Exploring the role of economic empowerment in HIV prevention

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It has been argued that women’s economic vulnerability and dependence on men increases their vulnerability to HIV by constraining their ability to negotiate the conditions, including sexual abstinence, condom use and multiple partnerships, which shape their risk of infection. In the face of escalating infection rates among women, and particularly young women, many have pointed to the potential importance of economic empowerment strategies for HIV prevention responses. Global evidence suggests that the relationship between poverty and HIV risk is complex, and that poverty on its own cannot be viewed simplistically as a driver of the HIV epidemic. Rather, its role appears to be multidimensional and to interact with a range of other factors, including mobility, social and economic inequalities and social capital, which converge in a particularly potent way for young women living in southern Africa. To date, there have been few interventions that have explicitly attempted to combine economic empowerment with the goal of HIV prevention, and even fewer that have been rigorously evaluated. This paper explores how programmes such as microfinance, livelihood training and efforts to safeguard women’s food security and access to property have begun to incorporate an HIV prevention focus. Although such circumscribed interventions, by themselves, are unlikely to lead to significant impacts on a national or regional scale, they are useful for testing cross-sectoral partnership models, generating practical lessons and providing a metaphor for what might be possible in promoting women’s economic empowerment more broadly. Despite numerous calls to ‘mainstream AIDS’ in economic development, cross-sectoral responses have not been widely taken up by government or other stakeholders. We suggest potential reasons for limited progress to date and conclude by presenting programme and policy recommendations for further exploring and harnessing linkages between economic empowerment and HIV prevention in Southern Africa.

Introduction

Globally, poverty, gender inequalities and social marginalization continue to pose major challenges to HIV prevention efforts [1]. Infection rates are highest among poor countries, with sub-Saharan Africa home to over 60% of cases [2]. Although transmission in the region was initially concentrated among more affluent, educated and mobile individuals [3–5], emerging data suggest this pattern may be shifting, with higher rates of infection borne by socially disadvantaged groups, particularly young women [6–11]. A fundamental difference between AIDS and other diseases generally linked with poverty in sub-Saharan Africa, such as tuberculosis or malaria, is its primarily sexual route of transmission. This has highlighted the importance of relational dynamics such as economic and power imbalances, which in turn influence the extent to which individuals are able to assert choices about sexual behaviour [1]. Recent evidence thus suggests that AIDS is a disease of inequality, often associated with social or economic transition, rather than a disease of poverty itself [1,12]. The scale and worsening impacts of the epidemic

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suggest the limited impact of prevention approaches to date, and the need to begin addressing the deeper social and economic realities that put current prevention strategies out of reach for so many. One such reality relates to women’s economic vulnerability.

Approximately one billion people in the world live in extreme poverty, have household incomes of less than US$1 per day and have difficulty meeting their basic needs for survival [13–15]. Women shoulder a disproportionate share of this burden [16]. They comprise almost two-thirds of the world’s illiterate people and are often denied property rights or access to credit. They earn 30–40% less than men for the same work, and most of those who are working are employed outside the formal sector in jobs characterized by income insecurity and poor working conditions [16]. It has been argued that this economic vulnerability increases their vulnerability to HIV by furthering their dependence on men and constraining their ability to refuse sex, negotiate the use of a condom, discuss fidelity with their partners, or leave risky relationships [17].

In this paper, we begin by reviewing global evidence surrounding the complex relationship between poverty and HIV risk. [There are clearly areas of overlap between this paper and others prepared for this meeting (Biological risk and vulnerability; Secondary education and HIV; Sexual violence and HIV; Intergenerational and age-disparate sex, and empowerment), highlighting the cross-cutting nature of economic vulnerability and economic empowerment.]

We then highlight experience with interventions that have attempted to combine economic empowerment with the goal of HIV prevention. In keeping with the goals of the UNAIDS meeting, this paper focuses on exploring the relationship between economic empowerment interventions and HIV prevention. Although economic empowerment undoubtedly carries important implications for HIV treatment, care and support (and vice versa), these are beyond the scope of the paper, and are not discussed here.

Finally, we conclude by presenting programme and policy recommendations for further exploring and harnessing linkages between economic empowerment and HIV prevention.

Examining the evidence: understanding the links between poverty and vulnerability to HIV infection

The relationship between poverty and HIV risk
Although there is general agreement that poverty plays an important role in relation to HIV transmission, research suggests that this role is complex [1,12]. In general, epidemiological studies examining the relationship between poverty and HIV risk have been constrained by important methodological limitations, including primarily cross-sectional designs, making it difficult to uncover the nature and complexity of associations and causal pathways. The measurement of poverty itself is not straightforward and has varied greatly between studies, which for the most part have compared gradations of poverty among chronically deprived populations, rather than comparing those who are poor against those who are economically secure [12]. At the country level in sub-Saharan Africa, there is a poor correlation between wealth (as measured by gross domestic product) and HIV prevalence, with higher rates seen in the wealthier countries of southern Africa. This is probably the result of strong urban–rural economic linkages, good transport links and high professional mobility, which can translate into higher incomes as well as higher HIV incidence [12]. More striking, however, is the strong relationship between national-level income inequality in sub-Saharan Africa and HIV prevalence. Greater inequality is associated with higher HIV prevalence rates, a relationship that is also seen in Latin America and Asia [1,12]. The complex and reciprocal relations between macroeconomic policies and HIV/AIDS are, however, only beginning to be explored [18]. Such policies impact on health and development by altering absolute poverty levels or inequalities in the distribution of wealth [19], thereby affecting household economies and health systems investment [20]. Some have argued that World Bank structural adjustment programmes designed to stimulate private sector growth and exports in debtor countries have had a negative impact on the HIV/AIDS pandemic by undermining rural subsistence economies, expanding transportation infrastructure, increasing migration and urbanization, and reducing investment in the health and social services sectors [21]. Questions remain as to how macroeconomic policies can be designed to contribute to reductions in HIV/AIDS internationally [18].

In general, most analyses of the links between poverty and HIV/AIDS have focused on examining direct links between income and levels of HIV infection. In the discussion below, we present a more nuanced picture of the many ways in which risk environment and wider circumstances that surround poverty are equally relevant in shaping vulnerability to HIV [22].

Socioeconomic status, education and HIV risk
In addition to material wellbeing, education is also considered a critical component of socioeconomic status, and numerous studies have investigated the relationship between educational status and HIV risk. In 2002, a systematic review of data predominantly collected before 1996 found that increased schooling was either not associated with HIV infection or was associated with an increased risk of HIV infection among men and women from both rural and urban communities in Africa [3]. A
How might poverty increase young women’s risk of HIV?
Qualitative and quantitative research suggests that material poverty increases the risk of contracting HIV mainly through the channel of increasing high-risk behaviours, particularly for women. In an ethnographic study in Zambia, for example, frequent droughts and limited wage job opportunities after the post-economic liberalization closure of companies were identified as the ‘push’ factors for women increasingly resorting to transactional sex [25]. Recent quantitative studies such as the Cape Area Panel Study, lend some support to these observations. Researchers surveyed youths aged 14–22 years in Cape Town, South Africa (2002–2005) and found that for girls, sexual debut was earlier in poor households, and that multiple partnerships were more common among girls living in households that had experienced a recent economic shock (e.g. death or job loss) [26]. Similarly, a prospective cohort study of youth in rural South Africa (2001–2004) found that condom use was lower among young women from poorer households [8]. In Botswana and Swaziland, food insufficiency among women was found to be significantly associated with inconsistent condom use with a non-primary partner, exchange of sex for resources, intergenerational sexual relationships and lack of control in sexual relationships. For men, food insufficiency was associated with only a 14% increase in the odds of reporting unprotected sex, and was not associated with other risky sexual behaviours [23]. The links between poverty and vulnerability to HIV infection are thus clearly multidimensional and not easily explained by the more straightforward associations characteristically tested through epidemiological studies. It is increasingly apparent that other factors, including gender inequalities, condition the manner and circumstances in which poverty interacts with the risk of infection [12,27].

Poverty, gender inequalities and HIV
It is well recognized that gender inequalities play a key role in the HIV epidemic through their effects on sexual relationships [28–33]. Women’s dependence on men’s economic support throughout much of the developing world has meant that women’s personal resources, including their sexuality, have taken on heightened economic potential [1,12]. Economic asymmetries between men and women are reinforced by various contextual factors, such as family and peer pressures, social and economic institutions and pervasive and deeply entrenched gender inequalities. Social norms in many sub-Saharan African contexts permit and even encourage men to engage in sex with multiple partners, with much younger partners, and to dominate sexual decision-making [12,33]. Particularly for younger women, a host of economic vulnerabilities reinforce their inability to challenge this sexual status quo. In the context of poverty, young women speak of money as the driving force for sex and relationship formation [34,35]. Partnerships with men who can provide financially are essential, transactional relationships (in which sex is exchanged for material goods or other support) are common, and relationships with older men are the norm [25,36–40]. Moreover, evidence points to significant positive associations between larger partner age differences, the value of economic transactions and unsafe sexual behaviours [40,41]. In South Africa, low socioeconomic status has been found not only to increase female odds of exchanging sex for money or goods, but also to raise female chances of experiencing coerced sex, and male and female odds of having multiple sexual partners. It also lowers female chances of abstaining, female and male age at sexual debut, condom use at last sex, and communication with most recent sexual partner about sensitive topics. Low socioeconomic status has more consistent negative effects on female than on male sexual behaviours and also raises the female risk of early pregnancy [41]. A study in Gabarone, Botswana, found that women’s negotiating power and economic independence were the factors most strongly related to their condom use. Because education level was only one of the elements directly related to women’s negotiating power, the authors suggest that providing women with greater access not only to education, but also to income-generating opportunities and negotiating skills may help empower them to protect themselves against HIV through greater condom use [42].

Poverty, gender-based violence and HIV
The most extreme manifestation of the unequal power balance between women and men is violence against women. Violence by an intimate partner is one of the most common forms of gender-based violence, and globally population surveys indicate that between 15% and 71% of women have been physically or sexually assaulted by an intimate partner at some time in their lives [43]. Moreover, intimate partner violence has been shown to affect women’s health adversely [44], and has been identified as an important risk factor for HIV infection [45,46]. Studies have noted that refusing sex or attempting to negotiate condom use with a partner can
raise suspicions of infidelity and carry the risk of violent outcomes [34,47]. Younger women are likely to be particularly vulnerable, as documented by a growing body of qualitative research [47–49]. A study of youth in a South African township, for example, showed ‘pervasive male control over almost every aspect of (women’s) early sexual experiences’, enacted partly through violent and coercive sexual practices [47]. Another study, based on a nationally representative sample of 15–24-year-old women in South Africa, found that those with low relationship control were twice as likely to use condoms inconsistently, which in turn was significantly associated with HIV infection. Moreover, women experiencing forced sex were more than five times more likely to use condoms inconsistently [50]. Although gender-based violence occurs across all socioeconomic groups, studies indicate that women who live in poverty are more likely to experience such violence [51,52]. In addition to absolute levels of poverty, economic inequality within an intimate relationship may also increase the risk of violence [52]. The relationship between women’s empowerment and the risk of intimate partner violence is complex. However, a recent systematic review of published studies from 41 sites exploring whether individual and household economic empowerment is associated with lower levels of intimate partner violence found that household assets and women’s higher education were both generally protective against intimate partner violence [53]. Emerging evidence thus suggests that intervening to reduce the vulnerability of young women to HIV infection will necessitate understanding and addressing the inter-relationships between poverty, gender-based violence, and HIV/AIDS.

Poverty, social capital and HIV
Recognizing the collective and interdependent nature of human interactions, social capital has been defined as the ‘features of social organization, such as trust, norms and networks that can improve the efficiency of society by facilitating coordinated action’ [54]. In relation to HIV, there is some evidence to suggest that the lack of social capital within communities may limit the effectiveness of HIV prevention efforts and heighten vulnerability to HIV infection [55]. An evaluation of an intensive HIV prevention programme in a mining community in South Africa noted how the absence of community cohesion or the transformation of social and sexual norms associated with chronic poverty played a major role in limiting the impact of an ambitious and well-conceived intervention programme [56]. Similarly, a qualitative study in Malawi found that some social groups persisted in engaging in high-risk sex despite knowing the risks, because doing so affirmed their social identity and served to deny that ‘anything they do makes a difference to what they perceive as a life of powerlessness and despair’ [57]. The ‘culture of poverty’ [58] and its attendant loss of hope and sense of agency may thus be as significant as material poverty in motivating high-risk behaviours [12,59]. When subjected to conditions of chronic deprivation and social exclusion, individuals may tend to take decisions, including sexual decisions, which are concerned with immediate gratification or survival rather than with longer-term goals [41,59]. This may be particularly true for young people living in settings of closely juxtaposed social and economic inequality, such as urban slums, where the disparity between one’s aspirations and one’s realistic opportunities may be especially stark. Research indicates that in South Africa, living in urban and peri-urban areas increases the risk of HIV seroconversion [60]. Similarly, in Kenya the urban poor are significantly more likely than their rural counterparts to have an early sexual debut and multiple sexual partnerships [61], and those residing in slums may be particularly vulnerable [62]. Therefore, when both economic resources and hope are absent, HIV behaviour change messages are less likely to be effective [59].

There are a number of ways in which increased social capital might impact on the prevalence and distribution of HIV in populations, and the results of observational and cross-sectional studies have been mixed [55,63–67]. At a very basic level, non-random mixing within high-risk ‘core groups’, such as intravenous drug users or sex workers, contributed to much of HIV transmission early on in the epidemic [68]. Well-functioning community networks and the social and material resources that flow between them may, however, also carry protective effects. Strong social networks may exert social or cultural pressure in ways that deter high-risk sexual activity. In addition to providing avenues for the exchange of information, these networks may shape community norms around sexual relations, communication and sexual negotiation. They may provide role modelling opportunities for health-promoting behaviours such as condom use or access to HIV testing. Individuals with wider networks and deeper trust relationships may have a stronger sense of self-confidence, self-esteem and hope, and may be better able to exert greater control over decision-making. The emotional support generated around these networks may reduce discrimination around HIV and create a more accepting environment for those living with the disease [55]. Finally, as experience from Uganda suggests, more cohesive social and geographical communities may be better able to take collective action and respond to common priority issues such as HIV/AIDS. As some observers have noted, effective social mobilization, particularly through women’s peer networks, critically underpinned the dramatic reductions in prevalence, and largely preceded widespread implementation of conventional prevention measures such as condom distribution, HIV testing services and the syndromic management of STI [29,69]. Although the emerging discourse on social capital is complex, and it is not always an unequivocal good [70,71], few studies have empirically examined social capital as an explicit component of the HIV risk environment, and even fewer
Interventions have attempted to strengthen social capital, particularly in developing countries [55].

**Conclusions and implications for HIV prevention interventions**

In summary, poverty on its own cannot be seen simplistically as a driver of the HIV epidemic. Rather its role is multidimensional and appears to interact with a range of other forces having to do with economic, social, and in particular, gender inequalities, as much as with stark impoverishment [72]. Moreover, the pathways by which poverty influences risk is shaped by broader contextual factors such as location, the mobility of individuals, age asymmetries, and the broader social ecology of HIV transmission [12]. These multiple factors appear to converge in a particularly potent and dangerous way for young women living in southern Africa.

Therefore, HIV prevention interventions need to urgently and explicitly address the multifaceted economic vulnerability of young women. In this respect, research suggests that such interventions cannot be simplistically conceptualized with the goal of ‘poverty alleviation’, but rather must embrace the broader dynamic of ‘economic empowerment’. Empowerment has been defined as ‘the process of increasing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes’ [73]. Therefore, given the multiple factors that interact to heighten women's vulnerability to infection, HIV prevention interventions should aim not only to increase economic resources and opportunities, but also prioritize young women's education, address gender inequalities and gender-based violence, and engage the broader social norms and networks that collectively shape the risk environment.

**Economic empowerment and HIV prevention: experience with interventions**

Addressing issues such as poverty, gender inequality or social exclusion may initially seem an abstract or unapproachable goal to programme managers and policy makers used to a primarily health sector-driven response to HIV/AIDS. Interventions targeting these areas are, however, increasingly recognized as an important, although underdeveloped, component of the public health response to HIV/AIDS [74–76]. In contrast to interventions focusing on individual behaviour or biology, such ‘structural interventions’ are directed towards social environments and populations [77,78], and therefore have the potential to affect the broader ‘context in which health is produced or reproduced’ [74]. In addition to implementing programmes, structural interventions consider how strategic shifts in laws, policies, or institutional frameworks can influence more ‘upstream’ factors such as poverty, social norms and social capital in ways that might generate more effective community responses to public health problems such as HIV/AIDS. In contrast to more conventional health sector interventions, structural interventions by their nature deliberately bring a range of cross-sectoral perspectives and expertise to bear on the epidemic.

The following section describes a range of interventions that have attempted to combine women's economic empowerment strategies with the goal of HIV prevention. To date, most documented experience relating to the intersections between economic empowerment and HIV/AIDS has emanated from the microfinance sector. Pockets of innovation have also arisen within the context of other economic interventions such as village banks, vocational training and other livelihood strategies; however, these have developed on a more modest scale, and as a result, are not as well documented or evaluated. For these reasons, it is useful to begin by reviewing experience from the microfinance sector in order to gain a deeper understanding of the potential areas for synergy between economic empowerment interventions and HIV prevention. By highlighting practical lessons, challenges and opportunities, these experiences may point the way for further innovation in other areas.

**Microfinance as a potential economic empowerment strategy to reduce women's vulnerability to HIV**

In order to understand the potential impacts of microfinance on reducing women's vulnerability to HIV infection, it is important to consider the evidence relating to its broader impacts on poverty, women's empowerment and gender-based violence, in addition to what is known regarding its impacts on health outcomes, including sexual behaviour and HIV risk.

**Impacts on poverty**

Over the past four decades, microfinance institutions have received increasing attention for their success in expanding credit and savings services to over 100 million poor clients, most of whom are women [79]. Because commercial banks rarely provide loans to poor households, and as women often have less access to education, credit, and skills training, these small loans are often one of few options for poor women to start income-generating activities, develop marketable skills and secure a modicum of economic independence. As the poor often lack financial collateral, microfinance institutions facilitate repayment through ‘solidarity groups’, in which members repay together before repeat loans are granted. Whereas these programmes address the needs of the poor, the ‘very poor’ and the ‘chronically poor’ often remain excluded as they are perceived to be a credit risk even by those in their community [80]. Recognizing the different dimensions and gradations of poverty has been the subject of much discussion in the microfinance literature, with
many institutions developing innovations to expand their reach among the poorest [81–83].

Targeting women in microfinance programmes has been shown both to increase cost efficiency (as a result of women’s higher loan repayment rates) and to deliver more effective poverty alleviation (because of their prioritizing expenditure on family welfare) [84]. Substantial evidence from a range of settings has shown that microfinance has the potential to play an important role in reducing poverty and making progress towards meeting the Millennium Development Goals [85–87]. A number of studies have demonstrated significant impacts of microfinance in reducing household poverty and in improving livelihood security among those living at the margins of extreme poverty [88,86,88–94]. Access to small-scale credit and savings services has been demonstrated to help low income clients improve household and enterprise management, increase productivity and food security, smooth income flows, enlarge and diversify businesses and increase incomes [88].

**Impacts on women’s empowerment and gender-based violence**

Beyond these economic benefits, there is also evidence to suggest that microfinance may be an effective vehicle for empowering women, and that newly acquired business skills can be accompanied by improvements in self-esteem and self-confidence, the ability to resolve conflicts, household decision-making power and expanded social networks [84,95,96]. Critics of microfinance have, however, questioned whether, in the absence of efforts to address broader gender inequalities and traditional cultural beliefs, simply providing financial services to women can be truly empowering. They note that offering credit to women does not necessarily guarantee their control over its use, and that the pressure to pay back loans can add to the already heavy burden of responsibilities borne by poor women [97–99].

Similarly, in relation to gender-based violence, whereas some studies have suggested that participation in microfinance can reduce the risk of intimate partner violence [99–102], others have noted that attempting to empower women might potentially exacerbate this risk by challenging established gender norms and provoking conflict within the household [52,96,103,104]. Evidence regarding the impact of microfinance on intimate partner violence has been mixed, with some settings noting a protective association and others documenting increased risk [53]. Such studies have been constrained by a range of methodological limitations, including predominantly retrospective designs, the absence of control groups and the lack of prespecified or clearly defined indicators of empowerment or violence [98,99,105,106]. Many have relied on cross-sectional surveys, raising problems with temporal ordering, causality, and selection bias. For example, when microfinance programmes have reported an association with increased levels of violence, such findings could be observed if women in violent relationships were more likely to join such programmes, rather than microfinance itself impacting on the risk of violence [105,107]. In this regard, two studies have reported that women in abusive relationships were more likely to join microfinance programmes [108,109]. It is possible that although many poor women may qualify for loans according to established programme parameters (such as poverty criteria), those who actually choose to join may be those in violent or controlling relationships, and who are consequently more drawn to or in need of the services offered. Taken together, these findings suggest that, beyond participation in income-generating activities, additional context-specific factors may influence whether women’s financial autonomy is protective or associated with an increased risk of such violence. In this light, many development practitioners have suggested that adding a gender-focused training component to the financial dimension of microfinance programmes could catalyse broader empowerment benefits for women, while potentially diminishing their risk of gender-related conflict in the household [98,101,104,110,111].

**Impacts on health**

Microfinance also has the potential to catalyse wider health benefits. At the most basic level, higher and steadier incomes make it easier to put food on the table each day. When health problems emerge, access to reliable ways to borrow and save can make it easier to pay for medicines and clinic visits. Financial access can also help individuals to cope with unemployment caused by illness and forestall their need to sell off valuable assets [112]. Interventions to improve financial access can thus complement interventions to improve health. Microfinance programmes have been associated with multiple health gains, including impacts on child mortality, nutrition, immunization coverage and contraceptive use [93,95,113,114].

**Combining microfinance with gender and HIV education**

Taken together, these potentially synergistic impacts on poverty, women’s empowerment, intimate partner violence, and broader health outcomes have sparked growing interest in the potential of microfinance to impact on HIV/AIDS [110,112,115,116]. The concept of ‘tie-ins’ that link credit with skills building and education as core components of the development package has been around for a long time [93], and in the face of HIV has been receiving increasing support [117]. A survey of 22 microfinance institutions in 14 African countries noted that 43% provide some form of health information to clients [118]. Although programmatic experience in addressing HIV prevention is still at an early stage, a growing number of organizations have begun to develop innovative HIV education and prevention components [119,120]. Most commonly, HIV
training is added to regular client meetings, although the content and duration of training modules is quite variable, with 15–30-minute sessions being a common standard. In some cases, the training is also made available to microfinance institution staff and clients’ families. Most frequently, it is provided through a partnership with a health-based non-governmental organization or local hospital, although in some cases the information is provided by the microfinance loan officers themselves [119].

Few such programmes have been evaluated using experimental designs. In rural South Africa, however, the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) Study used a cluster-randomized trial to evaluate the impact of a combined microfinance and training intervention on poverty, gender inequalities, intimate partner violence and HIV/AIDS. The programme combined group-based microfinance with a gender and HIV training programme, which was delivered to women during fortnightly loan repayment meetings. The participatory learning programme comprised two phases [121]. The first phase consisted of 10 one-hour training sessions, and covered topics including gender roles, cultural beliefs, relationships, communication, domestic violence and HIV. The second phase encouraged wider community mobilization to engage both youth and men in the intervention villages. The minimum age of participants was 18 years, and the median age was 42 years. Loan repayment rates were high (99.7%) and the training programme was integrated without compromising core microfinance uptake or delivery.

The IMAGE study found that after 2 years, improvements in economic wellbeing and nine indicators of women’s empowerment (self-confidence, financial confidence, challenging gender norms, autonomy in decision-making, perceived contributions to the household, communication within the household, relationship with partner, social group membership and participation in collective action) were observed among IMAGE participants [122]. Furthermore, their risk of past year physical and sexual intimate partner violence was reduced by 55% [100]. In relation to HIV risk (assessed among those under 35 years of age), the greatest impacts were seen among those directly exposed to the intervention. Young women participants reported higher levels of HIV-related communication, HIV testing, and greater condom use with non-spousal partners [123]. The study also assessed indirect impacts on 14–35-year-old men and women living within IMAGE households and villages. Although changes in sexual behaviour were not observed among these groups within the 2–3 year timeframe of the study, significant improvements in openness and communication about sex and HIV were documented among youth living in IMAGE households [100]. One of the central hypotheses of the IMAGE study was that the optimal way to address the complex HIV risk environment around adolescent girls may be to target them indirectly. Older microfinance clients, although not themselves at highest risk, have the potential to be important brokers for change in their households and communities. In terms of addressing economic vulnerability, providing credit to such women helps to meet basic needs for the entire household, including adolescent girls [84]. Moreover, in relation to challenging traditional gender norms, in many communities older women play a key role in shaping and sustaining such social and cultural norms [51]. Efforts to reach indirect target groups, although potentially taking longer to achieve, thus provide an interesting alternative to programmes attempting to work directly with high-risk youth [123].

**Targeting microfinance and life skills training to adolescent girls**

In spite of their heightened vulnerability to HIV infection, young women, and especially adolescents, are noticeably absent from the services provided by microfinance institutions [116]. Those that include younger women often do so by chance rather than design. For many microfinance institutions, young people are seen as a credit risk, with little enterprise experience, and liable to migrate for school, job-seeking, or marriage [116,124]. The Shaping the Health of Adolescents in Zimbabwe (SHAZ) programme is one of few that have deliberately targeted poor adolescent girls with the goal of reducing transactional sex, particularly with older men, known regionally as ‘sugar daddies’. Started in 2001 by public health researchers at the University of California, San Francisco, the programme was set up to test whether linking microfinance with life skills and business training could result in improved knowledge, increased control over economic resources, and ultimately reductions in HIV infection. SHAZ targeted 16–19-year-old out-of-school, orphaned and poor girls living in two slum areas outside Harare. The project failed to reach these goals, however, largely as a result of poor microfinance repayment rates. Only 20% of girls managed to repay their first instalment and only 5% repaid their loan in full. Additional mentorship and social support mechanisms did not address these problems. Moreover, once loans were repaid, participants were generally not interested in returning for further peer group meetings [29]. Reflecting on these findings, the researchers concluded that the economic intervention proved too removed from the realities of the young women. Participants who received business training, microcredit loans and mentoring overall were thwarted by multiple forces, in terms of both agency and structure, which reflect their age and gender status as well as Zimbabwe’s weakened political economy. Based on these lessons, SHAZ has moved away from microcredit and business skills and towards vocational training as the core livelihood component of the project [116].

Similarly, Tap and Reposition Youth (TRY), a multiphase initiative undertaken by the Population Council and the Kenyan microfinance institution, K-Rep Development
Agency, aimed to reduce adolescents’ vulnerabilities to adverse social and reproductive health outcomes, including HIV infection, by improving their livelihood options. The project introduced a modified group-based microfinance model in order to extend savings, credit, business support and mentorship to adolescent girls and young women aged 16–22 years living in the low-income and slum areas of Nairobi [125]. Although most participants were exposed to the training, savings, and mentorship components of the programme, only half of participants managed to qualify for a microfinance loan, and repayment rates among these were low. Younger participants were more interested in savings than loans, and those who did appear to benefit from the microfinance were a subset of older participants, who were in general less vulnerable than the adolescents primarily targeted [116]. The programme was evaluated as a longitudinal study; however, most respondents had dropped out by the time of end-line surveys, limiting the ability to assess programme impacts [126]. TRY went through a protracted and frank process of trial and error to identify issues relevant to young women and adolescents, and to adapt their approach to serve this age group better [116,126]. In the end, their experience indicated that microfinance was not the most appropriate economic empowerment model for their target group, for whom entrepreneurship and repeated borrowing were not primary interests. Rather, their fundamental needs related to acquiring social capital, including social support groups, friendships, mentorships, physical safety, and the opportunity to save their money in a safe, accessible place [125].

As with the SHAZ experience in Zimbabwe, the TRY programme raises a number of questions relating to the advisability of targeting microfinance to impoverished adolescent girls, who are often out of school, more mobile, less socially rooted, and less experienced in establishing income-generating enterprises than the usual profile of older microfinance clients. Taken together, these experiences raise a cautionary note about the risks of altering traditional microfinance target groups in order to align more directly with HIV-related goals. The economic viability of these pilot initiatives suffered, and in such settings, introducing HIV-related inputs can be a tremendous challenge. When viewed alongside the experience of the IMAGE study, addressing HIV risk through microfinance may be better achieved as a result of partnerships with well-established microfinance programmes working with diverse age groups in vulnerable communities, rather than specifically tailoring novel interventions to reach high-risk groups [123].

**Beyond microfinance: exploring other economic empowerment strategies and HIV prevention**

Given the diversity of the experiences described above, it is likely that in order to be most effective, efforts to promote women’s economic empowerment should embrace a broad range of strategies. In addition to microfinance, these might include livelihood training, such as vocational training, financial education or literacy programmes, as well as efforts to strengthen women’s food security and property and inheritance rights [120]. Although programmatic experience in these areas is not as well-developed or well-documented as the microfinance sector, emerging lessons suggest that these areas offer promising platforms for intervention, which should be explored further.

**Combining livelihood training and HIV life skills for youth**

As experience from both the SHAZ and TRY programmes illustrates, socially vulnerable adolescent girls may need a place apart from their families for dialogue, support, the protection of savings, and the development of rudimentary livelihood skills. The shift in the SHAZ programme’s focus from microfinance to vocational training for young women reflects a growing interest in the area of livelihood training and the potential for linking this to sexual and reproductive health goals. Because such training can be carried out on a regular basis with groups of participants, such programmes could provide potential opportunities for integrating HIV-related education and life skills in order to empower young women. Moreover, it has been suggested that by gradually building social and financial skills in an environment that is less pressured than microfinance programmes, such initiatives might be more suitable for younger participants, while providing a basis for later participation in credit programmes [116,125]. To date, however, reviews of such programmes reveal mixed results, with uneven and inconclusive findings as to whether such approaches can impact on changing sexual behaviour and HIV risk among young women and adolescents. One review surveyed nine programmes in Africa, Asia and Latin America, which aimed to link youth livelihoods (primarily job training) with reproductive health information or training, in order to enhance outcomes in both areas [127]. Some programmes were able to achieve short-term results by enabling some young women to find employment once they completed the training course. Others indicated some progress in increasing women’s agency and self-esteem, but only two could be seen potentially to address empowerment issues over a longer term. For the most part the link between reproductive health services and livelihood was inconclusive, and no inferences could be drawn about the potential for supporting empowerment processes within the programmes. The review concluded that currently most programmes are not implementing linked strategies in an optimal fashion, often achieving only marginal effectiveness in meeting both the reproductive health and livelihood needs of young people [116,127].

In South Africa, the Population Council has recently introduced a programme that aims to combine safe social
spaces, financial literacy, and HIV life skills for youth. Small groups of youth meet regularly with community mentors, and in addition to receiving education about sexuality and HIV, are taught basic financial skills such as how to budget, save, plan for the future, identify income-generating opportunities and access social benefits [128]. Preliminary assessments of the programme's acceptability and feasibility appear promising, and the next phase includes a more detailed impact evaluation [129]. Taken together, it appears that innovative attempts to link livelihood training and HIV life skills for youth are still in their own 'adolescence'. Although these are not yet intervention models for replication, this is an area that can provide fertile ground for further research and application [116, 127].

**Improving women's food security**

As described earlier, recent research in southern Africa suggests that protecting and promoting access to basic needs including food may decrease vulnerability to HIV, especially among women [23]. Although further research is needed, such findings suggest that, in addition to broader efforts to improve women's economic security, interventions that target food assistance and support women's subsistence farming and other means of food production should be considered as potentially important HIV prevention strategies for women in sub-Saharan Africa. Such programmes should also address equity of food distribution within the household, as a number of African studies have shown that women may be less food secure than men as a result of unequal household food allocation, a situation exacerbated by their lack of control over decisions related to food production, consumption and sale [23, 130, 131]. At the same time, HIV prevention programmes might consider ways of improving access to basic needs among vulnerable groups, as failure to do so may limit the effectiveness of other prevention efforts [132]. Addressing issues such as food insecurity is a complex undertaking, and to date integrated approaches combining food security programmes with efforts to strengthen HIV prevention for women have not been well developed or evaluated.

**Securing women's property and inheritance rights**

Access to, ownership of, and control over property such as land or housing are fundamental determinants of secure livelihoods: they provide a secure place to live, a site for economic and social activity, and collateral for credit and other resources and services. All are essential to household efforts to prevent and mitigate HIV/AIDS. Worldwide, however, women remain a minority of owners of land and housing and often face discriminatory customs, religious laws, and institutional practices that severely restrict their ability to gain and control such property [133]. Coupled with this, women often lose control over assets upon the dissolution of a marriage or death of a spouse, a situation that may be exacerbated when these events are linked to AIDS-related illness or death [134]. In sub-Saharan Africa, where poverty and HIV infection rates are highest, property matters are determined by a combination of residual colonial law, current constitutional law, and ongoing customary law, the complexities of which often allow for loopholes or legal gaps that undermine women's property and inheritance rights [133]. Research and intervention strategies are only beginning to explore the relationship between property ownership and inheritance and HIV prevention. There is growing evidence to suggest that upholding women's property and inheritance rights can promote women's economic security and empowerment, in turn reducing their vulnerability to domestic violence, unsafe sex and other AIDS-related risk factors. Securing women's property and inheritance rights can thus potentially contribute to the prevention of HIV infection [120, 133, 135].

Efforts to promote such rights can be broken down into three main categories: ensuring gender-sensitive legislation; promoting judicial capacity and effective litigation; and advancing public awareness and understanding. An example of the first area is the Legal Assistance Centre in Namibia, which has addressed women's rights to communal and commercial land as well as laws pertaining to marriage, divorce and inheritance, (which in turn affect women's ownership of and control over property). In the second area, Women and Law in Southern Africa, a regional educational and research trust, has been operating in seven southern African countries to promote the judicial sector's capacity to uphold women's rights and provide for effective litigation. In rural Zambia, they have been working with chiefs and local policy makers as well as providing legal aid clinics, in order to resolve land and property disputes; many related to women recently widowed through AIDS-related deaths. Finally, as an example of advancing public awareness and application of women's rights, Women's Voice in Malawi has conducted community sensitization and 'will-writing campaigns' in rural communities. Working with both women and men, they have aimed to raise awareness regarding women's rights, advocate for fair and equitable dispensation of property at the community level (including reform of discriminatory customary inheritance practices), and teach community members how to write a valid will and observe its provisions. By actively collaborating with chiefs and traditional authorities, they have found that local norms concerning property and inheritance are beginning to transform [133].

Many such programmes do not yet involve specific activities that feature a direct link between HIV/AIDS and women's property and inheritance rights. As with the microfinance sector, however, they nevertheless highlight strategic intervention points through which that link might be more fully developed. Such intervention points could be maximized by developing cross-sectoral partnerships across a range of organizations and institutions, whether oriented...
Economic empowerment and HIV prevention: programme and policy recommendations

In this review, we suggest that correlation between an individual's income and their HIV status only tells part of the story. Poverty shapes the risk environment for HIV in ways that are complex and multidimensional: by limiting educational opportunities, exacerbating gender inequalities and perpetuating social norms that subordinate women, by putting women at risk of physical and sexual violence, and by social fragmentation and the erosion of systems of norms and networks that might foster resilience in communities and support HIV risk reduction.

We also highlight a range of interventions that have attempted to address economic empowerment at the micro and macro levels, from microfinance, to livelihoods, literacy and vocational training, to broader interventions that secure women's property and inheritance rights. However, what is immediately apparent from this review is that despite over two decades of experience with HIV/AIDS, there remains an extraordinary dearth of experience in the design, implementation and evaluation of such strategies [75]. Public health, with its traditional focus on epidemiology and disease control models has often lacked the tools to conceptualize and mount broader social and economic interventions [137,138].

Our understanding of how to work together with communities to promote participation and sustainable development remains limited [139–142]. Interventions at this level are not as circumscribed (in goal or process), as more conventional health sector initiatives such as the prevention of mother-to-child transmission or antiretroviral therapy programmes, and require new collaborations across multiple sectors and disciplines. Furthermore, they do not lend themselves easily to experimental evaluation, and may require longer timeframes to demonstrate effects. [75,143,144].

Given the limited progress of HIV prevention efforts within southern Africa many experts suggest that it is time to get back to the basics and to stick to 'what works' [136]. Others have suggested that the recent setbacks in developing technical interventions, including microbicide and vaccine trials, provide an opportunity to re-examine global HIV prevention efforts. The intervention strategies presented here highlight strategic entry points for addressing women’s economic vulnerability as a critical component of such prevention efforts. Admittedly, we have a far better understanding of existing gaps, than we have a clear grasp of programmes, strategies, and evidence to guide the way forward. Nonetheless, we propose that there are a number of important lessons arising from experience to date, which can potentially invigorate global policy debates around HIV prevention. We argue that innovations that support women's economic empowerment are not efforts that should be pursued at the expense of technical, health sector approaches. Rather, they should be approached in unison, harnessing their potential for complementary and synergistic impacts. In this context, we put forward the following policy and programme recommendations.

Policies and programmes that promote the economic empowerment of women and girls should be included as core components of national HIV prevention strategies: Research suggests that addressing women's basic economic needs through programmes such as microfinance, youth livelihood and life skills training, and initiatives to protect women's food security and property and inheritance rights not only targets women's economic vulnerability directly, but can also offer a strategic opportunity for attracting sustained group-based participation in HIV prevention activities among the poor. Experience with combined economic empowerment and HIV interventions suggests that it is feasible to address structural factors such as poverty, gender inequalities and gender-based violence as part of HIV prevention programmes, and these goals should be explicitly included within national HIV/AIDS strategies. Adequate resources, technical expertise, and monitoring and evaluation mechanisms relating to these goals need to be included to support effective implementation.

Increase financial support to community organizations that promote economic empowerment of women, and ensure that these organizations are represented on National AIDS Councils, country coordinating mechanisms and in other relevant national and local decision-making and consultative bodies: Currently, most national and local bodies focusing on HIV/AIDS tend to reflect the participation of stakeholders and advisors primarily representing clinical and public health expertise. Given the need to encourage greater cross-sectoral collaboration, these should be expanded to include a more diverse range of expertise, including groups working on poverty alleviation, food security, gender-based violence and women's rights.

Support the development of cross-sectoral partnership models and encourage programmatic innovation to develop combined economic empowerment and HIV prevention interventions: Although there have been increasing calls for a 'cross-sectoral response' to the HIV pandemic, there are few
concrete examples of programmes that work, particularly in high-prevalence African settings. Emerging evidence suggests that adding a gender and HIV training component to economic interventions such as microfinance can expand their health and social impacts. Without specific funding to support the development of combined economic and health interventions, however, it is likely that further innovation will remain limited. Technical and financial support to develop cross-sectoral intervention programmes, and the sharing of expertise required to initiate and sustain these, should be encouraged.

Support the scale-up of promising cross-sectoral intervention models: When promising interventions combining economic empowerment and HIV prevention have been developed, they should be supported to scale-up where appropriate. Further research would help to identify how such programmes might be replicated or adapted in different contexts. Many programmes currently include an HIV training component, and best practice guidelines should be developed in relation to the content, delivery and intensity of such training. Technical support may be required for including newer elements such as content relating to gender norms, gender-based violence or community mobilization activities. Such support should also consider what kind of capacity-building might be required for programme implementers themselves, and what kind of institutional structures need to be developed in order to support and manage expanded activities and mandates. When there are pockets of innovation, lessons should be shared regionally, through the development of learning centres and exchange programmes.

Explore a broad range of economic empowerment strategies for women and adolescent girls as a platform for reducing vulnerability to HIV infection: To date, most experience with combining interventions aimed at women's economic empowerment and HIV prevention has arisen within the microfinance sector. There is a need to explore additional economic empowerment strategies that may carry important opportunities for cross-sectoral interventions. Programmes such as vocational training, literacy programmes, or other livelihood strategies may present relative advantages or disadvantages for different target groups and settings. Initiatives aimed at improving women's food security and safeguarding their property and inheritance rights have yet to develop strategic linkages with HIV training or service organizations. Lessons and partnership models from the microfinance sector should be further elaborated and expanded to include these other areas.

Evaluate interventions using realistic and relevant indicators, methods and timeframes: There is a need for further research in order to guide programme and policy development for linking economic empowerment strategies and HIV/AIDS interventions in a range of settings. Few economic empowerment strategies, with or without an additional HIV-related component, have been well evaluated and it is rarely feasible to implement a randomized controlled trial. Experience suggests, however, that strong and informative evaluations are possible. To date, economic programmes have tended to focus on measuring conventional financial indicators, such as poverty targets or financial sustainability measures. Broader impacts on dimensions such as women's empowerment, gender-based violence, sexual behaviour, and other HIV-related outcomes should be more systematically evaluated, and consideration given to the longer timeframes that may be required in order to observe change. In some areas, there is a need to address information gaps, for example, by developing sex-disaggregated national and local-level indicators that can measure progress toward women's equality in land and property inheritance rights. More research on such outcomes within different intervention models is needed, as well as operational research that evaluates the most effective institutional strategies for creating partnerships between economic empowerment and HIV prevention programmes.

Ensure that broader country-level policies support and sustain the impact of individual programmes: There are clearly limitations to what individual intervention programmes can achieve. Often, the impact of scaling-up or replicating locally successful models is constrained by a lack of realistic engagement with broader policies and structures that can curtail or expand their scope. Therefore, in order to be effective, intervention programmes need to be supported by country-level policies that carry the potential for far more sustained and systemic changes in women's status and health. Therefore, in addition to supporting programmes that strengthen combined approaches to economic empowerment and HIV prevention, countries should ensure that domestic legislation is consistent with international human rights norms, and that it is effective in protecting women's rights within marriage, securing their right to own and inherit property, ensuring equality in the workplace, and strengthening laws against domestic violence and sexual violence.

Ensure that economic development plans (whether involving the development of productive sectors or the provision of social safety nets) pass an ‘AIDS impact assessment’: Given the range of factors known to interact with poverty and increase vulnerability to HIV infection, economic development plans should be viewed with an ‘HIV lens’ in order to determine whether they may inadvertently increase the population risk of infection, and if so, whether deliberate measures can be taken to reduce this risk. Just as governments currently require private and public sector development projects to include an ‘environmental impact assessment’, such projects should also be required to pass an ‘AIDS impact assessment’. Relevant criteria might include: whether hiring practices critically examine the demographic profile of the workforce and
Strive to reduce dependency on migrant labour; industry standards that seek to provide alternatives to congregate, single-sex dwellings at work sites; transportation alternatives to long distance truck routes; the inclusion of workplace AIDS policies and policies promoting gender equity; and programmes that provide educational or economic alternatives to sex work for women living in communities surrounding high-risk areas. As with environmental impact assessments, good practices can be encouraged through preferential consideration for contracts, as well as tax and other financial incentives for programmes which can demonstrate that such HIV-related considerations have been taken into account. Such structural-level interventions have the potential to make important contributions to addressing the broader contextual factors that may be beyond the reach of individual economic empowerment programmes.

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