure.

For the elder children aged 9–16 years, the BMI was higher in children who had been exposed longer to the BSY programme, which could indicate an effect of the BSY programme.

There was a relationship between the **number of services mentioned and received** in terms of higher Hope Pathway scores for caregivers of the younger children (0-8 years). This means that caregivers are better able to devise workable routes to desired goals ("I will find a way to get this done"). This could be a measurable positive effect of the BSY programme toward creating families with more resilience.

With respect to the **actual linking services** accessed by the BSY families through the FCM/CV system, a similar finding as in the previous section was found for the younger age group whereby, for both the care givers assessing the Hope scale for their children aged 0–8 years as well as their own Hope Pathway scores, higher scores were seen with increasing number of services provided ($p=0.002$ (children) and $p<0.001$ (caregivers) although this was not seen for the children in the older age group.

Identification of the most vulnerable children in the BSY programme

Across all age groups children living with HIV had the poorest QoL and Hope scores, but at the same time when they were receiving anti- retroviral treatment the scores were better, especially for the younger children.

The analyses show that some children are more vulnerable to the adverse effects of living in families that have at least one person living with HIV. Children living with their grandparents of 9-16 years showed poorer QoL scores across all domains than those living with their parents. In households with a female care giver the scores for attending school (o-8 years group) and also the female caregivers themselves scored higher on the Hope Agency scales than in male headed households. Younger Children in male-headed households, on the other hand, had higher BMI scores. For the older age groups there were no differences.

Girls in general had better scores on their QoL scale for social behaviour and for the Hope Agency score. Also the BMI for girls was higher than for boys.

3 Findings on the Quality of Care

3.1. Introduction

This chapter aims to address the second evaluation question, on how the quality of care of children infected with or affected by HIV, and their households, has been improved as a result of capacity strengthening activities of the BSY programme. The question has been broken down into two components, namely: 1) how has the quality of care for children infected with or affected by HIV been enhanced? and 2) how has access to health and other services for children and their caregivers been improved?

The point of departure for looking at the quality of care for infected and affected children is the perspective of BSY children and their families. The evaluation, therefore, did not set out to do an audit of the quality or standards of health care services or any other government services provided. Further explanation of how the evaluation team defined quality of care is provided in the annex to this chapter (Section 3.1.1).

This chapter is based on a combination of quantitative data collected as part of the IHHT in West Godavari and waiting time analysis data collected in ART centres in West Godavari, Kurnool and Medak, and qualitative data collected at Technical Assistance Partner level, health facility level, and interviews with key stakeholders at national, state, district and mandal level. The chapter also makes use of BSY MIS data, BSY project documents and secondary literature. For a graphical overview, please see Section 3.1.2 in the annex to this chapter.

3.2. Quality of care and the operational guidelines for the protection, care and support of children affected by HIV

The newly formulated operational guidelines for the national scheme for children affected by HIV, based on the Policy Framework for Children affected by AIDS (2007),[11] suggests that all children infected with or affected by HIV in all 'category A' districts should have access to a comprehensive set of services. So the scheme is applicable for all children registered in BSY. The services mentioned in the operational guidelines are:

- health services (general, paediatric and HIV as well as safe water, sanitation and hygiene);
- psychosocial support (counselling and life skills education (LSE));
- nutrition (supplementary and fortified);
- education (formal, non-formal, special and compensatory tuition);
- social protection and economic support (support against discrimination, inheritance, cash transfer);
- legal support (children's rights and entitlements, legal protection and redress); and
- alternative care for orphans (foster care, extended family, adoption and institutional care).

The operational guidelines mention that these services are seen as "critical and necessary to ensure the immediate well-being and holistic development of a child affected by HIV". A more detailed description of these critical areas can be found in Section 3.2.2 in the annex to this chapter.

BSY is working on improving the access to care for children in most of the areas mentioned in the scheme, either directly or indirectly through referral and the establishment of linkages. The programme has specific health, education, nutrition and safety net targets. However, no such targets exist for social protection and legal support, and alternative care for orphans and targets for psychosocial support have been deleted as a separate domain

[11] For the objectives of the Policy Framework, please see Section 3.2.1 in the annex related to this chapter.

although some psycho-social support targets are reflected in the health domain linked to HIV testing, pre-ART registration and Adherence).

3.3. Enhancing the quality of care for BSY families in relation to health

3.3.1 Household-level perspectives on health care

3.3.1.1 Use of services

Households currently with an adult or child living with HIV were asked whether they accessed government or private health services. Of the families with children in the age group 0–8 years, 519 used government facility services only, while 11 families also used private facility services. Of the families with children aged 9–16 years, 836 used government facility services only, while 17 families also used private services.

Of the families accessing government services with children 0–8 years, over 90 per cent received HIV tests, CD4 count tests or counselling services, versus over 75 per cent of the families with children 9–16 years of age. All people on antiretrovirals (ARV) reported having received them from government facilities. Therefore, it seems to be entirely appropriate for BSY to focus on improving government services for BSY families. For details, please see Tables 3.3.1.1.1 and 3.3.1.1.2 in the annex to this chapter.

3.3.1.2 Overall perception of care by adults and children

Quality of care

The IHHT children and care-givers interviewed were also asked how they perceived the quality of care provided by health facilities. Only those households that currently had a child or adult living with HIV in the household were asked to respond to these questions.

Table 3.1. Care-providers' perspectives on health services

Questions	Answers			
	care-givers with children aged 0–8 years		care-givers with children aged 9–16 years	
	Yes	No	Yes	No
Are your needs adequately addressed by government facilities?	481 (95)	24 (5)	681 (96)	28 (4)
Are your needs adequately addressed by private facilities?	1 (20)	4 (80)	2 (50)	2 (50)
Data are given as number (%)				

The answers provided by both groups of care-providers indicate that the large majority of people are positive about the government services received. This finding also coincides with the findings from the ART centre during the waiting time analysis, where ART clients expressed high levels of satisfaction.

> ART client, Medak: "I have used private medicines earlier which were very expensive and not affordable. Now I am taking the medicines from the government ART centre."

The few people utilizing private services provide a more diverse perspective on whether their needs are adequately addressed.

Table 3.2. Perspectives on ART centres of HIV-infected children aged 9–16 years

Question	Answers	
	Yes	No
Are you comfortable going to the ART centre?	135 (96)	6 (4)
When you go to the ART centre, do you feel the doctor cares about you?	133 (95)	7 (5)
When you go to the ART centre, do you feel the counsellor cares about you?	123 (89)	15 (11)
Data are given as number (%).		

The large majority of children indicated that they were comfortable with going to the ART centre. Almost the same percentage of children felt that the ART doctor cared about them. Close to 90 per cent of the children felt that the ART counsellor cared about them. This in spite of the fact, as can be seen 3.4.7 that the time spent with the counsellor is minimal. This view of the children corroborates observations from FCMs and CVs on how ART clients are being treated:

> CV, Damien Leprosy Centre (DLC): "In the beginning nobody cares about the patients. Now they are treated better in the ART. They are telling everything."
>
> FCM, DLC: "In the beginning whenever we sent the patients to the hospitals, they did not treat them well. But after our FHI DC, facility coordinators are cooperating and sensitizing them, and now they are treating them well."

3.3.1.3 Experiences with timely delivery of ART

The tables below try to provide insight into possible stock-outs of ARV drugs experienced by patients. Although the large majority of care-givers said that they had no problem getting ARV drugs on time, 3 to 4 per cent said they had experienced a problem, indicating that some stock-out problems have occurred. A higher percentage of children living with HIV (12%) indicated not always receiving their medicine on time from the clinic.

Table 3.3. Experiences of children aged 9–16 regarding ARV stock-out

Question	Answers	
	Yes	No
Do you always get your medicine in time from the clinic (ART)?	72 (88)	10 (12)
Data are shown as number (%).		

Table 3.4. Experiences of care-givers regarding ARV stock-out

Question	Answers			
	care-givers with children aged 0–8 years		care-givers with children aged 9–16 years	
	Yes	No	Yes	No
For persons on ART: have you always received your monthly ARV drugs when you went to get them?	249 (97)	7 (3)	616 (96)	27 (4)
Data are shown as number (%)				

This corroborates what ART medical officers interviewed in the different districts reported. They indicated that there had been some stock-outs but that these have been minimal. However, stock-out of opportunistic infection (OI) and paediatric ARV drugs was reported in Kurnool:

> "We are running short of OI drugs for 2–3 months. From the hospital side we are only getting 10–20 per cent of OI drugs. ART drugs are coming regularly. Recently

> we had a paediatric drug shortage. So as per previous chart, we are adjusting adult tablets [for children]."

Care-providers and children were said to be informed by ART staff on how to break the tablets into two pieces at home.

3.3.1.4 Support received by BSY in the area of health

QoL and Hope Scale scores for the 657 children aged 0–8 years in the IHHT were higher for those households that indicated that BSY had helped them with facility-based services. Within the QoL and Hope Scale scores, the food-specific QoL scores and the Hope Pathway for both children and adults were also significantly higher than for those not having had that support. This means that adults indicated that their children and they themselves had a better practical sense of how to achieve their goals and that their child had a healthier appetite and ate sufficiently in terms of quantity and quality of food. For the 9–16 years age group no significant differences were found.

It has to be taken into account that while the parents/care-givers answered all questions on behalf of the 0–8 years age group, the 9–16-year-old children answered the QoL questions themselves, while their care-givers answered the BSY exposure questions. This may have influenced the results. The tables showing these results have been included in the annex of Chapter 3 (Tables 3.3.1.4.1 and 3.3.1.4.2).

FCMs and CVs mentioned having observed a number of changes in relation to health care as a result of BSY, such as: a) increased capacity of parents or care-providers to take care of children living with HIV, b) children having learned to take better care of their own health, and c) stronger focus by care-providers on hygiene, timely taking of medicines, and nutritious food.

> FCM, Apple: "Parents or care-providers did not know how to take care of children living with HIV before BSY. Now they know how to treat them, how to take care of them, when to take them to the hospital etc. These changes are happening because of BSY."

More quotes from FCMs and CVs can be found in the annex related to this chapter.

However, problems were also mentioned with access to health care for children whose care-givers are not familiar with being HIV-positive:

> FCM, DLC: "If the care takers are non-positive they do not know the problems faced by the children. If the parents are positive, then only they know their children's feelings. So care takers did not pay much interest to avail themselves of facilities provided by the government or any other agencies."

3.3.2 Perspectives on facility-level health care

3.3.2.1 ICTC services – overall comments

Changes observed in the ICTCs

Quite a number of changes have been observed by FCMs and CVs in the ICTCs in West Godavari and Kurnool. Changes mentioned were: sharing of addresses for case referral, ICTCs taking assistance from BSY for motivating family members to also come for testing, ICTCs informing clients about BSY, giving testing services to clients accompanied by FCMs/CVs without request slips or OP cards, and less time for TB testing. FCMs and CVs

stressed that this was the result of the increased understanding between the ICTC and BSY developed over time.

> FCM, Apple, and West Godavari: "There is lot of change from last year and this year in the ICTC in telling addresses to us and case referring. This was not happening in the beginning because we were all new and there was less understanding and less of a relationship between us".
> CV, Vimala Women Charitable Society (VWCS), Kurnool: "When we accompany the clients to an ICTC centre, without any questions, they are testing our clients. If any other people go for testing, they ask for the slips, OP cards etc. Earlier it took three days for TB testing, but now they test our client directly."

3.3.2.2 ART centres

CHAI, as part of BSY, has supported ART centres by upgrading the infrastructure to improve the patient flow and to improve patient confidentiality. To measure the current patient flow as a result of these improvements in infrastructure, waiting time analyses were undertaken in three ART centres, one in West Godavari, one in Kurnool and one in Medak.

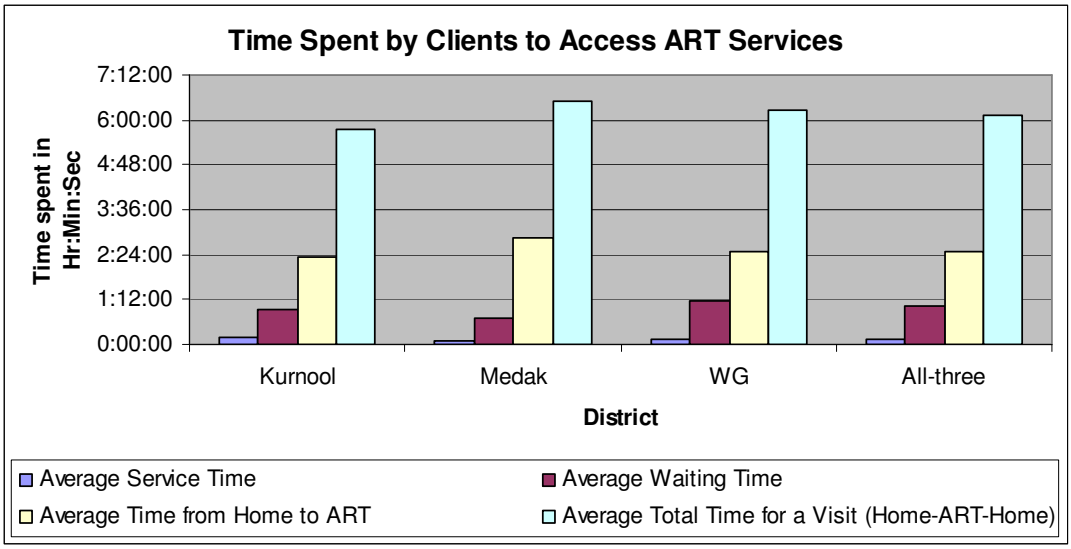
Profile of ART clients tracked

Of the 801 BSY eligible clients tracked during the waiting time assessment, around 4 per cent were accompanied by BSY FCMs, CVs or other staff, 65 per cent came alone, and 29 per cent were accompanied by a family member. Of these 801 clients, 41 were children, 13 in West Godavari, 20 in Kurnool and eight in Medak. Of these 41 children, eight were below 9 years of age, and 33 were 9–18 years. For further information, please see Figure 3.3.2.2.1 in the annex to this chapter.

Waiting time and service time

The figure below shows the average waiting, service and travelling time (one way only) for patients. Overall, approximately 14 per cent of the time spent in the ART clinic was spent on obtaining services, against 86 per cent on waiting for services. However, the figure also shows considerable differences in waiting and service time between the different districts. On average, waiting time is highest in West Godavari and lowest in Medak. While Medak has the lowest waiting time, it also has the lowest service time.

Figure 3.1. Time spent by clients to access ART services



The average time clients spent to travel from their home to the ART centre varies from close to 2 hours and 20 minutes in Kurnool to close to 3 hours in Medak. This means that a visit to the ART centres requires considerable time investment from clients. Several clients made comments that they would appreciate it if they could receive ART drugs without having to go so far to ART clinics:

> Client, ART clinic, Medak: "My friend and I are coming from Thandur. It is good if they give medicines at another alternative area, because this is far from our place."
> Client, Kurnool: "It is good if they give medicines in other areas like the hospital in Nandyal. It will decrease our travel time and travel cost. If it is near, we can easily come and reach the ART centre on time and get the services."
>
> ART client, West Godavari: "ART people are also giving medicines at Thadepalligudem and Tanuku hospitals. So it decreased our travel duration and save time to get the medicines. For any other health problems we are coming to the ART centre in Eluru."

Short service times also cause clients to travel even more:

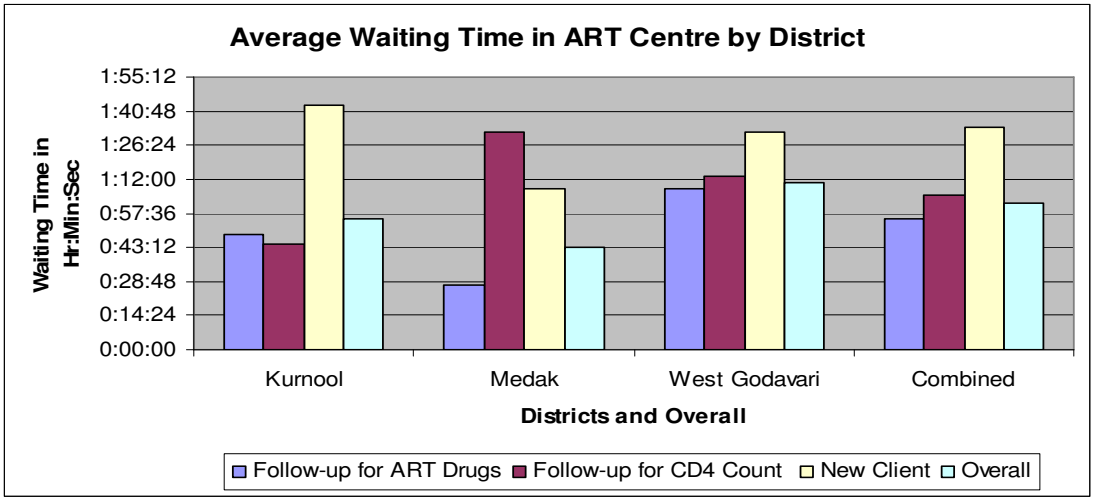
> ART client, West Godavari: "I have stayed at the bus stop because I reached the ART centre yesterday afternoon after 12:00 noon and the lab was closed by that time. So I came again on this day for testing. Closing the lab early causes inconvenience and increases the burden to afford shelter, food, travel charges to come on the next day."
>
> ART client, Kurnool: "The CD4 lab will close by 12:30 pm, and the clients who came after 12:00 noon were asked to come on the next day. As again they travel and come from their places on the next day, they are reaching the ART centre at the same time. If we are lucky, we will get services on that day. If not, we have to come again on the next day."

BSY FCMs and CVs in West Godavari mentioned a number of issues in relation to service time, such as staff not being on time, going for long tea breaks, and giving different days for appointments to clients for different services. For quotes on this, please see the annex related to this chapter (3.3.2.2 quotes related to service time).

The BSY April 2010 Quarterly Report states that the time and resources required and loss of income due to the time investment required are among the major reasons why people stop going to the ART clinics. This stresses the need for reducing the time people have to spend on travelling to and waiting in the ART centres.

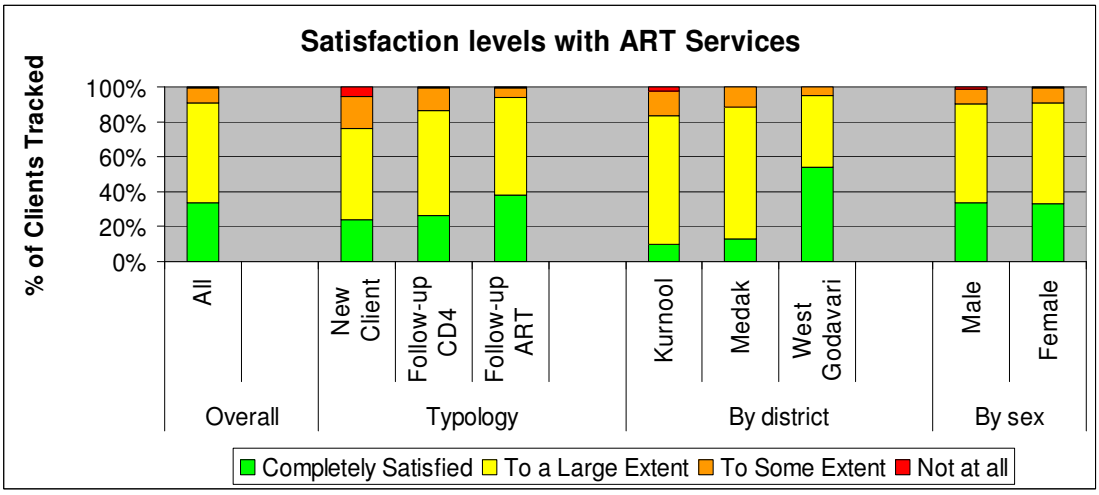
The graph below shows the average waiting time by type of client in each district. New clients spend significantly more time than ART follow-up patients and – with the exception of Medak – also for CD4 count follow-up patients. The differences between districts in waiting times for the different types of patients are quite large. Exploring how these waiting times could possibly be reduced to a more common standard could be a worthwhile exercise, especially as the heavy time investment required for visiting ART centres contributes to loss to follow-up (LFU). Furthermore, lobbying to fast-track the establishment of link ARTs or exploring alternative ways to distribute ART drugs would also be options that could be considered.

Figure 3.2. Average waiting time in ART centres by district



The waiting and service times were not found to have a significant correlation with client satisfaction. While waiting times were highest in West Godavari and the service time in West Godavari lower than in Kurnool, the highest level of client satisfaction was measured in West Godavari. In general, all type of clients – new, CD4 follow-up, and ART follow-up – reported being satisfied with the service they received at the ART centre. ART follow-up clients reported the highest level of client satisfaction.

Figure 3.3. Satisfaction levels with ART services



ART client, Kurnool: "My health condition is improved after using these medicines."

Another client, Kurnool: "They are giving good medicines and good treatment."

Higher client satisfaction was reported in West Godavari than in the other two districts. Client satisfaction from these clients could, therefore, be influenced by the impact of these medicines on their health, rather than the services itself.

Only among new clients did a small percentage report being not at all satisfied.

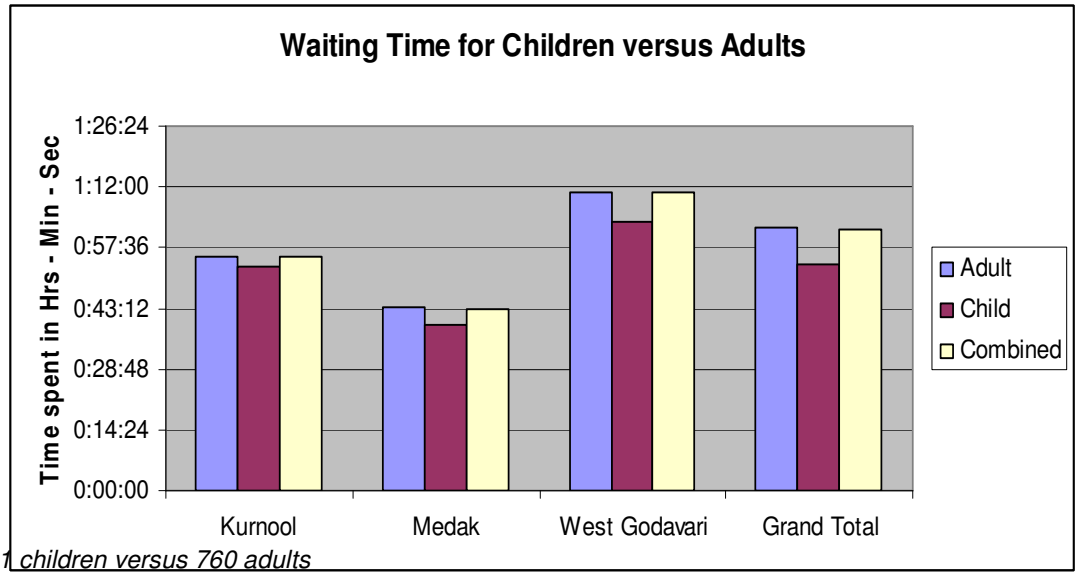
ART client, Medak: "I am coming for three days to the ART centre, but even today the counsellor asked me to come on Monday as the doctor was on leave. I am not completely satisfied with these services."

Staff at different ART centres indicated that attempts are being made to reduce the waiting time for children, by having adults with children seen first without having to stand in the queue.

ART Medical Officer (MO), Kurnool: "Children are given priority. Less than half an hour. For counselling they have to wait, for check up and then for medicines. All this is done in less than one hour. We do not have separate days for children."

While observations during the waiting time analysis exercise showed that this approach is not always followed, the figure below shows a difference between service time for children and that of adults in all districts. However, it has to be taken into account that only a small number of children were tracked (41 children versus 760 adults). The figure also shows that children in West Godavari have to wait considerably longer than children in the other two districts. In West Godavari it was mentioned that efforts are made to have children, especially those that come through organizations, come during the first 10 days of the month. Parents who come with children during that period are also given preference to reduce their waiting time. Headway seems to have been made to reduce the waiting time for children, but further exploration into how this could be reduced further, especially in West Godavari, could be useful.

Figure 3.4. Waiting time for children versus adults



41 children versus 760 adults

Changes in infrastructure

Diagrams of the layout of the ART clinics in Kurnool, Medak and West Godavari are provided in the annex to this chapter (figures 3.3.2.2.1 – 3.3.2.2.3).

In spite of the improvements supported by BSY, the ART clinics in all three districts still have some bottlenecks that hamper patient flow. Waiting areas are simply not large enough to accommodate all those waiting, due to the high patient loads. The waiting time data

collection team also observed some instances of confidentiality not being maintained because of people waiting in areas where they could overhear medical staff.

However, FCMs and CVs reported many changes in relation to improvements in the infrastructure of the ART centres, such as less congestion than before, fewer patients waiting outside, rooms having been separated, a more easy flow to be followed by patients, symbol boards so that clients can easily recognize where to go, chairs placed in the waiting area, drinking water made available, and the creation of a child-friendly area.

> CV, VWCS, and Kurnool: "We observed many changes in the ART centre. Initially the ART centre was very congested and the patients used to sit outside the centre. After BSY, they separated the rooms, and made it convenient for the patients. Before patients were confused where to get the services, but now they are separated they are moving easily and accessing the services."
>
> FCM, Apple: "Now there are separate cabins for the counsellors, chairs, and they have arranged water facilities recently".

In relation to the child-friendly area, remarks were made that these were not being used everywhere:

> FCM, VWCS, Kurnool: "They created a child-friendly area in the ART centre, but because of no space they kept it in the CD4 lab. So it is not useful to the children. If there is more space for that, it will be useful for the children."

The FCMs and CVs also talked about the introduction of games to help explain how children should take their medicines.

ART clients provided some suggestions for further changes in infrastructure in relation to improving the quality of drinking water and including toilet facilities:

> ART client, West Godavari: "There is no good drinking water facility, as it gives off a bad smell, and there are no proper toilet facilities in the centre."
>
> ART client, Kurnool: "There are no toilet facilities in the ART centre."

The changes in the infrastructure of the ART clinics have resulted in improvements for ART clients, and also children. However, the high patient load is still causing bottlenecks. Advocating for more link ART clinics and, once they are there, motivating clients to make use of these link clinics could potentially remove many of these bottlenecks. This would also allow children to make use of the play area and reduce the chance of clients waiting in areas were they can overhear ART staff talking with other clients.

Role of Peer Care Coordinators in ART centres

Peer Care Coordinators (PCCs), all people living with HIV (PLHIV), based at the ART centres do not seem to play a role in providing information to new patients and making them more at ease. The PCCs interviewed in West Godavari, Kurnool and Medak said that they were interested in learning more about their roles and responsibilities. They are now mostly used to help with the registration process, including getting files from the filing cabinets. One PCC said in relation to this "I want to know how to mingle and attend to PLHIVs coming to the ART centre." Another PCC said "Being a PCC in the ART centre, I feel very proud." Ensuring that PCCs can be used to their full potential and work towards achieving similar client

satisfaction levels among new clients as those of follow-up clients would appear to be a useful next step for BSY.

3.3.2.3 Comments on ICTC and ART centres combined
Issues with treatment of FCM/CVs at ART centres/ICTCs
FCMs and CVs reported that they were not always treated with respect within the ART centres/ICTCs and felt that there was a communication gap between the staff and the FCMs and CVs. Addressing this communication gap between the centres and FCMs would seem to be needed.

> FCM, DLC: "When I take one LFU case to ART one counsellor treated me very badly as if they are not interested, why you (BSY) have so much of interest in them? Like that, they are treating FCMs."

For further quotes, please see the section related to this paragraph (3.3.2.3.1) in the annex related to this chapter.

Stigma and discrimination in the health facilities
Stigma and discrimination in health facilities was also brought up in focus group discussions (FGDs). Examples given were hospital staff discriminating against and shouting at HIV-positive pregnant women, and staff not willing to operate on PLHIV without bribes.

> CV, VWCS: "We are seeing some cases where hospital people discriminate against and shout at HIV-positive pregnant women. If we train an HIV-positive woman in the Nurse Course and have her attend to these pregnant women, it will be better."

The issue of stigma and discrimination was also prominent in a recent client satisfaction survey undertaken by CHAI in January–March 2010. Sixteen per cent of clients in West Godavari (n=90), 12 per cent in Medak (n=100) and 8 per cent in Kurnool (n=50) who participated in this survey reported to have faced abuse and/or stigma and discrimination at their ART centre. For more quotes, please see section 3.3.2.3.2 in the annex.

Coordination between BSY and facilities
Various respondents made reference to the positive impact of the Care coordination meetings. They were said to have resulted in staff from ART/ICTC/PPTCT centres having better understanding of BSY, and potentially improving access to services for BSY families.

> MO, Kurnool: "Yes, with all ICTCs, PPTCTs, NGOs we have monthly review meetings. Almost at the end of the month this is done. We talk, for example, about LFU."

3.3.3 Treatment cascade over time

3.3.3.1 Treatment cascades

IHHT
Treatment cascades have been constructed for all 1930 children in the IHHT sample using the same analysis framework as in the BSY Quarterly Reports. The graphs below show that HIV testing is similar in both groups (83% and 85% of eligible children in older and younger groups respectively), although registration (89% vs. 73%) and eligibility (36% vs. 13%) for ART is higher among the 9-16 group compared to the younger age group. The graphs also

show that 11 children eligible for ART (three children aged 0–8 and eight children aged 9–16) are not using ART.

Figure 3.5. Treatment cascade for children aged 0–8 years (IHHT)

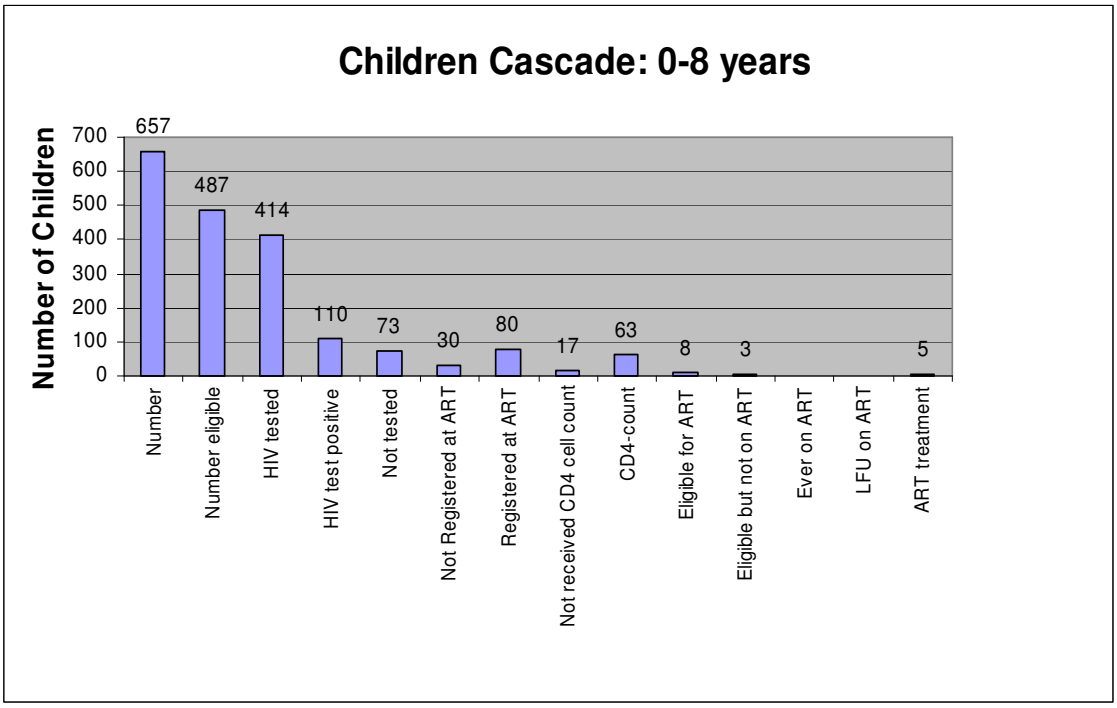
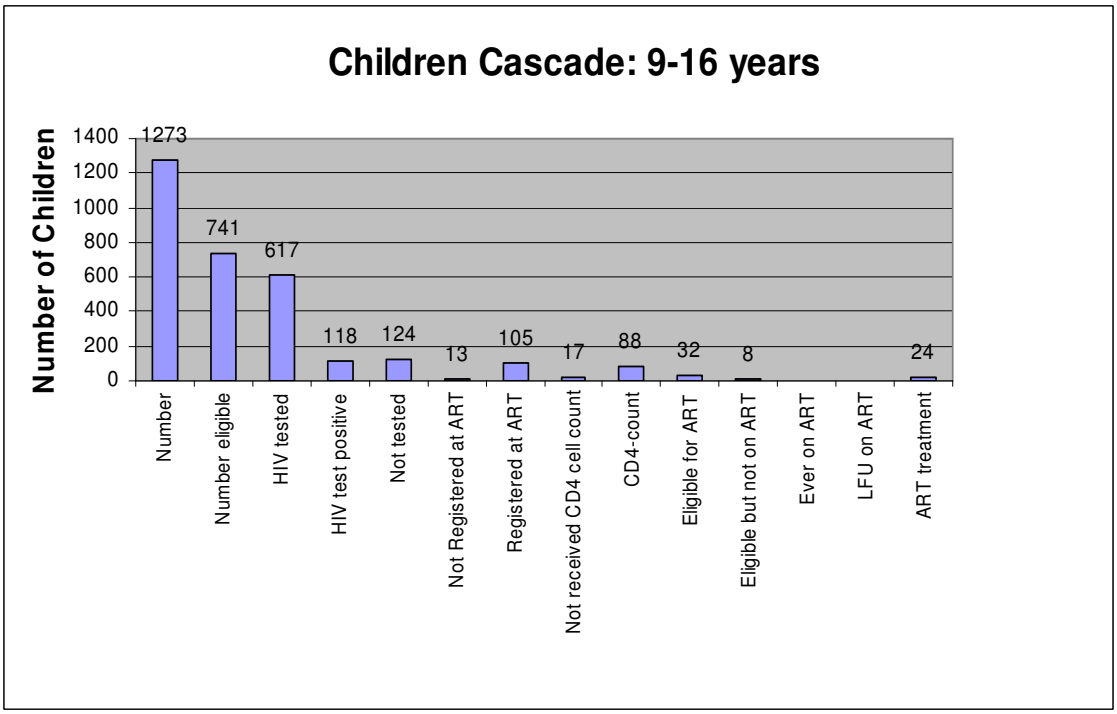


Figure 3.6. Treatment cascade for children aged 9–16 years (IHHT)



Criteria for eligibility
HIV testing: Children 0–8 years: age > 18 months + HIV status of mother is positive
Children 9–16 years: age < 14 years + HIV status of mother is positive
ART: CD4 count < 350
There were no data for 'ever on ART' or 'LFU on ART'.

Comparisons were made between treatment cascades of children who had been exposed to the BSY programme for less than a year and those who had been exposed for over a year. The comparison provided in the annex to this chapter (Table 3.3.3.1.1) shows that the number of HIV-positive children with CD4 count tests and on ART placements increases over time. For children aged 0–8 this increase was from 62 percent to 74 per cent, and for children aged 9–16 from 81 per cent to 89 per cent. The proportion of children on ART increased among those aged 0-8 years from 8 per cent to 23 percent, but for children aged 9–16 the numbers remained the same (45%). This concurs with the MIS findings, which also show higher numbers of children among those registered with BSY for a longer period of time having CD4 cell counts available and being placed on treatment.

When comparing the IHHT figures with the MIS data for the full BSY programme, based on BSY eligibility criteria, the % of children tested for HIV is higher in the IHHT (84% for all ages combined) than in the MIS data (60% of all ages combined). While ART registration data (80% of those testing positive of the IHHT data versus 81% of the MIS data) was similar between the two data sets, the % of children eligible for ART is considerable higher in the general MIS data set (47%) versus children in the IHHT (26%). See table 3.3.3.1.2 in the annex for details.

Treatment cascade and enrolment
FCMs and CVs remarked that identifying new cases is a challenging task:

CV from DLC: "For identifying new cases, even when we or FCMs or counsellors go for accepting our services, households are not always agreeing. Sometimes households migrate after a visit because of fear of identification."

> CV, VWCS: "There are a few stubborn cases where they even use some bad words and ask us not visit their houses again. In identifying the new cases, we are facing many troubles like the households scold the CVs etc."

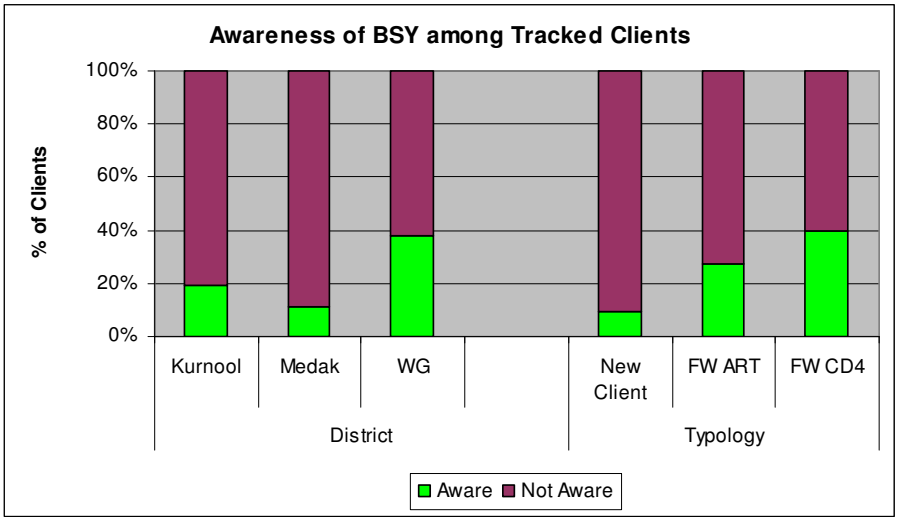
Stigma is also playing a role in enrolment in BSY:

> FCM, VWCS: "I have observed more poor people showing interest towards registration in the programme, some middle-class families say we are living in a joint family, there is a stigma problem so don't come to my home without informing me before. Then I feel very sorry on that day because I think that I have disturbed them. Sometimes their phones will not work and numbers may change. If there is an unwilling family it is very difficult for us to mobilize them. Nothing is easy."

The figure below shows the level of awareness of BSY among the clients tracked during the waiting time analysis. Only those clients who were eligible for enrolment in BSY (ART clients with children below 18 years (the children did not have to be present) or children visiting the clinic independently) were included. Probing around different names (i.e. name of a FCM, name of the Clinton health facility coordinator, name of the TAP involved, name of the FHI regional coordinator, etc) took place to avoid that people who had been in contact with BSY but were just not familiar with the BSY brand would fall into the category of people not being aware of BSY. New ART clients were less aware of BSY than CD4 count follow-up or ART follow-up clients. In West Godavari close to 40 per cent of the 430 clients tracked in the ART centre said they had heard of BSY. Twenty per cent of 260 clients tracked in Kurnool and 10 per cent of 115 clients in Medak were aware of BSY. The differences between the districts are not surprising, as BSY has been rolled out longest in West Godavari and shortest in Medak. The figures imply that there is a lot of room for expanding BSY

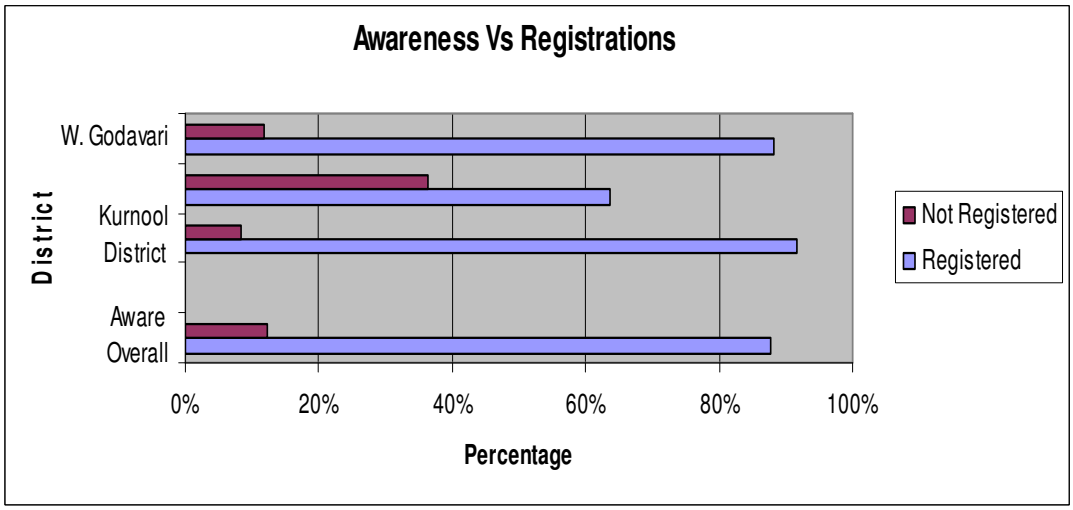
registration in all districts. This is especially true for districts such as West Godavari and Guntur in which the programme is rolled out to cover all mandals.

Figure 3.7. Awareness of BSY among tracked clients



As the figure below shows, 90 per cent of people who had heard about BSY had registered for the programme. A higher percentage of people who knew of BSY had not registered in Medak than in the other two districts. This is likely to be because roll-out of BSY in Medak had only just started.

Figure 3.8. Registration levels with BSY of those having heard about the BSY programme



Not many of the 10 per cent of the people who had heard of BSY but had not registered shared their reasons for not doing so. The few that responded to this question (19 in West Godavari, four in Kurnool and three in Medak) mainly mentioned reasons related to stigma and discrimination. For a breakdown of the reasons, please see Table 3.3.3.1.3 in the annex.

Treatment cascade and HIV tests

While 70–81 per cent of children in the IHHT were tested for HIV, BSY MIS data (please see Figure 3.3.3.1.1.in the annex) show that 46 per cent of all children in West Godavari had been tested and that testing results varied by district.

FCMs remarked that mobilizing parents to take their children for an HIV test is not always easy. Reasons provided for this were: parents not ready to receive bad news, parents not wanting to reveal their own status to their children, and parents being afraid that their children would become depressed when they learn they are HIV-positive. However, FCMs also indicated that it has gradually become easier.

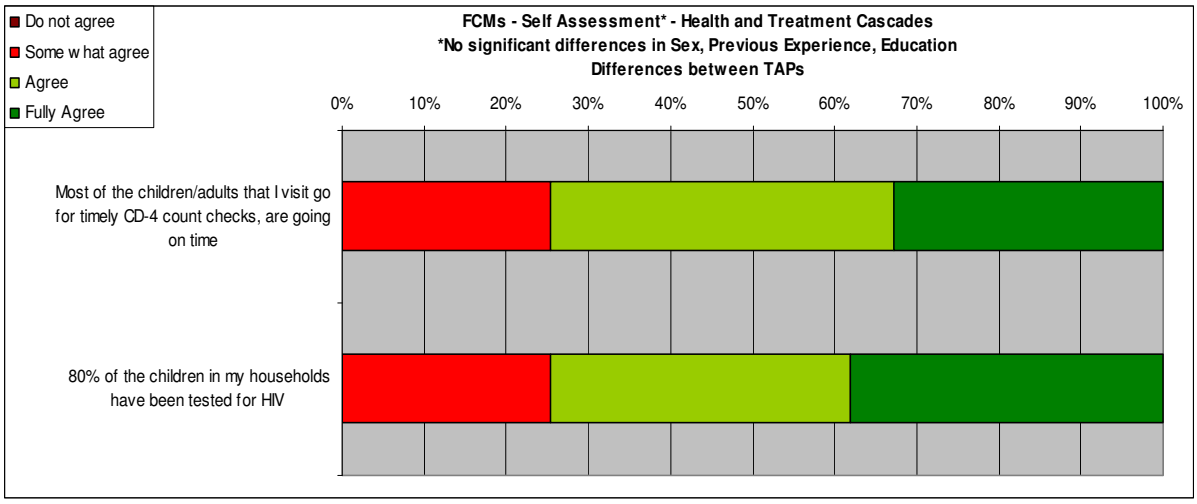
FCMs and CVs all confirmed that mobilizing children for HIV testing is an important component of their job:

> FCM, VWCS: "Earlier even though the husband is positive, the wife was not tested. But in BSY, if the husband is positive, we are asking and taking the wife for testing. If the wife is tested and it is positive, we are taking their children for testing. If they are infected, we are immediately going for CD4 testing. If they are eligible for ART, we are motivating them to start the ART drugs."

For more quotes, please see 3.3.3.1.1 Quotes in the annex.

The large majority of the 55 FCMs from West Godavari and Kurnool who completed the self-assessment questionnaire indicated that they believed that 80 per cent of the children in their households had been tested for HIV (see figure below). This concurs with the finding that 81 per cent of the children in the IHHT had had an HIV test. The DLC FCMs seemed more confident that 80 per cent of children in their households had been tested than FCMs from Apple and VWCS.

Figure 3.9. FCMs self-assessment – health and treatment cascades



BSY's strong focus on children compared to most other programmes and its outreach strength in the form of FCMs and CVs has contributed to an increase in the number of children being tested for HIV and thus has potentially contributed to reducing morbidity and mortality among HIV-positive children.

Treatment cascade and CD4 count and ART

BSY MIS data showed that of the 2409 children who tested HIV-positive, 75 per cent had had a CD4 count. This is lower than the 86 per cent of the 9–16 years age group and 77 per cent in the 0–8 years age group in the IHHT sample.

FCMs and CVs said they had observed an increase in pre-ART registration:

> FCM, VWCS, Kurnool: "If you see the ratio before 4 months back to now, the serial number was 2400 four months ago and now it is 6000 in pre-ART registration".

Ensuring that BSY families go for regular CD4 count tests also presents challenges for FCMs and CVs. While there are many ICTCs nearby where HIV tests can be done, CD4 count tests can only be done at the district headquarters. Some parents do not have the time or resources to travel regularly with their children to the district headquarters. FCMs said that they sometimes take the children instead; however, they also mentioned that their travel allowance has been reduced, which makes this harder for them.

CV, VWCS: "In one case, parents were dead because of AIDS, and the children were staying with the grandmother; child was suffering from skin infection and some wounds on the body. After getting the referral from the ICTC centre, we visited the house and spoken to the grandmother. She told us that the children were tested and she had shown the reports: one is positive and one is negative. Later I had asked about the CD4 count, and she told me that she doesn't know about the tests, but the child is not well; she was even unable to walk and stopped going to school. Then we took the child for a CD4 test and got the child tested; now the child is healthy.

The ART centre in West Godavari acknowledged BSY's contribution to an increase in ART registration. However, this was not the case in Kurnool and Medak, where BSY roll-out has been shorter. According to a West Godavari ART representative "When they are going to the field, they are bringing children and getting registered here." This points to the fact that the efforts made by FCMs and CVs to mobilize BSY households members to go for ART registration is not always visible within the health facilities.

Treatment cascade and ART

FCMs and CVs also play a role once BSY adults and children are on ART. They provide advice on side effects, especially for those just starting on ART, or bring in the BSY counsellors for counselling sessions (please see Section 3.3.3.1.3 in the annex for quotes). They also check adherence to ART. Some children were found to have problems with taking ARVs because of their taste. As parents and/or care-givers are not always able to follow up, this can lead to adherence

CV, VWCS: "A child called Harishitha, in Ramannathota, she is using the ARV from the last two years, and she takes 5 tablets for 2 times @ 2 ½ at one time, when I went for follow-up to that house, I asked her to bring the medicine box, while bringing it she removed cotton from the box and poured half of the tablets in the box aside, and then she brought the half box and showed it to me. This was observed by me, and I asked the child about this. She told me that the medicines are bitter in taste. Also I have observed that the child was becoming weak compared to before. Then I explained about the importance of medicines to the child. The same thing I have explained to the project coordinator, who is now supporting the family with Rs.75/- monthly. I asked the mother to buy some fruits or anything that the child likes; now they are doing that, and the child is using the

problems with children. Finding ways to make it easier for children to take ARVs, to avoid adherence problems, would seem to be important – especially when care-providers are not always around when children have to take their ARVs.

Treatment cascade and loss to follow-up

Of the three ART MOs interviewed, one said that the fact that FCMs accompany the clients to the ART centres has helped reduce drop-out: "They have also helped with providing follow-up to missing patients." While the other two were specifically asked about the role of BSY, they did not confirm BSY's contribution in relation to this. FCMs and CVs in West Godavari and Kurnool indicated that ART staff approach BSY whenever there is LFU related to children. At the request of the evaluation team, BSY partners tried to obtain data in relation to LFU in BSY versus non-BSY districts, but in spite of various attempts, this did not yield usable data. At this point in time it is therefore not possible to draw a conclusion whether there is less LFU in BSY versus non-BSY districts. Effort will be made to obtain this data for the next evaluation round.

Changes in the registration process in ART clinics were also reported. Clients are now asked to show ration cards or proof of identity so that follow-up on people lost to follow-up can be more easily tracked. However, not all FCMs and CVs find it easy to motivate people to go back on treatment. According to a CV in Kurnool, "Follow-up is also very difficult. There are children on ARV who do not take their medicines regularly. To make them use medicines regularly, it requires more time to spend with these children." Special LFU training focused on children could, therefore, be considered.

> CV, VWCS, Kurnool: "In Godadhanigiri, a 5-year-old child was infected and on ARVs. After the death of the child's parents, the child was staying with her grandmother. As the grandmother didn't know about the medicines, she stopped the child using the medicines. Later I got that case as LFU in ART centre. When I went for follow-up to that house, the grandmother said that she was suffering with chickengunya, and no other person is there to bring those medicines from the ART centre. Even after many follow-up visits by us counsellors, still

Community Care Centre (CCC) outreach workers also commented that it was difficult to identify LFU:

> CCC outreach worker, West Godavari: "LFU address is very difficult to identify. Each CCC outreach worker is in charge of four mandals."

CCC outreach workers from Kurnool also commented on BSY's role in LFU:

> "Previously for every three months the numbers of LFU are more, but from the last six months the number of LFUs is reduced. Ninety-nine per cent of LFU cases are reducing because of BSY FCM follow-up."

The fear of stigma and discrimination was said to be one of the causes of LFU. All three ART medical doctors interviewed in West Godavari, Kurnool and Medak mentioned that fear of stigma and discrimination – besides the distance patients needed to travel – was a major reason for people dropping out of the programme.

> FCM, VWCS: "I have a case where the parents worried that if the neighbours come to know about the child's status, they will separate the child and not allow the child in their houses. All the relatives of the client stay in the same area. From the last one

and half years, the child and parents are not visiting the ART centre and not going for CD4 test. I have observed that the child's health is decreasing day by day. I have tried many times to convince them, but I have not yet provided counselling services to that family."

Besides addressing stigma and discrimination to reduce LFU, misconceptions will also need to be addressed. Some care-givers, for instance, did not understand the need to continue ART once the child's health has improved. Orientation for these care-givers seems essential both through the counsellors in the ART clinics as well as through the FCMs and CVs during home visits.

3.4. Quality of care related to psychosocial well-being

3.4.1 Psychosocial support provided and QoL

The Hope Pathway score was higher for children aged 9–16 years who lived in households where psychosocial services were provided by BSY. Psychosocial services were defined as LSE provided or counselling from FCMs, CVs or BSY counsellors. The meaning of this higher score is that the children have a higher practical sense of how to achieve their goals than Table 3.4.1.1 in the annex.

3.4.2 Disclosure

The IHHT data (please see Tables 3.4.2.1 and 3.4.2.2 in annex) show that parents and or care-providers talk very little with their children about HIV, if at all. Close to 60 per cent of the children aged 9–16 said they had not talked about HIV at all in the last month with somebody in the family. One out of four children aged 9–16 said they were worried about other people talking about their family in relation to HIV. A further 42 per cent of the children of the same age category also indicated not knowing whether they were worried about this or not. Experiences while interviewing children and care-providers showed that talking about HIV is considered to be a very sensitive issue, and quite a few care-providers mentioned that their children were not aware that someone within their family was infected with HIV. All this may explain why so many children and parents indicated not knowing whether they or their child worried about other people finding out that their family had been affected by HIV.

Interestingly, 81 per cent of children aged 9–16 years said that they did not talk with anybody outside of the family openly about HIV or did not know whether they did so in the last month. This corroborates the information provided by FCMs and CVs that they do not talk about HIV specifically with children during their home visits, other than during LSE sessions. However, no clear differences in the disclosure data for children exposed to LSE versus those not exposed to LSE were found (see Tables 3.4.2.3 and 3.4.2.4.in the annex). This could point to the fact that disclosure issues are not so much looked into within LSE. At the same time, there seem to be high unmet psychosocial needs of children:

> FCM, VWCS: "Affected children always worry about their infected parents; they think that their parents cannot work properly, and they worry about their family situation. Infected children always worry about their health and face many health problems and not only that, they have to go for CD4 testing, they have problems with using the medicines, few children avoid them while playing etc."

Strengthening the capacity of FCMs, CVs and BSY counsellors to talk about HIV and the personal worries that children, including the younger ones, may have would seem to be

quite critical – especially as the scope for improvement in terms of disclosure is considerable, since low average scores were achieved.

3.4.3 Life skills education

In all FGDs the issue of LSE was frequently brought up. Supervisors, counsellors, FCMs and CVs all stressed that LSE is important because of its focus on children:

> Apple supervisors: "LSE training is important because LSE is a child-focused activity."
>
> Apple counsellors: "We require training once more on LSE as refresher training. If we get more clarity on this, we can work more with children. Then we will learn how to deal better with children."

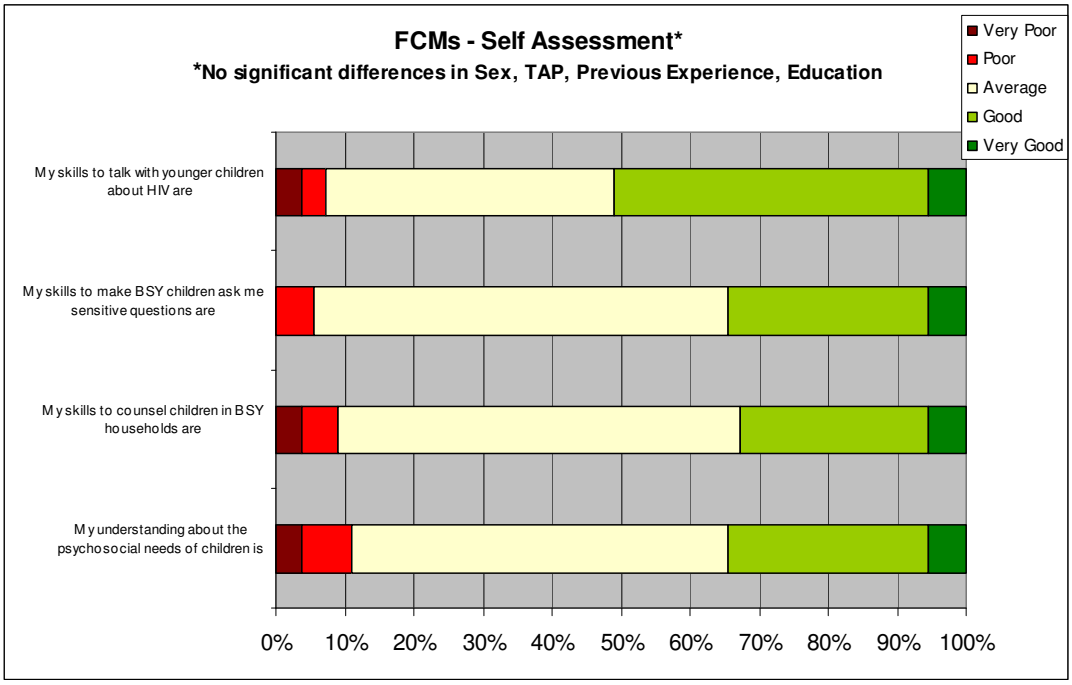
Most of the FCMs and CVs also indicated that LSE helped them to establish better relationships with the children and that they observed quite some change in the behaviour of children as a result of LSE sessions. However, some FCMs also mentioned that it was hard to implement LSE when families are scattered over different communities, although there have been attempts to overcome this barrier, such as by gathering all children in one place and spending a full day on LSE (for more quotes, please see Section 3.4.3 on LSE).

Working out strategies that allow these LSE sessions to continue would seem to be important – especially as it is one of the few tools through which FCMs and CVs directly interact with children to address their many unmet psychosocial needs.

3.4.4 FCMs – skills to talk with children and understand their psychosocial needs

As the graph below shows, of the 55 FCMs from West Godavari and Kurnool who completed the self-assessment questionnaires, approximately half said they had very good or good skills to talk about HIV with younger children. Around 45 per cent said they had average skills, and 5 per cent said they had poor or very poor skills. The majority of the FCM said they had average skills to make BSY children ask them sensitive questions or to understand the psychosocial needs of children. No differences in scores across technical assistance partners (TAPs) were found. Neither were there any differences in sex, previous experience and education. Strengthening the capacity of FCMs and CVs in this regard would seem important.

Figure 3.10. FCMs self-assessment



3.4.5 FCMs – counselling and communication skills

The 55 FCMs from West Godavari and Kurnool scored their communication skills higher than their counselling skills. Over 80 per cent said that they knew what to do the last five times they saw a child being depressed, and over 50 per cent indicated that they did not involve a counsellor from the TAP when dealing with difficult situations. The majority of FCMs also believed that BSY households were telling them their personal worries (please see Figure 3.4.5 in the annex).

During the FGDs two reasons were provided why FCMs and CVs find it hard to counsel children. Firstly, they have less interaction with children, and, secondly, they had not received any training on how to provide psychosocial support to children.

> FCM, DLC: "BSY is for children, but we do not know how far we are doing justice to them. Because children are not available in the daytime due to schooling, we are not able to cover children (with LSE) in the field except in the summer vacations."
>
> FCM, VWCS: "Even though there are counsellors for counselling, sometimes during the house visit, we suddenly need counselling support for families. It may not be possible for the counsellor to suddenly come. At that time, we are able to counsel the adults but not the children."

Across the board, there was agreement that FCMs and CVs would benefit from counselling training, but TAP counsellors also indicated the need for further training on how to counsel children to deal with grief.

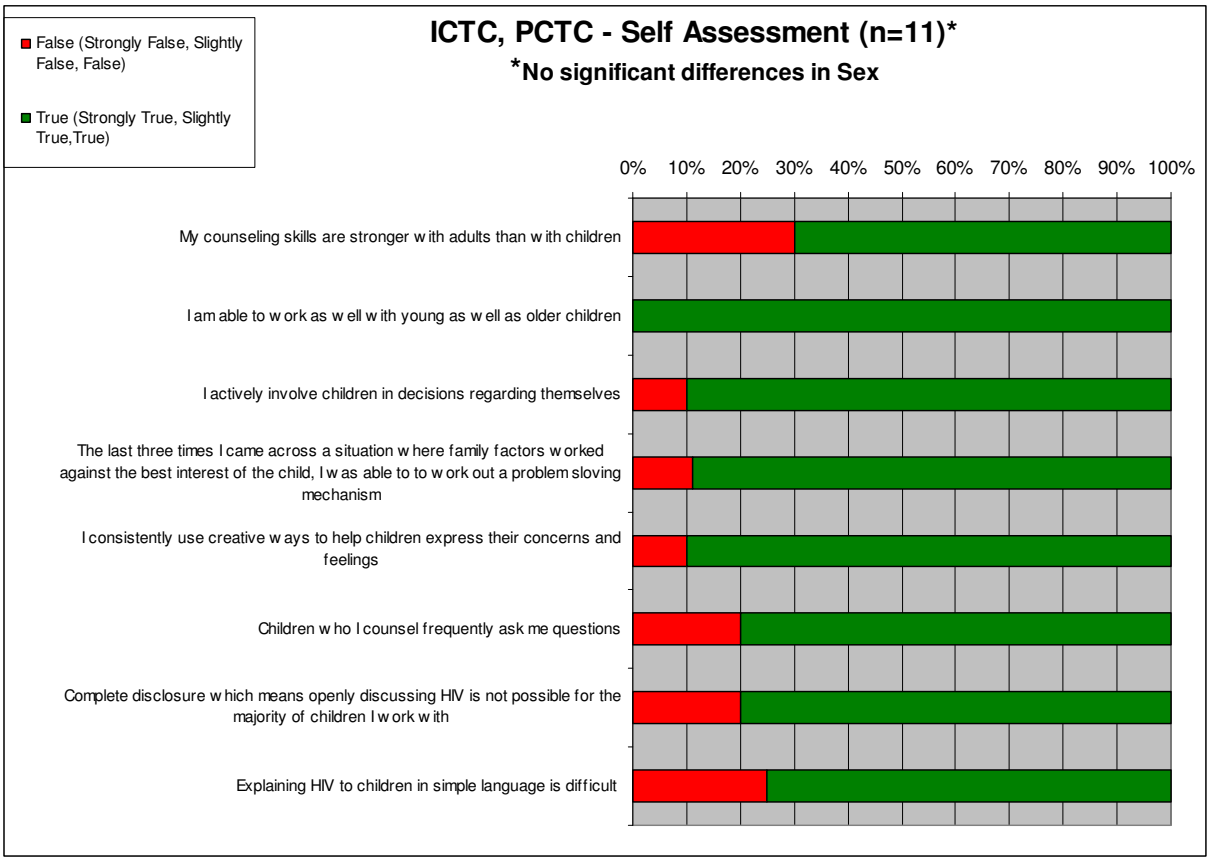
Providing training on child counselling and strategies to increase the interaction between BSY outreach staff and children would seem to be key to improve upon this area – especially as psychosocial support is not a one-off activity but a process and because the counselling during outreach work complements the very brief counselling provided in the ICTC and ART centres.

3.4.6 Skills of health care service providers to counsel children

The figure below shows the result of the self-assessment questionnaire completed by five male and six female ICTC/PPTCT counselors. Six of them responded that explaining HIV to children in simple language is difficult. The self-assessments were quite positive, and no significant differences between males and females were found. Interviews with 10 ICTC/PPTCT counselors were also conducted. Three of the 10 counselors interviewed had received training from BSY on child counselling. However, two of those three said that they did not have time to counsel children or adults, since they have very little time to interact with clients. The third counsellor, however, did report having changed as a result of the training:

> "After receiving training from the BSY programme, I am spending more time with children. Because of this, children are actively responding to our questions".

Figure 3.11. ICTC/PCTC self-assessment



Refocusing the paediatric counselling training provided by BSY would seem to be advisable so that counselors could put the learning into action. Furthermore, expansion of the training to a larger number of ICTC/PPTCT counselors (as well as to ART and CCC centre) counselors could possibly be considered.

3.4.7 Time spent on counselling in ART centres

The waiting time analysis showed that counsellors spent close to 6.5 minutes with new clients and less than two minutes per client on average (please see Figure 3.4.7 in the annex). However, some of those two minutes are also used for administrative purposes.

> ART MO: "We have a high patient load, so we are unable to provide much time for the patients. At the same time counsellors are made to fill the Sahara card which is an ID card for patients who are on ART. Sometimes counsellors also have to fill in feedback forms and referrals forms. So more time is spent on writing than on counselling. So if this writing work could be shared with other persons, then they can spend time in counselling. Of course counselling is going on, but 100 per cent satisfaction might not be there."
>
> ART client, West Godavari: "We need good counselling. As the counsellor is busy with the high client flow, he is not spending more time and at the same time we are not able to share more things with the counsellor."
>
> TAP counsellors, VWCS: "the ART centre is also carrying out counselling for patients. But there are a lot of patients, and they cannot give 100 per cent attention. In this

situation we are carrying out house visits, and counselling will help them to a great extent. This has helped to reduce LFU in the area."

Counselling and psychosocial support
Appropriate counselling is ultimately the responsibility of the paediatrician and the ART center staff. The counseling task can be delegated to counsellors, and must make sure that the psychosocial issues have been dealt with appropriately.

If the child is infected, the parent or the care giver must be told what to expect with regard to the health of the child, and how to take care of the child. Counselling and psychosocial support is the cornerstone of the management of HIV infected or affected families (*See section A10 for counselling support in Children*)

– NACO and IAP (2006) *Guidelines for HIV Care and Treatment in Infants and Children*

The NACO and IAP guidelines (see box above) indicate that providing appropriate counselling at the ART clinics is both the responsibility of the paediatrician and the ART Centre staff. The findings from this first round of evaluation indicate that there is much room for improvement of this counselling. BSY could possibly assist ART centres with reviewing the tasks of the counsellors to see how they could concentrate on their core tasks, namely that of counselling, which could help with improving the quality of counselling within the ART centres. Providing them with paediatric counselling training might also be considered.

3.4.8 FCMs and CVs living with HIV, and psychosocial support

The fact that quite a number of CVs but also of FCMs are living with HIV also contributes to improved psychosocial well-being of PLHIV:

> CV, VWCS: "Even before I don't have hope in my life, but after joining as a CV, I realized that there are many people like me, then I thought why worry and sit at home? So I came out and want to make people confident like me."

However, it was also mentioned that also for quite a number of HIV-positive BSY staff, talking openly about their HIV status remains a very sensitive issue. Despite this, sharing their HIV status with BSY community members could possibly make a positive contribution to reducing stigma and discrimination within the community.

3.4.9 Psychosocial support and stigma

CV, DLC: "Most of the people are not dying because of HIV infection. They are dying because of treatment by their neighbours or discrimination only. But we are allowed to visit them. Why? Because when we go, we call

3.4.9.1 Quality of life and community sensitization

Hope Agency and Path scores for adults in the IHHT were higher for households where community-based initiatives had been provided. Therefore, adults who had been involved in such community-based initiatives had a feeling of being more effective and knew better how to work out problems practically than those who did not. The same did not apply for the children in the IHHT. Please see Tables 3.4.9.1.1 and 3.4.9.1.2 in the annex.

3.4.9.2 Stigma and community sensitization activities

The FCMs and CVs brought up a lot of issues on stigma within the FGDs. While they said that stigma and discrimination was generally stronger before, they also said that it was still quite present.

They had also noticed changes in behaviour of neighbours, house owners, women's groups (inviting PLHIV to join), Anganwadi teaches and children infected with or affected by HIV.

> CV, VWCS: "I have seen a change in my field area where 13 to 14-year-olds are not shy or ashamed of their problem even though neighbours gossip about their parents' illness and death situation."

However, there are still many issues with stigma in the communities:

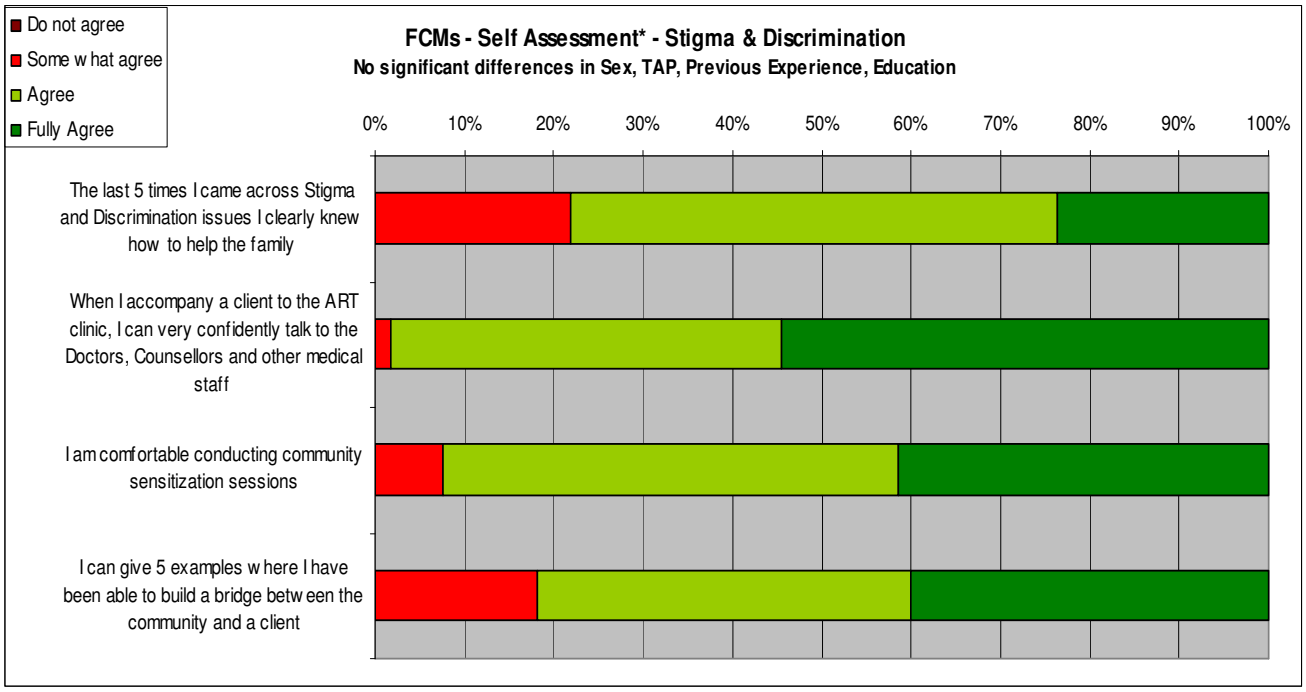
> FCM, VWCS: "We conduct these types of meetings in the communities, and the public will listen nicely in the meetings and after the meetings they observe us carefully to see which house we are going into; they bear in mind that we are working in that area, and then they think that the house which we are visiting has the same problem. Community members are also still thinking like this."

For more quotes, please see Section 3.3.9.2 in the annex on community sensitization activities.

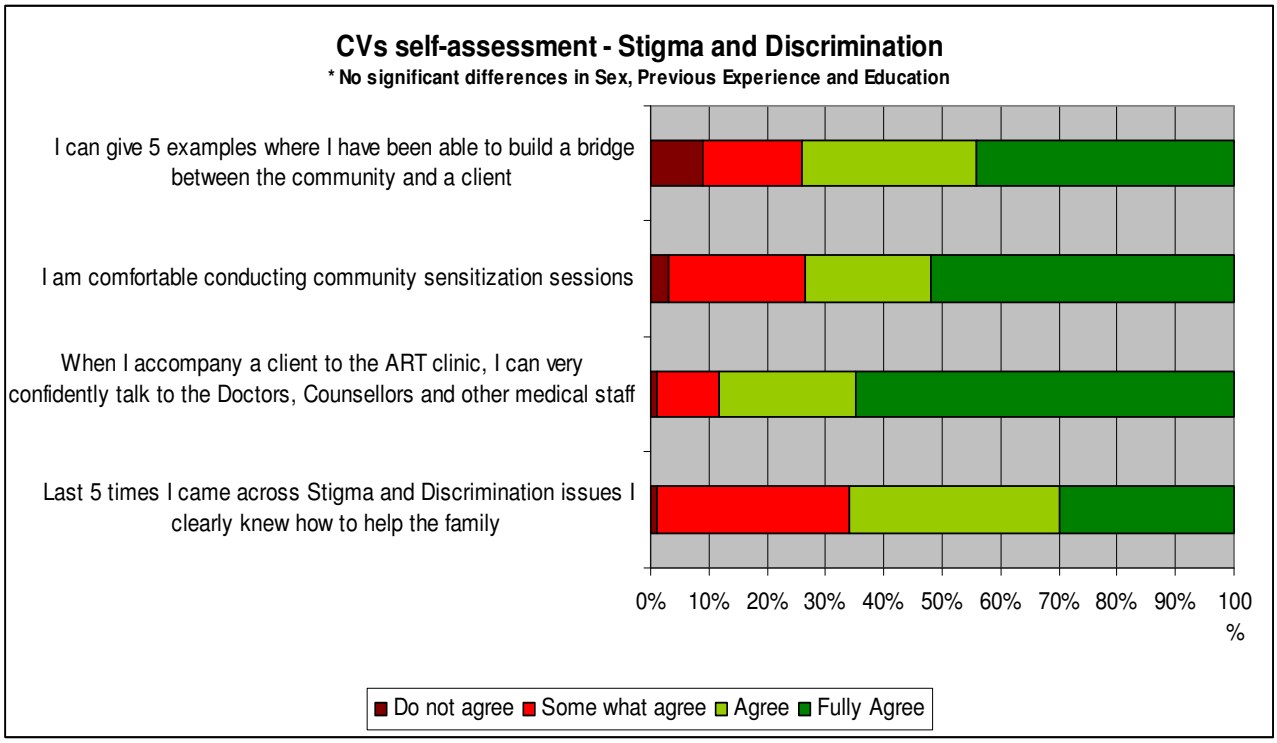
3.4.9.3 Skills of FCMs and CVs to handle stigma and discrimination

The figure below provides data on how well-equipped the 55 FCMs and 102 CVs who completed the self-assessment questionnaires consider themselves to handle stigma and discrimination issues.

Figure 3.12. FCMs self-assessment – stigma and discrimination



3.13. CVs self-assessment – stigma and discrimination



The 55 FCMs were found to be more comfortable than the 102 CVs with handling stigma and discrimination issues. Over 90 per cent of FCMs are comfortable with conducting community sensitization meetings, and close to 80 per cent feel that they are able to build bridges between the community and BSY families. However, one in five FCMs also said that they did not always know how to help families or how to build such bridges. The skill sets of CVs from different TAPs varied. TAP supervisors also talked about the changes seen in FCMs:

> "Earlier, FCMs did not have enough confidence in themselves and were scared when approaching community members. But now they are able to handle the community much better."

Supervisors from DLC talked about the difference in training received from elsewhere versus that of BSY training. The training from elsewhere focused more on the basics and the spread of HIV, while the BSY training also covered psychosocial issues related to PLHIV.

> DLC supervisor: "Now I have got enough confidence to handle community members, leaders and officials. It has given me so much confidence and courage to handle any situation."

The Hope Agency and Pathway Scales for adults indicate that community sensitization activities are contributing to a reduction in stigma and discrimination in communities. However, further training on how to strengthen the skills of FCMs and CVs to conduct community sensitization activities on a regular basis and in various forms could help to further reduce stigma and discrimination within the communities.

3.5. Quality of care related to education

3.5.1 Children having dropped out of school – IHHT sample, percentages and reasons for dropping out

Data on school attendance were available for 1272 children aged 9–16 years. Of these, 1079 (85%) attended school, while 193 (15%) did not.

The table below compares the school drop-out rates of children in the IHHT sample, BSY MIS data and Assessment Survey Evaluation Research (ASER) data on school drop-out of children in Andhra Pradesh in general. The percentage of BSY children out of school within the age group up to 14 years is higher than that of children in the overall population in Andhra Pradesh.

Table 3.5. Comparison of school drop-out rates

Source	Age group	In school	School drop-out
IHHT – West Godavari (n =1133)	9–14 yr	87%	13%
BSY QPR June 2009 – BSY districts	6–14 yr	89%	11%
ASER – Andhra Pradesh	6–14 yr		6.2%
IHHT – West Godavari (n =93)	15–16 yr	58%	42%
BSY QPR June 2009 – BSY districts	15–18 yr	44%	56%

Of the 83 children in the IHHT sample who provided reasons for dropping out of school, 52 per cent stated economic reasons (please see Table 3.5.1.1 in the annex). This reason was also brought up in the FGDs with FCMs and CVs. FCMs and CVs mentioned that school drop-out rates had been reduced over time. FCMs and CVs mentioned that some children who had been working were now enrolled in school or hostels again as a result of BSY. The role play, however, demonstrated resistance from parents to send their children to hostels, as this is seen as the last resort. FCMs talked about having been able to convince families to switch their children from private schools to government schools rather than dropping out of school, and having assisted children of families who had migrated to get the certificates from previous schools for enrolment purposes.

It was stressed in all FGDs that regular follow-up has really contributed to this reduction in school drop-out. The longer a child has been out of school, the harder it is to get him or her back into school. LSE was also mentioned as an important motivator for school attendance:

> CV, VWCS: "Through LSE also we are motivating the children towards education; we are conducting some games, drawings and distributing some gifts for the winners to motivate and create interest in them."

BSY FCMs and CVs demonstrated in the role plays that they very much focus on education during outreach work and that headway seems to have been made in reducing school drop-out.

> CV, VWCS: "In our area, a child was not going to school for the last three years because of fever; he went to a hospital and was admitted there for one month in a children's hospital. Later the doctor suspected the boy and he got the child for HIV and CD4 test. The child's CD4 was 134. After joining BSY, with our follow-up for ART and TB, the child's CD4 count was increased up to around 501, and after three years, he rejoined the school. The boy is 10 years old and

The IHHT data were further analysed to see whether a higher percentage of children who had been exposed to the BSY programme for more than a year were still in school versus those who had been exposed to BSY for less than one year. No statistically significant differences could be found for these groups. Also no significant differences were found in terms of school drop-out rates of children living with HIV versus those affected by HIV. For more details, please see Tables 3.5.1.2 to 3.5.1.5 in the annex.

Experience from around the world shows that education, especially for girls, is one of the most effective strategies to improve QoL. Further work on reducing school drop-out rates seems to be essential. Also keeping track of the number of children the FCMs and CVs have successfully been able to re-register in schools would be recommendable.

3.5.2 School attendance and behaviour

Table 3.5.2.1 in the annex shows that among the children aged 9–16 in the IHHT, Education received the lowest QoL outcome score of all the domains (85.5%). Among the same age group, the QoL outcome score of children living with HIV was the lowest found in the entire survey (79.3%). This means that education is one of the areas where BSY has most room to improve the QoL of the children aged 9–16 in the sample.

Data on current school/Anganwadi attendance and behaviour are provided in Tables 3.5.2.2 and 3.5.2.3 the annex. Of the children aged 9–16 years still in school, 91 per cent had attended school all or most of the time in the last month, and 71 per cent had not missed school in the last month because of visits to medical facilities for themselves, against 75 per cent of the younger age group. Missing school because of illness of care-givers or because of visits of care-givers to medical facilities is not uncommon: 14 per cent of children aged 9–16 and 28 per cent of those below the age of 9 had missed school for that reason. An FCM from VWCS raised the issue of the education of children living with HIV:

> "Infected children don't always like to go to school, when they are not well and healthy. Even if we send them to school with great difficulty they won't study properly and not participate actively in any activity."
>
> CV, Apple: "Education of infected and affected children will be the same, but infected children will lose some days due to being weak."

The issue of stigma and discrimination in schools featured in all six role plays, even though the issue was not referred to in the background notes for the role play characters. A table providing an overview of what was said in each of these six role plays in relation to stigma and discrimination is included in Section 3.5.2 in the annex.

How can this issue best be addressed? An APSACS representative indicated that the issue of admission of children living with HIV to school had been addressed in the steering committee. The steering committee had decided that bridging schools for children who had been denied access to regular schools should be set up, in line with a government order on this. However, this does not address the issue of stigma and discrimination in regular schools.

3.6. Quality of nutritional care

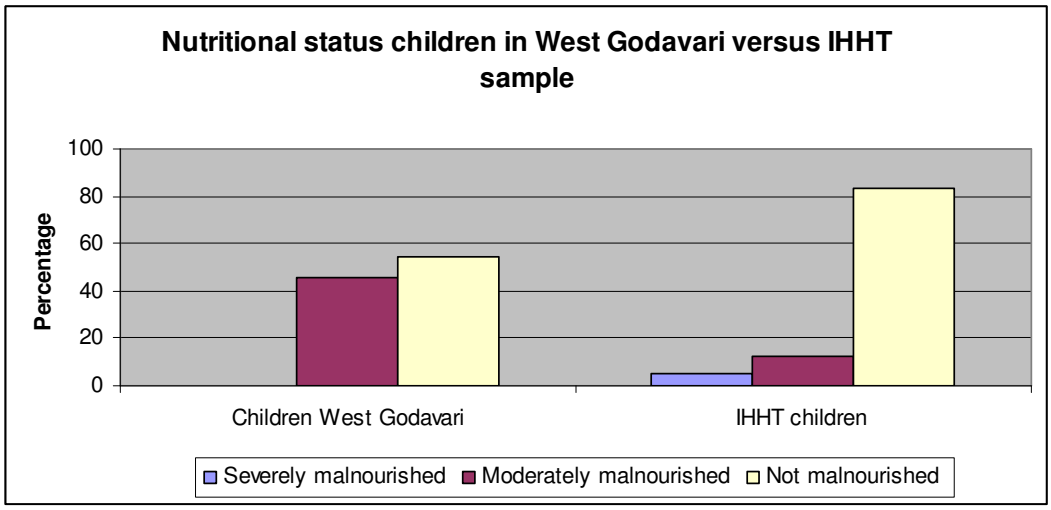
3.6.1 Changes in nutritional status of children aged 0–5 years

The IHHT sample contained 192 children aged 0–5 years from whom MUAC data were obtained. The MUAC data showed that nine children (4.7% of the total) were severely malnourished, 24

(12.5%) were moderately malnourished, and the remaining 159 children (82.8%) were not malnourished. Comparison was made between those enrolled in the BSY programme for longer than one year versus those for less than one year. However, the sample size of the severely malnourished and the moderately malnourished children was too small for this. No statistically significant difference in terms of exposure to BSY could be found between those not malnourished (see Table 3.6.1.1 in the annex). Analysis of nutritional status for children infected with HIV versus children affected by HIV was also done for 141 children aged 0–5 years. Due to the small sample size for the severely and moderately malnourished children, it is hard to draw any conclusions (see Table 3.6.1.2 in the annex).

Table 3.6.1.3 in the annex shows that care-givers of children aged 0–8 years who mentioned that they had received nutritional support from BSY during household visits had significantly higher Pathways and Agency scores than those who did not. No differences in MUAC and BMI scores of their children were found, however.

Figure 3.14. Nutritional status in West Godavari versus IHHT



Sources: IHHT n=194 – data collected between October and December 2010
West Godavari General – www.anganwadi.ap.nic.in n=238,546 (March 2010)

When comparing the nutritional status of children in the IHHT sample (consisting of children infected with or affected by HIV) with data from Anganwadi centres (mainstream children, including children infected with or affected by HIV), children in the IHHT sample are generally better off although the percentage of severely malnourished children is higher in the IHHT sample than in the Anganwadi centres sample. The data from the Angawadi centres and the IHHT are not directly comparable, but provide an indication that there is a possibility that the BSY programme reduces the number of children in the moderately malnourished category. To draw any conclusions, further analysis would be needed as seasonal trends in food insecurity may have affected the data, as the IHHT data were collected in October to December 2009 while the Anganwadi data are from early 2010 (see Figure 3.6.7 in the annex).

3.6.2 Changes in access to food-related government services

3.6.2.1 Nutrition in ART centres

A pilot is ongoing in some of the districts to supply nutrition at the ART centres. Comments were made that the

FCM, Apple: "Infected and affected children are living together in a family. The elder child is infected and her age is 11 years, and now her weight has increased up to seven kilogram's because of our nutrition and ART medicine. We used to tell the nutritionist, and they told us 'please do not take all items at a

taste and texture in which the nutrition is provided has improved over time:

> CV, VWCS: "Last December, they changed the nutrition food; households now are sharing that the taste of the food is like Ceralac, Horlics and that children are taking it easily."

The ART MO from Kurnool remarked that the nutrition provided had helped to increase adherence to ART in children, so rolling out the nutrition component in other ART centres would seem worthwhile. "Recently they launched a nutrition programme that is running at our ART centre. Children are coming regularly for the food and are taking monthly medicine also simultaneously. There is some improvement in adherence compared to before."

However, at the time of the FCM FGD in West Godavari this pilot had not yet been implemented in that district. An FCM from DLC, therefore, remarked:

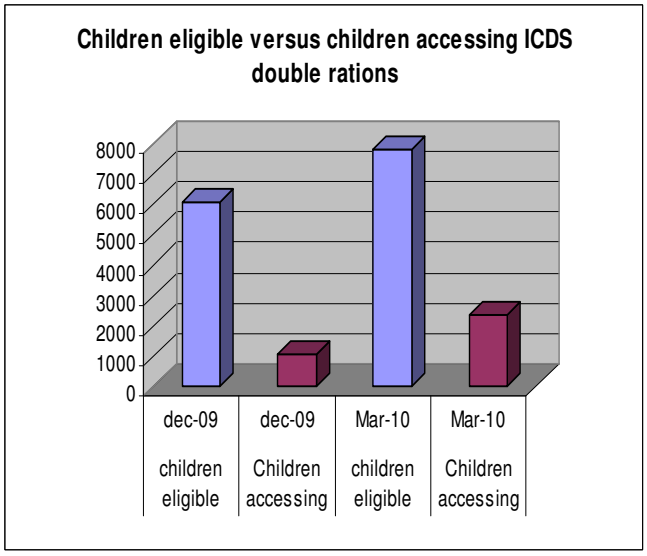
> "There is no direct support to the patients. Medicines are provided but no nutrition. Without nutrition how will they only survive with medicines?"

FCMs and CVs are also trying to link up children to other sources of nutrition.

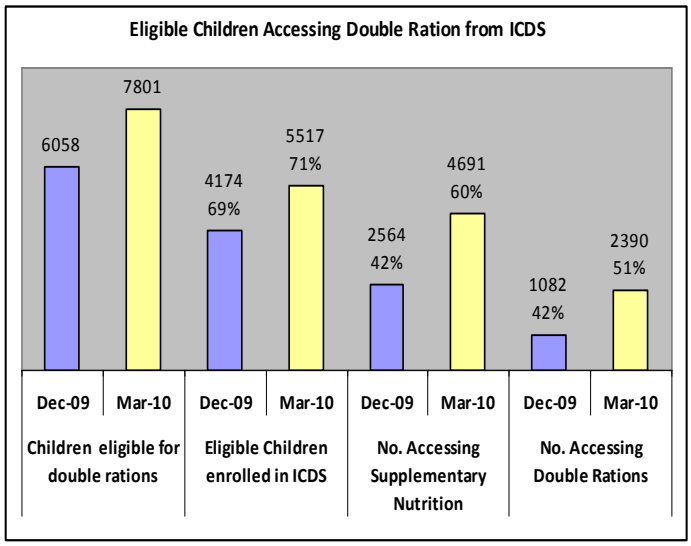
3.6.2.2 Integrated Child Development Services nutritional support

In the latter part of 2009 BSY was able to access the double-ration programme of Integrated Child Development Services (ICDS) for children below 72 months of age living with HIV. The programme was just being rolled out around the time the evaluation data were being collected. Key respondents interviewed mentioned that operationalizing the government order had taken quite some time. The BSY quarterly report from April 2010 shows, however, that while in December 2009 close to 18 per cent of children eligible for double rations actually accessed them, in March 2010 this had gone up to 30 per cent, while the number of children eligible for double rations had also increased from 6058 to 7801 in the same period. The percentages provided in the BSY quarterly report, however, are different, as BSY has taken the number of eligible children enrolled in ICDS as the denominator, instead of the number of children who are eligible for double rations. The report has not provided an explanation of why the percentage was calculated in this manner.

Figure 3.15. Eligible children accessing double rations from ICDS



Source: BSY quarterly report, April 2010



Source: BSY quarterly report, April 2010

Some key informants also mentioned that for children under 72 months of age living with HIV the issue of malnutrition is not always about the quantity of food. The double ration as such is focused on providing more quantity than ensuring that children obtain the right micro-nutrients. A key informant mentioned in this context "A small child can only eat so much." Working towards improving the quality of the ICDS double ration seems, therefore, something that should be taken forward, building upon the experiences of the nutrition programme in the ART clinics.

3.6.3 Other findings about nutrition

During their household visits FCMs and CVs also talk with families about what food to take and how to prepare low-cost, nutritious food. However, there is also a need to learn to provide information on a wider variety of low-cost food that they could advise people about. Further training on this was requested.

3.7. Quality of care related to food security/safety nets for BSY children and their families

3.7.1 Food security outcomes versus QoL

BSY's food security interventions are not meant for all BSY households, but only for households most in need based on food security assessments conducted by BSY project staff. The BSY food security strategy was revised in early/mid 2009 which resulted in prioritization of child and female-headed households in West-Godavari, the district of the IHHT sample. Roll out of that revised food security strategy happened towards the end of 2009 and partially overlapped with IHHT data collection.

The evaluation team analyzed whether differences in QoL, MUAC and Hope Scales (IHHT data) could be found between the different groups who were classified as severely food insecure, moderately food insecure and food secure (BSY MIS data). However, no significant differences could be found for these groups in relation to QoL, MUAC and Hope Scales. For details, please see Tables 3.7.1.1 and 3.7.1.2 in the annex. Food security assessment outcomes from the MIS were also analysed against MUAC and BMI found in the IHHT. While MUAC and BMI outcomes found were lowest among those severely food insecure and highest among those not food insecure, these differences were not found to be statistically significant. Please see Tables 3.7.1.3 and 3.7.1.4.

3.7.2 QoL and safety nets received

For the younger children, QoL for education and the Hope Agency for children were found to be higher for children of families not having had access to safety net services. The reverse was true for the BMI outcome. For children aged 9–16 higher Hope Agency and Hope Pathway scores were found among those not having had linkages services. This could imply that people linked up to services are in a worse situation than those who are not, and that targeting by BSY with safety net activities has therefore been appropriate.

Children aged 0–8 whose families had access to safety nets were found to have a statistically significantly higher BMI outcome than children whose families had no such access. No other significant differences were found. Please see Tables 3.7.2.1 band 3.7.2.2 in the annex.

3.7.3 Status of food security (MIS) and exposure to BSY food security intervention/food security information

The evaluation conducted on the food security component of BSY by Professor Naidu in March 2010 looked into whether the perceived food security of households that had received food security assistance from BSY had increased. Professor Naidu and his team concluded that the food security and safety net interventions had had a positive impact on the food security status of the household. However, they also said that the scale was subjective to the perceptions of the household respondents and of the BSY staff conducting the assessments. Furthermore, they also mentioned that as support for micro-enterprises had only been provided for a number of months, it was hard to measure its impact on improved food security. They also questioned the assumption that increases in income as a result of micro-enterprises would lead to immediate increases in spending on food. Please see Table 3.7.3.1 in the annex.

Data from the IHHT were also analysed to look at any differences in MUAC, BMI or family income of those having received safety net services (grain bank, kitchen garden, micro-enterprise or a demonstration plot) versus those who had not. BMI of children aged 0–8 was found to be statistically significantly higher for families having had access to safety nets. This was not found for older children. Also no significant differences were found in relation to MUAC. Please see Tables 3.7.3.2 and 3.7.3.3 in the annex.

Food security outcome data were also analysed against safety net support. A higher percentage of moderately food insecure households than severely food insecure households received safety net support. Quite a large number of severely food insecure households remain uncovered by safety net interventions, so increasing the focus of interventions on severely food insecure households might be considered. Please see Tables 3.7.3.4 and 3.7.3.5.

3.7.4 Linkages

Statistically significantly higher Hope Path and Agency outcomes were found for children aged 9–16 from families not having been linked to any schemes (see Tables 3.7.2.1 and 3.7.2.2 in the annex). A hypothesis for this could be that these children are from families that are still relatively better off than those who are in direct need of these schemes.

Table 3.7.4.1 in the annex provides an overview of what additional linkages have been established by BSY. The highest number of new linkages established relate to government pensions and white ration cards. The number of BSY households with access to a government pension prior to joining BSY was 2152 which increased to 3228 households since enrolment in BSY. Government pensions relate to pensions for widows, pensions for disabled, pensions for old-age, and pensions for persons on ART. The number of families having a white ration card increased from 82 per cent prior to enrolment to 84 per cent (323 additional households having access). Remarks from FCMs and CVs confirm that these schemes have been relatively easier to access than some other schemes. Figure 3.7.4 in the annex (self-assessment by 55 FCMs) also shows strong variations in relation to links established with different schemes.

3.7.5 Linkages established and FCM and CV capacity

The figures below show how BSY FCMs and CVs rate themselves in the area of linkages/safety nets. Across the board, CVs indicated that they had less knowledge and were less skilled in linking up families to safety net schemes or in assisting families with filling in forms. Thereby it has to be taken into account that until now it has not been the mandate of the CVs to link families to safety net schemes or to assist families with filling up such forms. FCMs from DLC were found to more confident in being able to link up eligible households to government schemes than FCMs from Apple or VWCS. FCMs from VWCS were found to have less knowledge on the schemes than the FCMs of the other two TAPs.

Figure 3.16. FCMs self-assessments – safety nets

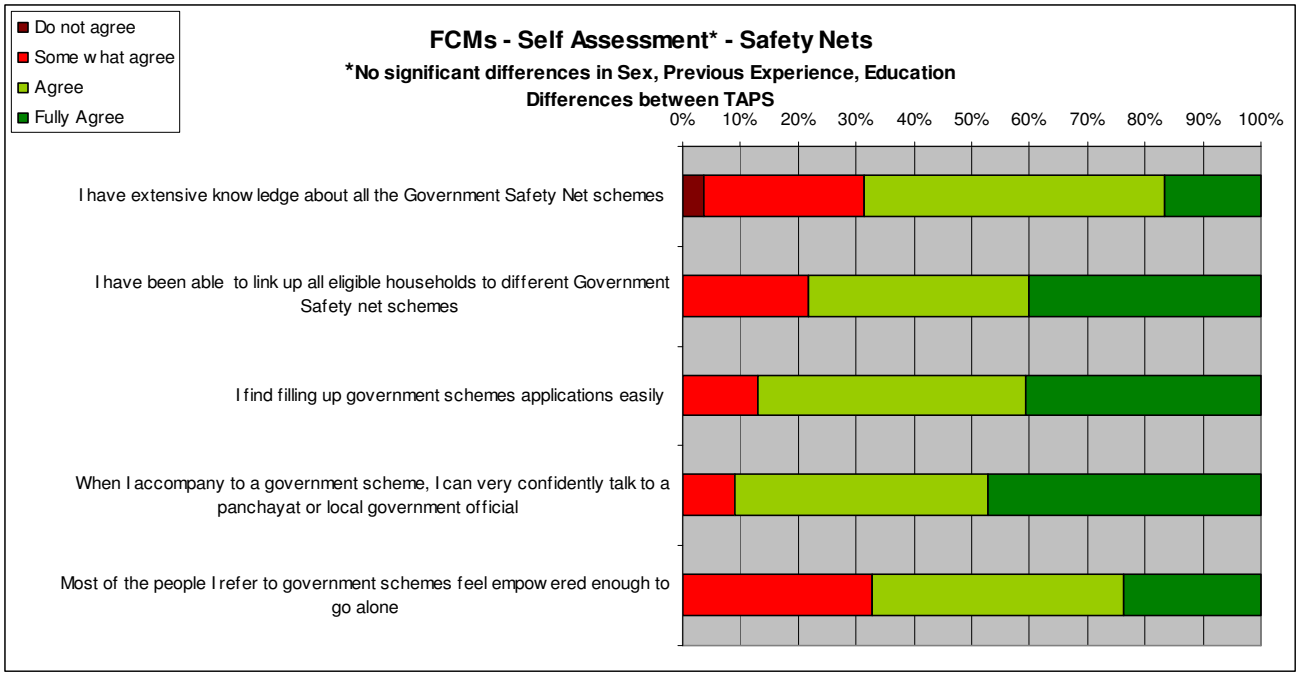
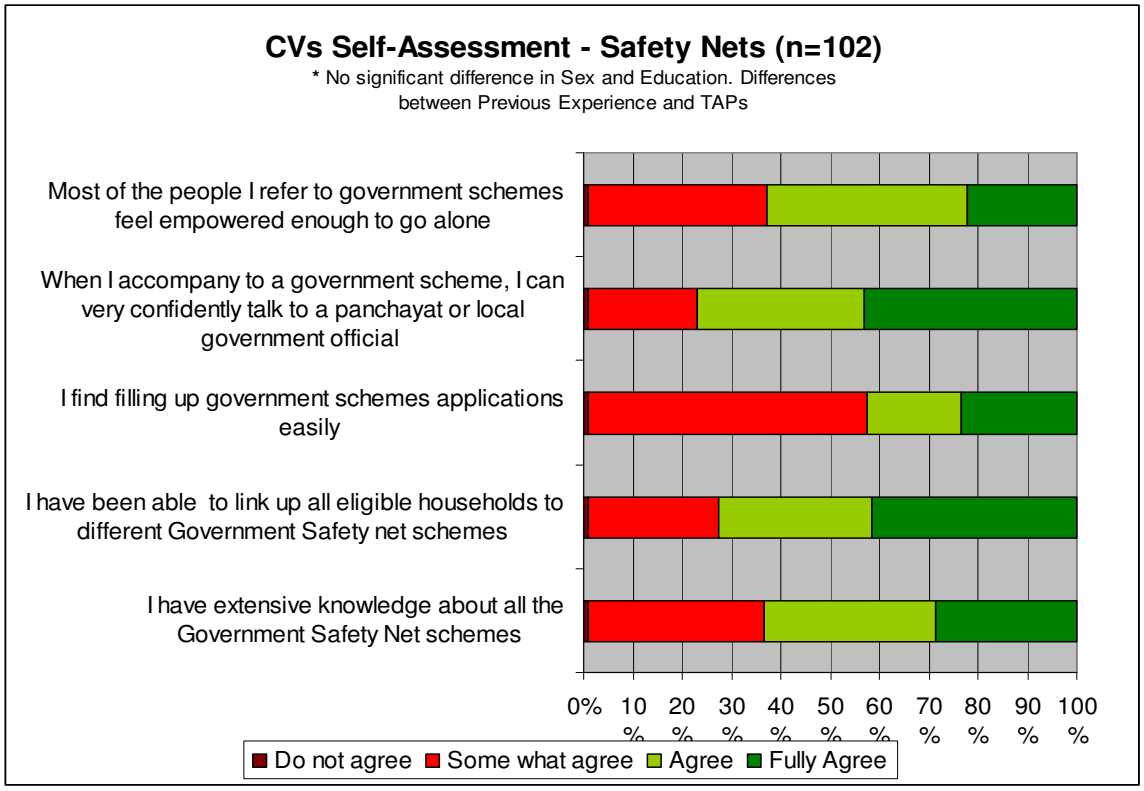


Figure 3.17 CVs self assessment – safety nets



A number of examples were provided of how FCMs and CVs had helped with increasing access, although it is not always an easy process. For the FCMs and CVs the schemes are also important to establish good relationships with the families.

> CV, VWCS: "Earlier many families didn't like the home visits by us. When we approached the families with the schemes – for example, in getting pensions or getting the MRO signature – they recognized our work. From then onwards they are talking to us very happily."

A number of examples were provided of how FCMs and CVs had helped with increasing access, although it is not always an easy process. For the FCMs and CVs the schemes are also important to establish good relationships with the families.

CV, VWCS: "Earlier many families didn't like the home visits by us. When we approached the families with the schemes – for example, in getting pensions

CV, VWCS: "One girl child and boy child became orphans after the death of their parents. At that time, no one came to the children and supported them. Since I knew that the mother was saving RS.10/- in Indiramma Pathakam, I followed up with the case in Velugu office and we succeeded in getting Rs.30,000/- for the children. After hearing this news, the child's paternal grandfather came and took the money from the children and beat them severely. Later we spoke to them, and the parental grandfather took Rs.5000/- and gave the rest of the money

or getting the MRO signature – they recognized our work. From then onwards they are talking to us very happily."

Some particular training needs were, however, also considered necessary to better understand the eligibility criteria of the different schemes – where they should be submitted, to whom etc. The role plays demonstrated that both the FCMs and CVs are very focused on offering a range of schemes to the BSY families but that they do not always know or check the eligibility criteria for the schemes. Further training on this for FCMs and CVs would be required.

3.7.6 Other findings on safety nets and food security

In various interviews the issue of legal support, which is part of the national operational guidelines of the comprehensive package of services for children affected by HIV, was also mentioned. In Section 3.7.6 in the annex an example is provided that illustrates issues that BSY families are faced with. However, currently no specific support is being provided by BSY on this issue. Consideration could possibly be given to how linkages with service providers providing legal assistance could be strengthened.

3.8. Other findings on quality of care

3.8.1 The meaning of visits by FCMs and CVs

The evaluation did not look into the quality of programme delivery as such by FCMs and CVs and focused more on their capacity. One of the issues that arose out of the nil finding on the QoL in terms of exposure related to the number of visits received triggered a discussion on how a 'visit' by a FCM or a CV is defined. During the FGDs, a few FCMs said that they would like to have a manual that would define more clearly the process to follow during a household visit.

3.8.2 Alternative care for orphans

Alternative care for orphans is one of the key areas mentioned in the MWCD/NACO 'National Operational Guidelines for the Protection, Care and Support for Children affected by HIV/AIDS'. The operational guidelines define alternative care as "alternate systems of care such as foster care, extended family and adoption and intermediate mechanisms of institutional care through short-stay homes, shelter homes and orphanages."

During interviews with key stakeholders this issue was brought up as one of the emerging issues for children that will need to be addressed more comprehensively within BSY.

Interviewees expressed various opinions about alternative care for children through hostels. In the IHHT when care-providers were asked whether their children were in hostels, a considerable number implied that their situation was luckily not desperate enough for that. The role plays conducted as part of the evaluation by the FCMs and CVs also provided some insight into how hostels are being seen. One of the FCMs from DLC mentioned having observed a change though:

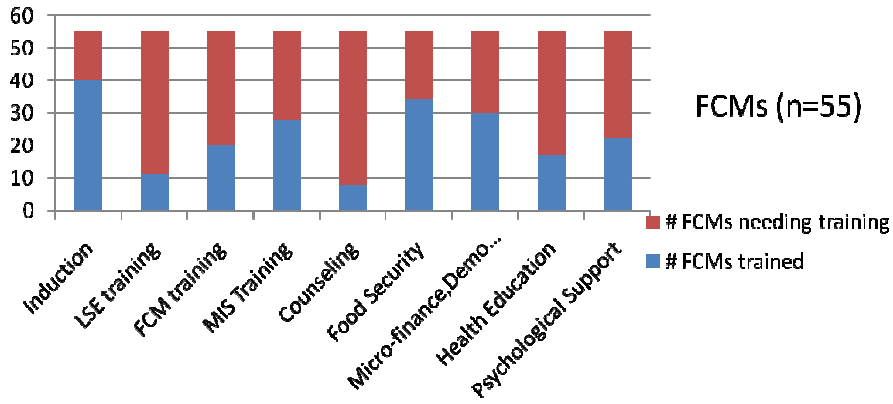
> "Children are asking where to join for education, hostels etc. by children on their own and sometimes parents are asking."

3.8.3 Quality of care and capacity of FCMs and CVs

The capacity of FCMs and CVs has been developed over time, even though CVs did not have any formal training. In spite of this improved capacity there are a number of training needs that were identified; priorities among these are counselling training and training on how to address stigma and discrimination. For more detailed information, please see Section 3.8.3 in the annex to this chapter.

Turn-over of FCMs and CVs is negatively affecting this capacity. Of the 55 FCMs having completed the self-assessment questionnaires, 15 had not had induction training (see figure below), indicating that they were relatively new to the programme. Working without such induction training reduces the effectiveness of these FCMs.

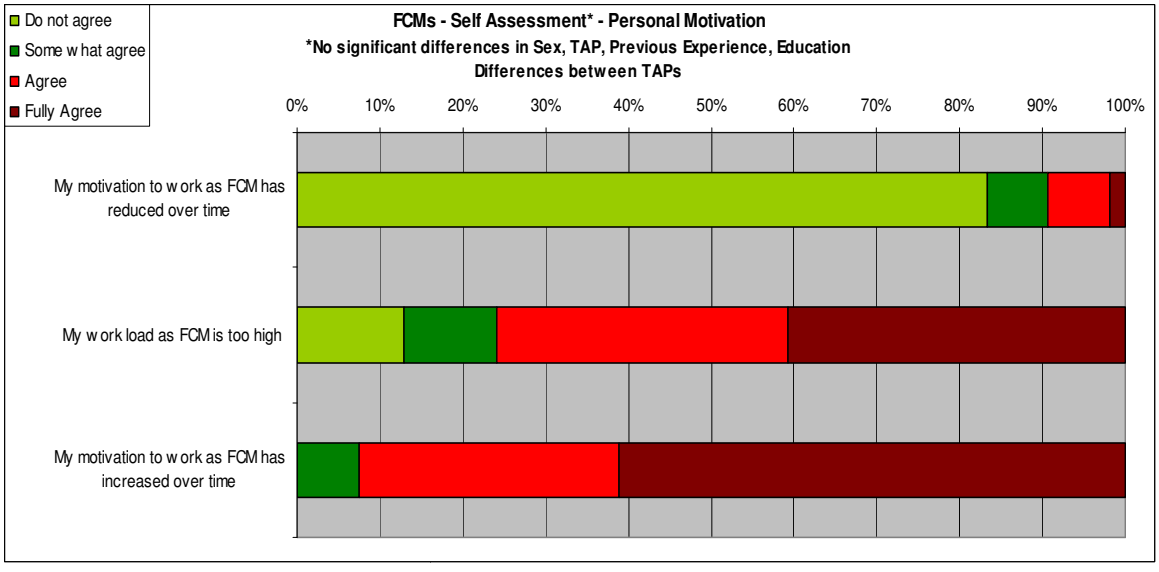
Figure 3.18. FCMs self-assessment – training received



3.8.4 Self-motivation and workload of FCMs and CVs

FCMs and CVs overall report having a high level of motivation, as can be seen from the graph below. DLC FCMs and CVs reported having the highest level of motivation of the three TAPs.

Figure 3.19. FCMs self-assessment – personal motivation



The issue of the high workload of FCMs came up in nearly all the FGDs:

> Supervisor, DLC: "FCMs are overloaded with work, and in my opinion even 24 hours is not enough".
>
> FCM, Apple: "CARE persons are concentrating on the CARE component; the evaluation team is concentrating only on evaluation. But FCMs and CVs need to concentrate on both. If one programme is carrying, another programme needs to plan when to do it. They are giving deadlines for everything. In such situations they have to reduce the load on us."

The workload of CVs was also brought up:

> Supervisors, DLC: "CVs are doing all the activities assigned to them with a lot of dedication and commitment. Though it is supposed to be a part-time job, it has become full-time as the job demands are more. But in new amendments, their TA is reduced, but their work responsibility is increased. Their salary including travel is reduced to Rs.2000 from Rs.2250. This has led to a bit of unhappiness among them, but they are not saying anything about that."

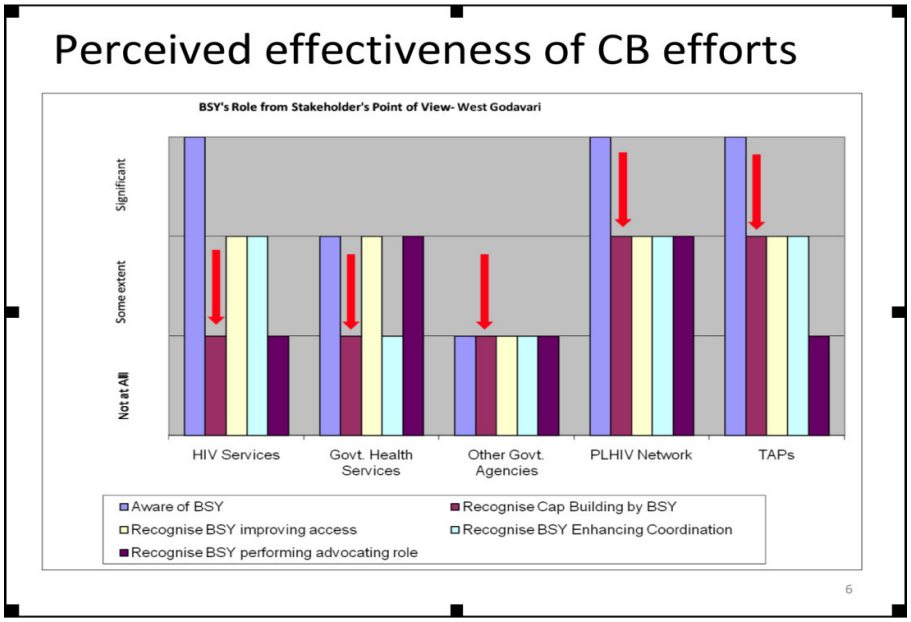
The issue of the need for role clarification was also brought up:

> FCMs, DLC: "FCMs require one handbook on their roles and responsibilities, guidelines on how to approach the new families."
>
> FCM, VWCS: "I want training… FCM training …to provide better services… but also to get a better understanding of the FCM roles."

3.8.5 BSY's perceived capacity-building efforts

The table below shows how key stakeholders in West Godavari (DAPCU, TNP+, Health, Education, Safety net, Nutrition, Administration (District Collector) and NGOs/TAPs) who were interviewed view BSY's role and contribution. Stakeholders linked to HIV services and government health services do not seem to recognise BSY's role in relation to capacity-building within ART and ICTC/PPTCT services. People working in HIV and government health services do, however, recognize that BSY increases access to services to some extent. BSY's role in enhancing coordination is also being recognized by people working in HIV services. PLHIV networks and TAPs recognize BSY's contribution to capacity-building to some extent. They also recognize BSY's role in coordination, advocacy and improving access.

Figure 3.20. BSY's role from stakeholders' point of view – West Godavari



3.9. Findings and conclusions

3.9.1 National Operational Guidelines and BSY

BSY addresses most of the critical and necessary areas mentioned in the MWCD/NACO 'National Operational Guidelines for the Protection, Care and Support for Children affected by AIDS'. The programme has specific health, education, nutrition, and safety net targets. However, the revised targets and key indicators from 2009 no longer include psychosocial support, although some psychosocial support indicators targets are reflected in the health domain linked to HIV testing, pre-ART registration and Adherence, whereas psychosocial support for children was found to be a critical issue in this evaluation round. BSY does not have targets for social protection, legal support or for alternative care for orphans either, whereas a number of respondents classified them as emerging issues.

3.9.2 Treatment cascade and focus on children

BSY has been able to place a stronger focus on children in relation to the treatment cascade. This can be observed from the increases achieved over time in the number of children tested for HIV and CD4 cell count, the number of children on ART, and improved mechanisms for tracking LFU. FCMs and CVs indicated that mobilizing children for HIV and CD4 count testing has become somewhat easier. Extra efforts to increase ART registration among the younger age groups, of whom a lower percentage have been registered (80 out of 110 children having tested HIV positive, versus 105 out of the 118 children having tested positive of the older age group) would seem to be required. BSY's role in relation to increasing ART registration and reducing LFU was acknowledged by the ART centre in West Godavari, but less so in the other two districts, where the BSY programme rolled out more recently. In Kurnool the recently introduced nutrition programme in the ART centre was reported to be having a positive impact, with children living with HIV attending more regularly for ART treatment. Rolling out the nutrition programmes in other centres as planned could potentially reduce LFU among children living with HIV, and tracing LFU has become easier through improved registration mechanisms. CCC outreach workers from Kurnool acknowledged that 99 per cent of LFU cases were reduced because of follow-up by FCMs. This is because BSY has a much larger workforce with its FCMs/CVs than the CCCs.

BSY's assistance in accessing facility-based services was found to have a positive impact on the overall QoL score and the Hope Pathways of children aged 0–8 years. BSY's support in this area also significantly increased the Hope Pathway for adults. Positive changes have been observed by BSY FCMs and CVs in relation to how families are taking care of children living with HIV since they have been enrolled in BSY. However, these changes were not observed for children whose care-givers are not familiar with HIV. Special orientation for these care-providers to enhance their understanding should be considered.

3.9.3 BSY enrolment and scope for expansion

Of the eligible families for BSY registered in the ART centres in West Godavari, Kurnool and Medak 60 to 90 per cent were not aware of BSY. There seems to be a lot of potential for expansion, including in the districts where roll-out first started, such as West Godavari where the project is now covering all mandals.

3.9.4 ICTCs and ART centres

While collaboration in general between ICTCs and ART centres and BSY has improved over time, FCMs and CVs all felt that clarification of their roles to the centres could further help to improve collaboration. In spite of improvements in infrastructure in the ART centres, there are still bottlenecks due to the high number of patients. The children's play area is being appreciated but not operational everywhere. The PCCs in the ART centres were not found to be used to their full potential in terms of providing advice to new clients in particular. Efforts could be made to clarify the roles of PCCs and to provide them with training.

3.9.5 Waiting time and LFU

The waiting time and service time in ART centres differ by district, including those for children. Headway has been made into reducing the waiting time for children in the ART clinics somewhat, but there seems to be room for reducing waiting times in some of the ART centres by developing a more common format. The travel time to the ART centres is considerable. The time and resources people have to spend on accessing the ART centres are among the most important reasons for LFU. Finding ways to reduce this time investment would contribute to increased quality of care in this area and less loss of resources and time for BSY families.

3.9.6 Client satisfaction and counselling

The large majority of patients both in the IHHT and at the ART clinics expressed high levels of satisfaction with the services they received. The large majority of children (96%) said they were comfortable going to the ART centre and felt that the doctor and or counsellors cared about them. This is even though only one of the three ART counsellors trained by BSY on paediatric counselling said they were able to put their learning into practice. Counselling within the health facilities for follow-up clients is minimal: much of the average two minutes of service time is spent for administrative purposes (such as filling in Sahara cards). There seems to be a need to improve the counselling process for children as well as for adults. This was also confirmed through the FGDs with BSY TAP counsellors, FCMs and CVs who mentioned that they regularly had to counsel people on treatment about adherence issues during home visits.

3.9.7 Findings related to psychosocial support

The Hope Pathway score was higher for children aged 9–16 years who lived in households where psychosocial services were provided by BSY. This means that these children have a higher practical sense of working out how to get from a to b as a result of these services.

Parents and care-providers were found to talk very little if at all with their children about HIV. The scope for improvement in terms of disclosure is considerable, since low average

scores were achieved. This would also address the currently unmet psychosocial needs of children infected with or affected by HIV. Strengthening this component of the programme would fit well with the MWCD/NACO operational guidelines. This could be supported by developing strategies through which LSE would be feasible in the BSY context as well as implementing the already scheduled counselling and communication training for FCMs and CVs.

Community sensitization activities were found to contribute to better Hope Agency and Pathways for adults. While stigma has been somewhat reduced, it is still very much present and preventing people from accessing services. Further strengthening the skills of FCMs and CVs to conduct community sensitization activities and for those staff living with HIV to be more open about their status could potentially contribute to a further reduction in stigma and discrimination.

3.9.8 Education

While FCMs and CVs demonstrated in the role plays that they were strong in following up on school drop-outs, the IHHT data demonstrated that in spite of these efforts a number of children drop out of school for economic reasons. No specific tracking of how many school drop-outs have been brought back into the educational system is undertaken. More than one in four children had missed school in the last month because of visits to medical facilities for themselves or care-givers. This points to the fact that reducing the amount of time BSY families have to spend on testing and treatment could also improve school attendance. Stigma and discrimination seem to be common in school.

3.9.9 Nutrition

BSY has helped children to access the ICDS scheme. Better tracking of the impact of nutrition on children through pre- and post-exposure measurement of MUAC or BMI would be useful. Working towards improving the nutritional value of the ICDS double ration, thereby building upon the experiences with the nutrition programme in the ART centres, could possibly be taken forward.

3.9.10 Safety nets/linkages

No significant differences in QoL, MUAC and Hope Scales (IHHT data) were found between the different groups who were classified as severely food insecure, moderately food insecure and food secure (MIS data). For families receiving safety net services (IHHT data), QoL education outcomes and Hope Agency outcomes for children aged 0–8 years were lower than those who had not received these services. A higher percentage of moderately food insecure than severely food insecure households were found to have received safety net services, leaving quite a number of severely food insecure households uncovered. While FCMs and CVs are offering a range of schemes to the BSY families, further training on these schemes is required, such as on eligibility criteria. MIS data show varying results in accessing schemes.

3.9.11 Capacity of FCMs and CVs

The capacities of FCMs but also CVs have increased over time, in spite of CVs not having any formal training. Capacities of FCMs and CVs differ by TAP. FCMs within DLC and CVs within Apple expressed the most confidence in their abilities. Specific training needs are counselling and LSE training. The issue of workload was raised within all FGDs with TAPs. Clarification of the role of FCMs and CVs and better planning were requested.

3.9.12 Recognition of BSY's capacity-building role

BSY's role in capacity-building in relation to HIV services does not seem to be acknowledged by government services (HIV and health). People working in HIV and government health

services do, however, recognize that BSY increases access to services to some extent. BSY's role in enhancing coordination is also being recognized by people working in HIV services. PLHIV networks and TAPs recognize BSY's contribution to capacity-building to some extent. They also recognize BSY's role in coordination, advocacy and in improving access.

4 What is the potential of the Balasahyoga model to be effective, replicable and sustainable?

This section of the report addresses the BSY programme itself. More specifically, it examines the history, design and milestones, and whether the proposed model, at this point, is effective, replicable and scalable.

The BSY programme is an integrated family care programme targeting QoL for children infected with and affected by HIV. Started in 2007 and ending in 2012, it works in 11 districts of Andhra Pradesh, covering 40,000 households affected by HIV/AIDS with high-quality HIV/AIDS medical care, nutrition, food security and educational support. The programme is funded by EJAF and CIFF and implemented by three partners: FHI, CHAI and CARE. FHI is the lead partner and focuses on strengthening community-based HIV care support services and providing technical assistance and capacity-building to implementing partners. CHAI strengthens facility-based treatment services and trains health care workers, laboratory technicians and other staff in government health centres. CARE (funded by EJAF) implements interventions to improve food and livelihood security in households.

This section integrates document and web review, secondary analysis of BSY quarterly and annual reports, MIS analysis and interviews with key informants from the different partners and stakeholders, including with people who were involved in the design phase but are no longer active in the programme. In total 23 international, national and state-level key informants were interviewed in Hyderabad.

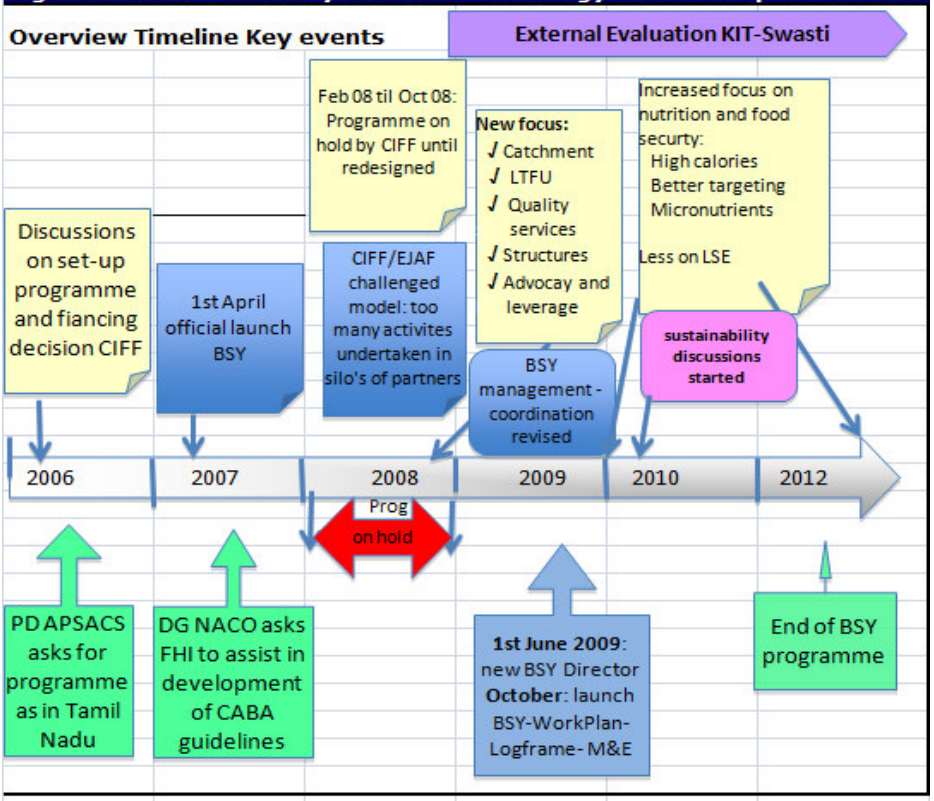
4.1. Timeline overview of key events in the programme

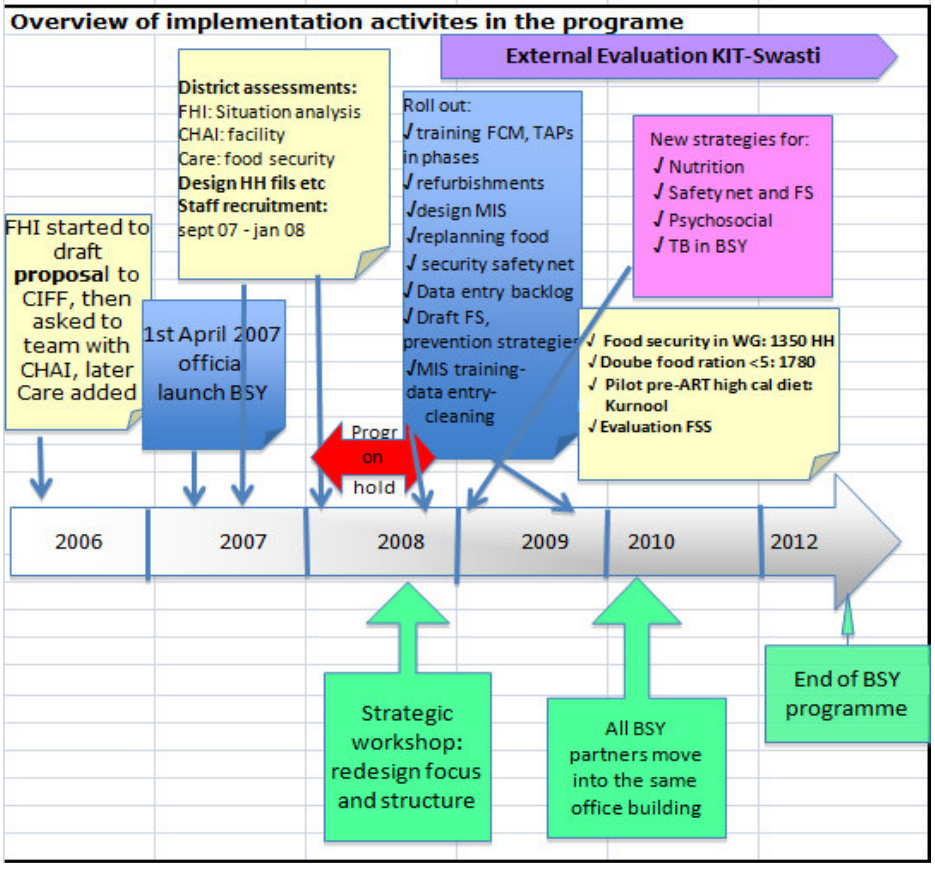
The programme was informed and influenced by many sources. The design was primarily influenced by the experience of CIFF from the TNFCC programme, and field strategies were influenced by prior implementation experience. Each of the partners within the consortium brought their own strong experience of working in this area.

The BSY model has been significantly influenced by reviews and planning exercises with CIFF and all the partners. The preliminary design of the programme was more at a strategic level, with only broad elements clearly laid out. As the programme was rolled out, details and depth of the field strategies emerged over time. Programme logic was not tight from the beginning as mentioned by many of the key informants. Each component had individual logic, but their contribution to the outcomes and the impact, the causal chain and the critical elements within them have all emerged over the course of the implementation (and are still emerging). In addition, focus on some of the key elements has also emerged over time (for example, treatment cascade, and nutrition). These have influenced the model over time in a variety of ways and have also put pressure on the partners in terms of constant change in implementation strategies.

The following figure shows timelines depicting the course of the programme both at strategic level and at the implementation level. There is no colour coding in the figure.

Figure 4.1. Timeline of key events: BSY strategy and BSY implementation





4.2. Design of Balasahayoga

The proposals and contracts for BSY provide some insight into the logic behind the design of the programme. Basically these documents assume that the greatest impact on the QoL of children infected with and affected by HIV is made through a comprehensive, family-centred approach, covering a wide range of services across five domains: health, education, psychosocial support, nutrition, and safety net/food security. Some evidence for this came from learning from a similar programme in Tamil Nadu (TNFCC) also funded by CIFF, and it was also based on the experience of FHI in Andhra Pradesh in their previous USAID-funded programme targeting communities.

> "A family approach would ensure that fewer orphans were created, and we believed that this would improve the QoL of the children."

> "Now (2009) CIFF looks at impact into a reduction in the number of orphans and vulnerable children and a reduction in new infections and mortality, and also how will they live; are they in school, are the parents alive, do they have income? Which are the core services in the cascade?"

The underlying thinking was that building resilient families and linking them to the services would reduce the need for actual support by FCMs.

During the interviews with different key informants at the international, national, state and district levels, questions were asked about how the programme was designed. The different views and perspectives of these interviewees are shown in the annex relating to Chapter 4 (Table 4.1.2). They indicate that especially in the design phase of the programme there was little joint and coherent planning, and domains were added as new NGO partners were identified.

The planning process for BSY was an iterative process whereby partners and components were added as and when strong NGOs were identified for specific components. The CARE component was designed for a three-year period as compared to a five-year programme for BSY. There were also several conceptual clarity issues, which had to be sorted along with the management challenges – for example, food security and nutrition.

4.3. Programme implementation

4.3.1 The BSY consortium

The BSY programme has suffered from a certain amount of 'consortium overdose'; three different partners, who individually are strong in their respective areas, had been brought together retrospectively (after each had their own area as a single programme) to form a consortium. This arranged marriage took substantial time in terms of partners adjusting to each other's needs, approaches, systems and meaningful ways in which their synergies could be harvested. Therefore, for quite some time the programme was an amalgamation of three different proposals, led by three different partners with independent funding streams and staffing. To compound matters, the needs assessments carried out were independent for all three partners; the roll-out on the ground was phased differently and in some cases based on geographical contiguity, in some cases different target families – all this took some time to co-ordinate. For quotes on the choice of partners, please see Section 4.1.3 in the annex.

CIFF is a committed and directive donor agency, perceived by partners as having a strong steer over the project. Partners also recognize the added value provided through reviews and re-planning, which has avoided a 'business as usual' way of working. Partners had to push the envelope in terms of strategies and their operationalisation. The down side has been that the

elaborate and repeated planning, re-planning and redesign have slowed down roll-out and affected staff turnover. It has undoubtedly helped nuance design and responds to changes in the field while providing the space for partners to understand each other's strengths and adapt.

The re-planning exercise in 2008 resulted in a revised implementation structure for the partners striving for a more coherent approach to implementation of the project. Also the programme as such was more harmonized towards bringing a joint package to the families in affected households.

The key performance indicators were revised and critical success areas identified in November 2008. In March 2009 some of the targets were revised whereby, in particular, the number of children to be tested for HIV increased. In the first quarter of 2010 BSY started discussions about the programme's sustainability and ways of transitioning to the government.

Despite this, there have been significant and genuine difficulties for the three partners to merge their activities in a cogent and coherent fashion for some time now. Even where the partners' programmes have merged, the implications of the merger, particularly relating to management systems, have not been fully factored. Structures and approach have taken time to synergize. Existing contracts, staffing and terms were taken as given. The fact that all three partners are large, with specific work cultures and payment structures, is only starting to be addressed. One office, one work plan, one monitoring and evaluation plan, one strategic director, Senior Management Team (SMT), and district-level workshops are all examples of how the partners have responded to amalgamating efforts; however, the partners still see inherent difficulty in this arranged marriage.

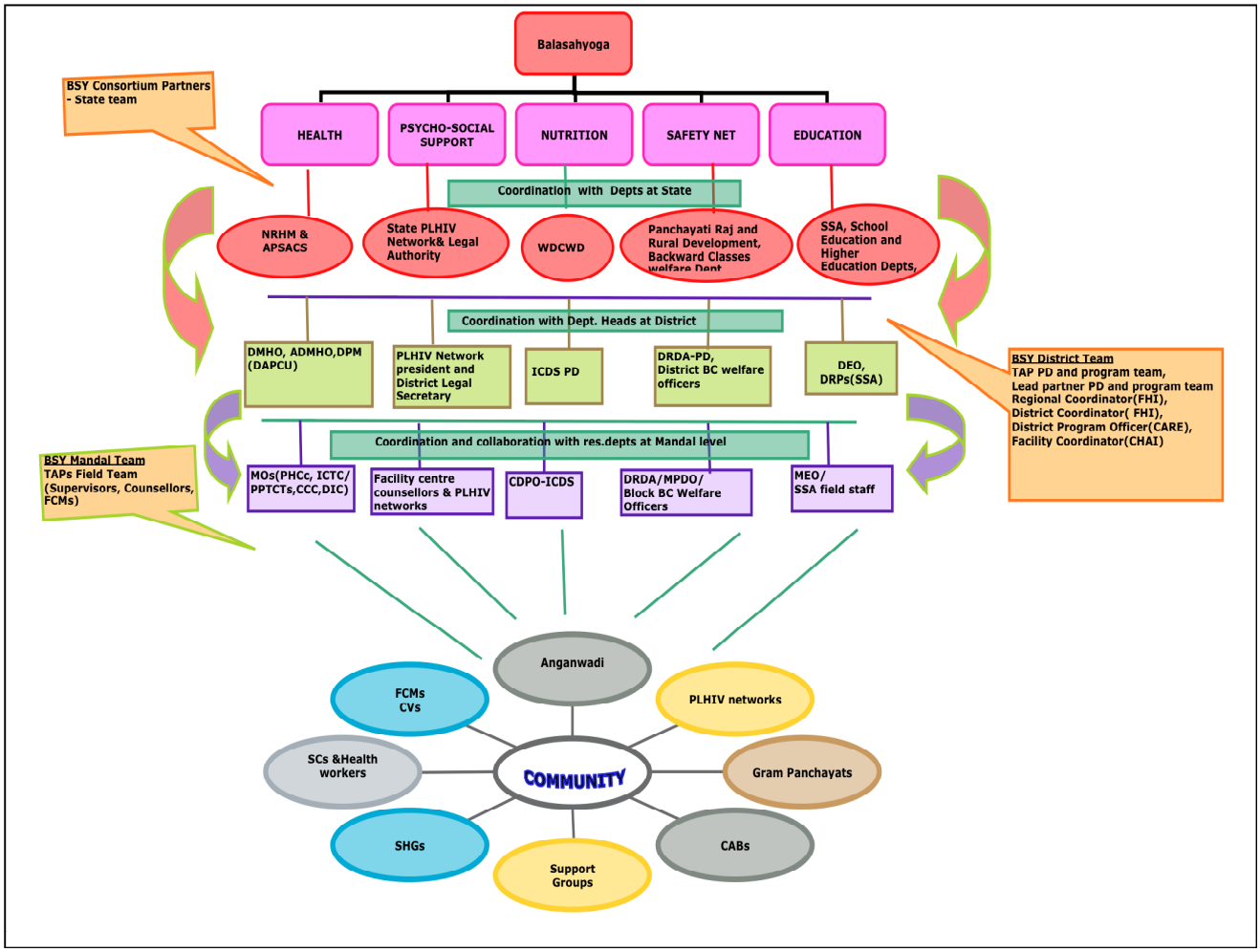
4.3.2 The APSACS environment

Apart from the complexity of the BSY implementing partners, the organizational structure of the state and districts and the way that BSY interacts with these is even more complex, as seen from the figure below (and the roles and responsibilities matrix in the annex 4 of this report (Matrix 4.4.1)). Different state- and district-level ministries and authorities are responsible for the outcomes in the five domains covered by BSY. APSACS falls under the health sector and is responsible for technical/managerial support for HIV prevention and control activities at the state level, surveillance, planning and implementation and for organizing stakeholder meetings. It has, however, no authority as such over the different line ministries. APSACS is the official coordinating body of the BSY partners, but it cannot be held responsible for mainstreaming of the five domains with the respective ministries and authorities.

APSACS has a somewhat ambiguous perception of the programme and feels that its role as coordinator of the programme is good but difficult to implement, as it does not 'own' the programme and has no insights into the budgets for BSY. The key concern of APSACS is that:

> "BSY has been well conceived, but the issue of sustainability and exclusiveness, as is the same with CHAHA, needs to be addressed. The programmes need to be integrated into regular programmes."

Figure 4.2. Interaction between BSY programme and different government structures at state and district level



4.4. How effective has the Balasahyoga programme been in reaching its targets?

4.4.1 Estimates of the number of children infected with and affected by HIV

It is difficult to find accurate estimates of the number of children living with HIV or projections of these in India. CIFF has based its estimates for the targets of the BSY programme[12] on a meeting with the National AIDS Control Organisation (NACO), whereby estimates indicate that 20 per cent of all children living with HIV live in Andhra Pradesh – an estimated 20–25,000 children. In the 11 BSY districts the target is based on saturated coverage of children living with HIV of 14,500 children in the programme and 4200 children alive and on ART by 2011 (Year 4 of the programme).

APSACS has published data by district on the children and adults that are alive and on ART up to 31 December 2008 in its annual Action Plan for 2009–2010 on its website. The evaluation team has grouped the data for these districts by coverage by BSY and CHAHA districts, whereby BSY covers 44.4 per cent of all children and CHAHA 55.6 per cent. The state reports having 1136 children alive and on treatment up to 31 December 2008. The BSY programme at that time reported having 553 children alive and on treatment. For the period up to 31st March 2009, the BSY programme had been able to enrol 48% of the children in the 11 districts. Compared to the roll-out rate this seems reasonable, as the project had only been implemented in a few districts.

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The targets set by APSACS in its State Annual Action Plan for children on ART for 2009–2010 were 1878 in all the BSY districts (44.4% of the total) combined. In terms of actual numbers, the NACO[14] ART report for Andhra Pradesh indicates that a total of 3634 children

[12] PowerPoint presentation: CIFF Balasahyoga Programme: Discussion with Board, 14 October 2009.

[13] PowerPoint presentation: CIFF Balasahyoga Programme: Discussion with Board, 14 October 2009.

[14] http://www.nacoonline.org/Quick_Links/HIV_Data/Patients_alive_and_on_ART/

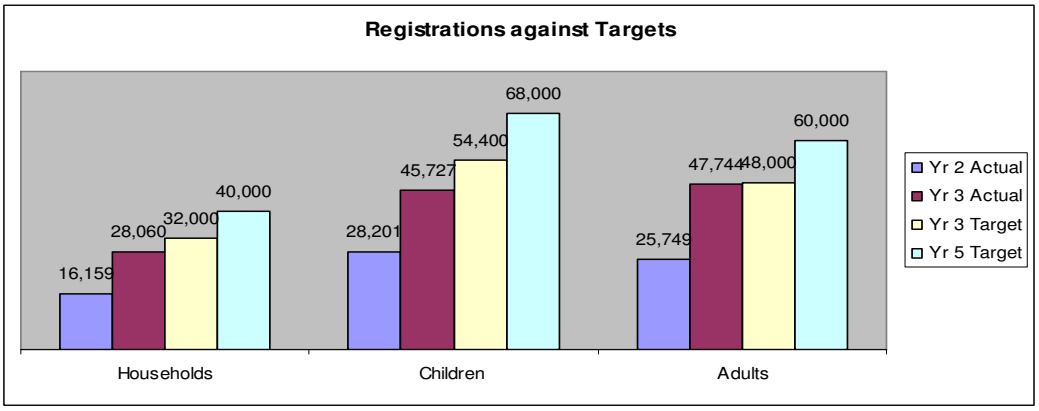
were alive and on ART towards the end of March 2010 for the entire state. In its 11 districts, BSY should, therefore, have about 1639 children alive and on ART, while in fact it reports that 841 children are alive and on ART, which is only 51 per cent of the children in the BSY districts. This is corroborated by the client interviews in the ART centre in West Godavari, whereby only 40 per cent of clients in the centre have been enrolled.

Fundamental to the programme is a clear definition of the target group and robust numbers (estimations) of children affected or infected by HIV. While the former exists, the latter is less than robust. The current numbers are broad estimates and have not been arrived at through a reliable methodology. While the project recognizes this issue, this is also an area where there are limited methodologies available. However, this is an opportunity for the programme to come up with a strong methodology to estimate and map out the affected and infected children. This becomes critical to the establishment of a reliable denominator, against which the programme's progress can be tracked.

4.5.2 How well is BSY reaching targeted households?

In addition to the analysis above showing that about half of the children in need of ART are reached by the programme, the BSY Year 3 report shows the trends in registering households; children and adults against the target of Year 5 (see the figure below). This figure shows there is a steady increase in the numbers registered.

Figure 4.3. Trend in registration of households, children and adults in BSY[15]

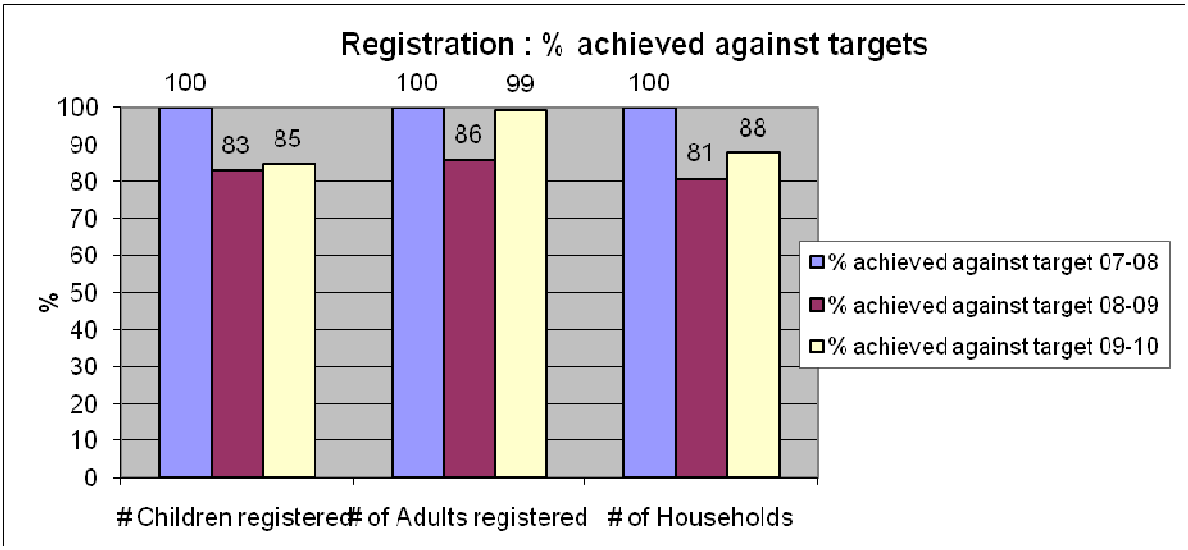


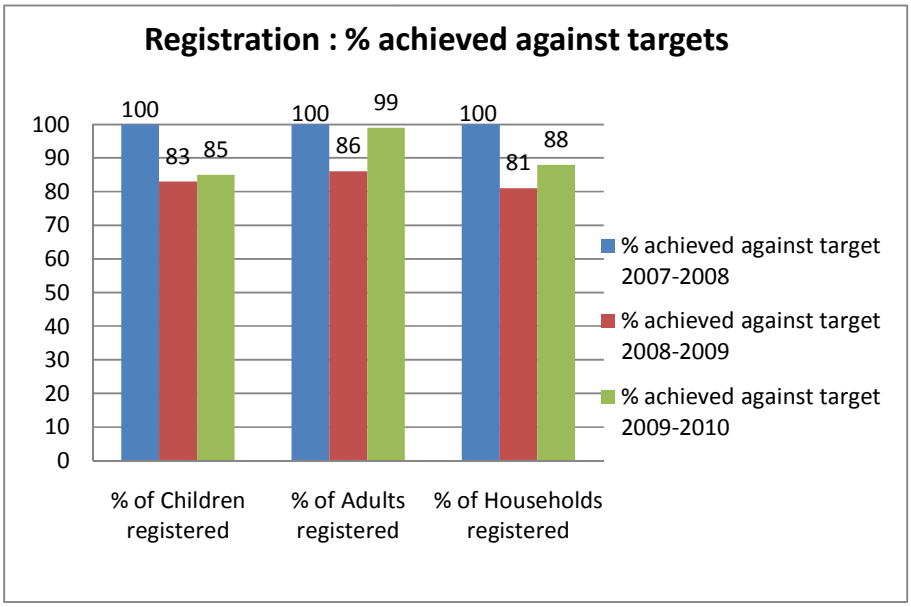
The evaluation team analysed the enrolment data against the BSY annual targets, and the graph below shows the percentage performance of the BSY partners against these. The first year shows a 100 per cent achievement of the targets, but this reflects that in Year 1, the targets were set as the baseline.

The figure shows an increasing trend in registration against the target, with the best result for adults reaching 99 per cent of the target. Even though somewhat lower for children, 85 per cent is still high.

[15] BSY partners. *Balasahyoga Year 3 Progress Report*. May 2010.

Figure 4.4. Trend in BSY household registrations against the targets set by reporting year





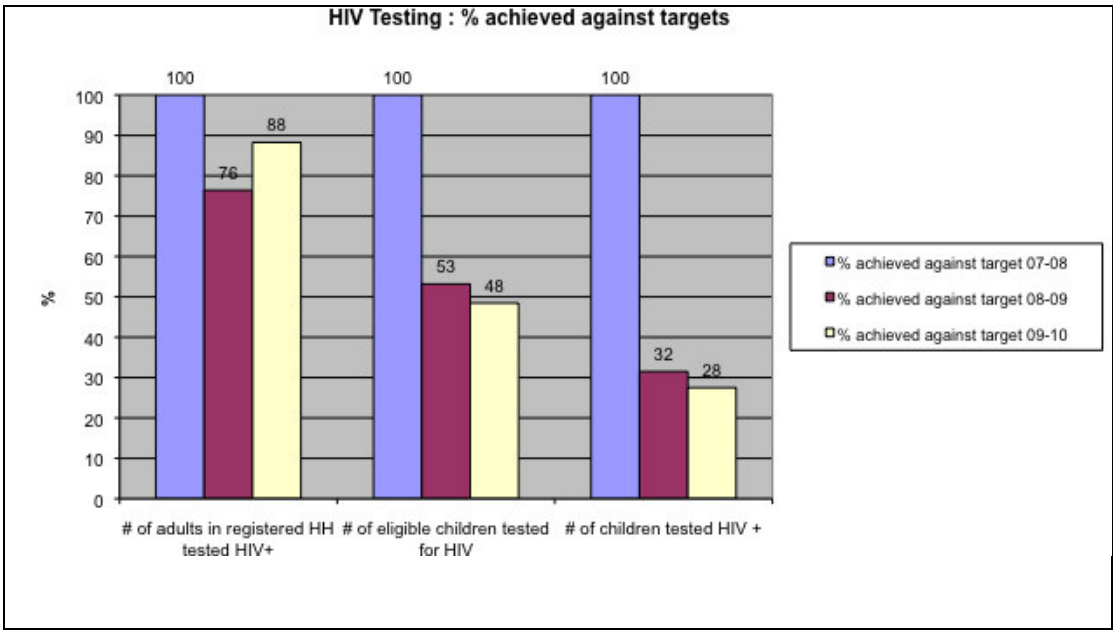
The scale-up plan for reaching districts and mandals also shows steady progress, whereby roll-out has been to all districts but not yet to all mandals. Year 1 showed 19 per cent coverage, Year 2 28 per cent and Year 3 61 per cent.

4.5.3 How effective is BSY in achieving its performance targets?

Looking at the performance-related indicators in the BSY annual reports, we see that the level of achievement against the targets is much lower than for the coverage indicators. HIV testing of adults is increasing against the targets, and 88 per cent of adults have been tested for HIV. However, only 48 per cent of the Year 3 target of eligible children has been tested for HIV. The number of children tested HIV-positive is also much lower than anticipated in the targets. The latter could have a number of reasons such as effectiveness of the PPTCT programme, whereby fewer children get infected with HIV or that the targets

for children living with HIV were set too high. The BSY annual report for Year 3 shows that the number of children tested is increasing from previous years, but when comparing this number against the targets there is a downward trend.

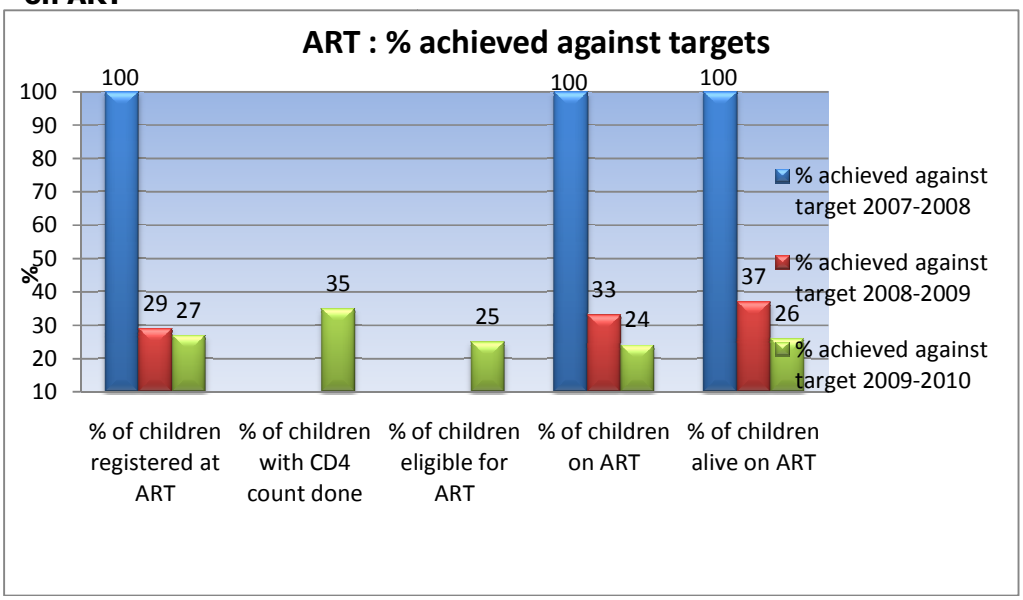
Figure 4.5. Trend in performance of the BSY programme in terms of testing for HIV[16]



The performance against targets for treating adults and children living with HIV with ART also shows a downward trend, with only 27 per cent of the BSY children living with HIV registered at an ART centre, so the programme is only able to put about one quarter of the target number of children on ART (from MIS). The interpretation of this could again be related to the targets being set too high in view of an effective PPTCT programme, incorrect estimation of the numbers of children infected with HIV (denominator issue explained earlier) or an inability of the BSY programme to actually register the most vulnerable children into the programme.

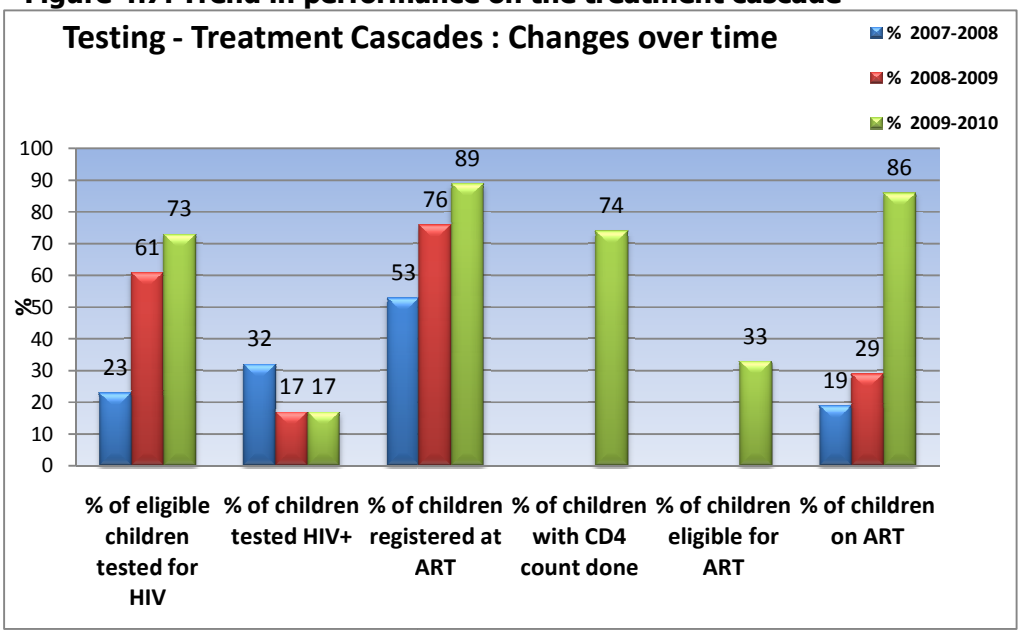
[16] The targets for Year 1 are 100%, being the baseline coverage of the programme.

Figure 4.6. Trend in achieving targets for children registered at ART centres and on ART



In the last annual report the BSY partners greatly improved their reporting on the treatment cascade and LFU data and the figure below is based on secondary analysis of these reports.

Figure 4.7. Trend in performance on the treatment cascade[17]



Even though figure 4.6 shows that against the targets only a fraction is reached, once they are in the programme the results are much better. Measuring against the treatment cascade, the percentage of eligible children tested went up in the past two years as compared to Year 1. What is clear is that there is a steady increase in registering children living with HIV at ART centres. Since Year 3 the majority of children have also been tested for CD4 counts. About one-third of the children testing HIV-positive are eligible for ART. Of

[17] For percentage on ART, the number of children that have CD4 counts is only available for 2009–2010, data from BSY partners quarterly and annual reports.

these children 86 per cent are put on ART, a huge increase from the year before, when only 29 per cent were put on ART.

In the Year 3 annual report the reporting on LFU was strengthened and efforts were intensified to better understand the reasons for LFU.

Reported performance on reaching loss-to-follow-up cases in Year 3

Key Performance Indicators	Numerator	Denominator	Achievement Percentage	Target Percentage
% of LFU among children on ART among Balasahyoga.	977	1,003	97.41%	90%
% of LFU among adults on ART among Balasahyoga.	8,245	8,770	94.01%	90%
% of children who are on ART and LFU put back on treatment at ART Centre	56	122	45.90%	NA
% of adult LFU who are on ART put back on treatment at ART Centre	1,171	3,103	37.74%	NA

The percentage of loss to follow up is relatively low, especially among children and about 46% of children and 38% of adults are out back on treatment. The introduction of the ART care coordination meetings in the ART centres where LFU is a standing item on the agenda, have certainly contributed to these results.

There is also an improvement in reporting on mortality, one of the key outcomes of the BSY programme. In the table below the number of children and adults that have died is reported. Even though it looks like mortality is going up, this seems more likely to be the effect of an increased focus of the programme to actually register people who have died. It is not possible from these reported data to calculate a change over time in the number of orphans occurring.

Table 4.1. Reported mortality among BSY-registered individuals over time

	Year 1[18]	Year 2	Year 3
Number of children died, as recorded by BSY	8	46	156
Number of adults died, as recorded by BSY	104	567	1594

The reporting on the targets outside the Health domain is more difficult to interpret for the evaluation team, as assessment of progress was not possible due to the inconsistent reporting on key performance indicators (please see table 4.1.5 in the annex to this chapter). For example, the indicators on education, psychosocial support and nutrition showed:

- Gaps for some years;
- Description in body of text not specific to key performance indicators (see the first indicator in table 4.1.5 in the annex, achievement 2009/2010); and
- Some indicators are not reported at all (for example, number or percentage of children above 2 years of age with normal nutritional status, i.e. BMI >18.5).

[18] For Years 1 and 2 these figures come from the MIS analysis done by the KIT team. For Year 3 the data come from the APR 2009–2010.

4.6. The value added by the Balasahyoga programme

The BSY programme has positioned itself in such a way that it has a great potential to add value to the HIV response for children in India:

- It addresses a key part of the NACP-III, wherein actual field strategies are not in place at the national level. There was a need to model.
- It works with and through the National Programme – which is rapidly scaling up the supply side of its response. The supplementary and complementary (gap filling) approach of the project does not duplicate any parts of the National Programme; however, they are strengthened while directly providing some critical services to the clients. This approach is unique and synergistic.
- While substantial investments have been made at health facilities, this is a supply-side investment. BSY is a key demand-generation mechanism for these services, but also works on the other end in terms of follow-up, ensuring treatment adherence and general well being.
- Most HIV programmes in India focus on either prevention or care. This programme straddles prevention, treatment, and care. In addition, most programmes *either* operate through community outreach *or* provide services through facilities, whereas this programme straddles both of these.
- FHI was a key partner in a panel of experts designing the CABA strategy for NACO. The BSY programme is well aligned with the new CABA guidelines, albeit with a slightly more narrow focus.
- Outreach is focused not only on the child but also on the family. This has been a key lesson learned for organizations working with children: the family needs to be addressed along with the child, not in isolation.

Reaching the neediest in any programme is critical. Apart from targeting children in HIV affected households, additional focus is given to child-headed households amongst others. There is a need to revisit this list and also develop clear but simple and local indicators that can help the programme to identify families in higher need of BSY type of services.

A further analysis of the IHHT cohort attempts to identify which households are more vulnerable than others and to analyse any patterns. The table below shows where there are significant differences in QoL outcomes for actual services that have been provided to these households and children. Younger children provided with facility-based services showed higher QoL and Hope, when compared to the older children. For the older children provision of "linkages" and psycho-social support showed higher Hope scale outcomes than younger children. It shows facility based services are more important for increasing their hope and QoL in younger children , while for the older children psychosocial support and linkages are more important for increasing their Hope scale.

Table 4.2. BSY exposure and QoL and Hope Scale scores for children aged 0–8 years

Services provided	QoL domain or Hope Scale	p-value
1)Facility-based	Food	0.002
	Social behavior	0.001
	QoL overall	0.019
	Hope Path children	0.002
	Hope Path adults	<0.001
2) Household – Community-based initiatives	Hope Agency adults	0.026
	Hope Path adults	<0.001

P-values reflect the difference between the two groups, adjusted for age and sex.

Table 4.3. BSY exposure and QoL and Hope Scale scores for children aged 9–16 years

Services provided	QoL domain or Hope Scale	p-value

1)Facility-based	Food	0.917
2)Household – Health	Social Behavior	0.708
	QoL Overall	0.886
	Hope path children	0.996
Household – Psychosocial	Hope Path children	0.019
3)Linkage services	Hope Agency children	0.047
	Hope Path children	0.044

P-values reflect the difference between the two groups, adjusted for age and sex.

4.7. Stakeholder environment

In terms of processes, there is broad involvement of all types of stakeholders in different processes of planning. However, a few of the stakeholders (networks of people living with HIV, TAPs and some parts of the government) feel that they have not been adequately consulted or their views been incorporated; this could be partly due to the rapid change in staff amongst the stakeholders. Overall there is a general recognition among the stakeholders of the need for a programme like BSY.

Selected verbatim reflections of partners about the BSY programme

"I fully agree with the present model which is a really unique and sustainable model. We have been able to change their mind set from a service delivery programme to accessing services to existing linkages and government."

"I think the programme has been slightly confusing in terms of going through various stages of re-design and bringing things together, and I think that has been complicated. It has also dragged sometimes in terms of the timeframe, and that is something, I think, with the benefit of hindsight would be actually getting things, you know turnaround and re-designs implemented, but I think it is very easy to focus on that, but it has been difficult with this programme. But I think actually there has been a huge amount of strong pieces that have come out, and I am kind of looking forward to the next phase."

"We have had feedback from the FCMs, from beneficiaries, and from some of the other staff, that food security is the tangible piece of the direct interventions, that they actually can see happening and feel happening and that has actually been used as an entry point for some FCMs; they can see a perceived benefit to it, whereas they cannot associate perceived benefit to some of the other elements of the programme, so I think you know undoubtedly that has been a really valuable part of the way that the structure is at the moment."

Awareness of BSY in the districts

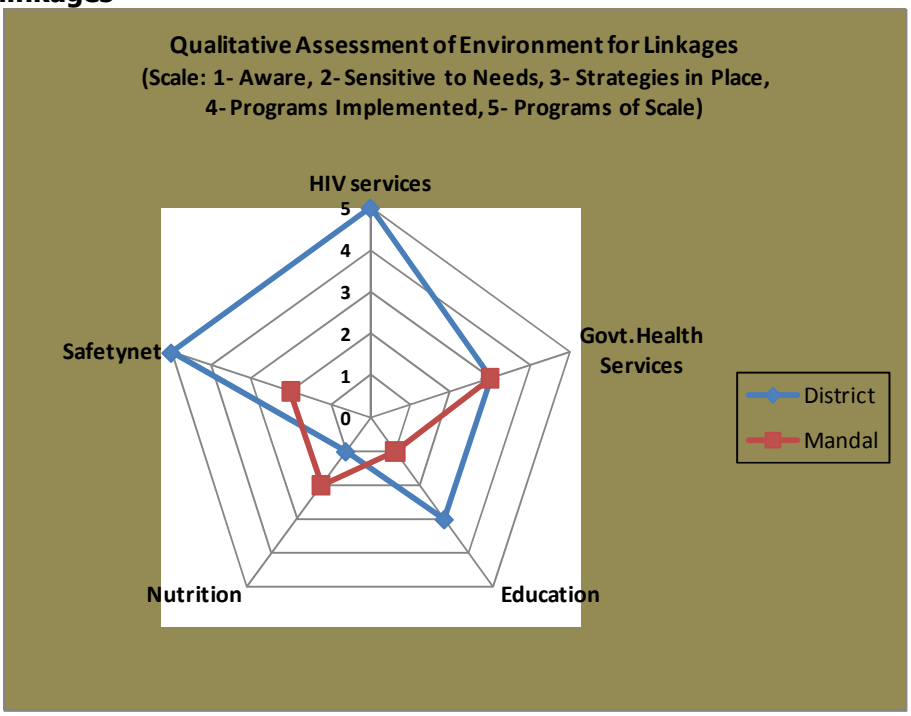
To test the linkages and potential for sustainability, we interviewed key government stakeholders at the mandal and the district level in the HIV services such as ART, PPTCT and voluntary counselling and testing centres, government health facilities, the Departments of Education, Revenue, Women and Child Welfare, Rural Development etc. The purpose of this exercise was to determine awareness of HIV context, sensitivity to the needs of children infected with or affected by HIV, if their department had any strategies or plan in place, if there were small programmes, and if there were scaled-up programmes within the department for children infected with or affected by HIV (see chapter one, table 1.2 and annex to Chapter 1, Table 1.2 for details of key informant interviews).

At the district and mandal level (in West Godavari), awareness of BSY is limited to 28 per cent of the respondents; only 12 per cent feel there is a need for a programme like BSY, and 16 per cent feel that it should be left to the government to implement programmes of this nature. There is a strong need to communicate and advocate with stakeholders at the

district and mandal level. Disaggregated data show that in West Godavari the awareness levels were highest, with other parameters being similar to the other two districts.

The figure below graphically represents the involvement of HIV services in relation to health and education, and the Department of Revenue for generating employment for those affected. There was no one representing HIV services at the mandal level, hence the null score. A key concern is the fact that the key stakeholder in charge of nutrition was barely aware of the HIV context at district level; however, at the mandal level there is awareness and sensitivity about nutritional needs.

Figure 4.8. Qualitative assessment of in-depth interviews on environment for linkages



4.8. BSY replicability and scalability

For a model to be replicable, there are some pre-conditions:

- Felt need for a model;
- Similarity of contexts (where it was designed and is being replicated);
- Ease of adaptation (simplicity);
- Cost-effectiveness (within the National AIDS Control Programme context);
- Proven impact;
- Perception of model (communication, relationships);
- Packaged (e.g. toolkits, checklists, standard operating procedures); and
- Other models and their efficacy and communication.

Some of these factors are within the control of the programme, others not. At the time of assessment, the programme – in its current form – appears replicable to a limited extent. A qualitative analysis of the factors and controllability are given below.

Table 4.4. Extent of replicability of BYS programme

Replicability unpacked	Control of Project	Extent of progress				
Felt need for a model	No					
Similarity of contexts (within India)	No					
Ease of adaptation	Yes					
Perception on model (communication, relationships)	Yes					
Packaged (e.g. toolkits, checklists, SOP)	Yes					
Other models and their efficacy and communication	No					
Cost effectiveness (within the NACP context)	Yes					
Proven impact	Yes					

The model at the time of assessment is still far from being complete and packaged, but there are still about 2 years left to achieve better packaging of the model. For example:

- The food security programme needs to roll out in West Godavari;
- Different and new outreach models are being tried out in newer districts;
- The nutrition component is being piloted in ART centres;
- Sustainability is being defined by the programme and actions initiated; and

This kind of modelling is critical for the government to consider scale-up. The programme partners are already on the job to do this delineation and definition. There is still much work needed, particularly in the areas where the project has control.

4.9. Issues related to the sustainability of Balasahyoga

Figure 4.9. Outcome and impacts of the BSY programme

The sustainability of the programme can be measured in five ways – of which the sustainability of outcomes and impact are critical, with the other four contributing to sustainability. While this evaluation will provide crucial data relating to outcomes and impacts, this can only be really assessed at the end of the programme. In the case of each of the other elements, the current situation is analysed below.

4.9.1 Ownership

Ownership at the state level is limited but cautious. The programme is feeding into broader processes (for example, Steering Committee). The state's expectations are higher (more coverage, better information – particularly on finances). At the district level there is increasing ownership. There are new structures emerging. Scope exists for increased involvement and ownership at all levels (district, state and national).

4.9.2 Leverage

The programme has set up several links and leverages and is already leveraging services provided by the National Programme (such as testing, PPTCT and ART) and other services and entitlements. It has also influenced the start of new entitlements such as double

rations. The linkages are currently limited to services and programmes (for entitlements and benefits). There is an opportunity to work with other programmes such as with link workers, and to increase funding or replicate the programme within the state.

4.9.3 Structure and staffing

During the design of the project, it was felt that separate and dedicated staffing was needed, particularly at community facilitation level. The FCMs and CVs are the key people that make the programme work, but the salaries and travel allowances of the FCMs are fully paid by the BSY programme and, therefore, not sustainable as such.

New structures such as District AIDS Prevention and Control Units (DAPCU) are coming into play. More importantly, there is a plethora of schemes and projects that have committed individual field-level workers (PPTCT, link workers, and many others – seven at last count). There is a need for a larger study of the various extension-staffing models at district level and below. Based on this, long-term decisions on structures and staffing are essential to ensure that the families are linked to the services. The programme is already reviewing different outreach options (and staffing).

4.9.4 Financial

Budgets exist within the National Programme for addressing children infected with or affected by HIV, although they are still limited. State-level funds are even more limited. Given that NACP IV may be a more mainstreamed health programme (starting in 2013), the implication for programmes such as BSY need to be considered now. There is also a need to carry out a cost analysis of BSY and allocations – comparing costs at various levels with the National and other comparable programmes.

4.9.5 Resilience of families

One of the assumptions of the programme is that families become more resilient through the support of the FCMs and CVs, by establishing linkages to different kinds of services for the affected households.

The Hope Trait Scale, specifically the Pathways dimension for adults, was used as a proxy indicator for family resilience. Pathways are a person's perceived ability to generate workable routes to desired goals and are seen in internal speech such as "I'll find a way to get this done". Caregivers in households completed this scale with children aged 0–8 years.

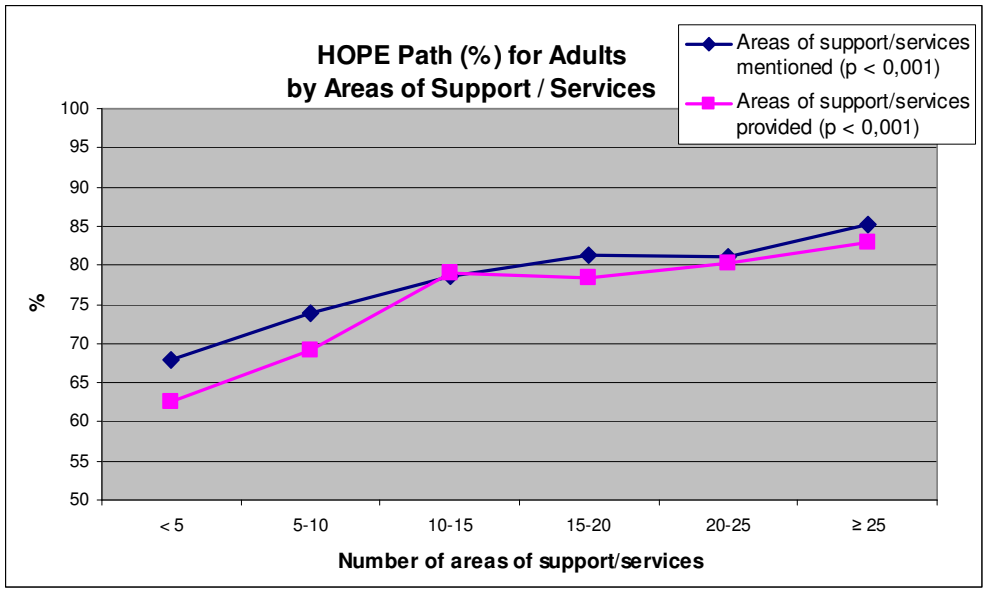
Analyses of covariance were used to compare Hope Scale scores between groups (HIV status of children, HIV status of care-giver, ART treatment, gender of child, gender of head of household, family situation), and all analyses were adjusted for age and sex.

Female-headed households showed higher Hope Scale scores than male-headed households. In households headed by grandparents (in other words, where parents have died) a trend toward lower resilience ($0.05 < p < 0.1$) was also seen.

Family size did not have an effect on Hope Scale scores, but a trend towards significance was seen with number of family members with HIV ($0.05 < p < 0.1$): the more family members with HIV, the lower the family resilience. A marked decline in resilience was associated with families with four or more HIV-positive members.
This study also showed that resilience is built by an increase in the number of areas of support/services. Families reporting (both unprompted and prompted) more than 25 areas of support/services had average Hope scores of 85 per cent and 83 per cent respectively.

This was significantly higher than those families reporting fewer areas of support/services (p<= 0.001).

Figure 4.10. Resilience and number of services



A further analysis of the IHHT cohort attempts to identify the significant differences in the quality of life and hope scale outcomes for the type of services mentioned by the families and to analyse any patterns. The table below shows where there are significant differences in QoL outcomes for actual services that have been mentioned to these households and children, providing some pointers as to the perceived value of these services in the households.

Services mentioned and scores for children aged 0-8 years[19]

Services mentioned	QoL Domain/Hope Scale	p-value
Household-Health	Food	0.001
	QoL overall	0.015
	Hope agency adults	0.027
	Hope pathways adults	0.001
Household-Nutrition	Hope agency adults	0.001
	Hope pathways adults	<0.001
Household-Psycho-social Support	Health	0.039
Linkages		

Services mentioned and scores for children aged 9- 16 years

Services mentioned	QoL Domain/Hope Scale	p-value
Household- Health	Health	0.041
	QoL overall	0.479
	Hope agency adults	
	Hope path adults	
Household-Safety net	Social behaviour	0.02
	Hope pathways children	0.008
Household-Psycho-social Support	Food	0.035
	BMI, kg/m^2 (Not mentioned Psycho-social support)	0.005
Linkages	Food	0.049

The Households services categories "Health", "Nutrition", and "Psycho-social" were related to higher QoL or Hope scale scores in the age group 0-8 years. For the older age groups the

[19] Facility based services were not significantly linked to QoL and Hops scale outcomes in both groups.

services mentioned in the categories of "Health", "Psychosocial" and "Safety net" were related to higher QoL or HOPE scale scores. The elder age group also mentioned their quality of Life score across the "food" domain increased with the linkages services.

These results might indicate that services received at the Households are related to higher QoL and Hope scale scores across mainly health, nutrition/safety nets and psychosocial domains. There is no clear relation between mentioning Facility based services and QoL and HOPE scale scores.

With regard to length of exposure to BSY, it was observed that families with more recent exposure, i.e. between six and 12 months, showed the highest resilience, whereas families who have not been on the programme and very recently enrolled families showed the lowest resilience. This was, however, not statistically significant (see table below).

Table 4.5. Hope Path for adults against exposure to BSY

BSY exposure	0–6 months (n=92)	6–12 months (n=140)	12–18 months (n=93)	18–24 months (n=272)	≥ 24 months (n=53)	p-value
Hope Path adults	78.8%	82.3%	81.8%	81.1%	78%	0.168

4.10. Main findings and early conclusions on Balasahyoga as a model

4.10.1 Programme design

CIFF is a committed donor and a relatively new organization that clearly sees learning from its programmes as an important strategy to inform programme planning. This also means that CIFF's approaches and visions changed over the course of the BSY programme. From the perspective of BSY implementing partners it has been difficult to keep up with the many changes over a relatively short time.

CIFF wanted to build a comprehensive, family-based approach for children infected with and affected by HIV and found different partners with capacity in the different areas, but in the design phase the communications between the different partners were disjointed and took place in different stages. Moreover, at the start, the partners did not plan the interventions together as one continuum of care, but were basically transferring clients from earlier projects into the BSY project. This probably contributed to the programme not being properly designed from the start, resulting in a suspension of the grant in February 2008. It was, however, a wise decision at the time to redesign the programme, even though it caused a lot of frustration and delays in implementation. After the joint re-planning exercise partners came together gradually, working towards a more common approach to the affected households and children.

4.10.2 Programme implementation

The initially foreseen duration of the BSY project of five years – from April 2007 until April 2012 – has been considerably reduced, as the programme only really took off in October 2008. This means that a lot of activities had to be implemented at the same time and in a very short timeframe. The evaluation team questions whether the BSY project has sufficient implementation time to demonstrate a real impact on the lives of the affected families and households. Many BSY partners felt it would be difficult to achieve the targets.

The BSY programme with its five domains operates in a very complex environment, whereby both at state and district level different government bodies and civil society groups should

all be working together. APSACS has no authority over the other line ministries, so mainstreaming of the BSY domains in the respective line ministries might be difficult.

At the organizational level the programme was not well integrated in the beginning. Different components were implemented under separate contracts and budgets, and coordination was rather loose. This was redressed in October 2008, and increasingly the partners are streamlining their efforts using a joint logical framework and joint planning process.

All partners now agree that the programme is much better designed and positioned than in the beginning and that stronger integration has been achieved. The decision to have the FCM deliver the safety net and food security direct interventions has unified the different components better at the community level.

APSACS still expresses some difficulty with its role as coordinator of the BSY programme, as it does not have the tools to do so:

> "The programme is not really owned by APSACS, and they do not have control or insight into the budgets involved."

Within APSACS there are different views concerning the programme, ranging from "need to replicate the BSY model in all districts" to "the programme does not seem to make a difference at all".

Non-health or HIV services seem far removed from awareness of the HIV context and will need to move from an 'unaware' state to a state of awareness and with programmes in place.

4.10.3 Programme effectiveness

The registration of households, children and adults has been going well, and even though not yet reaching 100 per cent of the target still has the potential to achieve this in Year 5.

The BSY programme seems to be able to test only 48 per cent of the programme target for eligible children for HIV, and the trend shows a downward inclination. The number of children who tested HIV-positive is also much lower than anticipated in the targets. This could be for a number of reasons such as effectiveness of the PPTCT programme, whereby fewer children get infected with HIV, or that the targets for children living with HIV were set too high. It is also possible that the programme is not able to reach the eligible children with the required services.

There is a need to calculate more precise estimates of the numbers of infected and affected children, also in view of potential effects of the PPTCT programme, which should result in fewer children becoming infected with HIV. This will also allow the programme to review if the targets are realistic. Based on this, further strategic discussions are needed to explain the reasons behind the difficulty in getting performance up to standard.

The BSY programme is also underperforming in terms of getting the forecasted numbers of children onto ART (reaching 51 per cent of those expected in the 11 districts). Also in terms of performance against the BSY target the programme seems to reach only 26 per cent of the children for ART.

The above findings of the evaluation raise a number of questions that this particular evaluation cannot answer: are the targets set correctly, is the reporting done correctly or are about 50 per cent of the children on ART not enrolled in the BSY programme? And if the

latter is the case, why are 50 per cent of the children on ART not enrolled in the BSY programme, and are there any other providers supporting these children and their families? What is the role of stigma and discrimination in this?

The BSY progress reports have changed in focus over time due to change in programme priorities. The team noted that the latest annual report has less information on the performance against key performance indicators than have the previous reports. It is, therefore, difficult for the evaluation team to generate accurate assessments, especially for the domains of education and schooling, psychosocial support and, to a certain extent, food security as these areas are deprioritised over the course of the programme.

The reporting on LFU and mortality has improved, especially in the last year, but it is as yet not possible to calculate the number of orphans and vulnerable children caused by the mortality of adults in the programme, as the analysis of mortality shows an upward trend that is probably more related to better recording than to an actual increase in death. Reductions in mortality, morbidity and number of orphans are the key outcome indicators of the BSY programme. In the annual progress reports these are, however, not consistently reported. With the way the MIS has been set up in the past year, it should be possible to calculate for each adult death how many children became orphaned, and from Year 3 onwards this would provide a better insight into the impact the programme is having on these indicators.

4.10.4 Replicability and scalability

The model of BSY has never been clearly defined by any of the partners. It is a mix of activities and components through which the partners believe they will together improve the QoL of children and families in the programme. Over the past years some efforts have gone towards identifying the key elements of the model, but much more effort is needed to come to a replicable and sustainable model. The view of the evaluation team is that the model is about linking communities and households to services and less about key elements.

It is too early to assess the potential replicability of the programme at this stage of the evaluation, but this chapter provided pointers for the programme to develop further into packaging and targeting. The current model of BSY has a heavy implementation structure that is costly and complex. A more simplified model leveraging the government HIV and ART facility-based programme with a stronger focus on the community side and linkages through strong outreach with already existing community workers and with involvement of key-players in the community like TNP+, DAPCUs and local health departments could be one way forward.

4.10.5 Sustainability

This chapter defines the key elements to be addressed for a programme to become sustainable in terms of ownership, leverage, structure and staffing and financial elements. More work is needed at all levels by the BSY programme to reach this important target at the end of the five years of implementation.

While there is some level of institutional linkages, they seem largely based on persons, and with changes in leadership this seems tenuous in the current environment. Where public officials have been sensitized, there has been good momentum to put together programmes; where there are none, BSY has a lot of scope for engaging partners to be involved in this cause.

Linkages will have to be strengthened and institutionalized at both mandal and district levels for referring the registered families to access the other services/social welfare schemes and social entitlements. The linkage environment needs to be focused on bringing about an environment of readiness for transition and, ultimately, sustainability.

The intensive approach to supporting affected families – with the target of reaching full saturation at the end of five years – ultimately aims at building a large number of resilient families that can manage their lives on their own. Families seemed to be more resilient when headed by a woman or when one or both parents were alive (i.e. non-grandparent-headed households) and when fewer family members were HIV-positive. Furthermore, a strong correlation was seen with family resilience increasing as the number of areas of support/services provided increased. After six to 12 months of exposure to BSY, families experienced relatively high Hope Scale scores. This possibly implies that recent BSY strategies became more effective than strategies at the beginning of the programme.

The FCMs are the key persons in the BSY programme, but this paid cadre is unsustainable in the long run. There are also many other outreach workers operating in the districts, both from the government as well as from NGOs. The BSY partners and APSACS should conduct an assessment of all outreach worker schemes (e.g. Link workers, ASHA workers, Health/ANMs, PPTCT ORWs) and analyse (feasibility, potential cost, alignment) which of these could be taking on the role of FCM once the BSY project comes to an end.

5 Overall findings, conclusions and implications for Balasahyoga

This chapter builds upon the findings and conclusions of the previous chapters as well as on the 1st of July meeting at which partners provided feedback and further input on these findings and conclusions. This chapter, therefore, aims to provide reflections on the meaning of the 1st round evaluations and gives pointers for recommendations for the BSY programme to guide the programme towards achieving its most important, albeit implicit, goal: "the development of an effective, sustainable and replicable multi-sectoral family focused model that improves the quality of life of children in families suffering from the adverse effects of HIV infection".

From an evaluation point of view we would like to clarify that all the findings and conclusions should be seen as assessment of the status of BSY at this point in time. Due to the timing of the first line this is therefore not a "true" baseline and therefore some changes have already been realized by the programme. The team will provide recommendations on how BSY partners could build further evidence for the added value of the project in the next two years. There are no recommendations for the assessment of the QoL of the children other than reflected in discussions about the design of the End Line.

5.1. Assessment of the Quality of Life of children and households

The QoL and Hope Scale scores for the children in the IHHT sample were relatively high. When QoL scores for healthy children from other previously performed studies in the world, were compared with the QoL scores of the children in the IHHT sample, the IHHT children had the highest scores. However, when comparing them to a similar group of infected and affected children in Tamil Nadu, the scores were quite comparable. The extensive validation exercise of the tool undertaken by the evaluation team showed that its internal consistency and ability to discriminate were high.

As a consequence of the relatively high QoL scores of the IHHT sample, the likelihood of improving these scores as a result of the BSY programme seems limited for the entire group of children, but not for certain sub groups, most notably for the children living with HIV. The reference group and end line design will address these specific concerns.

The evaluation design tries to link exposure to the Balasahyoga programme with the outcomes on perceived and objective quality of care of children. Because the programme was already implemented for about two and half years in the sample district for the IHHT, the children in the sample had been in the programme between 3 month and two and half years. Therefore the team consulted with BSY partners to construct an exposure variable, resulting in three measures: the time being in the programme, the linkages and services mentioned by the families interviewed and actual services received.

The exposure variable related to the time the families were enrolled in the programme did not yield significant results across perceived QoL and Hope scales but for the elder children aged 9–16 years, the BMI was higher in children who had been exposed longer to the BSY programme, which could indicate a possible effect of the BSY programme. The timeframe of the first interval of 0-6 month in the programme could have influenced these results as from TNFCC it was learned that the largest change in QoL occurs in the first three month after enrolment.

A stronger relationship was found for the variables related to linkages and actual services received by children and families, especially on the Trait Hope Pathway Scale for adults and children. This might be an early indication that the Balasahyoga is contributing to building resilience in families affected by HIV.

The single one group who was worst off across all domains of the perceived QoL and Hope scales were the children infected with HIV across all ages. Also for the more objective QoL indicators these children were worse off with lower MUAC and BMI as compared to those testing HIV negative in both age groups in the IHHT. When especially younger children were receiving ARVs however, their scores improved.

The analysis also provides an early indication that some children are more vulnerable to the adverse effects of living in families that have at least one person living with HIV. This was especially so for elder children living in households where a grand parent was the primary care giver. Girls in general had better scores on their QoL scale for social behaviour and for the Hope Agency score. Also the BMI for girls was higher than for boys.

5.2. Assessment of quality of care

In relation to the quality of care the evaluation aimed to assess current capacity of institutions as well as service providers (including FCMs and CVs), accessibility of different services for BSY families, as well as how BSY has possibly influenced this capacity and accessibility during the first 1,5 year of its existence. A key conclusion of this first round of evaluation is that BSY, through its outreach work approach, has been able to build a bridge between families affected by HIV and health services and to some other government services and schemes. However, there are many more families affected that are currently not being reached. The capacity of the FCMs and CVs has grown over time, but a number of constraints were identified that affect the implementation capacity and of this essential cadre. These include the heavy workload, the turn-over of FCMs/CVs and the fact that FCMs/CVs's role is not always being recognized by ART and other health staff. Also FCMs/CVs were found to be not fully aware about eligibility criteria for government schemes, which impacts on the effectiveness of the bridging function. Regular reviews of the specific needs of families that have been in the programme for a longer period of time, could lead to a less intensive support model, so that FCMs/CVs could reach out to new families.

Realizing real change in the government health facilities is very challenging. Infrastructural changes – although being appreciated – have not had much impact on patient flows due to the high patient load, but have created good-will within facilities through which further changes could possibly be realised. Counselling of BSY clients within ART centres appears to be minimal as most of the time is spent on administrative tasks (filling forms).

A major learning is that in order for (pediatric) counselling training to be effective, a critical mass needs to be trained, practical skills and motivation provided, and administrative burdens of counselors reduced, to ensure that they can bring the learning into action. A major hurdle to be taken is how to ensure that patients have easier access to ART treatment. Work done on LFU by BSY appears to have great potential, but has just been intensified.

Stigma and discrimination are strongly influencing access to services, government schemes and school, but is also affecting the willingness of eligible clients to join BSY. Community Sensitization activities were found to have a positive impact on stigma reduction. Enhancing the skills of FCMs and CVs to conduct such sessions, not only within communities but also within schools, might help to further reduce stigma and increase access to services.

Enhancing the counseling skills of FCMs and CVs to discuss about disclosure of HIV within the family was also identified as a priority as there were many unmet psycho-social needs of children. While there seems to be less focus on the provision of psycho-social support over the course of the project, this seems to be an area that was identified in the field as critical for improving access to services and increasing people's confidence to demand good quality services.

The systems capacity development focus of BSY is mostly on increasing capacity within health institutions but less so on building capacities of institutions working on the other domains of BSY: nutrition, education, psychosocial support, and safety nets. Recognition of BSY outside of health institutions seems to be much less. However, in order to assist BSY families with accessing services, visibility of BSY within those other institutions could help to increase access as well as to ensure easier transition of the project.

5.3. Assessment of the Balasahyoga model

One of the conclusions of the first round of evaluation is that there is a clear need for models that help to operationalize the CABA guidelines. BSY is covering five of the seven components seen as critical and necessary in these guidelines to "ensure the immediate well-being and holistic development of children affected by HIV", using a family-centred approach. As such, the guidelines do not question the contribution of any of the individual components to the overall well-being of children living with HIV or living in affected families, but they imply that there is sufficient trust that a comprehensive approach would achieve this goal. One of the underlying assumptions of the BSY programme is that when building resilience in families they can eventually access services as and when required themselves, and this is essential for sustainability

The 1st round of the evaluation used the Hope Trait Scale, specifically the Pathways[20] dimension for adults, as a proxy indicator for family resilience. Even though real conclusions can only be made after completion of the End line there are indications that resilience of families is influenced by a number of factors. In female-headed households caregivers had higher Pathway scales than male headed. Households headed by grand parents and those with more members infected by HIV scored significantly lower on the scale.

An important finding that needs further analysis at End line is related to the fact that more resilience is built with the increase in the number of areas of support/services received by families (see Chapter 4, Figure 4.9). Families reporting more than 25 areas of support/services had average Hope scores of 85 per cent and 83 per cent respectively. This was significantly higher than those families reporting fewer areas of support/services ($p <= 0.001$). Potentially this could lead to conclusions about the effectiveness of the linkages established through the FCM/CV model.

At the moment CABA has no funding stream established as yet and in order to better understand effectiveness of the different components CIFF and BSY partners seek to understand which of the components contribute most to an increase in different QoL indicators. The evaluation has not been designed to provide answers to questions of relative attribution of the different components to the overall wellbeing of children and families, but is focussing evaluating the comprehensive approach. The perceived QoL scale however, is subdivided in different components and could therefore be used to provide some indications. The analysis of the QoL across the 5 domains, however, did not show significant differences,

[20] *Pathways are a person's perceived ability to generate workable routes to desired goals and are seen in internal speech such as "I'll find a way to get this done".*

in that any of the five domains contribute substantially more to the perceived QoL scores of families and children. Even though the end line evaluation potentially provides the BSY partners with an opportunity to analyse this further, with the suggested reduction in sample size for the End line IHHT it remains questionable if the numbers will be high enough to make inferences about attribution.

The evaluation team sees the uniqueness of the BSY model in its bridging function between families, communities, health facilities and other government and NGO services. Central to this is the role of the FCMs and CVs, as they have regular and direct contact with the BSY families, identify vulnerabilities, put these families in contact with health facilities and other government and civil society services and also trace children and adults when they have been lost in the system. The FCM and CVs in the BSY model, therefore, form an indispensable bridge between the community and the services environment in the BSY programme. At this point in time there is not yet conclusive evidence about the effectiveness of this model in terms of reaching eligible clients:

- The IHHT data from West Godavari, one of the districts where the programme interventions started early, show that in the younger age group (0-8) 90% of children had received HIV tests, but only 75% of children in the age group of 9-16 years. However, when analysing data from the ART centres in this district only 40% of eligible clients were aware of BSY of whom 90% had registered (see chapter 3, section figure 3.8;). This finding indicates that even in a District where interventions started early there is still need for increasing coverage.
- For the entire programme (MIS) at this point in time, there is insufficient evidence that BSY offers added value in enrolling children in the programme, reaching currently about 50 per cent of the total number of children on ART, while considerable numbers of children remain untested and do not know their HIV status (chapter 4, section 4.1.1 and fig 4.5). This can in part be related to the phased roll-out of the programme and can only be conclusive at End Line.

The evaluation found that stigma and discrimination are highly prevalent in the three districts at all levels in the system: government services and departments, service providers, communities, neighbourhoods, schools and also within families. It may be one of the reasons why the programme is reaching only 50 per cent of its intended target. It was found that stigma reduction activities within communities, schools and government settings have great potential to strengthen the resilience of families and increase their access to services as indicated by the FCMs and CVs. During FGDs, FCMs and CVs showed examples of innovative and effective approaches to decrease stigma and build bridges between BSY families and their neighbours and BSY families and services.

5.4. Assessment of sustainability, replicability and transitioning potential

Essentially the CABA guidelines were developed to address a major public health problem in India, and the BSY programme is in a unique position to provide essential information to the Indian government on operational issues and challenges when implementing a comprehensive programme for CABA.

During the design phase of the BSY programme the operational and conceptual thinking about the BSY model were not well thought through (see annexes related to chapter 4). It was designed to build upon the strengths and portfolios of three strong international NGOs, each having strong experience in their respective fields (FHI: community models and psychosocial support; CHAI: health systems strengthening; and Care: community-based food security and safety net interventions). Even though a lot of progress has been made in

harmonising and aligning efforts between the three partners, the impression of the evaluation team is that there seems to be some tension about the relative importance of each partners' intervention area.

CIFF has been a very engaged partner and the "learning by doing" approach has contributed to frequently changing focus and priorities. There seems to be an increased focus on health and nutrition interventions and on improving the testing and treatment cascades and less focus on fully scaling up of safety net, psychosocial and schooling efforts. This is corroborated by the QoL scores for schooling which were the lowest of all (table 3.5.19 in annex), which were even lower for children living with HIV at 79.3%. From our evaluation perspective the questions with regards to replicability and scalability of the comprehensive model may prove difficult to answer.

It is questionable at this stage of the implementation whether the model of BSY where it is managed by three strong NGOs with infrastructure replicated at state, regional and district level could be taken over by the government.

This is to a certain extent also reflected in the way the programme looks at sustainability issues. The discussions about this seem to go in the direction of transitioning key activities in the five domains of the programme to respective government departments and programmes, rather than on taking a step back and looking at the model not as a sum of activities but as a way of bridging an important gap in bringing people into contact with essential services and ensuring that they consistently access these services related to the outcomes of the programme (outcome and impact focus).

As part of the programme's replication efforts the essentials of the programme and model would need to be packaged for use by other programme implementers. This package could include, amongst others, the description of the model, key strategies and standard operating procedures, the M&E system, training modules, minimum capacities needed for the community workers, and the management and technical support system required.

5.5. Design of the evaluation

The first round of the evaluation has been designed to provide a baseline against which changes at end line could be measured. As data collection for this round started while the programme was already well on its way, the key impact indicators, QoL and Hope Scale, already show a relatively high QoL, especially for children affected by HIV, and limited scope for improvement. The reference group of 200 infected and 200 affected children from the same household will provide supportive evidence for the assumption that the high QoL and Hope Scale scores in BSY result from a longer period of exposure. The Reference Group is therefore essential in establishing a 'real baseline' against which the efforts of the BSY programme will be analysed at end line.

It remains important for the BSY partners to keep a strong focus on finding evidence of the effectiveness of the programme through the MIS and government data, in addition to what the evaluation team will review at end line. At present the MIS data for example the CD4 counts are available for about 74% of the children. Repeat testing for CD4 counts could more objectively indicate health improvements of children over time. The indicators for measuring Opportunistic infections, morbidity and mortality are of great importance for the End line. Also it is important that the MIS provides information on the number of orphans that occurred over time.

The end line will add valuable information for comparison and changes over time in terms of perceived QoL, Hope Scale, and more objectively changes in BMI and MUAC against findings of the first round of evaluation and the reference group. The two measurements combined will provide robust evidence:

- The end-line measurement of the IHHT: given the high QoL and Hope Scale scores that show little room for improvement, a reduced number of children would be interviewed. A total of 270 HIV-infected and 270 HIV-affected children from the same households will allow conclusions to be drawn from the IHHT.

- The reference group of non-exposed children will provide supportive evidence for the assumption that the high QoL and Hope Scale scores in BSY result from prolonged exposure to the programme. The minimum sample required is 200 HIV-positive children plus an additional 200 HIV-affected children from the same households so that scores for both infected and affected children can be analysed.

The key questions to which the end line should provide answers relate to 'What signs of change in the different QoL indicators for children and families did BSY programme bring about, and how this change did occur?' The key data sources will include the IHHT, the MIS of the BSY partners and the APSACS data for the entire state for making comparisons.

The recently[21] released Children Affected by AIDS (CABA) guidelines were developed with support from the BSY programme and are along the lines of the BSY programme. This evaluation should provide relevant and robust information for NACO in terms of effectiveness, impact and replicability of the model. The evaluation team will develop a separate concept note for the design of the end line for discussion with CIFF and the partners.

A separate note for the end line design is under discussion with CIFF and seeks to ensure that all three original evaluation questions can be answered towards the end line.

5.6. The Balasahyoga Management Information System

BSY has gone to tremendous efforts to build a rich MIS system that has now been fully computerized. This MIS system could potentially be transitioned to APSACS or NACO if the system were to be simplified. Please see Section 5.1 in the annex to this chapter for some key indicators that could help to build further evidence for measuring effectiveness.

Part of the essential package for replication is a monitoring and evaluation (M&E) system derived from the current MIS. This requires defining the essential data input needed as well as adding evaluative elements (such as BMI and MUAC before and after nutritional intervention with double rations etc.). Strengthening the evaluation component of the system would include, for example, an assessment of QoL, Hope Scale score and BMI/MUAC (measured and recorded) for the first 100 children enrolled in each new district, with regular follow-up. These measurements would add to the robustness of the data acquired thus far.

The MIS model of the BSY programme has so far mostly been used as a monitoring instrument rather than for evaluation. The MIS, in its design, houses important possibilities for providing answers to effectiveness questions once the in-built time sequences are operationalized. Potentially key data could provide information on the number of children tested (community component), of children with CD4 count, of children back on ART, of

[21] 2009

children still alive attributable to BSY, as well as on their BMI, QoL and Hope Scale scores, and the number of BSY children who dropped out of school placed back into the system. Section 5 in the annex to this chapter provides the team's initial thoughts on which measurements are essential for the M&E system. Once the M&E data from APSACS are shared with the partners, this analysis will provide crucial information for reviewing the added value of the BSY programme as compared to other interventions in the state.

5.7. Recommendations

This section will provide some key recommendations for the Balasahyoga partners to review and discuss. These could be expanded by the partners themselves, depending on what is useful for refocusing some of the efforts.

One overall concern the evaluation team would like to raise at this point relates to the fact that BSY programme is very ambitious and complex and in view of the reprogramming exercise, the five years duration of the programme as initially foreseen, has been reduced by over a year. This meant that a lot of activities had to be implemented at the same time and in a very short timeframe. The evaluation team questions whether the BSY project has sufficient implementation time to demonstrate a real impact on the lives of the affected families and households. Many BSY partners felt it would be difficult to achieve the targets.

5.7.1 Medium term improvements in service delivery aspects

Capacity issues

Address the issue of FCM and CV turnover effectively – by putting in place a tracking system to inform change, handover and smooth takeover.

Examine the role of the PLHIV groups to provide FCMs and CVs – which will integrate the work with the larger PLHIV-led treatment and care system that is operational.

- Develop more tightly defined field strategies, which address role clarification of FCMs (and also CVs), clarification of household visits, rationalization and prioritization of household visits according to needs and work load reduction. As annual turnover of FCMs is around 30 per cent, create an ongoing, dynamic learning and training cycle. Enhancing shadow leadership and mentoring of the CVs by FCMs, and motivation and incentives for FCMs.

- Ensure that the FCMs and CVs are better equipped to maximize their bridging function as described above through training in community sensitization, child counselling skills, ways to address stigma and discrimination, and better skills for identifying an essential package of linking schemes and better understanding eligibility criteria and how these schemes can be accessed.

Institutionalizing these stigma reduction field strategies and training less skilled FCMs and CVs would seem a good way to go forward to build such resilience.

Testing and treatment cascade issues

There is an increasingly strong focus of BSY partners and CIFF on improving the treatment cascade. There are a number of important operational issues to address that could strengthen the cascade, such as:

- BSY partners should deepen analysis of reasons behind the relatively low reach (reaching only 51 per cent of children, even in districts where full roll-out has been achieved) of the programme. Stigma was found to be one of the reasons (chapter 3) behind and a better understanding could lead to designing strategies to increase the uptake in the BSY programme of affected families.
- Review how the travel cost of clients to the ART centre can be reduced in discussion with the Ministry of Health and ART clinic staff. Possibilities could include: reviewing opening hours of the clinic, exploring other modes of ART service delivery, task-shifting approaches as used in many countries, mobile ART/testing clinics, and reviewing how ICTC could play a role in bringing treatment closer to the people.
- Even though CD4 counts are now available for about 75% of children, there are few data on repeat testing and trends in this.
- Counselling in ART clinics, especially for follow-up clients, was found to be inadequate and might negatively contribute to ART adherence, including for children, and contribute to loss to follow-up. Expanding counselling training, making it more practical so that counsellors are well-equipped with putting the learning into action, and including activities and tools around adherence and loss to follow up, could be explored.

Psychosocial support

- Review how the evaluation findings can be used to better target specific vulnerabilities with more focused interventions – for example, the special needs of families headed by grandparents, and provide more focus on keeping children in the educational system, especially in male-headed households.
- Even though psychosocial support was de-prioritised, there still seems to be scope for strengthening psychosocial support especially for children aged 9-16, as the ones that have received LSE score better on QoL and Hope scales.

Nutritional support

- Better **tracking of the impact of nutrition on children** through pre- and post-exposure measurement of MUAC or BMI could help to document the impact of the programme. Working towards improving the nutritional value of the ICDS double ration, thereby building upon the experiences with the nutrition programme in the ART centres, could help to provide added value to this government scheme for children infected with HIV.

Food security and safety nets

- Quite a number of households classified as severely food insecure were found to be uncovered by safety net services something that should be looked into when rolling out the in 2009 revised food security strategy. Linkages to different government schemes could be established more effectively if FCMs and CVs receive further training on eligibility criteria and and back-up support through advocacy and higher level multi-stakeholder meetings.

5.7.2 BSY model and effectiveness measurements

Increasing access and coverage

A key recommendation relates to the relatively low coverage of the programme. As stated before in chapter 4, the BSY programme seems to be able to test only 48 per cent of the programme target for eligible children for HIV, and the trend shows a downward inclination. The number of children who tested HIV-positive is also much lower than anticipated in the targets. The BSY programme is also underperforming in terms of getting the forecasted numbers of children onto ART (reaching 51 per cent of those expected in the 11 districts). Also in terms of performance against the BSY target the programme seems to reach only 26 per cent of the children for ART.

The above findings of the evaluation raise a number of questions that this particular evaluation cannot answer, but require urgent review by the BSY partners:

- Are the targets set correctly?
- Is the reporting done correctly or are about 50 per cent of the children on ART not enrolled in the BSY programme?
- And if the latter is the case, why are 50 per cent of the children on ART not enrolled in the BSY programme, and are there any other providers supporting these children and their families?
- What is the role of stigma and discrimination in this?

The BSY model

In essence, what the Indian government seems to need from the BSY partners is evidence that a comprehensive programme for children has a positive impact on the QoL of children and families, and a simple, effective, replicable and sustainable implementation model that can achieve these results, whereby costs are balanced against outputs/effects. It would be useful if the BSY partners engage with the NACO and APSACS to identify their specific needs for being able to adopt and replicate the BSY model.

Therefore the evaluation team appeals to the BSY partners to rise to this challenge. This requires the BSY partners to look at the model as an implementation mechanism rather than looking at the model as the sum of five domains addressed by three strong NGOs. The following questions could support these discussions:

- What are the key bridging functions that the FCM/CVs address in the five domains of the programme and which cadres are in place that could take this function?
- Which skills are needed at various levels in the system (both at FCM/CV level and in the different domains that families are linked to)?
- What minimum support system is needed to operate the model, leveraging existing efforts such as UNICEF, networks of people living with HIV and others (for supervision, coordination, capacity development and continuous education, financial management system, structure and a simplified M&E system)?

Even though the team feels that the FCMs and CVs are the essential bridging cadres in the BSY programme, we also note that there might be other cadres that are already performing community functions that might be well placed to take on the functions of the FCMs (paid) and CVs (not paid) – among others, the 'link worker' as advocated by the NACO and APSACS strategic plans. As such the FCM/CV model does not seem to be sustainable at this point in time. There is an international tendency to support a move in many countries towards employing paid cadres for implementing community functions. The 1st round findings provide early evidence that the "linking function" requires well trained cadres, especially in

addressing the needs of children/families infected with or affected by HIV, have the ability to link families to schemes and services, and have a support system that enables them to do their work.

Another factor that could assist in simplifying the programme and the BSY model would be to review the time path for which families need intensified support (when are they resilient enough that they can graduate from intensive support, which milestones?) and what should a leaner support system offer, once families move out of the more intensive phase. In view of this the BSY partners could also reflect on how they can best target the neediest.

The BSY partners should engage in discussions with the APSACS about getting the denominators right for the target group of children living in HIV affected households (through appropriate methods – a possible key contribution to the sector), also in view of potential effects of the PPTCT programme, which should result in fewer children becoming infected with HIV. This will also allow the programme to review if the targets are realistic. This could potentially greatly impact on the effectiveness indicators as the KPI's are based on assumptions.

Linkages will have to be strengthened and institutionalized at both mandal and district levels for referring the registered families to access the other services/social welfare schemes and social entitlements. The linkage environment needs to be focused on bringing about an environment of readiness for transition and, ultimately, sustainability.

Once the discussions about the model have been clarified more attention is needed to packaging the tools for this.

BSY Monitoring and information system

One of the assets in which the government might be interested includes the BSY's automated MIS. To develop a replicable system, more work is needed on simplifying the data required, with an enhanced focus on effectiveness information such as mortality, the number of orphans and vulnerable children, re-enrolment in school, alternative care arrangements etc. It would be advisable to discuss this with the government partners about requirements for the M&E system.

For the end line to be successful there is a need to ensure that the indicators related to mortality, morbidity and incidence of orphans and vulnerable children in the MIS are giving reliable data. Moreover the necessary indicators, that have been discussed with partners and in the ECG, to review effectiveness comparing BSY to the rest of Andra Pradesh are essential for coming to an end conclusion about the BSY programme at End Line.

Project Evaluation of South Asia Resource Team (SART)

to
, Chennai

By
Sampark, Bangalore

December, 2010

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The production of the written report has been done by the Study team at Sampark in Bangalore, and for any errors and omissions in the report, we continue to be responsible.

Abbreviations

AP	-	Andhra Pradesh
AVVAI	-	Avval Village Welfare Society
BWDC	-	Bharathi Women Development Centre
BDP	-	Business Development Plan
CAMP	-	Christian Association for Medical Mission and People Development
CAMEL	-	Camel Mahila Mutually Aided Co-operative Thrift Society Ltd
CASHE	-	Credit and savings for Household Enterprises
CEO	-	Chief Executive Officer
CFH	-	Centre for Hope
CDE	-	Centre for Development and Education
CJWS	-	Chaithanya Jyothi Welfare Society
CREED	-	Centre for Rural Education and Economic Development
CCFID	-	Community Collective Society for Integrated Development
DRDA	-	District Rural Development Agency
FGDs	-	Focus Group Discussions
HDFC	-	Housing Development Finance Corporation Limited
IOB	-	Indian Overseas Bank
ICICI	-	Industrial Credit and Investment Corporation of India
IWB	-	Institution for Women's Banking
JLGs	-	Joint Liability Groups
MACTS	-	Mutually Aided Co-operative Thrift Society
MBT	-	Mutual Benefit Trusts
MFI	-	Micro Finance Institution
NBFC	-	Non- Banking Financial Company
NABARD	-	National Agriculture Bank and Rural Development
NGOs	-	Non-Government Organization
NREGA	-	National Rural Employment Guarantee Act
PACT	-	Partners Capacity Assessment Tool
PPSS	-	Praja Pragathi Seva Sangham
RMK	-	Rashtriya Mahila Kosh
REAL	-	Rural Education and Action for Liberation
SARDS	-	Social Activities of Rural Development Society

SBI	-	State Bank of India
SHGs	-	Self Help Groups
SATMIF	-	South Asia Tsunami Microfinance Investment Fund
SIDBI	-	Small Industries Development Bank of India
SKS	-	Swayam Krishi Sangam
SART	-	South Asia Resource Team
SMVP	-	Sree Madhava Vidya Peetham
T N	-	Tamil Nadu
T V	-	Television

Executive Summary

This study is about the processes, outcomes and impacts of the SART Project, a post Tsunami intervention by CARE, to strengthen the nascent MFIs in order to build up their institutional capacities to deliver effective MF services to the affected and needy communities in the Tsunami affected and disaster prone locations in India and its neighbourhoods.

The study primarily comprised of field visits to four partner organizations/communities and desk reviews of the available project documents.

The project, through an intensive institutional assessment process over a period of four and a half of years, has identified fifteen organizations in Andhra Pradesh and Tamil Nadu, two southern States of India, has entered into partnerships with them and has provided a series of services to build the institutional capacities of the MFIs. Under this project, each partner organization was provided with a grant support for the first year and technical support for the remaining years. Each of the partner organizations was also exclusively allocated an experienced SART staff member to ensure the technical support, on the site and on line.

Development of business plan, development and establishment of policies, internal systems and procedures for efficient MF operations were the key components of the technical support. A series of customised training programmes, participatory exercises and mentoring to build the capacities of the officers and board members of the partner organizations were also part of the technical support.

A few of the partner organizations which were facing liquidity crunch and difficulties in defraying the cost of expansion were identified and provided with a short term loan support through SA-TMIF. Also, livelihood incubation services were offered to two partners on pilot basis.

The technical incubation services to the partner NGOs have been instrumental in "transforming" the emerging MFIs into organisations with profit orientation and distinct institutional identities. It has also equipped the CEOs of NGOs /MFIs to think ahead, set a vision for the MFI and to work for the linkages and thereby gain and consolidate the requisite technical expertise to not only strengthen the MFIs but also to reorient them by fine tuning the MF operations to suit the needs of the clients affected by Tsunami and the subsequent floods. The inputs and the resultant increased/improved capacities of the partner MFIs in terms of governance, overall management, introduction of policies systems and procedures, linkages and monitoring has helped them in establishing and widening the bank linkages and thereby maintaining the liquidity to meet the on-going needs of the community.

The financial management inputs have helped the partner organizations to seriously consider the factors of operational costs and financial sustainability and as a consequence, measures are in place to gradually reduce the cost of operations and to increase the financial and operational self-sufficiency of the respective MFIs. Some of the measures employed by the successful partners are: pruning of staff to maintain a healthy ratio of portfolio per credit officer and restructuring branch operations. Four of the twelve MFIs are financially sustainable.

With the increased confidence, partners have expanded their operations in terms of branches and introduction of insurance products. There is a marked increase in the outreach. The clientele base has gone up to 279701 from 119678.

For the clients, access to credit and insurance services has been substantially improved. The average loan size has gone up to Rs11682/- per client, and it has almost doubled in the last financial year. The loans have helped the clients to invest in small businesses, traditional livelihoods like agriculture and allied activities, children's education and in assets, both productive and household. The introduction of insurance services combined with disaster orientation/training has reduced the disaster related vulnerability of the affected communities. The insurance coverage has increased from 19% to 39% during the last financial year.

The SART inputs have resulted in some of the best practices among the partner MFIs, like inclusion of board members in NBFC(CREED) from the community, board members retiring by rotation, mobilisation of share capital from clients that gives a legal ownership and a say in the overall policy making, collection of loan security deposits (BWDC),bundling of insurance with credit, recruitment of frontline staff from the community and building capacities of the staff members on their own to improve the service delivery capacity of the team.

Partner organizations have also experienced a few difficulties in the transformation process, like overcoming the hangover of charity mode and delays in adopting a thorough business approach. High turnover of key staff members, difficulty in accessing funds for enlarging loan demands, designing of new products and services, multiple borrowing by clients and deterioration of SHG structure are all issues that are still haunting them.

The gains of the SART project could be enhanced with the continued support for capacity building of the field level staff and board members of the partner MFIs, and long term credit fund to meet the growing needs of the clientele.

The specific recommendations for CARE'S future MF programmes are:

- *Provision of technical inputs at least for five years*
- *CARE to establish a legal structure to provide long term revolving loan capital for partner MFIs or to make appropriate linkages/steps to provide venture capital like tapping social investors*
- *Lobbying and sensitizing lead banks about the current status of SART initiatives and the funding needs of emerging MFIs*
- *Adequate attention to the creation of baseline relating to poverty, gender and women's' empowerment parameters in order to get a comprehensive data base to measure the corresponding impacts during the course and at the end of the project. of poverty targeting, women's empowerment and gender aspects*

On the whole, during the currency of the project the partnership with CARE SART has helped all its partners to increase their capacities to offer community oriented financial services that reduce vulnerabilities in disaster prone areas. The SART project has not only contributed to the institutional strengthening of nascent MFIs of chosen partner organizations but also brought out substantial good practices which could be adopted by the MFIs operating in disaster context. It has been decisively proved that the charity oriented NGOs could transform themselves towards providing sustainable financial services with meticulous technical inputs and carefully designed financial supports. The early gains of the project could be sustained and consolidated only with further internalization of inputs at all

levels in the MFIs and the successful mobilization of the much required loan fund, which CARE India needs to play key role in this regard in their future MF programmes.

Study Team

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6 Introduction

South Asian Resource Team (SART) is CARE International's Tsunami related project. CARE conceived this project and established the SART team in Chennai to strengthen the microfinance institutions (MFIs) and microfinance (MF) programmes in Tsunami affected regions with the objective of providing improved and sustained access to financial services to the affected communities. SART's mandate was to accomplish the above objective in four and a half years resulting in restoration of livelihoods for the Tsunami affected people, by building local partnerships with NGOs and providing technical inputs and small grant support to them. CARE-India, Chennai had invited Sampark to undertake an evaluation of the above project in order to document its outcome, immediate impacts, potential best practices and lessons from the Indian experience.

7 Background of the SART Project

7.1. Microfinance in Tsunami Context in SART

Microfinance approaches aim to raise income levels and improve living standards of the poor by providing thrift, credit and other financial services and products at small levels. There is increasing acceptance on the ability and utility of microfinance in helping poor households meet basic needs, increasing their protection against risk, stabilizing existing livelihoods, promoting new enterprises, supporting women's economic participation, promoting gender-equity, and improving household well-being.

Though it is believed that disasters indiscriminately affect all people, the social reality reveals that certain groups of people are more vulnerable to natural and man-made disasters than others. Disasters thereby reinforce and further aggravate the poverty and vulnerability of the poor, and render several other victims poor and vulnerable, increasing the spread of poverty in the disaster affected population.

Microfinance, through its long term impact of reducing poverty and supporting sustainable development, has immense potential to reduce the vulnerability of the poor to disasters. Microfinance contributes to disaster preparedness by creating the possibility of poor households having higher net worth, more savings, and with access to loans for consumption and reconstruction expenditure, which significantly reduces the impact of disasters on poor households.

Disasters have a distinct effect on the MFIs which deliver the MF service for the disaster affected poor households. Disasters tend to result in the loss of the MFIs' portfolio and render liquidity crisis a distinct possibility within MFIs. It is critical for the very existence of any MFI to meet this challenge as it would otherwise lead to imprudent financial practices and loss of clients' confidence in MFIs in the changed ground rules with a large inflow of grants and with changed expectations of the clients. It is a challenge for MFIs to meet these demands and retain the clients' confidence and simultaneously maintain the quality of their portfolio. In the post-disaster context, most MFIs find it difficult to cope with the loss of clientele and portfolio,

cater to their demands, and offer appropriate savings, loan and insurance products. In such situations, MFIs need to have preparedness to cater to the urgent needs of their disaster affected clientele.

Institutions in the nascent and emerging stages of development find it a daunting task to address such a situation. Also, these institutions usually do not have the requisite technical expertise to make sufficient adjustments in their savings and loan portfolios to ease the burden on their clientele in the aftermath of disasters even while retaining the efficiency of their programme and avoid any full-fledged liquidity crisis. Specialized technical assistance to MFIs is required for meeting such situations arising out of disasters.

The Indian Ocean Tsunami which struck Andhra Pradesh and Tamil Nadu on 26 December, 2004 resulted in large-scale loss of lives and livelihoods. It is in such contexts that microfinance for livelihoods enables communities to diversify their livelihoods, create new sources of income and expand their asset base, thereby enabling them to spread risk, reduce vulnerability and dependency, while enhancing their capacity to rebuild their lives.

Temporary shelters of migrant fishermen which are prone to disaster

To meet this objective and the immediate relief needs of the affected population, large amounts of funds have been channelized to the NGO-MFIs which have been operating in this region. This has also been accompanied by the formation of new SHGs, a proven mechanism for self-help and collective action. With the expansion of the number of groups, the promoter NGO-MFIs faces the daunting task of building the capacities of these groups and maintaining their quality. Furthermore, some of these NGOs themselves lack the required capacities and technical expertise.

Though the SHG model has been widely employed in the aftermath of the tsunami as an effective means of credit, the possible downside is that the proliferation of SHGs could dilute the quality of groups. To ensure quality and best practices, capacity building would be required at two levels. First at the MFI level, to cater to the expansion of the clientele and the portfolio, and second, at the group level, so that quality of groups is maintained.

There is also a need to strengthen the institution and programme in the context of the current disaster and to prepare them for future disasters. The institution could have inbuilt tools to enhance the capacity of the poor and vulnerable to overcome effects of future disasters.

Institutional development, including building the quality and capacity of the governance and management of MFIs, is seen as critical for a vibrant microfinance sector. The necessity of institutional development is reinforced by many factors, such as meeting the prudential and regulatory requirements, especially if the MFIs goals include capitalization and scaling up of operations, which would require their legal metamorphosis into a bank; enabling growth in client outreach, achieving scale of operations and ensuring financial sustainability; and finally, there must be institutional maturity to attract capital investment from external sources.

In this context, CARE has started the South Asia Tsunami Microfinance Investment Fund (SA-TMIF) and South Asia Resource Team (SART) project to respond to both short and long-term needs of MFIs serving the affected communities.

7.2. The SART Project

CARE's SART project was launched immediately after the close of the Credit and Savings for Household Enterprise (CASHE) project and many of the experiences of CASHE project have been instrumental in SART project design. SART planned to provide grants and technical assistance to strengthen the MFIs. Through SA-TMIF, SART planned to extend concessional loans to MFIs in order to bridge liquidity crunches and defray the cost of MFI expansion to affected regions.

The project period was from May 2006 to September, 2010. SART intended to operate in three of the South Asian countries most damaged by the tsunami (India, Indonesia, and Sri Lanka). SART was launched successfully both in India and Indonesia, but met with difficulties in Sri Lanka due to political turmoil.

In India, SART entered into partnerships with fifteen non-governmental organizations (NGOs), of which three were recent entrants. There were seven partners from Tamil Nadu and eight from Andhra Pradesh. The SART team developed and applied a score based Partner's Capacity Assessment Tool (PACT) to identify potential partner organizations in Tamil Nadu (TN) and Andhra Pradesh (AP). The ''PACT'' tool, has also served as a baseline to determine the nature and extent of technical services needed to motivate and equip the partner NGOs to increase the access to the credit services for the needy community. Preference was given to small and nascent organizations which had a weighted score in the range of 2-3, to enter into the SART partnership.

7.3. CARE's Strategy and Inputs Provided in SART

The SART project was implemented with the following **strategies**:

- Offering specialized and quality technical services in Microfinance and Livelihoods
- Working through direct partnership with CBOs/MFIs/NGOs for capacity building, trainings, consultations and assessment/research
- Focusing on new and nascent organizations
- Emphasising on Institutional strengthening to enhance internal capacities of institutions
- Offering innovative approaches, institutional forms, delivery mechanisms and products to enhance quality of services to the community
- Building strategic partnerships for the development of communities and healthy sectoral growth
- Facilitating greater participation of domain experts to tap available pool of resources and
- Focusing specifically on marginalized communities and women.

Board and staff members of Chaitanya Mahila Masts, discuss with the study team.

SART adopted the proven CARE-CASHE (Credit and Savings for Household Enterprises) incubation model for start-up MFIs, with three distinct phases spread over a period of four and a half years, so that the supported organizations will graduate to an on-going growth phase by the end of the technical incubation process.

First Phase

Internal capacity of the NGOs/CBOs was assessed through an Institutional Assessment Tool called PACT. Following the identification of institutional gaps, SART designed the intervention strategies for the respective institutions. Further, a participatory exercise was conducted with each of the partners to conceive a Business Development Plan (BDP) for a period of 4-5 years. Revision of BDP was also undertaken with the Partners in a workshop process.

Second Phase

Technical assistance and mentoring support was rolled out during this phase to implement the plan, which includes the establishment and development of internal systems, procedures, policies, and operational manuals for human resources and finance management. Thereafter, the capacity of the personnel involved in microfinance

activities was built with special focus on SHG formation and management, accountancy, financial management, portfolio and delinquency management, new product design and development, capital structuring and transformation processes. It was during this phase that SART provided resource support towards operational and automation processes. The assigned SART team members worked closely with the selected partners and provided onsite technical services through a well-structured mentoring process. Intensive monitoring of the progress of BDP was also undertaken by the SART team to ensure optimal performance.

Third Phase
During this phase, the partner institutions are expected to achieve maturity and gain the confidence of institutional investors by attaining investment grade ratings from an accredited rating agency. This will enable the partner institutions to develop long term business plans and diversify funding resources.

In addition to the above specific technical inputs and grant support, CARE has established the South Asia Tsunami Microfinance Investment Fund (SA-TMIF) to bridge liquidity crunches and defray the cost of MFI expansion to the affected regions.

While CARE has been extending the technical incubation services as evinced in the original proposal, it was not able to respond adequately to the grant component due to the low materialisation of commitment made by the donors. The legal constraints faced by CARE have limited the extension of SA-TMIF services beyond the pilot level.

In consonance with the above strategies and phased technical incubation services, CARE India provided grants support (for the first year) and technical assistance to strengthen institutional capacities of the partner NGOs/MFIs so that they can build the existing organizations; effectively use the available resources in the affected areas and develop disaster preparedness plans to mitigate the effects of future disasters on MFI operations. In a few cases, the SA-TMIF loan was also offered. The entire process was led by the SART regional team consisting of high profile experts.

In addition to the above services and support, SART has developed a livelihood incubation process on a pilot basis with two partner institutions; CDE in Kanayakumari and ASSIST in Chirala. Under this initiative, sustainable livelihood opportunities were pursued with a market based approach along with the institutionalization perspective, to support the Tsunami affected communities. Banana sub sector was the focus in CDE, while the Handloom sub-sector for the communities covered by ASSIST. Market Assessment, Enterprise and Skill Development, Social Intermediation, Institutionalisation of Producer Company, Production and Productivity Enhancement, Facilitation of External Linkages, Development of MIS and Monitoring and Learning are the key components of the initiative.

During the second half of the year 2009, pre-rating exercises were conducted for the partner organizations interested in going for rating by professional MF rating agencies. Efforts were also taken to translate the governance related training modules in vernacular. Documentation of case studies was also taken up during this period by the SART team.

Livelihood Incubation Services

A study (Desk Research) was carried out in Banana Sub Sector. 690 households of banana cultivators were surveyed and the preliminary market study is also over. All these studies have been consolidated as a diagnostic report. A cluster development workshop was also conducted in September, 2009 with the banana cultivators, wherein the findings of the above study were shared and their feedback was obtained. The exercise has led to a decision to undertake a full-fledged study of the Banana-Chips Value Chain. Subsequently, during the first quarter of this year, three rounds of discussions were held with the stakeholders. Besides, about 50 chips manufacturers/exporters were also contacted across the country. Discussions were also held with officials of institutions like Food Technological Research Institute, Veritas BVQI and National Research Centre for Banana to explore the technology and markets for the product. Based on these exercises, a cluster development plan was prepared.

Likewise, a study of the handloom sub sector was undertaken in Chirala to gain an insight into the problems faced by the weavers in this area. This study was also a desk research. A household survey of 492 weaver families was conducted. A market assessment study was also taken up. As in the other case, a diagnostic report was prepared with these baselines, and shared with the weavers in a workshop held in February, 2010. After a series of interactions, the partner NGO said that they could work with the varied players in the value chain of the handloom sub-sector, to facilitate appropriate linkages for the weavers. As a follow-up, a one day workshop was conducted with the stakeholders, like master weavers and designers to gather additional information. Discussions were also held with the officials of the Textile Committee, Chennai; and Aruna Industries, Hindpur to secure more information on market trends. The elaborate discussions have led to the modification of the diagnostic study

8 Objectives and Scope of the Study

The **objectives** of the evaluation are:

1- To evaluate the SART project with respect to its stated objectives.

2- To document best practices and lessons learnt in terms of project implementation.

The **scope** of the evaluation is limited to the implementation of the Project in India. It has been reviewed broadly at two levels: institutional and community. The following criteria have been reviewed at the institutional (MFI) level:

Institution Level

- Governance
- Management
- Policies and systems (accounting, MIS, FM)
- Planning
- Program monitoring
- External financial linkages
- Outreach effectiveness
- Portfolio monitoring
- Products and services
- Sustainability
- Gender and vulnerability sensitiveness
- Capacities and skills of Human Resources (Efficiency of service delivery, disaster preparedness, risk management, transformation and growth management)

Community Level:

- Access to financial services
- Assets - productive and household durables
- Community governance
- Resilience with insurance coverage
- Spending on basic needs
- Capacity to address vulnerability issues

The review also commented on:

- How the changes effected by the SART initiative contribute to CARE's overall goals of poverty reduction and sustainable development.
- The extent of gender sensitiveness and women's empowerment both at institution level and community levels.
- The key challenges faced by MFIs (viz., staff turnover, mobilizing resources, transformational, etc.).
- The good practices arising from the project.

The review has also provided recommendations for guiding CARE's future microfinance policies and initiatives.

The detailed study parameters studied under each of the above evaluation aspects are given in Table 2 in section 4.2.

9 The Methodology

The study involved both quantitative and qualitative methods. Greater emphasis was given on qualitative methods like focus group discussions (FGDs), interviews, case studies, and before-after exercises. The sample size and detailed work plan are outlined in the following sections.

9.1. Sample Size

CARE supported 15 partner MFIs from Andhra Pradesh and Tamil Nadu. The study has covered all the 15 organizations (see the accompanying box) to analyse the overall outreach and some of the financial performances based on the available secondary data at the CARE Chennai office and at the partners' offices. Identical periods in two successive financial years (Oct2008-Mar2009 and Oct2009-Mar2010) have been chosen for the comparative analysis of MF performance. Three organizations entered the partnership in February 2010 and were not reckoned for the comparative analysis.

CARE Partner Organizations

1. Camel Mahila Mutually Aided Co-operative Thrift Society Ltd (CAMEL)
2. Christian Association for Medical mission and Peoples development (CAMP)
3. Sree Madhava Vidya Peetham (SMVP)
4. Chaithanya Jyothi Welfare Society (CJWS)
5. Institution for Women's Banking (IWB)
6. Praja Pragathi Seva Sangham (PPSS)
7. Centre for Development and Education (CDE)
8. Centre for Rural Education and Economic Development (CREED)
9. Bharathi Women Development Centre (BWDC)
10. Centre for Hope (CFH)
11. Community Collective Society for Integrated Development
12. Avvai Village Welfare Society (AVVAI)
13. ASSIST – A society for Integrated Rural Development
14. Social Activities of Rural Development Society (SARDS)
15. Rural Education and Action for Liberation (REAL)

For an in-depth assessment of the project, the study covered 4 partner organizations out of the 15. The number of partners to be covered for the study was collectively determined by the SART and evaluation team members during the preliminary meeting held at Chennai. The availability of time for the study, geographical coverage, representation of MFI models, provision of SATMIF loans, and performance of the MFIs based on PACT-initial scores, willingness of the partner organizations, distance and remoteness of the location were some of the criteria that were deemed essential for the sampling process.

Table 1: Sample Size covered for the Field Study

State	District	Partner MFIs	No. of Branches
Tamil Nadu	Cuddalore, Thiruvarur	CREED BWDC	2 2
Andhra Pradesh	Nellore	CAMEL CJWS	2 2
Total	**4**	**4**	**8**

It was agreed that for the field visit, the evaluation team would visit two partner organizations in Andhra Pradesh and two in TamilNadu so as to give equal geographical representation. It was also decided to see at least two different models of MFIs. A minimum of two years old partnership was selected in order to assess the internalisation of SART's inputs and services and to capture the impact it has had on the community. It was further decided that the evaluation team would spend three days in each of the selected organizations for field study. However, it was agreed to get and incorporate the opinions, feedbacks and suggestions of all partners.

9.2. Detailed Work Plan

The process of implementation of the study involved the following steps:

Step 1: Preparatory Work for Development of Detailed Study Design

Sampark made a preliminary visit to CARE India, Chennai for a meeting with the SART team to get an orientation of the project and to finalise the methodology and schedule for the evaluation. The team also collected the all the basic documents needed from CARE India and prepared a detailed methodology including the tools of data collection for the field visits.

Step 2: Preparing the Team and Conducting Data Collection

A team of 4 people including a leader, lead consultant, senior researcher, and a field investigator was involved in carrying out the data collection activities in the field. The team spent 3 days in each state to collect primary and secondary data from the partners and from their field of activities. The team used both quantitative (in the form secondary data) and qualitative methods (interviews, FGDs, case studies) to collect data from institutional and community levels. The details of the data collected are given in Table 2.

Group discussion with board members of Chaitanya Mahila MACTS by the study team member

Interview with CEO and Operation Manger of CREED by the study team member

Table 2: Details of Methodology

Aspects to be studied	Methods and Process
<u>Institutional level</u> 1. External financial linkages: • Sources and size of credit accessed by MFIs • % of external credit lent out 2. Outreach effectiveness: • No. of families covered • % of very poor covered 3. Portfolio monitoring • Total outstanding loan portfolio • % of portfolio yield • % of portfolio at risk • Current repayment rate • Average credit portfolio per credit officer 4. Sustainability • Operational self sufficiency • Financial self sufficiency • Portfolio parameters covered above 5. Governance • Adherence to principles of good governance 6. Management • Technically qualified and experienced HR in place • Strong second tier staff structure in place • Grade rating of the MFI	All the quantitative data will be collected from secondary sources: from the respective MFIs and at CARE office level in both the states. Interviews FGDs with senior and project staff of the MFI

7. Policies and systems: • Accounting, MIS, FM 8. Planning • Level of disaster preparedness plan • Level of risk mitigation mechanism in place 9. Programme monitoring • The level of monitoring systems in place 10. Gender and vulnerability sensitiveness • Women and leadership issues <u>Community level</u> 1. Access to financial services • Members' savings and their use • No. and size of loan accessed by members • Purpose for which loans were accessed • Financial products and their analysis 2. Insurance coverage • No. of families accessed micro insurance services 3. Community governance • No. of women who participate in household and group level decisions • No. of women who participate in Panchayat 4. Spending on basic needs • Consumption level on: food, clothes, education, health, shelter, assets creation 5. Capacity to address vulnerability issues • Effect on food security, grain bank or similar interventions	Secondary source: project reports, earlier review reports, Interviews and FGDs with project team members FGDs with community

The categories of people covered under different methods for collecting the data stated above are given in Table 3.

Table 3: Categories and Number of People Covered in the Study

Category of People Covered	FGD		Interviews		Cast -Study	
	No. of FGDs	No. People covered	No. of interviews	No. of people covered	No. of cases	No. of people Covered

CAMEL						
Head office, (CEO, Operations Manager)	1	3	1	1		
MIS – team	1	3				
SHG	2	13				
Boards Member	1	5				
Branch team, (Branch Manager ,Field Office, Accounts , MIS – Staff	2	11				
SHG – Members					2	2
SBI - Bank - Chief Manager			1	1		
Sub- Total	**7**	**35**	**2**	**2**	**2**	**2**
CJWS						
NGO - Head			1	1		
Project- team (CEO, Branch Manager, Field Office	1	5				
SHG	4	23				
Field Office			1	1		
Boards Member	1	5				
SHG – Members					2	4
Accounts , MIS - Staff Accounts , MIS – Staff			1	1		
Sub- Total	**6**	**33**	**3**	**3**	**2**	**4**
CREED						
NGO - (CEO, Operations Manager,)	1	2				
Branch team	2	13				
SHG	6	49				
SHG Members					2	2
SHG training, & Ex- Field Office			1	2		
Micro insurance coordinator			1	1		
Operations Manager,			1	1		
Mutual Benefit Trust	1	3				
Panchayat level federation Leaders	1	2				
Sub- Total	**11**	**69**	**3**	**4**	**2**	**2**
BWDC						
Chief Executive Officer,			1	1		
Real Meeting Observation						
Branch Manager	2	13				

Branch team	1	7				
SHG / JLG	4	38				
MIS Manager			1	1		
Operations Manager,			1	1		
Sub- Total	**7**	**58**	**4**	**4**		
Total	**31**	**195**	**11**	**12**	**6**	**8**

Step 3: Data Entry and Data Analysis

The collected data was entered and comparative analysis on the major parameters was done. Based on the data analysis, a draft result was prepared covering the major review themes.

Step 4: Presentation of Preliminary Findings

Sampark shared the preliminary findings relating to the qualitative aspects of the SART project by making a presentation to the CARE staff and partner MFIs. This allowed the participants to contribute by way of their comments and inputs to improve the quality of the analysis and the report.

Group discussion with branch staff at Vedaranyam, TN

Step 5: Finalisation and Submission of Final Report

The comments from the partners were incorporated in the final draft report and submitted to CARE India and the final version submitted adhered to the feedback of the CARE India team.

10 Findings

The findings are presented on three main parameters: profiles of the NGOs studied and then institutional and community level assessments.

10.1. Background Profile of the Organizations Studied

A brief profile of the four MFIs covered for detailed analysis is given in Table 4.

Table 4: Profile of the Organizations Studied

Parent NGO	Name of	Legal	Year	No. of.	MFI	Loan

	MFI	Status of MFI	of Regn.	Branches/ Clients	Staff	turnover in INRs
CAMEL, Sulurpet, A.P.	CAMEL Mahila MACTS	1995 MACTS ACT	2001	4 Branches covering 12 Mandals/8490 Clients	29 M:24;F:5	11.55 crores
CJWS, Nellore, A.P	Chaitanya Mahila MACTS	1995 MACTS ACT	2006	4 Branches covering 7 Mandals and 1 Municipality/7125 clients	20 M:4;F:16	2.74 crores
CREED, Chidambaram, Kuddalore T.N.	Attractive Capital Private Limited	NBFC	Acquired in 2010	3 Blocks , 1 Municipality and 1 Town Panchayat 10 Branches/41680 clients	20	4.65 crores
BWDC, Tiruvarur, T.N.	Mahasakthi Microcredit Services Limited	NBFC	Acquired in 2010	6 Branches/28970 clients	68 M:30;F:38	12.18 crores

Table 5: Key Features of Sampled Partners' MF Programme

	CAMEL	CJWS	CREED	BWDC
Membership fees for MFI	y	y	y	Y
Share capital by members for MFI	y	y	y	N
Pooling of savings at MACTS	Y	Y	N	N
Internal loans in SHGs	Y	Y	Y	Y
Bank linkages to SHGs	y	y	Y	N
Loans through' MFI	y	y	Y	Y
Interest on deposits	y	y	Plan to give	N/A
Autonomy for branches(Partial)	Y	y	N	N

The partners' MFIs, irrespective of the model chosen have a set of common features like collection of membership fees during the enrolment and mobilisation of share capital towards MFIs. Savings mobilisation takes place in CAMEL, CAMP, CDE, SMVP, CJWS, CFH and PPSS. They provide relatively larger loans through MFIs and offer insurance services for the clients. SHGs in partner areas continue to maintain internal lending among the members and direct bank linkages. The combination of modus operandi suggests the co-existence of two popular models of MF in the target areas.

Table 6: MFI Competition in the Study Area

Andhra Pradesh	• Government Sponsored "Velugu" Programme; an off shoot of State DRDA Programme. • Direct /NABARD -SHG Linkages programmes supported by SBI, IOB and Syndicate Bank. • Professional MFIs: SKS, SHARE and Spandana.
Tamil Nadu	• State Sponsored "Vazhndhu Kattuvom" project; an off shoot of DRDA programme. • Direct linkages for SHGs through Nationalised Banks like SBI, Indian Bank and local co-operative banks. • NGO sponsored MFIs: ASSEFA; KRDS, NAMCO, SEVALAYA.

The MFI sector in South India is characterised by stiff competition not only within the NGO sector but also spearheaded by other financial institutions as well as Government programmes in the two states.

10.2. Institutional Level Assessment

The institutional level assessment and observations are based on the scrutiny of the available documents, interaction with the partner NGOs team, availability and use of physical infrastructure and business operations in the visited MFIs. The assessments are presented under various functional heads for easy conceptualisation and understanding.

10.2.1 Outreach

The outreach targets stems from the BDP. Scrutiny of the documents of SART has revealed that the programme has been instrumental in strengthening MFIs in terms of expansion in the two southern states of Andhra Pradesh and Tamil Nadu. The MFIs operates in seventeen districts covering 132 development blocks/mandals, providing MF services to 279701 members representing 2163 villages, by promoting and nurturing community level organizations like SHGs and JLGs and integrating them into MFIs.

SHG members of the CAMEL MACTS, AP

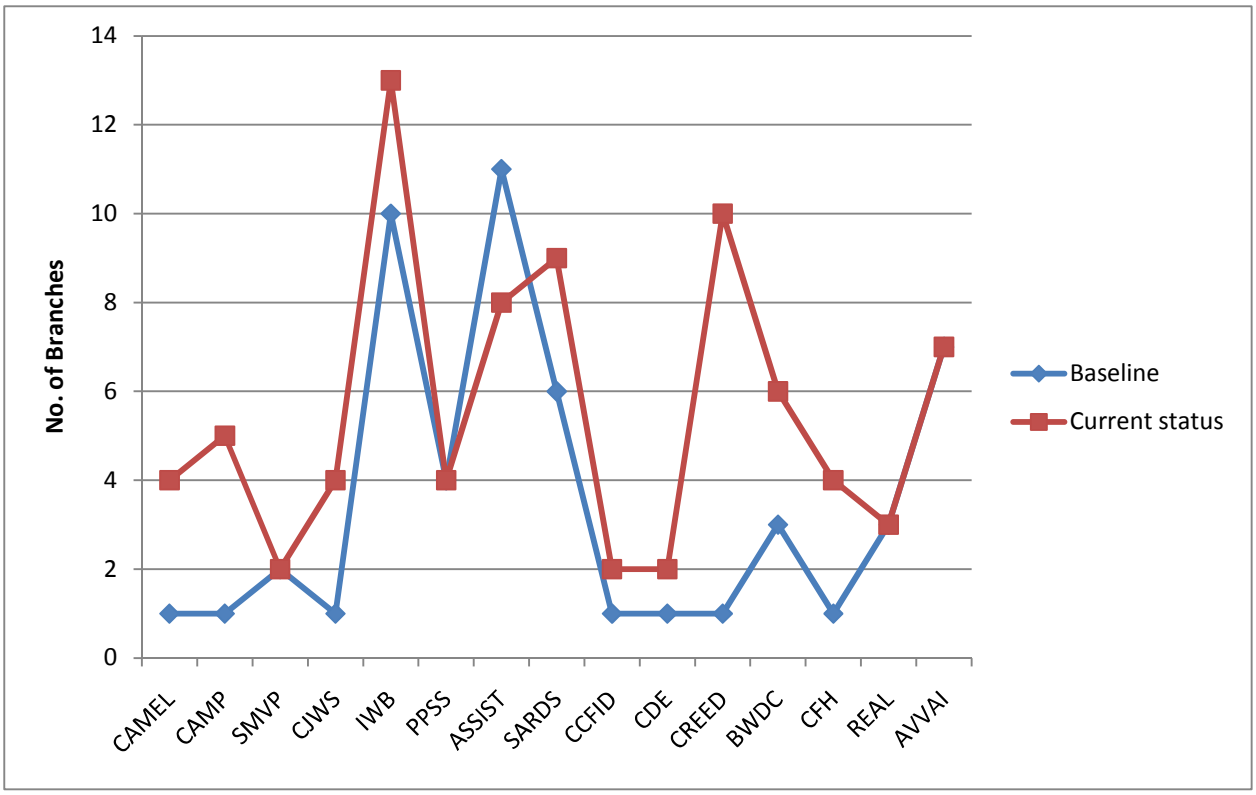
Table 7: Number of Groups and Members in Partner MFIs

	Groups		Members	
NGO	**Baseline**	**As of Mar,2010**	**Baseline**	**As of Mar,2010**
CAMEL	147	844	2684	8490
CAMP	95	157	8157	5662
CCFID	102	752	1920	11401
CDE	209	524	4162	8941
CREED	95	2778	8157	41680
SMVP	42	390	420	4470
CJWS	374	703	4862	7125
IWB	1750	4200	1900	46495
BWDC	1635	1599	24525	28970
CFH	263	340	4734	6515
PPSS	608	1155	6171	13925
ASSIST	NA	1066	7563	11085
REAL	1458	1278	21870	21970
AVVAI	1318	4042	18452	56588
SARDS	273	532	4101	6384
	8369	**20360**	**119678**	**279701**

(Source: SART-CARE India, 2010)

The above data reveals that the number of groups have increased by nearly 2.5 times.

Figure 1: Growth of MFI Branches

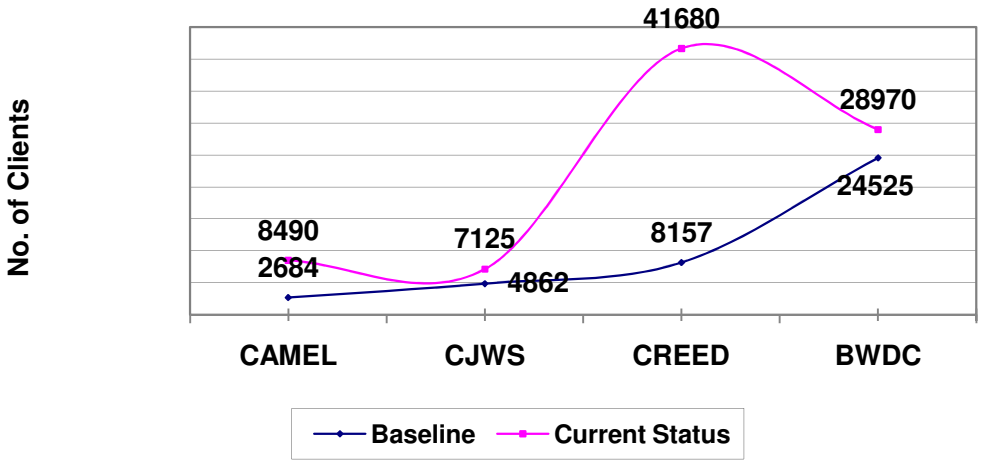


(Source: SART-CARE India, 2010)

The above graphical presentation further captures the accomplishments of partner organizations in terms of branch expansion as a consequence of SART initiatives. Twelve of the fifteen organizations have been successful in branch expansion. The total clientele of the partner MFIs has gone up 1.3 times, from 1, 19,678 (baseline) to 279701, due to the branch expansion and intensified membership drive as of 31st March, 2010. While the promotion of new branches is even in both the states, the membership increase in Andhra Pradesh is 57%, which is relatively high. However, in terms of actual numbers, the clientele is higher in Tamil Nadu with a share of 61%.

The overall outreach target is commendable. It's progress in the sampled organizations is quite good in comparison to the baseline enumerated at the time of the SART partnership and this is highlighted in the following graphic presentation.

Figure 2: Clients in the Sampled



(Source: SART CARE – India, 2010)

The social grouping of the MFI clients in partner organizations is varied and it included members from socially marginalised and economically deprived communities like Yanadis, Scheduled Castes, Most Backward Communities and Fisher folk. Women are the major clients cutting across the caste background.

Further, the partner MFIs is following the three major income groups to segment their clients. They are:

- Below $1/ a day;
- $1.5/ a day and
- Above $2/ a day.

The majority of the clients (52%) in CAMEL fall within the first category (below $1/ a day). In CJWS, the primary segment (45%) is below $1.5/ a day and in BWDC, below $1/ a day segment, tops (40%) in the clientele base. Though the targets were initially the poor and potential entrepreneurs in rural segments, now the focus is shifting towards the existing entrepreneurs and self-employed in semi-urban centres and emerging towns. The extreme membership growth in CREED is due to the massive promotion of SHGs in collaboration with the State Government's Women Development Corporation in the neighbourhood areas. The analysis of the year-wise figures specifies that there was a dent in the clientele base of all the four MFIs in 2009. Partners attribute it to the non-availability of sufficient funds for issuing loans. However, since the last six months the trend is reversing in CAMEL and is largely contained in BWDC.

10.2.2 MF Performance

MF performance is analyzed on three aspects: MF products and services, loan portfolio and efficiency.

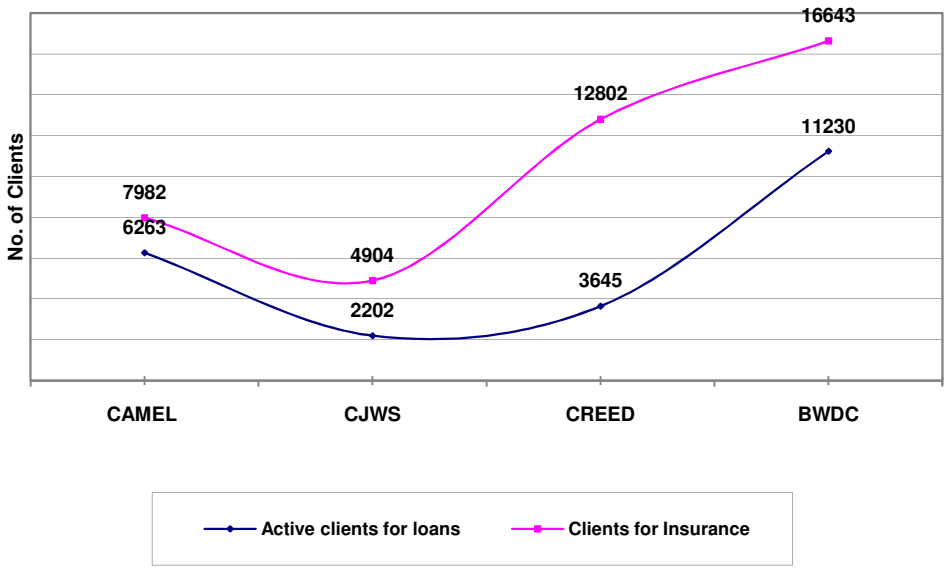
MF-Products and Services

Provision of credit and micro insurance services are the predominant MF Products and Services across the partner Organizations. Even though the Savings is also a formidable component of MF Products and Services, the provision for the related services depends on the legal structure of the partners' MFIs. The organizations registered under the MACTS Act in Andhra Pradesh are allowed to take thrift deposits from the members. Accordingly, CAMEL, CAMP, SMVP, CJWS and PPSS accept thrift deposits from its members. In Tamil Nadu, there is no uniform Act under which the MFIs can be registered and as a result the partners have registered the MFIs either as a Society under the Tamil Nadu Societies Registration Act 1975, or as a Trust under the Indian Trust Act. A few organizations have opted to get registered u/s 25 of the Indian Companies Act or as a Non-Banking Finance Company. The organizations registered either as Society or Trust and u/s 25 of Companies Act are prohibited from accepting savings or thrift deposits. In the case of NBFCs, only those rated by approved credit rating agencies are permitted to accept deposits. Hence, the savings deposit services is available only in CDE.

Other products like optional savings, seasonal savings and fixed savings, which are outcomes of the MF Products and Services development training, are in the conceptual stage in the above partner organizations.

The client coverage by Products and Services (As of March, 2010) is given below.

Figure 3: Client Coverage by Product and Services (as of March, 2010)



(Source: SART CARE – India, 2010)

The above diagram shows that the insurance coverage which includes both new and renewals are picking up in the partner organizations. It also suggests that clients without loans are also opting insurance products. The comparison of overall clients for insurance products conveys

that is high in Tamil Nadu, on account of the special drive made by CARE with the partnership with insurance agencies like Bajaj Allianz.

The data relating to the purpose wise break-up of the loans from sampled MFIs show that a larger chunk of credit has gone to agriculture and allied sector and the remaining has been employed in small business and fishing sectors respectively. The use of credit for agriculture and allied activities is high (80%) in CREED, followed by BWDC (67%), CAMEL (66%) and CJWS (51%). The application of loan funds in fishing related livelihood activities is high in CJWS (31%), handy in CAMEL (20%) and least (7%) in CREED. One fifth of the loans are invested in small businesses in BWDC, near one fifth of the loan amounts are for petty business activities in CJWS and one eighth of the loan funds of CAMEL and CREED are lent to accelerate small business activities.

Active Clients, Loan Portfolio and Repayment

The following Table presents the active clients in all the partner MFIs of the project.

Table 8: Active Clients in Partner MFIs as of March, 2010

NGO	Active clients	% of Active Clients
CAMEL	6263	73.77%
CAMP	249	4.40%
CCFID	6011	52.72%
CDE	320	3.58%
CREED	3645	8.75%
SMVP	4410	98.66%
CJWS	2202	30.91%
IWB	9074	19.52%
BWDC	11230	38.76%
CFH	449	6.89%
PPSS	679	4.88%
ASSIST	17	0.15%
REAL	89	0.41%
AVVAI	2279	4.03%
SARDS	1293	20.25%
Overall	**48210**	**17.24%**

(Source: SART-CARE India, 2010)

The percentage of clients who are active borrowers is 17%.Further analysis shows that among the visited organizations, CAMEL MACTS is better placed with 74% of their clients as active borrowers, followed by BWDC's Mahasakthi Microcredit services Pvt. Ltd with 39% of their clients as active borrowers. CJWS' Chaitanya Mahila MACTS has 31% of its clients as active borrowers, while the CREED's Attractive Capital Pvt. Ltd has less than one tenth (9%) of their clients as active borrowers.

The following Tables present the loan portfolio, the repayment rate and the portfolio yield.

Table 9: Receivables and Arrears (Rupees in Lakhs)

NGO	Receivables As of Mar,2010	Receivables in Arrears	Arrears in %
CAMEL	384.63	41	10.66%
CAMP	20.88	260.47	1247.46%
CCFID	227	1	0.44%
CDE	12.12	1.65	13.61%
CREED	108.76	0	0.00%
SMVP	173.74	3.97	2.29%
CJWS	138.26	0	0.00%
IWB	616.95	0	0.00%
BWDC	546.1	0	0.00%
CFH	22.25	0	0.00%
PPSS	22.6	4.62	20.44%
ASSIST	63.2	28	44.30%
REAL	5.45	0.84	15.41%
AVVAI	60.07	1.88	3.13%
SARDS	85.7	0	0.00%
	2487.71	**343.43**	**13.81%**

(Source: SART-CARE India, 2010)

The above data discloses that the arrears in receivable accounts are on the higher side. Nearly one seventh of the loans issued are in danger and thus affect the cash flow for further rotation and also set a bad precedent for loan default by fellow clients. With regard to the sampled organizations, except for CAMEL all the other partners do not have any arrears. Their present loan repayment rate is very good and they are listed below:

Table 10: Details of Portfolio and Repayment

MFI	Receivables (Rupees in thousands) (As on March,2010)	Repayment Rate (%)
CAMEL	384.63	99.6
CJWS	138.26	98.0
CREED	108.76	98.0
BWDC	546.10	99.9

(Source: CAMEL, 2010; CJWS, 2010; CREED, 2010; BWDC, 2010)

Governance

Governance in an MFI, like in any other enterprise, is the responsibility of its governing body. The governance basically deals with the objectives, goals and policies of the MFI and the governing body has the responsibility to ensure that the management pursues the set objectives and policies. The legal structure, composition of the board, and the vision and mission of the partners' MFIs operating in the study area are described in this section.

Legal Structure

Most of the MFIs in Andhra Pradesh have been registered as MACTS, in order to take advantage of the existing MACTS ACT 1995, which allows both the community ownership and professional management to conduct financial business. Partner MFIs in Tamil Nadu have opted for entities like Societies, Trusts, Company u/s25 and or NBFC.

Table 11: Legal Structure of partner MFIs

Name Of NGO	Legal Structure of the MFI
CCFID, Karaikal, Pondicherry	Trust
CAMP, Guntur, A.P	CDF Model
CAMEL, Guntur, A.P	MACTS
CREED, Chidambaram, T.N	NBFC
CDE, Kanyakumari, T.N	Section25 Company
PPSS, Machilipatnam, A.P	MACTS
SMVP, Ongole, A.P	MACTS
IWB, Nellore, A.P	MACTS
CJWS, Nellore, A.P	MACTS
BWDC, Tiruvarur, T.N	NBFC
CFH, Kanyakumari, T.N	Not registered separately for MF programme
ASSIST, Guntur, A.P	MACTS
REAL, Pondicherry	TRUST
AVVAI, Nagapattinam, T.N	Sec25 Company
SARDS, Ongole, A.P	MACTS

Regarding the legal framework of the visited organizations, in Andhra Pradesh, CAMEL and CJWS adopted the MACTS as the institutional setup for MF services, whereas in Tamil Nadu, BWDC and CREED assumed NBFC as their MF institutional set up by purchasing existing entities.

Board

In both the modes, partner organizations have constituted the Board of Directors as the governing body of the MFIs. The size varies in accordance with the provisions of the Act under which MFI is registered. There are nine board members in MACTS and usually eight are drawn from the communities as the Secretary/CEO is drawn from the promoting NGO. In the case of Societies it is a minimum of seven members and in Trust and NBFCs it is varied as per the preference of the promoting NGO. For instance, in CREED, Chidambaram, the communities, the promoting NGO and the financial professionals find space in the board, whereas in BWDC, the president is from the community. A minimum of primary level education and two-three years of SHG experience has been witnessed among the board of directors representing the community. A handful of community level board members (CAMEL and CJWS) are familiarised with their roles and responsibilities as the board members of MFIs and as well as on the activities of the promoting NGOs. Recently, they have started inducting MF/banking professionals in to the board.

Vision/Mission

The discussions with the partner NGOs have shown that the MF activities crystallised with the SART initiatives are in conformity with the overall goals of the respective organizations: 'Enabling poor and the marginalised community members to raise their income and thereby improve the living standards". Based on the SART team inputs, there are well articulated and developed vision/mission for the MFIs. More specifically they are in alignment with the mission of economic development of MFIs. Almost all the senior team members of the MFIs are aware of the vision and mission statements. A few board members from the community even recounted them when they visited various organizations.

Stakeholders' Relationship

The primary stakeholders of MFIs are the clientele groups and members who used to avail the services. The clientele groups in Andhra Pradesh, particularly the board members are aware that they are accessing credit facilities through the MACTS and it is managed by the promoting NGO/CEO. As for as the SHG members in all the visited sites are concerned that they have a feeling that the entire services are either provided by the NGO or by the NGO head. Hence, there is a "WE-THEY" divide in the conceptualisation of MF operations.

Leadership

Leadership in the organization is the pivot that keeps the team together to achieve the best results. The quality and the effectiveness of the leadership are reflected in the growth of the MFIs along with the professional approach adopted in MF operations. The overall data relating to the growth suggests that almost all the partner organizations' leaders are pro-active and striving for excellence. A look at the sampled organizations reveals that CEOs in CAMEL and BWDC have a thorough knowledge of MF operations and have a clear vision and strategy on how to lead the institution. Both of them are adopting a ''head on'' approach to MF business. The other two CEOs, in CREED and CJWS are cautious and adopt a step by step approach. They have practical difficulties in balancing the developmental and profit making goals of MF.

CEO of CAMEL MACTS sharing details of their MF operations with the Study team member

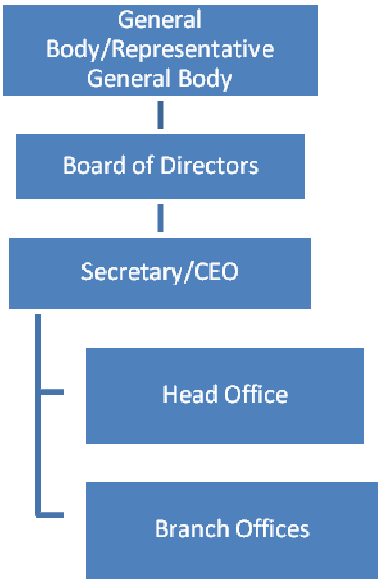
10.2.3 Management and HR Aspects

The management function in MFIs primarily deals with staffing as they are responsible for providing vital information on the ground realities and the spectrum of opportunities available for MF operations. They are the critical link in the implementation of agreed strategy and actions along with the administration of the necessary systems and procedures to accomplish MF goals. This section analyses the organizational structure of MFIs, systems and policies developed and followed, planning of the MFI programme, human resource systems, monitoring and MIS systems, and financial management practices of the MFIs.

Organization Structure

Almost all the partners have been instrumental in promoting SHGs under government programmes in the past. These SHGs continue to serve as the foundation for the present MF operations. Both the MACTS and NBFC models, irrespective of their distinct legal identities, evince direct membership for clientele and as such technically drift away from the SHG model and informality, and tend towards a formal structural identity. However, the original SHGs are functioning in the villages to tap government resources and schemes. Partners are using the SHGs, wherever active, to process loan applications and to ensure loan recoveries. With reference to the visited organizations, MACTS in CAMEL and CJWS have the following organizational structures:

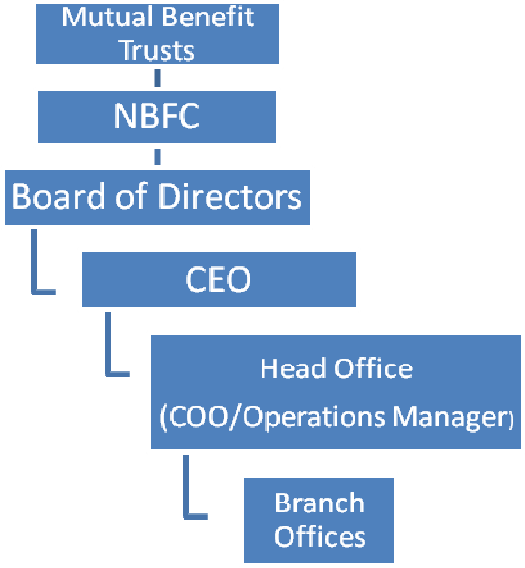
Figure 4: MACTS Structure in CAMEL and CJWS



By the virtue of the MACTS ACT 1995, the members have the control over the organization.

The organizational structure in CREED is depicted below:

Figure 5: Structure of NBFC in CREED



CREED has adopted a structure where 'Mutual Benefit Trust" (MBT) is the foundation for mobilising members and share capital from the block level. With pooled share capital, MBTs are the shareholders of the NBFC. As shareholders, MBTs can nominate board members to NBFC and technically they will have control in the NBFC.

The organizational structure in BWDC is the same except for the foundation structure of Mutual Benefit Trusts. In the BWDC model, the communities remain as clients.

In general, an NBFC is more of a centralised organization that is largely controlled by the CEO along with a senior level staff team.

Systems and Policies

There are established systems and policies to carry on the MF business in all the visited organizations. All the partner organizations have written policies in the form of operational manuals which contains policies related MF Operations, Human Resources and Financial Management. The difference lies in the level of implementation. The adoption of the written policies is visible in CAMEL and BWDC and is emerging in CJWS and CREED. However, the frequent staff turnover had its repercussions in CREED.

Planning

The BDP exercises led by the SART team seem to be the starting point for the MF-business planning for all the partners. The BDP document is referred to by the partners for outreach and portfolio targeting. The monthly review meetings are also serving as the monthly planning meeting. These planning cum review meetings are conducted at the head office by the CEO and or Operations Manager of the respective MFIs. The meetings are recorded for future references. They compare the current progress with the previous month's accomplishments and discuss follow-up measures.

Human Resources

After the SART intervention, there has been a marked improvement in the process of staff hiring. Positions are advertised, formal interviews are conducted, and appointment orders are issued. Service rules indicating the benefits and privileges are implemented. Specific allocation of human resource to MF operations is varied depending on the scale of operations and fund availability. Regarding the sampled organizations, CAMEL and BWDC have been fortunate to have separate staff teams for MF operations. Unfortunately, there is an overlapping of work allocation in CJWS and CREED due to the staff's time sharing with other projects. The overlapping is seen at the middle level staff in CJWS and at the field level in CREED. The following staffing pattern is witnessed in the sampled MFIs:

Table 12: Staff Details in the Organizations Studied

Name of MFI	Number of Senior Team members	Number of Field Team members	Total Staff
CAMEL	3	26	29
CJWS	4	16	20
CREED	4	16	20

BWDC	16	52	68

(Source: CAMEL, 2010; CJWS, 2010; CREED, 2010; BWDC, 2010)

The overall gender break-up of the staffing in the sampled MFIs portrays a slight advantage (53%) to women. However, the senior positions like operations manager; MIS officers and accountants are occupied by men. In branches it is a mixed scenario, wherein most of the branch managers are men and the field officers are predominantly women. The only exception is the CJWS Mahila MACTS, where all the officers including the branch managers are women.

All the visited partners have more than a decade of institutional experience in savings and credit programmes in the respective local areas. The CEOs of the MFIs have been constantly upgrading their knowledge in MF due to the SART training, field level technical inputs and due to attending special programmes on MF. The partners have also recruited experienced staff in MF, both in the second and third levels of the team.

The span of control of the field team members could be viewed in two different angles depending on the lending model of the MFIs. If the MFIs are adopting group lending, then the ratio would be based on the number of groups to be nurtured by the field personnel. In case of direct lending to the clients, then the number of borrowers matter. As of now, the sampled MFIs preferred group lending, either through the SHGs or JLGs.

Considering the above criterion the staff-group/clientele ratio is as follows:

Table 13: Staff Client Ratio in the Studied Organizations

MFIs	Staff-Group Ratio	Staff-Active borrower Ratio
CAMEL	32	608
CJWS	44	249
CREED	174	120
BWDC	31	519

(Source: CAMEL, 2010; CJWS, 2010; CREED, 2010; BWDC, 2010)

The above data indicates that the group based lending increases the span of control for the field staff to provide and track MF services. The staff-Group Ratio is high in CREED, in view of the scaling down of the overall field staff previously supported by TNWDC Project and the SART Project. Nevertheless, the field officers have to spend quality time in moulding the groups. Otherwise they have to chase individual borrowers in the group which will eventually lead to the span of control described under the staff-active borrower relationship. SART has been recommending 1:350 for group based lending (which works out to 1:29 groups with an average of 12 members for a group) and 1:150 for individual based lending as the standard for field staff-active borrower ratio. On the whole, the partners' average case load ratio is well within the stipulated figure. It is 323 active borrowers for a field officer. The case load figure for the sampled MFIs is above the SART standard in almost all the sampled MFIs.

Staff Capacity: It is evident from the interactions with the staff team of the visited organizations that the senior level officers have attended most of the formal training offered by SART and other MF institutions, while the field level staff members are equipped with in house and on the job training. The SART trained staff members have been training the field personnel on MIS, Micro insurance. In exceptional cases, the field staff members had formal and extensive training exposures in their previous employment. For instance, one of the branch managers of CREED-MFI had substantial training prior to the current appointment, and it has become handy to groom the branch activities. In addition, partner organizations have been providing training for the field staff in livelihood, supervision and monitoring and impact assessment of MF programmes.

Topics of learning provided by SART team through formal and on job training:

- Principles and Practices of Governance to MFIs
- Business development plan (BDP)
- PACT assessment
- MFI-Transformation process
- MF-Products design and development
- Financial Management and Accounting (Accounting for MFIs, Financial analysis, Studying Balance sheets, Internal Audit and Financial control)
- Portfolio quality analysis and Delinquency Management
- Financial management and interest rates setting for MFIs
- Management Information Systems and field level reporting formats
- Orientation on Disaster Management

Monitoring

The assigned team members from SART intensively monitor the progress of the partner organizations to ensure the performance correlates with the Business Development Plan. They resorted to quarterly, half-yearly and annual reviews with the partners to understand the status of the project and to provide further inputs for progress. The reviews used to take place both in the head office and in select branch offices.

Records for Review by SART

Head Office:

- Consolidated MIS (Portfolio, Outreach)
- MFI level cash flow
- BDP(Plan vs. Performance)
- Balance Sheet(Income-Expenditure and Ratio analysis)
- Progress Report

Branch Office:

- MIS
- BDP(Cluster wise Plan vs. Performance)
- Balance Sheet and other financial statements

As far as the partner MFIs are concerned, monitoring of the day to day operations is undertaken by the next level supervisors. For instance, field workers are monitored by the branch manager, branch managers by the operations manager and operation manager by CEO. The day to day monitoring is informal except the cash transactions. Daily cash collections are monitored through the day book/roaster. Monthly review meetings at the branches and the head office serve as the progress monitoring. The duly filled in MIS formats by the respective branch managers serve as the monitoring tool. The Operation Manager makes branch visits and reports it to the CEO. Both the CEO and Operation Manger take active part in the monthly review meetings. The monthly review is mainly focussed on the progress of

financial data on the outreach, portfolio and aging analysis. The review could also focus on some of the trend and comparative analysis of the financial performances.

MIS

Standard formats to monitor the MF performance have been developed for each of the partner organizations with the active support of SART team members after a long deliberations and trials. All the four sampling partners have been using spread sheets to maintain the MIS-data base. Trial of software is on in CAMEL and BWDC. Data are collected from the field level through branch staff members and entered at the branch office and forwarded to the head office for verification, collation and analysis. However, the MIS formats needs some improvement in order to capture the important details that would add more value to the review of the financial performances. Data like group information, detailed loan demand estimation of the groups, member wise details including basic household socio-economic details and loan details and impact of members are not captured by the MIS formats or in the computer.

Study team observing the branch manager level review meeting

Reporting: Branches report their financial details to the head office on daily basis. Other details are reported normally in the monthly meetings. Critical information such as cash deficits and problems in loan collections is reported then and there for information, guidance and solutions.

Financial Management

Financial systems: Standard financial systems are in place to ensure good financial management. There is a written financial manual for MF operations at the head office. The Head office accountants are aware of it. The operations mangers of CAMEL and BWDC are aware of the existence and use of manuals. The branch accountant/managers are conversant with their respective portions.

Accounting: The MFIs adopts double entry system of accounting at all levels. The branches adopt petty cash system to manage their expenditures. Branch managers or branch accountants keep the branch accounts. The accounts are consolidated at the head office by a designated accountant.

Budget and Forecasting: Budgeting in MFIs is in the initial stage. Many of the partners need further capacity building and follow up. As the outlook for formal finance is not very bright, this further detracts from the motivation to undertake budgeting and financial forecasting.

Internal auditing: Internal verification of loans issuance and recoveries are in place in the partner MFIs. Such verifications are undertaken by the assigned team members, either from the head office or by the other branch staff members. Formal internal auditing procedures and practices are yet to develop in partner MFIs.

Statutory auditing: The MFI accounts are audited every year, by a chartered accountant. The audited accounts are shared with the board of directors during the Annual General Meeting.

10.2.4 External Linkages

Funds mobilisation is seen as a critical indicator of the organizational capacity to ensure adequate resources for on lending. The need for funds has enlarged in view of the increase in outreach and the volume of loans. The partner MFIs are trying hard to raise the required funds from various quarters, including private institutions. Many of the partners' commenced fund channelization/mobilisation, under ''Partnership Model" with HDFC (Partnership Model was mooted by ICICI, as an effort to ensure MFI's access to rural clients. Under this model, the MFI acts as a service agent on behalf of the bank for a commission and handle the loan portfolio, while the same is represented in the balance sheet of the bank). The partners' persistent efforts with bankers (SBI, SIDBI, AXIS, NABARD and Development Credit Bank) and financial institutions (Manaveeya Holdings, RMK) have been instrumental for further mobilisation of funds. The meetings facilitated by SART team with SBI, AXIS Bank as part of lobbying was also useful to the partners.

The head of CJWS and CEO of Chaitanya Mahila MACTS sharing the details of the external linkages

A comparison of fund flow for identical periods in the preceding two financial years is presented in the following table. It suggests that the fund in-flow is lesser during the period: Oct2009-Mar2010, while the outflow is higher. The figures also reveal that the partner organisations are able to recover loans and ensure adequate repayment.

Table 14: Loans Leveraged and Repaid under Partnership Model

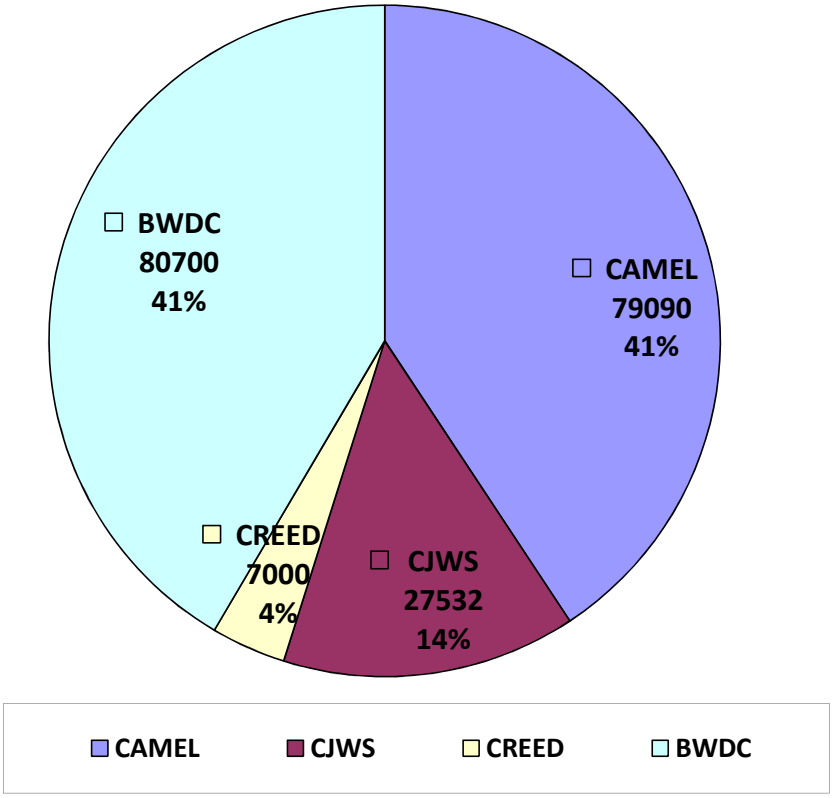
	Loans Leveraged (Rupees in Lakhs)		Loans Repaid (Rupees in Lakhs)	
NGO	**Oct2008-Mar2009**	**Oct2009-Mar2010**	**Oct2008-Mar2009**	**Oct2009-Mar2010**
CAMEL	73.05	11.45	91.12	54.02
CAMP	21.00	26.28	0	15.36
CCFID	30.00	0.00	28.79	11.5
CDE	52.05	38.00	38.97	24
CREED	113.00	0.00	115	142.51
SMVP	44.25	100.00	44.9	32.11
CJWS	12.82	86.90	17	17.67
IWB	341.73	0.00	495.17	232.32
BWDC	1224.00	0.00	998.01	133.61
CFH	0.00	0.00	0	0
PPSS	298.00	0.00	59	8.54
ASSIST			9	5.77
Overall	**2209.90**	**262.63**	**1896.96**	**677.41**

(Source: SART-CARE India, 2008b, 2009b, 2009c, 2009d, 2010)

Regarding the sampled organization, the persistence of CAMEL and BWDC proved helpful to raise a good chunk of funds to meet the credit demands of the community. CAMEL MACTS has already accessed credit from HDFC, SBI, Manaveeya holdings. However, the efforts of CJWS and CREED are yielding limited results for the bankers demand for greater equity, more experience and formal rating of the MFI. CJWS has been able to link with HDFC on Partnership model but has second opinion on the commercial borrowings for MACTS. The opportunities for the partner MFIs to go in for lobbying to influence the bankers exist at individual level.

The following graph illustrates the fund mobilising capacity of the sampled partners from the day of entering in to the SART partnership.

Figure 6: External Funds Mobilized by the MFIs (Rupees in thousands)

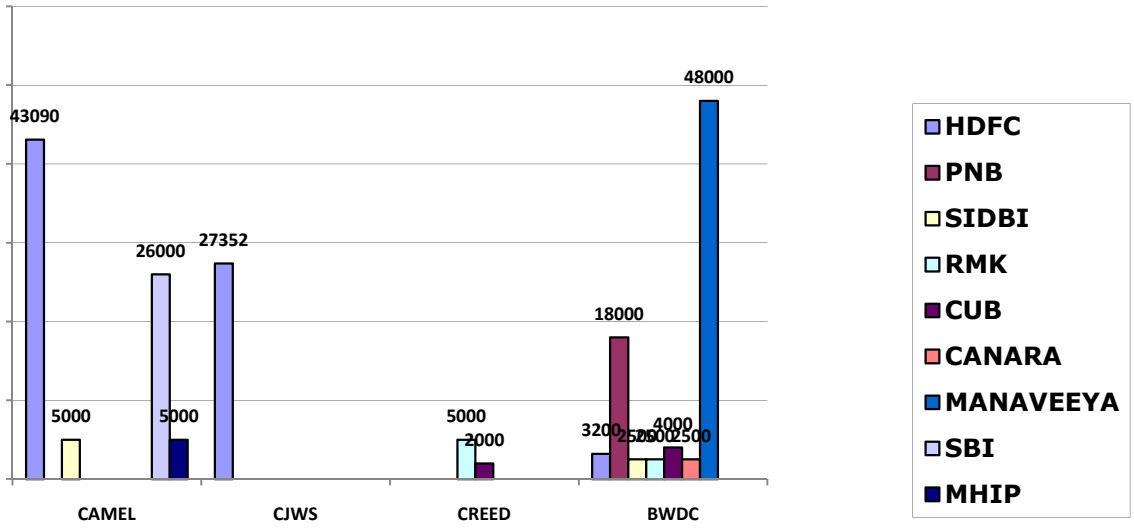


(Source: CAMEL, 2010; CJWS, 2010; CREED, 2010; BWDC, 2010)

Note: The Direct linkages for SHGs are not included in the above table

The total mobilisation of lendable funds by the four institutions studied as of March, 2010 is Rupees 1, 94,142 thousands, of which 55% is mobilised by Andhra Pradesh partners. It suggests that the external linkages seem to be better in Andhra Pradesh. Further analysis of figures specifies that HDFC is the dominant provider (38%) of funds. Manaveeya holdings follow it with the provision of ¼ of the total funds supply. The money supply from the Nationalised banks together works out to another 1/4th of the funds pumped in for MF services. Among the Nationalised banks, SBI accounts for major share (13%). The much touted RMK's share is just 4% of the total money supply, which is little above than the local co-operative bank (3%). The funds flow to MFIs from the Nationalised banks is dismal in Tamil Nadu.

Figure 7: Mobilisation of Funds According to Banks and other Financial Institutions (Rupees in thousands)



(Source: CAMEL, 2010; CJWS, 2010; CREED, 2010; BWDC, 2010)

The diagram also shows that CAMEL and BWDC, in spite of their different MF modelling have been highly successful in mobilising funds for on lending. It also highlights that they have been

able to tap funds from varied sources. This is because these two organisations have taken the inputs from SART team and put their systems and resource team in place to deliver the financial services. However, in terms of meeting the entire credit needs of the clientele is a struggle for all the organisations, particularly the other two organizations (CJWS and CREED). Due to less mobilisation of funds, many of their clients, particularly in CAMEL are started withdrawing their memberships and started accessing from other MFIs.

CAMEL has approached SBI to enhance the cash credit limit. The SBI branch office is in favour of it. But the head office needs to go in for a professional assessment to take a decision on the enhancement.

CJWS has approached both SBI and SIDBI for term loans to the tune of Rupees 1 crore and 2 crores respectively. They have submitted application to SBI in November, 2009 and it is still in process. They are also thinking of approaching RMK and Manaveeya holdings for loans.

CREED has approached IFMR and NABARD to secure start-up/equity capital (Rupees 1 crore) for the NBFC and a loan fund (Rupees 1 crore). They have also applied to SONA MFI and BWDA Finance for loan funds.

10.2.5 Disaster Preparedness, Address to Vulnerability

The MFIs work areas include both disaster and non-disaster prone areas. The government has played a major role in collaborating with local NGOs, in disaster preparation, management and mitigation where the disasters are recurrent. Hence, the disaster preparedness is viewed by SART as a means of meeting the economic challenges by the affected communities and as a consequence efforts were directed towards training the NGO-MFIs on disaster preparedness and how microfinance can respond to disasters, helping them to develop and incorporate policies around this. In response to the disaster preparedness the NGO-MFIs are providing micro credit and viable insurance options to the communities through the MFIs. As far as the MFIs are concerned, they are allowing loan re-phasing and rescheduling in disaster situations besides offering emergency loans (CAMEL). SART has played a major role to bring in major insurance providers like Royal Sundaram and Bajaj Allianz to design and roll out local specific products to face the disaster-related losses. The insurance products are ranging from simple life coverage to family health coverage for the MF clients. The life coverage for an annual premium is bundled with MF loans. NGOs like CJWS and CREED have distinct disaster preparedness and mitigation programmes with which they have equipped local youth members to liaise and co-operate with the government and other agencies to issue early warning communications, and engage in relief and rehabilitation measures.

People in the geographically vulnerable locations like sea-shore and river banks attach less importance to disaster risks as they conceive it part of their routine life. For instance, communities living on the banks of the rivers Kollidam and Amaravathi (CREED"s project area), in spite of the district administration's repeated attempts to resettle them away from the vulnerable locations, refused to move out as they felt that the location is highly conducive for livelihood and the "flood effect" is after all a month's problem. According to them, except for the loss of cattle and collapse of mud structures, so far, there has been no loss of human life even during heavy floods. When raised a question about the insurance coverage for such losses, they informed that it worked in the first year of the introduction of micro insurance by CREED, but the coverage of flood was withdrawn by the insurance agencies subsequently citing non viability of the product. Further interactions revealed that they are mentally prepared to face the situation as and when it comes. During the recent floods, they stayed on the top of concrete buildings and government infrastructures like schools and community halls. They are anticipating floods during the coming season and are saving food grains for emergency. They are aware of the district administration and NGO's disaster support initiatives. However, people from all the four NGO-MFI fields have acknowledged that access to credit facilities with less interest from the MFIs at the time of flood has helped them to recover quickly from whatever damage that happens to the crop, cattle and for repairing of the houses and whitewashing the walls.

Members of Vigneshwara Sangha from Krishnapatnam village, Muthukuru Mandal A.P, sharing their experiences on how they coped with flood situations

10.2.6 Institutional Transformation

It is evident from the interactions with the CEOs of partner organizations that they have convinced about having a separate legal entity to carry on MF business. Partners have seen the entire process as a series of steps to gain legitimacy of MF operations in the eyes of financial institutions, commercial lenders and government authorities. They agree that without undergoing the transformation process, could not have grown to this size, accessed this much of funds and served more needy clients. They recognized the mentoring support by SART team as valuable to build organizational capacities, systems and procedures. They have also clearly understood the need to generate profits, in order to survive in the long run and to ensure sustained financial services to their clientele and the ensuing need to apply business principles in MF operations. They are also recruiting qualified people to keep the board robust to meet the current and future challenges in terms of scaling up and diversifying MF business.

- The MFI team members got orientation training on disaster preparedness
- There is no follow-up plan prepared by the partner organizations
- Training to NGO-MFIs as to how MF can respond to disasters and to develop policies on the same.
- The organizations have insurance linkages with mainstream agencies
- CAMEL plan to provide emergency loans
- CJWS has programme supported by CARE India where they have trained local youth to handle disaster situations – early warning, relief and rehab.
- The MFIs constituency is a mixed one, in areas where frequent flood the governments takes care.

The CEOs felt that the transition from the project mode to a business mode was not all that easy as it necessitated intensive reflection at each and every stage. The transition has affected the entire organization from the field office to the board room. The transition has also put the partners in rough weather as they could not completely cut off from the development agenda, for it is the primary mandate of the NGO. Partners are reconciled to the fact that they should carry on both the activities, but with two different entities, preferably headed by two different persons. In the words of CAMEL CEO, ''Our NGO does the foundation in the villages by undertaking development activities for a year, by that time the communities are aware of the economic opportunities and the need for productive credit. It is at that time, the

The CEO, Secretary and board members of the CAMEL MACTS happily share details about their transformation processes

MFI steps in to provide financial services. Hence, we need both as our two hands. We can't say no to either." The above statement illustrates the ground reality. Hence the transformation process for the sampled partners is not simply converting the entire organization in to profit mode, but to have a separate, formal entity to carry on the MF operations systematically to earn profit to sustain the activity on its own.

Looking at the way the MF operations are being carried out, CAMEL and BWDC have almost been transformed as professional MFIs and CJWS and CREED are still striving.

Factors contributed for successful transformation into professional MFI (CAMEL, BWDS):

- Separate dedicated CEO and also separate physical office established to carry out the MF operations
- Taken straight decision of engaging mainly in MF in commercial term
- Fresh staff who are commerce or management background and have not worked in development projects been recruited to MF work. Their mind set is only commercial oriented and no development mixing of development thinking
- Good system establishment and focused credit work enabled to generate adequate income to cover salaries from the MFI and not depend on the development projects
- Qualified staff particularly the second level staff (next to the CEO) are in place to take care of the planning and execution of the work with the branch level and has dedicated staff for each of the role to move things faster.

Factors hindered for complete transformation (CJWS, CREED):

- CEO of the NGO or senior person worked in the NGO with development projects and taken up CEO position of the MF programme has been finding difficult to leave development agenda and look at people issues with empathy
- Staff are forced to work in development and MF commercial activity as the MF programme is unable to cover the salary of the staff. This is due to limited credit supply because of mobilization of credit fund has been restricted due to non-fulfillment of financial institution's requirement in terms of systems and equity capitals.
- Unable to make a clear path towards commercial MFI because of integrated activities of government programme (Mahalir Thittam structure) and NGO

10.2.7 Sustainability

The sustainability of an MFI is about its ability to cover all costs. It is professionally measured by three specific indicators: operating cost ratio, operating self-sufficiency and financial self-sufficiency. The operating self-sufficiency specifies the adequacy of revenue earned to cover the MFI's total costs (operational expenses, loan loss provisions and financial costs). Similarly,

financial self-sufficiency refers to the measure of sustainability of the lending operations. It is expected that the MFIs have to attain 100% self-sufficiency in both the respects to ensure unbroken and sustained credit services.

The percentage of the active borrowers is one of the factors that affects the profitability of the MFIs. The cost effectiveness in service delivery is the other critical factor to be considered.

Table 15: Cost per Loan Made (in Rupees)

NGO	Oct2008-Mar2009	Oct2009-Mar2010
CAMEL	2949.50	1167.76
CAMP	2162.50	848.95
CCFID	696.50	204.00
CDE	1951.00	22.00
CREED	824.50	841.80
SMVP	1382.00	376.73
CJWS	852.00	1421.90
IWB	334.00	807.60
BWDC	159.00	2772.45
CFH	4040.00	77.86
PPSS	0.00	2530.00
ASSIST	6968.50	0.00
Overall	1859.96	922.59

(Source: SART-CARE India, 2008b, 2009b, 2009c, 2009d, 2010)

The average cost per loan, as per the March, 2010 figures, for the partner MFIs, as a whole stands at Rs923/-in the last half-year. It has come down when compared to the identical period in the previous financial year. The sampled partners' cost per loan indicates that it is lower in CREED (Rs 842/-), low in CAMEL (Rs1168/-), high in CJWS (Rs1422/-) and higher in BWDC (Rs 2772/-) for the same period.

Operating Cost Ratio

It represents the level of operating costs to the outstanding loans of the MFI. The following table highlights the operating costs of the partner organisations:

Table 16: Operating Cost Ratio (in Percent)

NGO	Oct2008-Mar2009	Oct2009-Mar2010
CAMEL	10.5	2.5
CAMP	14	6.5
CCFID	3	6

CDE	11.5	1
CREED	1.5	26.5
SMVP	4	5.5
CJWS	2	2
IWB	1	1
BWDC	0	2.5
CFH	14.5	15.5
PPSS	3	5
ASSIST	1.5	1.5

(Source: SART-CARE India, 2008b, 2009b, 2009c, 2009d, 2010)

The above data suggests that the operating cost ratio was higher in CREED, high in CFH, while it is lower in CDE, IWB and ASSIST during the period Oct2009-March, 2010. The operating costs have gone up in CCFID, SMVP, BWDC, CFH and PPSS when compared to the corresponding period in the previous financial year.

Operating Self Sufficiency

It is the measure of financial efficiency equal to total operating revenues divided by the total administrative and financial expenses.

Table 17: FSS-Operating Self-Sufficiency (in Percent)

NGO	Oct2008-Mar2009	Oct2009-Mar2010
CAMEL	41.5	64
CAMP	37.5	28.5
CCFID	96.5	158
CDE	87	27
CREED	93.5	71.5
SMVP	58.5	101
CJWS	89.5	69.5
IWB	98	91
BWDC	138	116.5
CFH	55.5	131.5
PPSS	0	12
ASSIST	26.5	40

(Source: SART-CARE India, 2008b, 2009b, 2009c, 2009d, 2010)

The MFI is considered to be operationally Self-Sufficient when the resulting figure is 100 and above. Using this criterion CCFID, SMVP, BWDC and CFH have attained operating self-sufficiency. Among the visited organizations, CAMEL, CJWS and CREED are yet to reach the Operating Self-Sufficiency.

Financial Self-Sufficiency

It refers to the MFI's realisation of sufficient revenue to pay for all administrative costs, loan losses, potential losses and funds. The exploitation of credit market, pumping of sufficient funds for lending, the excellent recovery of loans and prudent management are also contributing to the financial sustainability of the MFIs. By this criterion, four of twelve old partner organizations qualified as financially Self-Sufficient. Among the sampled organisations, BWDC alone passed this test. Nevertheless, CAMEL and CJWS are improving in comparison to the corresponding period in the previous financial year, while CREED is slipping. The positive factor for the visited organisations is the loan recovery rate, and it is 98%.in CJWS and CREED, while it is 99.6% in CAMEL and 99.9% in BWDC.

Table 18: Financial Self-Sufficiency (in Percent)

NGO	Oct2008-Mar2009	Oct2009-Mar2010
CAMEL	39	64
CAMP	27	28.5
CCFID	68.5	158
CDE	78.5	27
CREED	91	71.5
SMVP	48	101
CJWS	48.5	69.5
IWB	82	91
BWDC	79	116.5
CFH	48.5	131.5
PPSS	0	12
ASSIST	20.5	40

(Source: SART-CARE India, 2008b, 2009b, 2009c, 2009d, 2010)

For the partner organizations, which have not yet reached the earmarked figure of 100 with regard to Operational Self-Sustainability and Financial Self-Sustainability, the provision of sustained credit services will be undermined.

Portfolio per Credit Officer

The amount of loan portfolio per field officer is another important indicator of financial viability of MFIs. As of March, 2010, the average portfolio per field officer is Rs11.38 lakhs. A

comparison of the sampled MFIs depict that the portfolio per field officer is above the average figure in CAMEL and BWDC, while it is less in CJWS and meagre in CREED.

Table 19: Portfolio per Credit Officer

NGO	Oct2008-Mar2009	Oct2009-Mar2010
CAMEL	46.57	33.46
CAMP	2.97	1.53
CCFID	5.37	21.00
CDE	10.66	10.00
CREED	8.98	0.79
SMVP	11.16	20.48
CJWS	9.37	10.11
IWB	92.20	33.50
BWDC	60.14	26.95
CFH	38.89	4.52
PPSS	5.15	0.42
ASSIST	8.66	2.54

(Source: SART-CARE India, 2008b, 2009b, 2009c, 2009d, 2010)

Further analysis of the portfolio by comparing data for the identical periods in two successive financial years indicates that the size of the portfolio is fluctuating in many organizations.

10.3. Community Level Assessment

Two key aspects were analyzed; access to financial services is followed by assessment of impact.

10.3.1 Access to Financial Services

The transformation of MFIs into professional mode and the subsequent fund mobilisation drive has resulted in increased credit access to the community, both for new and old clients. The new clients are swelling in number to get a sizeable first credit of Rs 5000/- from the MFI, which gradually goes up to Rs.20,000/-. The savings loan ratio is also rising depending on the number of years of membership. The ratio for the new client (members recruited after the formation of MFI) is 1:4 times while it is 1:10 times for the older clients (members who have been prior to the MFI). Members look for MFIs for bulk loans while they resort to SHGs for smaller loans.

Access to Credit

Table 20: Average Size of the Loan

Name of MFI	Average Loan Size per Client (In Rupees)
CAMEL Mahila MACTS	12656
Chaitanya Mahila MACTS	11816
CREED-Attractive Capital Private Limited	15554
BWDC-Mahasakthi Microcredit Services Private Limited	11739

(Source: CAMEL, 2010; CJWS, 2010; CREED, 2010; BWDC, 2010)

- In the new groups, members get bigger loans(Rs5000-24000/-)
- Savings-loan ratio: ranges from 1:4 to 10 times
- Women have accessed one or two loans through the MFI in 3 years.
- Accessed cheaper loan (helped to repay high cost credit , to create assets, to invest in business and agriculture activities)
- Women in SHGs have savings accumulation
- People also access loans from various sources; each woman have at least 3-5 loans taken from SHG, other MFI, bank, subsidy schemes, money

The analysis of all the Partner MFIs indicates that the average size of the loan per client, as of March, 2010 is Rs11, 682/-. The figures for the sampled partners affirm that the clients are getting slightly bigger loans through the MFIs.

Table 21: Loans Issued and Closed

	Number of Loans Issued		Number of Loans Closed	
NGO	**Oct2008-Mar2009**	**Oct2009-Mar2010**	**Oct2008-Mar2009**	**Oct2009-Mar2010**
CAMEL	1478	1324	832	985
CAMP	289	139	1054	274
CCFID	747	4824	432	1176
CDE	426	64	524	158
CREED	434	192	0	403

SMVP	3146	1428	0	235
CJWS	518	861	16	42
IWB	3321	2029	4470	3220
BWDC	688	1035	1240	456
CFH	281	174	147	37
PPSS	3448	4	2640	2012
ASSIST	158	0	220	0
	14934	**12074**	**11575**	**8998**

(Source: SART-CARE India, 2008b, 2009b, 2009c, 2009d, 2010)

The above data reveals that on an average, 2012 loans were issued in a month during the year 2009-10. Even though the figures suggest that there is a slide in the number of loans issued, the amount of loans issued more than doubled when compared to the corresponding period in the previous financial year. It was Rs1281.56 lakhs in Oct2008-March2009, and Rs2652.78 in Oct2009-March2010. This suggests that the size of the loans per client is enlarging.

Resilience with Insurance Coverage

Insurance services in general, are less popular among the poor because they often do not perceive immediate benefits. However, CARE's innovative initiatives with a few leading insurance agencies have changed this normal perception. Partners have established insurance linkages with leading providers like Tata-AIG, Royal Sundaram, ICICI Lombard and Bajaj Allianz. Except the CAMEL MACTS, all other sampled MFIs are bundling insurance products with the loan products.

The Micro Insurance Coordinator of CREED, TN sharing the details of different insurance products offered to the clients

Table 22: Life Insurance Enrolment Rate in Percent

NGO	Oct 2008-Mar 2009	Oct 2009-Mar 2010
CAMEL	72.5	81.5
CAMP	16	9
CCFID	2.5	56

CDE	19	17
CREED	19	45
SMVP	35	53
CJWS	8	61
IWB	5	13.5
BWDC	19	58.5
CFH	12.5	23
PPSS	0	6
ASSIST	0	0
Overall	18.95	38.50

(Source: SART-CARE India, 2008b, 2009b, 2009c, 2009d, 2010)

The above figures indicate that the insurance coverage is increasing in almost all the partner organizations. All the sampled organisations are faring well on this count. CAMEL tops the list with their strategy of insisting insurance coverage as a qualification criterion for the MACTS.

Table 23: Details of Active Micro insurance Clients

MFI	Total Clients	Active clients for Micro insurance		
		Accident	Health	General Life
CAMEL	8500			7982
CJWS	4973	1672	2348	884
CREED				
BWDC	27524			16643

(Source: CAMEL, 2010; CJWS, 2010; CREED, 2010; BWDC, 2010)

The insurance covers for flood prone areas have benefited a majority of the clientele population to recover crop and property losses in the year 2009 and this has changed their mind-set in favour of insurance coverage. Unfortunately, the insurance agencies have abandoned this flood coverage citing severe financial dent as the reason. The on-going successful insurance product is ‘’simple life cover” for a yearly premium, which takes care of accident related coverage. Household level ‘’health insurance” and wage compensation covers are the other products that make gains.

10.3.2 Impact

The impacts of the programme are presented at the individual, household and community levels.

Impact at Individual Level

The SART project through the partner NGOs have created several impacts at the individual women's level. These are highlighted below:

Knowledge and Increase of Confidence Level

Women have gained knowledge about group functioning, how to save money and take loans from the groups. Through their membership in the group, they now know about bank and how to apply for a bank loan. Women were able to talk confidently to external people including bankers, government officers and others. The study team has witnessed many women speak confidently about their group. The women also got more confidence while their house members give respects and value her the most when she brings loan for the household needs. She also feels proud that she could contribute to the household income. One of the women in Angamma Chatram village in AP expressed her proud moment: *"I bought a motor cycle for my husband from my dairy business income and enjoyed going with him proudly in that vehicle. He appreciated me for getting this for him and encouraged me to concentrate in my business which he will support me in any way that is needed. This encouragement boosted my confidence more to expand my business by taking more loans from the group."* In Kodiakarai village, the leader said, *"my husband support me a lot at household work when I am in the meetings and encourage me to spend time for the group".* In fact, he has provided the study team a nice tea after our discussion with the group members that showed what she means. The family member's encouragements have helped the women's confidence level to participate effectively in the group and outside when they travel.

The awareness level of women about the financial products offered by the NGO is high in Tamil Nadu, because of the level of education and exposure of the clientele groups. Women know how much interest they are paying and other charges to the MFI, and also they aware about the arrangements of the insurance products. The group members of Magara Jyothi in Kodiakarai village in Vedarniyam district, TN is one of the examples of how women

The members of Magara Jyothi Sangha in Kodiakarai village in Vedarnyam district, TN sharing their knowledge on the loan products offered by the NGO, BWDC

understand the loan products offered by the NGO-MFI. The women explain that they took a loan of Rs. 1 lakh of which they got Rs.90,000 for their group which they provided loan to 5 members. When asked why they got Rs.10,000/- less, they said, that is the policy of the MFI about which they can't do anything because they need the loan. Asked further why they are not given that amount, the women said, "*It is for security reasons that they have retained that amount, which they will adjust to our loan repayment on the last instalment*". When asked about the interest rate, they said that it was 6%. When told that they will not be given any benefits, they said, "*Yes it has some benefit but very little from what we pay to them. We are paying 18% to them and they give 6 and they will get 12 from us for the money which was not used by us. They are gaining from our payment and also taking this Rs.10,000 and add it to the money got from the other 9 groups and give loan of Rs. 1 lakh to other groups like they gave to us, and get 18%. Now you calculate how much they get and what they are giving to us. We all know all these background details but we agreed to take this loan because it is still worth for us, as our members take loan for higher interest (5%/month) of loan from money lenders".* When we asked how you know all these calculation, they said "*the staff told us that they need it for security reasons and we also visited their office when we went to collect the loan, and understood how their system works*". They appreciated that the NGO did not hide anything from them unlike other agencies. This helped them to have good knowledge about the product that offered by them. The MFI was very transparent and also educated the members about what the loan product is about.

Increase of self confidence, development of leadership skills and able to motivate others

Boina Poleru is a 45 year old woman living in Vetapalem village (Vetapalem mandal, Prakasam district, Andhra Pradesh). She was a native of Bapatla town (about 90 kms away) and shifted to Vetapalem village when she was fifteen years old, after her marriage with Subramanyam. They worked together in cultivating leased lands; grew vegetables and sold them for a living.

However, a few years later her husband started having an extra marital affair with another woman and started to live with the other woman. He stopped taking any responsibility for the house and even began to harass Poleru. She informed that the domestic violence went to such an extent that he used to come home drunk and even used to drag her out of the house and beat her up on the streets. Moreover, he stopped contributing any finances at home and even took whatever little savings that they had at home for his vices. Unable to bear the harassment and humiliation any longer, Poleru asked her husband to formally divorce her, to which he reluctantly accepted and left her alone to fend for herself and her their three daughters, the eldest of them being 12 years old, the second one being 10 years old and the third one about 8 years old at the time of her divorce. However, as a divorce agreement he allowed her to stay in the small land (of two cents) that they owned, and gave a written unregistered note to this effect.

At this juncture, being illiterate, with no finances of her own and unable to cultivate land single handedly; she was totally distraught at her condition. Recalling her agony of those days, she said, "This was about 12 years ago. At that stage, I thought of committing suicide thinking that everything was over for me, I have only lived through just because I had three daughters to look after". Moreover, as she was left with no land vegetable cultivation could not be continued

and she shifted to seasonal fruit vending. Life for Poleru was very hard; she used to earn hardly enough to feed her three daughters and herself by selling seasonal fruits by head loads in a basket. She used to borrow from local money lenders at high interest rates, often above 60% pa, for both her business and consumption needs. Due to the high interest rates, there was hardly anything left at the end of the day. Such a life of penury carried on for about five to six years; and the big task of getting her daughters married in the future was a thought that haunted her every day.

It was at this stage, she joined the Ushodaya MACS promoted by ASSIST. Initially she availed a loan of Rs.5,000 with a repayment period of 10 months and at an interest rate of 24%, which she invested for buying fruits. She began working very hard to make her business successful; she informs that she usually starts her day at 4.00 am by going to the wholesale market to buy fruits and sells them in the local market from 6.00 am to about 9.45 pm every day. Based on seasonal availability, she sells all fruits such as apples, mangoes, grapes, banana, orange, etc. Due to her hard working nature and disciplined life, she was able to repay her installments without any defaults and since then has availed about four more loans at an interval of approximately one year. Her second loan was Rs.7,000, third loan was Rs.10,000, fourth loan was Rs.15,000 and fifth loan was Rs.15,000. She has used the loans for mostly working capital requirements and also for purchasing a cart.

She says, "Availing loans is not the only benefit that I got by being a member of the MACS, regular interaction with other women on a regular basis enabled me to develop my business acumen to such an extent now I sometimes go all the way to the wholesale market at Vijayawada, which is about 100 kms away, to purchase fruits". Even though she is illiterate and her literary skills are limited to only being able to sign her name; she has however developed skills in financial calculations due to regular group meetings. With her developed business acumen and financial discipline, she totally overcame her dependence on local money lenders. She proudly says that today she trades about eight baskets of fruit per day, which would be worth Rs.5000, leaving her with about Rs.200 to Rs.300 to save per day (after deducting all expenses) depending on market trends

Her slow but steady success in her business helped her manage to get all three of her daughters till 10th standard. Furthermore, in the last few years, she has also got her three daughters married. Being a single parent, this was her biggest worry over the years which she was able to overcome. She says with pride, "I have not only married my daughters to good sons-in-law, but also have given each of my daughters a marriage gift". The unassuming Poleru has not kept her success to herself, she has motivated about 33 women to join the MACS in the last few years. Now she is the group leader of her Self Help Group and also an executive committee member in the Ushodaya MACS.

The real test of leadership skills and self-confidence came to her about 2-3 years back; her former husband sold off the house in which she was living as she did not have a registered document proving her ownership. Being an NGO-MFI, ASSIST also has a strong social inclination towards its clients; so on hearing her plight, the organization supported her and based on this support, she approached the State Human Rights Commission in Hyderabad and also met some top politicians of the state to get justice to herself. She says with pride, "From a small village, I went all the way to Hyderabad and expressed myself to top officials and politicians of the state; all this could happen because I learnt to talk with strangers and to

groups only because of group meetings". Bowing to the pressure, Poleru's former husband backed out from selling the house and registered the house in her name. Now she is respected to such an extent that almost all the women in the whole neighbourhood take her advice on all important matters.

Since she stays alone, she now takes care of her granddaughter and plans to get her educated, which she feels she couldn't provide to her children. Asked about her future plans, she says, "Now I have a good relationship with several fruit vendors and understand the nuances of fruit selling to a very good extent, so I plan to have my own wholesale shop and get fruit by truck loads". Poleru has come a long way from being a depressed woman with the thought of suicide, to being a guide and role model to several other women to changes their lives.

Source: Progress Report: Jan- March 2010, CARE India, Chennai

A proud father says:
"My daughter has acquired skills to handle finance very efficiently through SHG and hence, now a days all the important matters at home and business are looked after by her. We take her word as final".

Father of Patibala Ganeshwari, member of Siva Parvathi Self Help Group Nadendla village, Prakasam district, Andhra Pradesh.
(Source: CARE India Progress report: Jan-March 2010)

At least 2-3 board of directors of the MACTS in AP and federation leaders of the mutual benefit trust in TN have full knowledge of their organisations, and shared their vision/ mission, their financial operations, profit and member's problems. By taking various training programmes organised by the SART team and the NGO-MFIs, women's knowledge has increased in running their organisation.

Decision Making at the Household level for both Economic and Social Life

After becoming members of group, some women got engaged in economic activities, and now play an important role in decision making at the household level. They have started taking more decisions related to businesses (taking loan for buying cattle, business expansion, and purchase of raw materials), purchase of gold, vehicle, cloths, children's education and household expenses. Men acknowledge that now more joint decisions are taken including those on big expenses of the household like purchase of cattle. Women have a say as they are now aware of monetary issues.

Increase of Mobility

In general women's mobility has increased after they joined the SHG. Many women said that they travelled out of their houses and villages for the first time after joining the group. They frequently travelled to the bank which is away from their village, to taluk and district towns for meetings of MACTS, federations and some have even travelled to nearby markets (Chennai, Nellur, etc) to buy raw materials or stock for their business activities, to sell their products and to get business orders.

Access and Control over Credit and Income

Women now, exercise control over the credit money that they take and the income that they earn. They now decide how the money should be utilized. Women generally keep and spend the loan amount taken from the group if it is taken for household consumption, their business activities or children's education. If the loan is taken for agriculture then they give it to the men to use it. There are quite a number of women who said that they took loan for setting up a business or expanding her husband's business, such as, buying an auto for running a share auto business, improving the rice selling business, fishing activity, etc.

Credit-confidence-co-investment: A reflection from the ground

Varalakshmi (50) is a four years old member of the Parvathi Sangha, in Basavaiah Palayam, located in Sri Kalakasthi. Her family of five, spouse and four daughters, was dependent on her husband's retailing in rice, which fetched them about Rs.5000 per month. She took a loan of Rs10000/- from the group, added Rs2000/- by pledging her gold ornament and with that purchased a cow for Rs12000/-. She sells milk locally and gets an average monthly income of Rs4000/-. She reinvests Rs2000/- from this income to meet the feeding and heath requirements of the cow, repays Rs700/- a month towards the loan, and thus generates a surplus every month. The surplus has helped her to redeem jewels, purchase new gold ornaments for her daughters and clothes for the children. She is proud that she took the decision of taking a loan for purchasing the cow on her won which has been adding income to the family. Now, she even decides on how she should use the income. The experience of handling money and the related decision making experience has helped her a lot in managing the household after the demise of her mother in law, who used to handle the entire finances and other decisions for the family. Now, the calf of the cow has also grown and is ready to yield milk, and Varalakshmi foresees additional income. With her increased confidence and sense of empowerment, she is looking for a bigger loan of Rs 50000/- to expand her spouse's rice business.

Ownership of Business and Assets

It was noticed that the businesses are owned by the women and men provide support to them in purchasing raw materials. Not many women have created bigger assets in her name. Only

one of the women interviewed has mentioned that two out of three acres of land was registered in her name, and that she had taken a loan through the group to buy them. However, informally women own gold, furniture, etc which are mostly purchased out of their business income and cattle which is purchased from the group loans.

The important asset women were proud of is their savings. Some of the women have savings of over Rs.5000/- and feel that they have created this asset and can buy gold for themselves or use it for any household emergency.

Involvement in Politics

There was not much evidence on participation of women in politics and panchayats after they joined the group. However, women in CAMEL and CJWS have participated in the election process of their MACTS for the director's post.

Impact at Household Level

The impacts at the household level have been presented through a few case studies which convey that the extended credit facilities through MFIs have considerably contributed to the welfare of the concerned households in terms of asset creation, asset redemption, creation of new businesses, supporting and expanding the existing activities, prudent investment in education and increased investment for household improvements.

Access to Cheaper Credit

After being part of the group, women and their family can now access cheaper credit compared to times when, in emergencies, they could only get credit at interest rates of more than 5% per month from money lenders. This has helped the poor families immensely. The below case study is an example of how the loans have helped the families to progress in life.

Small loan but significant progress

Malleswari's family in their new house, which she has constructed recently with the earnings from her business and her in laws support.

Malleswari, 26, is a member of the Lakshmi Saraswathi group in Gopalapuram village, Muthkur Mandal. She studied up to 5th class and was married to Mani when she was 14 years old. She has two daughters; one is studying in class 7 and another in class 3 class in government school. She lives in a joint family with her in- laws, too live in the same house. A few years ago, the entire family was engaged in salt forming in their own land, which was taken over by the authorities for construction of a new port. They were paid compensation. Now, her husband is a daily wager in the port and her father in- law works as an agricultural coolie. He also works in the port during off season as a casual labour.

During her frequent visits carrying food to her husband, Malleswari noticed that labourers walked a distance to have tea as there was no tea stall. She has also noticed that many trucks were moving in and out of the port to load and unload materials. The truck drivers too went out for tea and food. On seeing the situation, she thought of supplying tea from her house. So she purchased a flask and materials for tea-making with her own money. With this minuscule investment she started supplying tea to 40 customers and out of this activity she earned an income of about a hundred rupees a day.

In 2008, she joined the group promoted by CJWS and took a loan of Rs5000/- and used a part of the money to expand the tea business and the remaining for household consumption. With

the new loan amount, she purchased one more flask and added beedis, cigarettes, pan, sweets and cakes. With the addition of new products, she reached more customers, but with an additional daily expense of rupees 40-50/- towards auto hire to carry the materials to the site. The expanded business has had increased her income to Rs300-400/- day depending on the movement of trucks. She repaid the loan in fifteen months. Over a period of time, she has accumulated money from profits and with that purchased a gold ring worth rupees three thousand and anklets for her daughters, worth about three thousand rupees.

On seeing the regular and increased movement of trucks as a consequence of full-fledged activities in the port, she thought of taking another loan, slightly bigger to start an eatery on the main road to cater to the needs of the drivers and migrant labourers.

Malleswari is happy that the loan for expanding the tea business has led to increased income, not only to meet the household needs but also to generate small assets like jewels.

There are many more examples of how the group money has helped people to access cheap credit for their household and livelihood needs.

Increase of Household Income; Income Generating Activities

Though there are several sources for women to access credit for their livelihood needs, the credit accessed from the MFI service has contributed significantly to increase the income of the family. For example women invested their loan in dairying business gained profit of Rs.4500/- per month, got Rs.10,000 from fishing activity, Rs. 20,000 from paddy cultivation apart from keeping rice for their home and Rs.9-10,000 from passenger auto rickshaw business. The women feel that they are contributing 50% of money towards the household income.

Petty shop, an income generating activity started by a member of Kalesha group based on the loan taken from the Chaitanya Mahila MACTS, AP

Increased household income through multiple business activities

Patibala Ganeshwari is a woman of 35 years married to Patibala Purna Chandra Rao, who is 38 years old. Both of them have studied up to 10th standard. They have two children; one son who is 15 years and studying 9th standard and a daughter who is 10 years old and studying 5th standard. They live along with Ganeshwari's father and mother in a small rented house paying a rent of Rs.200 per month in Nadendla village (Nadendla Mandal, Prakasam district, Andhra Pradesh).

Ganeswari says, "We used to live in extremely poor conditions. My husband works as an agricultural laborer and earns about Rs.100 per day, so if all goes well her husband earns up to Rs.2000 to Rs.2500 per month. But, this is not guaranteed for all days in a year. Considering that only my husband's income was not enough, I used to do embroidery work as home and started earning about Rs.2,500 per month from this work. To earn this amount I used to work for long hours every day stretching late into the night; sitting in a dimly lit room and getting very few hours of sleep in a day. The amount earned thus was used to feed the whole family of six people and also used for educational needs of my children. However, due to the extremely stressful conditions in which I worked, my eye sight got affected and I was advised by doctors not to do this kind of work anymore. However, I continued to do this work at a much lesser scale even though I wanted to stop as I had no other option and also to keep the family moving. With reduced income, the family was struggling to make ends meet, and children's education was major worry".

At this stage, she was approached by the field officer of ASSIST who apprised her of the opportunities that existed by joining a Self Help Group. After giving thought to this, she joined the Siva Parvathi Self Help Group promoted by ASSIST in November 2005 and has taken a loan of Rs.10,000 at a declining interest rate of 24% pa with repayment tenure of ten months. With this loan, she bought a sewing machine and started doing small time tailoring works based on orders. Even though this was less straining on her eyes and health; the income earned from this was less barely enough to make ends meet and repay the loan without any default. Being a member of a self help group she attended all the meetings on a regular basis. These interactions have developed her confidence and she began to look for further opportunities to increase her income.

She observed that there are a few tobacco processing factories in the area which employ a large Number of people, and there was no Tiffin shop located in the area. Identifying this opportunity, Ganeshwari took another loan for Rs.10, 000 in February 2007 with the same terms and conditions and she used this amount for capital investment requirements like purchasing a gas stove and utensils and working capital requirements like taking a small make shift shop for rent and raw materials (food ingredients). Thus she started her Tiffin centre in a very small way. She started cooking at home making tiffin items and started selling in her shop, which is located just outside her house. She works very hard to run her business and her day starts at 4.00 am and end at 11.00 pm. She runs her tiffin centre from 6.00 am to 10.00 am and 1.00 pm to 8.00 pm. But, she feels that this business is less Stressful than her previous work as she would be able to sleep for a few hours during the afternoon as her father assists her in running her business.

Her tiffin centre has started to get popular with her tasty idlis and puris in the morning; wadas and bondas in the evening; and tea and coffee at all times. With this small tiffin centre she started to taste success and she was well disciplined to replay all loan installments on time. With her good repayment track record to back her, she availed anther loan of Rs.15,000 in April 2008 from ASSIST under the same terms and conditions. With this loan, she bought a wet grinder; due to which she was able to make batter for idlis and wadas at home. She has also included other small items in her small tiffin centre like toffees, sweet meats, etc to also attract school children to her shop. Now she earns about Rs.3500 to Rs.4500 per month from this tiffin centre after deducting all expenses including the rent of Rs.250 towards her shop.

In addition, Ganeshwari saves about Rs.30 per month through her group and recently has increased that to Rs.50 per month. This was she has accumulated about Rs.2500 in her account. Interestingly, she has even developed the habit of saving small change from her hotel and she gleefully displays these coins, which she estimated would be about Rs.1000, which she thinks would be useful in case of any emergency. Moreover, members of the household also hold her high esteem that no important decision at home is taken without her consent. Moreover, the family now use the gas stove for cooking and discontinued the use of firewood as a source for cooking, so this has resulted in a healthier atmosphere as people in the household are not subjected to smoke inhalation anymore.

Ganeshwari says, "In spite of all the hard work that I put in, I feel happy that I am able to send her children to a reputed school in the neighbouring town. In addition, we could also take up construction of a small house of our own in our ancestral land which is about 2 cents". When asked about her future plans, she says, "I plan to have my own shop and buy a refrigerator for our tiffin centre so that I could include cool drinks to increase our income". Ganeshwari has not put up any name board for her tiffin centre, but she proudly says "Because of my small business, now I have gained an identity of my own in the locality as my tiffin centre is popularly called as 'Ganeshwari tiffin kottu'

Source: Progress Report: Jan- March 2010, CARE India, Chennai

Increase in Consumptions

As the loans have helped the women to contribute towards household income, the consumption of food and health expenses has improved. They are also able to invest the loan directly or earning through the business on children's education mainly noticed in Tamil Nadu despite the significant government's support. Women who earn from business activities stated that there is no tension in the house about meeting household requirements such as food, children's education and medical expenses.

Ability to Address Economic Shocks and other Vulnerability

The main intention of the project is to support the poor families who are affected by the Tsunami and also prepare themselves from the future disaster like flood. The project have some impact towards people affected by the flood by ways of cheaper credit to the affected families compared to money lender's rate, and insurance coverage in the Tamil Nadu region for

crops, house damage, health problems and wage compensations. People felt that it helped to recover quickly from the flood. In CREED project region alone Rs.45 lakhs insurance settlement made to 1300 people affected by the NISA flood. People felt that it helped to rebuild their livelihood with this support but the insurance agency has withdrawn the flood coverage from its package due to loss incurred. However, still there are other schemes like mutual health insurance has coverage of wage compensation due to illness and admitted in the hospital which helps them to meet the basic needs at the time of unable to earn to meet the livelihood needs of the household.

Creation of Assets

Through group discussions and individual household interview the study team found that some people have created assets like milch cattle, gold, furniture, camera, machineries and home appliances like refrigerator, TV, etc. The following case study is an example of how she able to create assets that helped to provide regular income for the family:

A proud Subaratnamma a member from Parvathi Sangha in Basvaiya Palayam, Kalahasti, shows her assets created in the form of 8 grams gold chain

Credit for education and asset creation crystallizing regular income for family: Life story of a lady from a rural village

Mookayee (55), is a member of Annai Therasa SHG in Adari village. With her education stalled at the primary level, she got married early. Both she and her husband work as agricultural labourers. She has six children; one girl and five boys. She wanted to provide education to all her children.

She has been in the group for more than 10 years and has taken several loans (at least 10 times, cumulatively about Rs 2 lakhs) for educating the children, purchasing land and to repaying other loans. Every loan, she recalls, has helped her to progress in life. But the most important one was to pay the fees for second son's engineering education. This loan had come handy at a critical stage of his higher education, when she had exhausted all other sources of funds for his fees. She had struggled to repay the loans until her engineer son secured a job. She considered the loan as an investment for the family's future. Her hope turned right when

the educated son gave money, not only to settle the loans, but also contributed to his sibling's education, marriages and family assets.

After five years of this loan, she got a loan of Rs.1.2 lakhs with a subsidy of Rs.40, 000, as the group was part of the Government's programme. With this money she purchased 3 acres of dry land. She registered 2 acres of land in her name and one acre in her spouse's name. They went in for two cropping in a year, and cultivated millets, sesame, coriander and paddy, which yield regular income for the family. She has managed her money well and have three of her children married off with incomes from land and the money given by her engineer son from his earnings.

A few years later she went for two major loans (Rs1.2 lakhs and Rs1 lakh) from outside the group to send her third son to Dubai for a job and for supporting the first son's business. Unfortunately both turned out a burden as they were not successful. Yet she is able to survive because of the wise investment of the group loan in agricultural assets, and the intermittent loans from groups to tide over the financial crisis.

Community Governance in MFI

Communities (Clientele of MFI) have a role in the governance of MFIs with the representation in the Board of Directors by the virtue of the MACTS ACT, 1995 in Andhra Pradesh. The MACTS setup formalises the community ownership of the institution. The NGOs are non-owners but could play the role of CEO/Secretary and thereby exercise control over the transformed institution. The MACTS can access credit linkages with mainstream financial institutions, both public and private.

In Tamil Nadu, the partners have adopted Societies, Trusts, u/s 25 Company and or NBFC model for MFI. The models provide little control to the communities. In such a scenario, commitment to the MFI mission drives the board. The NBFC model thrives on Client-Service provider relationship. Even the community (Clientele) representation in the Board is optional. Nevertheless, partners like CREED are contemplating about providing community ownership in NBFC by allocating shares to ''Mutual Benefit Trusts'', formed by the target community.

The existing opportunities for community governance have also been handicapped by the low-literacy and low-involvement of the members and show-case commitment of the promoting agencies. The fact that the loan size, terms and repayment schedules are determined by the senior level teams of the visited MFIs upholds the above observation

10.4. Challenges Faced

During the field level interactions the partners indicated the following as challenges to further growth. The same was echoed by the other partner MFIs during the consultative meeting organized at Chennai.

- **Delays in adapting to business model**: Many of the partners agreed that the inputs by the SART team have enabled the NGO board members to accept the creation of a separate entity for MF. Nevertheless it took a fair amount of time to change the mind-set of the entire organization, from the non-profit mode of operation to the profit making mode.
- **Hangover of Charity**: The hangover of charity and the continued dilemma of the NGO head towards the profit centric MFI plays a vital role in the shaping up of the MFIs in CJWS and CREED.
- **Ambitious targets**: Setting ambitious, time bound targets for outreach and portfolio was also mindboggling in the initial stage. They stressed that the retention and addition of poor clients, has compounded the task.
- **Fear of risks:** The fear of loan defaults by the clientele group also looms large in their minds of organizations like CJWS when they think of bank linkages, where they are personally held accountable.

- **Staffing:** Too much emphasis on the loyalty factor in choosing the number two has resulted in either over bearing or unassuming staffing and the consequent delays in organizational adaptation and transformation in a few organizations. The staff turnover is the other factor that has derailed the process, has been reported both at the field level and the middle level (number two) in a few partner organizations. Better employment and wages is the reason behind the staff turnover. The absence of personal growth within the organization is also the other factor for the staff turnover. The turning over of trained staff has been responsible for communication gap between the clients and the MFIs, slowing down of the transformation process and crisis in data management. The lack of systematic induction training and knowledge transfer mechanisms also affects the MF operations.

- **Difficulty in getting start-up capital**: Almost all the partner organizations have expressed difficulties in obtaining the start-up capital for the MFIs. The mainstream financial institutions do not want to be the first lenders for the new MFIs. Mobilisation of funds from private financial agencies/foundations is costlier than the nationalised banks, and partners have been sparingly approach them.

- **Insufficient cash flow:** The repayment of loans secured from mainstream financial agencies and the lack of SA-TMIF start-up capital has been affecting the cash flow to maintain the same level of credit to clients in three of the four organizations visited. The expansion spree of the partner MFIs with the promise of a loan to clients on the seventh month of their enrolment necessitates the additional funds to on lend. The efforts for further linkages are yet to be materialised for want of technical clearance by the bankers. The cash flow gaps have led to the withdrawal of membership in CAMEL and CREED. The CJWS MACTS is struggling to retain clients. One should also not underestimate the real motive for good repayment is the idea of getting another loan and in most cases bigger one. Hence the good repayment has a direct correlation with the funds available for future loans. The funds for next loans are already a taxing burden for almost all the partners. Again, the lendable funds are closely linked to the amounts of profits. Hence, the central issue is funds for further lending. As of now, all the partners are pursuing bankers to get additional funds and hope that it will come through. Any delay or negative response may become a stumbling block to achieve sustainability.

The following challenges have been observed and inferred by the evaluation team during the field visit as a result of interaction with the MFI clients, board members of MFI, staff team of partner organizations, and the CEO of the respective MFIs:

- **Designing new products and services**: Designing of new products and services assumes significance in a highly competitive sector like Microfinance. So far, the partner MFIs are successful with the traditional small savings, micro credit and new found micro insurance products. The launching of products like fixed and recurring savings has not clicked yet. The stiff competition by other financial players will eat in to the existing MF market of the partner MFIs unless they undertake research to capture both the current and the emerging financial and non-financial needs, wants and preferences of the customers and prospects. The designing of innovative financial products will not only help to retain the customers but also able to attract funds from mainstream agencies. The BWDC's ''Water and Sanitation'' loans are the best example to quote as it has helped 7000 low-income group families to build household toilets. Products and services are different in many ways. Unlike products/manufactured goods, services are intangible and cannot be stored, transported or resold. The services marketing function go beyond traditional marketing, requiring close co-operation between the frontline staff and those managers responsible for operations and human resources, in order to ensure unique services to retain customers. By introducing door delivery of ''credit'' to clients, the other MFIs in the partner areas have already put them in a tight spot.

- **Highly ambitious targets for outreach and portfolio**: CAMEL and BWDC has future vision for their MFIs. CAMEL would like to reach a portfolio of Rs.25 crores in ten years time (i.e. 2020, which is double folded to the present portfolio. BWDC aims for Rs.100 crores portfolio by 2015 and it is eight times of the current portfolio size. A look at the following table indicates that the SHG promotion is taking a beat with almost all the partners during the second half of the previous financial year, which affirms the challenge. The extremely competitive environment in Tamil Nadu and legally constraint and clouded MFI environment in Andhra Pradesh, the partners' targets for outreach and portfolio seems to be highly ambitious. The targeting is further handicapped by the tight funding for on-lending.

Table 24: SHG Formation Growth Rate in Percent

NGO	Oct2008-Mar2009	Oct2008-Mar2009
CAMEL	18	1
CAMP	-25	-5
CCFID	3	-4
CDE	0	2
CREED	27	6
SMVP	16	-2
CJWS	7	3
IWB	7	0

BWDC	4	-3
CFH	6	4
PPSS	3	0
ASSIST	1	0
Overall	**67**	**2**

(Source: SART-CARE India, 2008b, 2009b, 2009c, 2009d, 2010)

- **Retention and reaching out to poor**: The concept of financial inclusion encourages MFIs to include the neo- poor (not poor, but low income groups) to expand their client base. Partner MFIs are not averse to this concept. In the absence of a well-defined bench marking for poor, they have already started recruiting clients from the not so absolute poor category from the semi-urban areas. This adjustment helps them on two counts: The first is the outreach target and the second is the sound loan recovery rate, which is an essential parameter for MF- survival and sustainability. The ever increasing size of the loan (from Rs5000/- to Rs50,000/- except for housing)and the restrictive loan repayment schedule(50 weeks to 24 months as determined by the MFI) will be a constraining factor for very poor($1 a day income).

- **Deterioration of the SHG structure and gradual erosion of savings for the clients**: As of now, the government sponsored SHGs and partner MFIs function parallel in the target areas. The MFIs focuses on micro credit and micro insurance activities. However, in order to create a separate identity, particularly in Tamil Nadu, MFIs are promoting JLGs. In such a scenario, many of the members of SHGs are getting enrolled in MFIs as JLG members. In the upcoming JLG model, savings product is not insisted and as such clients loose the habit of savings. The gradual erosion of this critical habit will not only affect the savings at the individual level but also in the loan repayment as they will refrain from setting aside money for repayment.

- **Multiple borrowings by the clients**: It has been observed in the target areas that most of the clients resort to multiple borrowing and they use one loan to settle other. Partners do not have a mechanism to assess the overall indebtedness of the clients. Ignoring this critical issue will amount to abandoning of responsibility (Prudent lending) and it may lead to MFI-Governance problems. The clients' mounting overall outstanding dues will be a death blow for the MFIs if they recourse to en-mass default on their own or with the support of a legislation.

- **Constraints in the partnership model of channeling funds for MFIs:** It is interesting to note that almost all the partners did not want to continue the linkages with HDFC under the partnership model in spite of the fact that for many of them, it was the first major credit linkage programme. The reluctance was for three reasons: first, the high volume of paper work which consumes more labour; second, the increasing interest on loans (now20%) and third, the client shift (from NGOs to HDFC, as HDFC is opening their own branches in NGOs operational areas once the customer base is stabilized) which will hinder the partner promoted MFIs.

- **Constraints in Insurance Coverage:** The insurance agencies showed little interest in products leading to recurring compensation for disaster oriented losses is affecting the renewals of premium and loss of confidence about the service.

- **Limitation to achieve women's empowerment**: The MFI structure that opted for NBFC or Section 25 Company act has no scope for much empowerment of women other than certain level of economic empowerment through having control over their income generated from their business activity. However, there is scope for women's empowerment through the SHG and MACTs structure but the pure MFI approach with commercial financial actions it provides little space for women's empowerment, particularly social and political empowerment. The staff or the board of directors are forced to relate to the women members of MACT or SHGs only related to loan disbursement and recovery. There is no additional capacity building of the members in other social and political aspects of their livelihood.

- **Constraint in measuring the impact of the poverty targeting and women's empowerment**: As there is no adequate baseline data indicators established and monitored for the poverty targeting of the clients and women's empowerment through the regular monitoring system by the MFI, it has been difficult to arrive at how much the project has covered the poor families and achieved in terms of empowerment of women.

The study team has shared these concerns with the partners so that they can take corrective measures.

11 Good Practices from the Project

CARE SART has contributed several lessons and good practices for NGOs on provision of financial services especially for disaster prone areas. Some of the key practices are highlighted below:

- **Selection of SART partners by PACT tool**: Deriving from the experience and lessons of its CASHE programme, CARE has developed and applied a wetting tool to select the partner organizations for the SART project. The PACT (Partners' Capacity Assessment Tool) is a score based tool dealing with eight key parameters relating to the MFI; like Governance, Management, Human Resources, Financial Management, Microfinance Services, MF Programme Performance, External Linkages and Disaster Risk Management. It is not only the tool but also the manner in which it was applied makes it to consider a good practice.

The scores of PACT was categorized in to three segments: Low score, moderate and High scores based on the assessment of the proposed partner NGOs existing capacities and gaps. The organizations with moderate scores are selected for the SART collaboration keeping mind the narrow time line and scant resources for the completion of the project. The other reason was the moderate score suggests that the organization has considerable experience in MF, prospects for scaling up but lacks in professionalism to go further. By this good decision, SART has not wasted time and resources in grooming the organizations from the scratch on the one hand, and invested the precious resources to build the matured and opportunity abound organizations on the other.

The methodology of conducting the PACT assessment was participatory in nature where the SART team involved the MFI staff in the assessment and also reflecting the assessment by feedback process. Such processes enabled the staff to internalize the areas of strength and weakness to improve by themselves. It is more of a learning oriented assessment for the team to acquire internal strength to analyze about their organization.

- SART followed participatory and learning oriented process
- SART allowed partners to choose the appropriate MFI model
- Share capital by community (CAMEL, CJWS)
- 10% as loan security that supporting fund flow of the org (BWDC)
- Partners attempted own links for training(CAMEL and CJWS with RASS)
- Frontline MFI staff from among the members(CJWS)
- Package of insurance with credit
- Inclusion of board members and infusion of capital from community (CREED) in NBFC.

- **Flexibility for partners to choose appropriate model of MFI**: SART has provided professional inputs and sectoral insights to the partners both to strengthen the existing MF structures and to choose appropriate new structures to suit to local needs has helped the partners in MF institutional building. Those who had MACTS model in Andhra Pradesh have continued to operate but with a professional approach, and where as in Tamil Nadu, partners whose MF operations were structured as Societies, Trusts, u/s 25 Companies continued in the similar mode but with more professional approach. The organizations that were functioning with informal set up like SHG federations have been encouraged to opt for appropriate institutional structure. Accordingly CREED and BWDC has opted for NBFCs. The fact that SART has not insisted a particular model suggests their democratic and local specific approach of project management. Equally the local freedom has instilled the much required motivation and freedom for the partners to decide appropriate legal structure for MFIs. SART has provided further capacity and institutional inputs according to the partners' model and in concurrence with the pace of the progress.

- **Mobilization of share capital from the community**: MACTS has a legal provision for mobilizing share capital and thrift from its members and as such share capital is mobilized during the enrolment of members. No such legal requirement is there for other forms of MFIs. Yet partner organizations like CREED have attempted mobilization of share capital (Rs102 lakhs from 18500 members) from members to

ensure community ownership, but through an intermediary structure of Mutual Benefit Trust (federation of SHGs), which will be the legal shareholders of the NBFC.

Table 25: Mobilization of Share Capital

NGO	Share Capital Collection in %
CAMEL	96.00
CAMP	60.00
CCFID	0.00
CDE	50.14
CREED	52.00
SMVP	80.57
CJWS	72.29
IWB	0.00
BWDC	17.86
CFH	53.00
PPSS	49.43
ASSIST	101.00
Overall	63.23

(Source: SART-CARE India, 2010)

Good mobilizations of local share capital provide the NGO/MFIs with increased capacities to leverage external funds.

- **Practices in the MFI Board**: A practice of members retiring by rotation is adopted in the MACTS board, which is good to ensure even control within the organization. The newly recruited board members learn from experienced colleagues are also a good practice. Inducting MF/banking professionals in to the Board for want of guidance and expert service is also good. Though it needs to be more systematized in the form of training of trainers in transferring the knowledge from the experienced board members to the new members.

- **Insistence of loan security deposit**: Though the very foundation of MFIs, particularly for those founded on the roots of SHGs, is against the principle of tangible securities, organizations like BWDC opts for it in view of the financial sustainability and the enrolment of unfamiliar clients resulting out of massive expansion. They resort to a security deposit of 10% of the loan amounts, which will be refunded on the settlement of loans to the member concerned. This is considered as a good practice as it increases the temporary cash flow for on lending and from people's point of view it enable them to be a disciplined in credit access.

- **Own capacity building initiatives**: Partner organizations have comprehended the MF capacity building at three levels: senior staff and board members of the MFIs, middle level staff members and thirdly the field level staff. Since the SART capacity building initiatives are focused on the senior staff and board members of the MFIs, partners have attempted to equip the secondary level and field team on their own.

They have sponsored the team members to training programmes organized by professional bodies and conducted in house training for the field level staff. In exceptional cases, they have deputed the senior staff to Certificate courses in MF. For instance, senior staff members from Camel Mahila MACTS and Chaitanya Mahila MACTS have undergone MF-specific training conducted by RASS is an example for this good practice.

- **Recruiting frontline staff from the community**: Almost all the frontline staff members (below branch managers) of partner MFIs are from local areas and it is helping the organizations in terms of proximity, client enrolment, client assessment, loan follow-up and loan recoveries. Local recruitment also increases the confidence on the MFIs. The local recruitment is a good practice wherever the SHG structure is weak or where only the JLG structure is operating to ensure community contact and rapport.

- **Establishment of All women MFI branches**: Microfinance operations are seen as a process of empowerment of women, especially with the SHG approach. With the emergence of more individual oriented microfinance services, avenues need to be built for the women's' participation in the new found MFIs. Establishing all-women branches is one such attempt in this direction. Chaitanya Mahila MACTS leads on this count as all of their branches are run by women staff members.

- **Packaging insurance product with credit:** The negative perception (benefits only after an unfortunate event) about the benefits of insurance products restricts its outreach among poor and it poses greater trial to the partner MFIs, in spite of the push given by CARE in mustering institutional support from some of the leading insurance agencies to design and provide simple and attractive products. After promoting stand-alone insurance products with less success, partner NGOs found it easy to introduce insurance services along with loan products. They are recommending policies with small premium (less than a rupee a day) and meant for a year as a strategy to inculcate the habit of insurance coverage.

- **Extensive Audit notes:** In CAMEL the auditor notes is exhaustive to include commentary on the MF performance. The information is useful to the board of directors and for external agencies like bankers and evaluation team.

- **Provision for loan losses:** The adherence to one of the Financial Self-Sustainability principles of providing for loan losses is the positive factor to counter the threat of loan arrears.

These positive changes described above related to institutional strengthening and provision of community oriented MFIs. These were possible because of constant high quality professional inputs from the staff of CARE SART project and constant supervision and direction with the partners. The openness and flexibility provided by the CARE project and SART team has both contributed immensely to achieve the significant and positive results in the project.

12 Conclusions

The study concludes the overall contribution of the SART initiative towards CARE's overall goal, achievements towards gender sensitiveness and women's empowerment, and achievements of the technical inputs to partner MFIs by the SART team.

It may be one of the very few Tsunami Projects, where processes (to build institutional Capacities of the Partner NGOs/MFIs) and targets (Outreach, Portfolio) are simultaneously pursued with vigour to reach the Project Goal.

It is proved by SART project that a small grant, for a short duration could make a huge difference in Institutional Strengthening and Service delivery, when there is clarity and commitment to project mission duly followed up by strategic and meticulous non-financial technical support by the donor agencies.

The opinion of Partners that the Non-financial technical services are unique as only a few donor agencies support building up of organizational capacities is quite valid.

12.1. Contribution of SART initiatives to CARE's Overall Goal

Based on the field observation and interaction with community members, the SART initiative has contributed to improve the poverty conditions of the families. Families have acknowledged that the loans obtained through the MF organistions have helped them to meet their regular household needs, improve their shelter, create assets like cattle and land that assures sustained income for the households. Women participated in the MF programme expressed that they are increasingly confident to take household and business decisions. The SART initiatives have contributed significantly to improve the economic condition of the families and some extent towards women's empowerment.

12.2. Gender Sensitiveness and Women Empowerment

The SART project design has seen gender equality and vulnerability reduction as cross cutting issues in MF operations and as such no specific focus was assigned to them. However, efforts have been encouraged at the partner NGOs level to incorporate gender sensitive components in the human resource policies of the partners, particularly in recruitment, equal opportunity in promotions, privileges and workplace safety. Many of the partners MFIs have gradually started implementing them.

12.3. Assessment of Technical Inputs

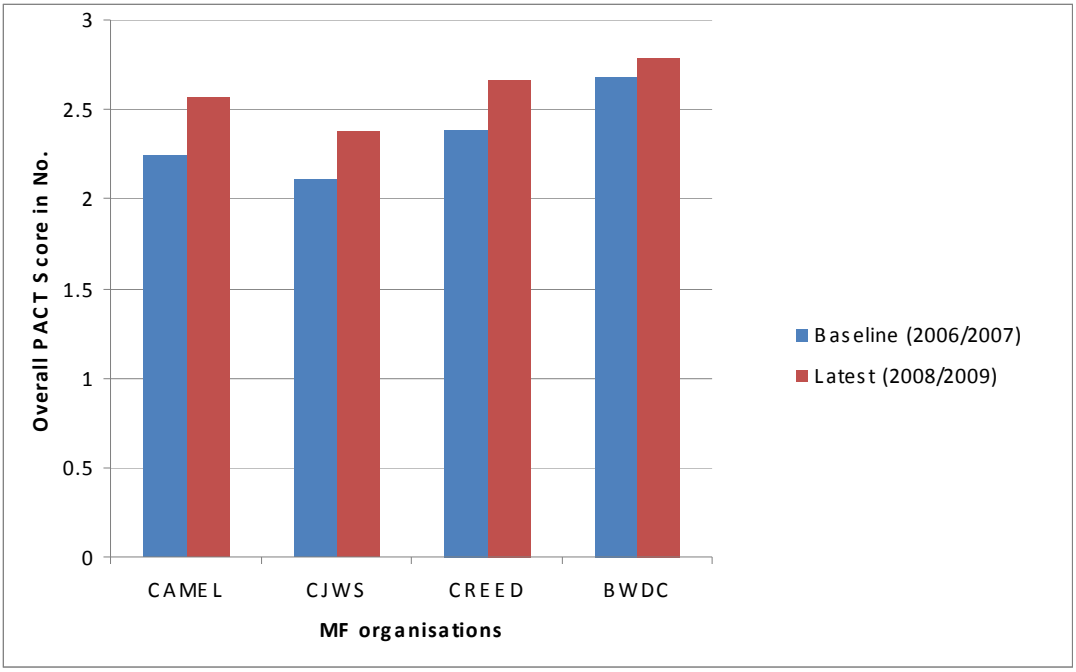
SART's training initiatives are directed towards building the institutional capacities for the MFIs promoted by the partner NGOs. They did not insist on a particular model of MFI. Rather they have enabled the partners to choose the model that suits the local conditions. This freedom has necessitated the customized technical inputs from the SART team, so that each partner could build the appropriate staff team and systems. The internalization process among the partners is varied depending on the quality and tenure of the staff members. The SART inputs have certainly equipped the CEOs of NGOs /MFIs to think ahead, set vision for the MFI and to work for the linkages. Likewise the training to the second line staff on MIS has been helpful to put the monitoring systems on track. The training for board members (largely community members) has been able to penetrate their mind about the need for MFI as a separate entity. The class room and on the site training have been supplemented with

the training materials drawn from MF global experiences so that partners could exposed to various best practices in the sector.
Initially the partners were treating the SART project as a normal NGO project. With the SART team's inputs and persistence, the partner NGOs have been ''transformed''. The umbilical cord has been cut from the mother NGO, giving birth to a separate MFI with ''profit-orientation'' within the available legal framework. The partners have chosen an institutional set up, which is appropriate to the local, like Mutual Benefit Trust, MACTS or NBFC. Depending on the chosen legal entity, the promoting NGOs has the corresponding responsibilities to establish and settle ''Ownership'' issues, such as shareholding, capitalising, legitimacy of operations, stakes, roles and responsibilities of the newfound office bearers and other legal compliances for which the handholding by SART staff conceived.

- Technical incubation services have resulted in the creation of distinct MFIs with the partners
- Clear targets for outreach and portfolio
- Operational plans to secure and manage funds
- Provision of defined savings, increased volume of credit and insurance products
- Emergence and application of monitoring systems and tools
- A clear shift towards profit orientation
- Partners' confidence to carry on and scaling up of MFIs
- External Rating for MFI
- Preparedness for external rating

- The activities relating to institutional assessment (by PACT Tool), and the consequent technical incubation has resulted in the creation of distinct, and professionally oriented MFIs in the partner organizations. Figure 8 supplements this conclusion.

Figure 8: Comparison of PACT Score Results (Baseline to 2009)



(Source: SART-CARE India, 2008a, 2009a)

- The subsequent Business Development plan exercises with the emerging MFIs have contributed towards a clear cut vision for the MFI in terms of outreach, portfolio, and operational plans to secure and manage funds.

- Operations manuals that were developed as a result of the SART initiatives, relating to MF services, Human Resources and Financial Management became handy to partners to initiate streamlining process in the MF operations. However, the internalisation and implementation of the same differ partner to partner. For instance, partners like CAMEL and BWDC are relatively better, for the CEOs are pro-active and knowledge hunters. CJWS and CREED are lagging behind in its implementation. The lack of availability of these manuals in vernacular (now in process) further limits its comprehension and usage by a wider section of staff, especially by the penultimate front line staff. In such a scenario, the operational manuals would become superfluous over a period of time.

- The capacity building training programmes for the CEOs and board members of the MFIs, despite their higher level orientation considering the low level of literacy of board members, especially in MACTS, have been instrumental in sowing seeds for the transformation process.

- The middle level staffing is the vital link in an organization to carry on the CEO's/MFI vision and imbibe it to the next level. The quality of the middle level team which is critical for the implementation of MF services remains weak and trouble spot. The turnover is also very high among them. As of now, the training for intermediary staff has enabled them to internalise and implement MIS. However, due to the lack of mechanism for knowledge transfer to the new recruits, all the accumulated knowledge drains away with the resignation of the concerned staff.

- Partners have got inputs relating to the development of new ideas for designing savings and credit products, which has amplified the thinking in a few MFIs to launch optional and special savings products and aggressive insurance promotion. The absence of the systematic research to document and analyse the existing savings patterns by each client segment undermines fresh options. The low incentives offered for the additional savings is also contributing to the slow start up.

- The handholding support extended by SART by assigning a mentor for each partner has been beneficial to the partners in terms of quality time to firm up the training inputs and translate in to applied knowledge, particularly in MIS. Yet, the change of mentor has debilitated the transformation process in organizations like CREED.

- Strengthening of existing monitoring mechanisms and introduction of financial monitoring systems in partner MFIs, has led to the improved financial performance, particularly in loan recovery, and thereby a better credit history to access bank linkages in almost all the partner organizations. Mobilisation of funds from mainstream and private financial agencies for on lending has been the mainstay of the partner MFIs after SART initiatives, and it is evidenced by the inflow of Rs31, 11, 37,795 in the four sampled MFIs. These funds have certainly increased the accessibility of credit for more number of clients. However, the desertion of the clientele base towards other MFIs and traditional money lenders in the study areas in search of credit suggest that partner's inability to mobilise sufficient funds to meet the growing credit demands of the clients. The second opinion of some of the partners like CJWS in accessing larger bank loans due to the misapprehension of the loan recovery coupled with rigidity of the bankers (CREED) restricts the bank linkages.

- The technical inputs relating to financial management has helped ten MFIs to understand the concept and the importance of active clients, eight MFIs about the operating cost ratio, and three MFIs about the financial self-sufficiency. The inputs have helped them to generate and maintain data relating to the above critical performance parameters. However, these critical factors are still beyond the reach of field officers and the board members from the community.

- The successful implementation of the refined systems and procedures in MFI operations has helped partner organizations to go in for professional rating. To cite an instance, BWDC's external credit rating by SEMRA and the preparation for such ratings in CAMEL and CJWS. The improved organizational and management systems in CAMEL has elevated them as the 50th ranked among the 100 best MFIs, by MIX MARKET is another evidence for the effectiveness of SART project.

All of these activities together made the MFIs operational and strive for financial sustainability. Thus the objective of improving the technical capacity and the financial sustainability of the MFIs are nearing accomplishment. It is evident by the fact that one fourth of the twelve old partners' financial performance, especially with the achievement of breaking even. The indicators relating to case load, loan portfolio per loan officer and the good on time recovery rates in the above organizations affirm the above observation.

The provision of initial loan support (SA-TMIF Loans) to four organizations, of which two are object of the study, on a pilot basis has enabled them to commence lending process immediately. With this critical support, they are able to demonstrate to the community their commitment to extend credit services on the one hand and to establish the much required monitoring and tracking systems for fund and credit management on the other hand. SART was keen to have 90% recovery of the SA-TMIF loan. They were able to achieve 100% recovery without any difficulty. Nevertheless the withdrawal of the funds within a short duration has affected the fund flow of the respective MFIs.

The creation and firming up of the capital base for the MFIs with the community's share capital has been hastened after the SART initiatives in ten MFIs. The mobilisation of share capital has been good (100%) in three MFIs, moderate (Above 50%) in 4 MFIs and low in three MFIs. It is yet to be taken up in the remaining five MFIs due to legal limitations of the chosen MFI structure is a matter of concern with reference to the stake holding of the clientele group.

The inputs and the subsequent follow-up services provided by SART team have enabled the partner MFIs to introduce and renew insurance products for the targeted clients as a vulnerability protective mechanism. The introduction of Micro insurance component packed with credit provision has been well received by the community. The fact that the number of clients availing the insurance coverage has surpassed the credit services as of March, 2010 affirms the above conclusion. However, the figures will reveal a dismal picture if it take it into consideration of the total MF client base. CAMEL was awarded the Micro Insurance Award in 2007, by ING Vysya bank for having enrolled maximum number of clients in the target area is an encouraging factor and it reminds others to design appropriate strategy to enrol more clients. Nevertheless, the sudden withdrawal of flood related insurance products by insurance agencies thwart the consolidation of insurance services by partners.

The institutional capacity building for disaster preparedness has reflected in the implementation of preventive measures in MFIs with the insurance cover for assets, staff and cash on transit, data back-up arrangements and the installation of UPS in offices. On the client side insurance coverage for loan loss on account of accidental death, has been seen.

The partner organizations are located and serving in the coastal regions which are subjected to frequent floods gives a hope that it will lead to the accomplishment of overall goal in the coming years. As of now, given the limited time line of four and a half-years, the progress towards the accomplishment of the overall goal of the SART (Vulnerability to disaster has been reduced and income as well as economic security of Tsunami affected families has been recovered and or increased) has been shadowed by the meticulous focus on the realisation of the purpose i.e.; 'building up of a sustainable MFIs'. In the process the clientele base has been expanded to include other needy groups. The data and interactions with the Communities/clients revealed that the increased access to credit through the new MFIs has enabled them to settle high interest loans with other lenders, invest in agriculture and allied activities, children's education, and house repairs and to build/expand income earning activities.

13 Recommendations

The recommendations are presented based on the challenges and gaps in the present MFIs, and are based on discussions with partner MFIs as well as the evaluation teams assessments.

1. **Provide technical plus long term (5 years) revolving loan capital for MFI**.

Providing technical support to the MFIs helps in great deal to improve their systems and performances, and thus has scope to attract external credit. However, MFIs needs seed loan fund to meet the client's immediate needs as it takes more time for MFIs to access external credit. CARE needs to provide long term credit fund along with technical support to make the MFIs to achieve the goal of delivering effective financial services to the poor.

2. **Provide longer period of capacity building support to the MFIs in order to make them self-sustainable organization to deliver MF services.** Some of the supports need to provide further are:

- *Staff training support:* The level of the internalization of SART training is good at the CEO level and at the senior level staff members. Yet the turn over at the senior level undermines the process of internalization, leave alone the penetration to the branch level staff team. The internalization has to percolate even up to the level of field team. The partner organizations are struggling to provide and transfer the training inputs for want of qualified, efficient trainers and funds to organize training for the entire team. Almost all the partners insisted that the staff training opportunities have to be continued by SART for two more years, which is essential to consolidate the ground capacities of the MFIs, particularly in data analysis synthesis, inference and feeding to decision making. In depth training to design products and services is also a felt need of the partners.

- *Intensive hands on training for Board of Directors:* The level of knowledge, skills, experience and exposure needed to govern the MACTS and NBFC is phenomenally high. As of now, the CEOs of the MFIs have better knowledge about it with experts support. To prepare the board members hailing from the clientele community to that high level requires dedicated, persistent efforts by the CEO, including on the job training and exposure to similar setting. Alike, refresher training programmes for the continuing board of directors and induction training programme for the newly recruited board of directors have to be made compulsory. Barefoot legal education may also be necessary to enable the board members aware of role clarity and statutory responsibilities and thereby adhere to the related compliances. A simple practical training on fund management and financial analysis will add value to their roles.
- *Branch level autonomy*: The branch level autonomy has also to be maintained to ensure speedy loan processing and disbursement. The autonomy will also add to the decentralization of power and provide room for staff satisfaction. In the long run, the vibrant branches can fill the organizational affinity gap arising out of the disintegration of SHGs.

- *Making use of ICT in MF servicing*: Partner MFIs need to think ways to provide ''fast-track credit'' with the help of information communication technology (ICT), if they are keen to retain their clientele base in the given competitive scenario. They have to explore the possibilities of providing credit within twenty four hours by introducing on line loan processing and approval mechanisms

Due to the early close of the project some of these tasks could not be completed, and CARE would be well advised to consider how the project partner can access the necessary support needed at this stage of their development.

3. Set up a legal structure to facilitate provision of loan capital to MFIs

Through a legal structure CARE can facilitate to provide loan fund:

- *Provision or linkages for long term revolving fund for on lending*: Alike venture capital, the need for lendable funds are escalating as a direct outcome of scaling up operations. As of now, the bank linkages are inadequate to meet the growing demand. This inability, according to the partners is obstructing the outreach expansion, besides causing a dent in the existing clientele base and portfolio. Partners seek a revolving fund or a long term loan either from SART or through a linkage, to fill the gap which could be repaid after a period of moratorium.

- *Provision or linkage for venture capital for NBFC-MFI:* Partners feel that the linkage to obtain the venture capital shortfall (NBFC requires rupees two crores) have to be taken up by SART as part of their partnership responsibility. In case of difficulties, SART may have to explore the possibilities to provide the venture capital as a loan from their own sources.

- *Mobilize capitals from social investors to provide loan capital to MFIs:* CARE needs to create a website to mobilize capital from individual social investors who would like to give loans to rural poor. CARE can also partner with organizations like Rang-de to mobilize capitals from social investors to channel loan fund to MFIs (The process has already commenced at CARE level).

4. **Lobbying and sensitizing lead banks about SART initiatives and the funding needs of emerging MFIs:** Along with partner MFIs, CARE had meeting with Axis and SBI banks, and IFMR Capital to sensitize the institutions and encouraged to partner with MFIs through providing credit fund. Partners expect SART continue to play a lead role to highlight its initiatives to firm up the MF sector and the succeeding progress among the mainstream financial agencies. Partners opined that such efforts are crucial to motivate the lead bankers to understand the ensuing needs of the nascent MFIs, which often found the existing banking requirements like ''rupees two crore turn over'', ''personal security'' are beyond their means.

5. **Adequate attention to baseline in the programme design to measure the impact of poverty targeting, women's empowerment:** The baseline indicators related to gender sensitiveness, social performance and women's empowerment is not designed in the project design of SART project. Without this it has been difficult to derive the impact on these aspects. In the future programmes of CARE it is important to include the baseline indicators as well as establishing a good monitoring system to track the impact as part of the regular monitoring processes of the project.

6. **Focus to promoting Community Based Microfinance Institutions**: Though NGO-MFI institutions have proved that they were able to provide effective financial services to the poor families to come out from vulnerable and disaster situations, it had certain limitations in empowering the local community to attain stronger and more sustainable benefits to the poor. As noticed from the SART project, the people led MFI has more

scope for women's empowerment. Not only a people led approach but it should also encourage people's regular savings, thus enabling them to have control over it.

In conclusion, the SART project has contributed to institutional strengthening as well as in terms of lessons which other development organization can replicate. It has been community oriented, and has supported the NGOs to move towards MF models that can lead to financial sustainability, along with keeping the cost affordable for the client. The early conclusion of the project has put the partners at the risk of losing the advantage we have already gained, as external funds mobilizations and some aspects of institutional strengthening could not be completed when the project ended in September 2010. During the currency of the project the partnership with CARE SART had helped all its partners to increase their capacities to offer community oriented financial services that reduce vulnerabilities in disaster prone areas. This is a significant achievement at a time when MF organizations have been found wanting in their community orientation, and are being criticized for increasing the vulnerability of the poor through increased indebtedness and high cost of lending.

Sampark, Bangalore
December 30, 2010

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Annexure 1:
Interview Schedules/ Checklist Followed for Data Collection

I. Interview with CEO

Approx. Time: 2 hours

1. Background of the NGO and MF Programme

- Year of inception, legal entity, vision, mission, activities, partners, major accomplishments
- Has the organisation made special efforts or paid special attention toward MF services to its target groups? What is the motive/inspiration to initiating MF?
- What are the steps taken to move towards that activity?
- What is the vision/mission/goal of the MF programme? Who are the target groups? How many of them are poor and very poor in that group?
- Which are the geographical areas covered for MF programme?
- What is the model and strategy followed in MF? Why has the organisation opted for this structure?

2. SART Intervention

- When did the organisation collaborate with the SART project?
- What are the supports provided by the SART project?
- What are the technical supports provided to the programme staff by the SART team, and what is the outcomes of these inputs?

	Technical training	Inputs received	Knowledge gained	Knowledge applied	Results for the applied knowledge	Difficulties faced in application of knowledge, reasons for non-application
1	Governance					
2	Management					
3						
4						
5						

- What are the financial or linkage support provided?

3. Effectiveness of SART at Institution level

3.1. Governance, Management

- What is organisational structure of the MF programme? Is there a separate entity for delivering this service? Is it registered under legal provisions? If so, under which Act?
- What are the good governance principles followed?
- Who are your board members, what is their background (education, experiences)?
- What are their roles? How often do they come to the office?

- What is the main contribution of the board members to the organisation over the years?
- How often board meetings are held? What are the key aspects discussed, and decisions made?
- Do the board members take any specific areas of work/ decision to follow up the action with the project team?

3.2. Systems and Policies (Accounting, MIS, Finance Management)

- What are the accounting, finance and MIS systems in the organisation?
- What are the policies the organisation follows? Are these in written form?
- What are the difficulties in following these policies?

3.3. Planning and Program monitoring

- Is the MF programme engaged in making any plan or do you made any business development plan?
- What are the planning components? For how many years the plan is prepared?
- How many days were spent in making this plan? What are the processes involved in making this plan? Who facilitate in making the plan? What are the learning aspects gained in involving in the processes?
- Who participates in these plans? Are there field staffs and board members of the community organisations participating in the planning? Do they bring any field level priorities into the discussions or are they made only based on assumptions?
- Is the duration reduced to prepare the plan? If yes, did that affect in making good plan or curtailed the learning?
- Do you see any value in making the BDP?
- How far has this plan helped to reach towards the organisation's vision, enabled to reach sustainability of the organisation?
- How well will this plan document be useful in bringing new funding to the organisation?
- Has the making a detailed plan helped to make a mind shift of looking at the MF as a business activity?
- What are the monitoring systems that are put in place?

- How often are review meetings held with the project team at the branch and at the head office level? What are the contents of review in each of the meetings? Whether the minutes of the meetings are recorded and followed up in the subsequent meetings?

3.4. Products and Services

- What are the financial products and services offered to the target groups? What are the different loan products offered? What are the savings and insurance products offered?
- What is the interest rate on different products?
- Are these products designed based on the consultation of people or what is the basis for offering these products?
- Are target groups happy about the products offered?
- What are the services offered to the target group members in accessing these products?

3.5. Performance of MF (portfolio, external linkages made)

- What is the total portfolio as on date?
- How are the loan amounts repaid by the clients? What is the repayment rate?
- What are the external linkages made for meeting the financial requirement of the clients and the organisation? Which are the agencies have extended financial support and how much from each of them?
- How easy or difficult is it to access finances from these organisations? What are the terms and conditions of these organisations?
- Is the organisation able to mobilise the required loan amount from the external agencies? If no, why?

3.6. Sustainability of the MF Programme

- Is the MF programme breaking even?
- What is level of organisational sustainability?

3.7. Gender and Vulnerability Sensitiveness

- What are strategies followed in addressing gender issues at the institutional and community level?
- How many female/male staffs are there in the organisation? What are the special policies existing and followed for female staff?

- How sensitive are the staffs when working with the women/ poor clients during the delivery of the products?

3.8 Disaster Preparedness and Management

- Has the organization prepared any disaster preparedness plan?
- If yes, what are the disaster situations taken into consideration?
- Is there any financial plan for addressing disaster situations? What are these plans?
- Are there any examples of addressing financial needs of disaster situations?

3.9 Institutional Transformation

- When did the organisation start thinking about MF role? Why?
- What kind of difficulties have you encountered in the transformation process?(from Charity to Profit Making)
- How long it will take to complete the process of transformation?
- What sort of support do you seek to aid this process?

4 SART impact

- What are insights gained from SART?
- Are there any demonstrable outputs by this SART project?
- What are the constraints faced in the SART project?
- Has the transformation process had any impact in the way the NGO is operating?
- How do you value this partnership with CARE?
- Suggestions/ opinions for future modification.

II. Focus Group Discussion with the Head office team (Operations Manager, MIS/Monitoring Officer and Finance Officer/Accountant)

Approx. Time: 4 hours

1. General

- Personal profile
- When did you join this organisation?
- How did you secure this appointment? (Open advertisement? referral? Personally approached?)
- Have you got appointment order?
- What for are you responsible?
- Has you appointment letter indicated this clearly?
- What was your previous experience to match this present job?
- Have you undergone any orientation training in this organisation?
- Who has given it? What was the outcome of such orientation?
- Who has helped you learn the current job?
- What is your salary? What are the other benefits?
- Is there any provision for salary increase? Or incentives?
- Is there any policy to deal with the salary, benefits, performance measurement, and disciplinary action?
- Are there any special policy/privileges to Women staff?
- From how long these policies exist? (Prior to your appointment? After your appointment? Or very recent?
- Who are all involved in designing these policies?
- Under what circumstances these policies will be reviewed or modified? When it will be done?
- Have you undergone any training after your appointment? What are they? Who has organised it? Is it relevant to your role?

- When your performance appraisal did take place? By whom?
- Whether it was oral? On based on a written check list?

2. Background of the NGO and MF Programme

- What do you know about the programmes of the NGO?
- What do you know about the MF Programme as a whole?

3. SART Intervention

- What is your knowledge and experience about the SART Programme?
- Do you aware of the various components of SART programme?
- From whom you have got the above information?
- Who is accompanying your SART project, from CARE? What do they do?
- What are the technical supports provided to the programme staff by the SART team, and what are the outcomes of these inputs?

4. Effectiveness of SART at Institution level

4.1 Governance, Management

- What is your working relationship with the board of directors of MACTS?
- Do you have any role in moulding the board of directors?
- Do you consult board of directors? For what?
- How often do you meet the board of directors? Where do you meet them? (In the Head Office; Branch Office? Or in the village?)
- Will you attend the board meeting of MFI? If yes, what will you do in the meeting? (sharing of information, taking notes of the discussions, provide solutions to problems)
- Whom do you report? (CEO of MFI? CEO of NGO?)
- What is the reporting mechanism? (Daily briefing? Written reporting?)
- How many people are working under you? What do they do?

- Do you recruit staff?

4.2 Systems and Policies (Accounting, MIS, Finance Management)

- Are you aware of any written organisational policy for MFI? (Like accounting policy? Finance policy? Human resource policy? Credit policy?)
- Are these policies are old? Or new?
- Who has helped you to design them?
- Whether any MIS system exits in the organisation?
- What are difficulties in following these policies/Systems? At what levels?

4.3Planning, Program Monitoring

- Is there any business development plan for MFI?
- Who are involved in the business development plan?
- What are processes involved in making this plan?
- What are the items covered in the business development plan?
- Could you please highlight its vision, mission… etc.?
- Do you see any usefulness for the BDP, in terms of planning and monitoring?
- How do you fix targets?
- What are major components of BDP that you used to monitor?
- What MIS formats do you use to measure the progress?
- How do you monitor the progress of the activities and outcomes described in the BDP?
- How often review meeting are held with the project team at branch and head office level? What are the contents of review in each of the meeting? Whether the meetings are recorded and followed up in the subsequent meetings?
- Do you monitor staff? Explain the process.

4.4Products and Services

- What are the financial products and services offered to the target groups? (Savings, loans, insurance)
- How do you design the new products?
- Are target groups happy about the products and services offered?
- By which mechanism, are you concluding that they are happy with your products and services?
- What you will monitor with regard to MF products and services? Why? And how often?

4.5 Performance of MF (portfolio, external linkages made)

- What is the total portfolio as on date? What is the trend?
- What is the current repayment rate? Is it increasing? Decreasing? Or maintained?
- Whether the funds mobilisation from external agencies is sufficient to meet the demands?
- What are the opportunities available to raise funds for on lending? (Banks, Federations, Deposits) additional finances from these organisations?

4.6 Sustainability of the MF programme and its organizations

- Whether the MF programme is breaking even?
- Whether all the branches are making profits?
- Why some branches are not able to generate profits?
- How long it will take to make profits in all the branches?

4.7 Gender and vulnerability sensitiveness

- How do you view gender sensitiveness in MF project?
- Do you have any Women specific products/services?
- What are the special policies exists and followed for female staff?
- How sensitive the staff in working with the women/ poor clients during the delivery of the products?

4.8 Disaster preparedness, management

- Whether the organization prepared any disaster preparedness plan?
- Whether any financial products / services to address disaster situation? What are these plans?
- Are there any examples of addressing financial needs of disaster situations?

4.9 Institutional Transformation

- What are the difficulties you are encountering during the Institutional Transformation process (from NGO to MFI)?
- How well are you prepared to motivate your team to cope up with the change?

5. Effectiveness of SART at Community Level

- What kind impact noticed at individual, household level changes based on the financial services offered to them?

6. SART impact

- What are the benefits of SART? (for the NGO, for the staff)
- What are the benefits of improved MIS and monitoring systems?
- What are the limitations/difficulties in implementing the changes?

III Group Discussion with Project Team Members (Branch Managers/ field officers)

Time: 3 Hours

1. **Personal profile**

- Name, Designation, Education, Experience in General , Experience in MF and Experience in MF programme in the Current Organisation

2. **SART Intervention**

- What do you know about the SART Project?
- How many of you have attended the SART training?
- What was the training? In what way it is useful to you?

3. **Branch Information**

- What is the structure of the Branch? How many Villages/ Federations/ SHGs are covered by each Branch?
- What are the roles and responsibilities of the Branch Manager?
- What are the roles and responsibilities of the Branch Accountant?
- What are the roles and responsibilities of the Field Officers?
- What are the operational manuals available in this branch?
- Who used to refer this manual? For what?
- Are the manuals available in vernacular?
- How many clients are assigned to each field officer?
- How many of them are active clients?
- What is the size of the portfolio for each field officer?
- What is the repayment rate of this branch?
- What is the amount of loans in arrears?
- What is the reason for arrears?
- What steps you take to recover loans and arrears?
- What is your loan collection methodology?

- What is your Branch Accounting System?
- Who maintains it?
- Who verifies the Branch Accounts? At what intervals?
- What kinds of records are kept in the Branch?
- How is the loan issued? (Cash/Cheque? From Branch/Head office?)
- Who monitors the Branch? How do they monitor?
- What are the criteria followed?
- What is your monitoring schedule?
- What MIS formats are you using?
- What kind of MF Products and Services are offered in your Branch?
- In what way these Products and Services are helpful to the borrowers?
- What are the challenges faced in the Branch? How did you overcome them?
- Are you providing any disaster related services?
- In your opinion what is the level of disaster preparedness among the community?
- What are the credit policies of your branch?
- What are the loan processing systems exist in your branch? (Loan application, endorsement, approval, issue etc.)
- How long it will take to get a loan?
- What is the interest for loans?
- What are the other charges?
- What is the level of participation of community in designing and implementing the system and procedure for MF services? (Who decides the purpose, size, repayment schedule, interest and penalties of loans?)
- Do you practice loan utilisation checking?
- What is your assessment about your Branch Performance? What criteria you look for?
- What kind of Gender specific policies and practices available in your Branch?

- How often do you have planning meeting? What are the things you discuss in the meeting? Whether you record these discussions? What follow-up work you used to take up?
- What are the good practices are adopted in your Branch?

IV Interview/ FGD with the Community Represented Board of Directors of MFI

Time: 3 hour

1. **Personal profile**
2. **About the MFI**

- What is the name of your MFI?
- Is it a Society? Trust? MACTS? NBFC?
- When was it started? By whom? Why?
- What are you in this MFI?
- How many members are there in the Board?
- Who has (s) elected you?
- Under what criteria they have selected you?
- What are your roles and responsibilities in the MFI?
- How did you know that these are your expected roles?
- Have you undergone any training to understand what a MFI is?
- Have you undergone any training to understand how you have to discharge your role as a board member?
- What are your legal obligations as a board member?
- How long you will continue in this position?
- Under what circumstances, the board members can be replaced?
- Who has more power- Board members? Secretary?
- How often the Board members used to meet? Where? Why?
- When was the recent meeting? What was discussed in that meeting? Has it been recorded?
- How many Board members used to attend the meeting?
- How many members are needed in a meeting to take a decision?
- Who writes the minutes?

- Did your MFI need to file any returns to the Government Authorities? To whom? When?
- What is your MFI's staff structure?
- How do you recruit staff? What do you expect from them?
- What is the working relationship of the Board with the staff?
- Whether there are any staff rules and policies for your MFI? What are they? Who has decided that?
- What is the role CEO and Operations Manager?
- What is the staff monitoring mechanisms follow?
- How many Branches are there in your MFI?
- How many members are there in your MFI?
- Who are all eligible to become members of your MFI?
- How many clients you want to reach? What are your strategies to reach this? Whom do you fall on to realise this?
- What are the total loans issued by your MFI?
- From where do you get money for this?
- Who manages this money in your MFI?
- So far, how many members/Groups got loans from your MFI?
- What is your MFI's credit policy? Who has designed it?
- What is your loan procedure?
- In how many days will you sanction a loan?
- How do you release money?
- Who is releasing money?
- What is the present size of the loan? (Per member/per group?)
- What is the rate of interest?
- Do you give a second loan, when the previous one is pending?
- In case of default of a loan, what you will do?

- What are the purposes for which you give loan?
- Do you verify loan utilisation by borrowers? What will you do in case of wrong utilisation?
- Who are all the signatories of the MFI Bank Account?
- What are the expenses incurred in the MFI? Who approves it?
- Do Board Members go to Banks? For What?
- Have you signed any loan documents on behalf of the MFI in the Bank? When? For What?
- Who maintain the Accounts of MFI?
- Whether the Accounts are audited?
- What does the Balance Sheet of the MFI convey?
- What are the things discussed in the Annual General Meeting of the MFI?
- Are you visiting any Groups? Why?
- Are your Groups are part of any Government Sponsored Groups?
- So far, what kind of benefits your members are getting from your MFI? And NGO?

3. SART Intervention

- Have you heard about SART? What is it?
- Has SART offered/conducted any training?
- How many of you attended the training offered by SART? What was it? Where it was conducted?
- What were the topics of the training? What did you learn? What is the new information you have got in the training?
- With whom you have shared the learning?
- What changes you have introduced in your MFI after the training? Why?
- Whether anybody from SART has visited their MFI? Who? For what?

- Whether the SART staff had any discussion with the Board members? What was the matter discussed?

V Focus Group Discussion with the members of SHG/JLG

Duration: 1-2 Hours

1. General

- Tell us about your village. Whether it is the main village? Or a sub-village? Or only a hamlet?
- Since how long you are living in the village? By Birth? Or by Marriage?
- How many of you have own lands? And how many of you have leased land?
- What kind of Livelihood/Occupation is available for you in the village? And in the neighbourhood?
- What is the wages? Is it daily? Weekly? Is it Cash or Kind?
- Is the employment is regular? Seasonal?
- What do you do in the off season?
- How many of you have NREGA card?
- How many days you get NREGA job?
- What is the mode of wages for NREGA? Cash? Bank Credit?
- How much you are getting for a day?
- Is there differential wage for Men and Women?
- Is there any Government Health Card system? How many of you got the Health Card?
- What are your major expenses?
- What will you do if you have a deficit in income?
- What kind of disasters strike in your area? How often? What are the effects of it?
- What kind of relief support you get from NGO? Government?

2. About SHG/JLG

- What is the Name of the Group?

- When was the SHG started? By whom?
- Why did you start this SHG?
- How many members are in your SHG?
- Is there any increase or decrease in members? Why?
- Who can become a member of the Group?
- How much do you save in the Group? Weekly? Monthly?
- Why do you save in the Group?
- Do you have any optional or special savings in your Group?
- How many Group meetings are conducted in a month? What is the purpose of these meetings?
- Do your Group have a Bank Account? Who are the signatories? How often they change?
- Do you take loans from Group?
- What type of loans do you take? Internal loan? Bank loan? Subsidy loan? MACTS loan?
- How many loans a member can take at a time?
- What is the Size of loan?
- Is the loan size uniform for all the members? Or differ according to the need?
- Who decides the loan Size? Repayment Schedule? Interest Rate?
- Suppose if you do not have money to give it to all members, what will you do?
- What are your Group rules for a loan?
- What is the rate of interest for loan?
- How do you dispose a loan? Cash? Cheque?
- What happens if a member could not repay the loan for certain reasons?
- From which sources your members repay loans? Own income? Spouse's income? Borrowing from other sources? Pledging jewels?
- Who writes and maintains Group records?
- Who taught you to write the books?

- Other than Savings and Credit what other activities are undertaken by your Group?
- Have any of you attended training programmes? What are they? Who has conducted them? For how many days?
- What is your Group's plan for disaster situations? Have you discussed these plans with your NGO? MFI?
- Did your group is rated? By NGO? Local Bank? Panchayat Officials?
- Is your SHG a member of any Federation?
- What is the name of the Federation?
- Since how long your Group has become of the Federation?
- What was the purpose of becoming member of the Federation?
- What are the conditions to become members of Federation? Age of the Group? Number of members in the Group? Total Savings of the Group? Rating of the Group? Entrance Fees?
- Who is attending the Panchayat Level/Block Level Federation meetings on your behalf?
- How often they attend meeting?
- What is the advantage of attending these meetings?
- Who is your NGO? What do they do for you?
- Do you attend Gram Sabha meeting? If yes, why? If not, what are the reasons?
- Have you become the member of MACTS? MFI?
- What were the conditions? Who has told you the conditions?
- When you are getting loans through your Group, why are you becoming members of Federation and MACTS/MFI?
- How many of you have benefitted by loans through Groups? MACTS/MFI? (Started new income generation activity, used money for rotating in the existing business/ agriculture/fishing, paid school/college fees, purchased assets like milch animal, redeemed assets etc.)
- How many new groups have you formed?
- For how long you want to continue the Group?
- Have you ever shared the interest income of the Group?

- What will be the maximum size of the loan are you comfortable with?