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Leveraging strong social ties among young men in Dar es Salaam: A pilot intervention of microfinance and peer leadership for HIV and gender-based violence prevention

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Abstract

Gender inequality is at the core of the HIV patterns that are evident in sub-Saharan Africa. Gender-based violence (GBV) and lack of economic opportunity are important structural determinants of HIV risk. We piloted a microfinance and health promotion intervention among social networks of primarily young men in Dar es Salaam. Twenty-two individuals participated in the microfinance component and 30 peer leaders were recruited and trained in the peer health leadership component. We collected and analyzed observational data from trainings, monitoring data on loan repayment, and reports of peer conversations to assess the feasibility and acceptability of the intervention. Eighteen of the loan recipients (82%) paid back their loans, and of these 15 (83%) received a second, larger loan. Among the loan defaulters, one died, one had chronic health problems, and two disappeared, one of whom was imprisoned for theft. The majority of conversations reported by peer health leaders focused on condoms, sexual partner selection and HIV testing. Few peer leaders reported conversations about GBV. We demonstrated the feasibility and acceptability of this innovative HIV and GBV prevention intervention. The lessons learned from this pilot have informed the implementation of a cluster-randomized trial of the microfinance and peer health leadership intervention.

Introduction

HIV/AIDS is eliminating generations of youth in sub-Saharan African settings such as Tanzania. Among Tanzanian youth, AIDS is the leading cause of death (UNDAP, 2011). The prevalence of HIV among young girls aged 15–17 has nearly doubled since 2008 to 1.1%, and increases steadily with age to 6.6% among girls aged 23–24 (TACAIDS & NBS OCGS, 2013). Additionally, HIV prevalence among young people aged 15–24 in Dar es Salaam is higher than the national average for this age group (5.3% vs. 3.7%, respectively) (UNICEF,

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2011). Gender inequality is at the core of the HIV patterns that are evident in sub-Saharan African settings like Tanzania. There is a well-documented overlap between HIV and gender-based violence (K. Dunkle et al., 2003; Kouyoumdjian et al., 2013; Li et al., 2014; Maman et al., 2002). Men who report engaging in HIV risk behaviors are also more likely to report perpetrating violence against sexual partners (Maman, Yamanis, Kouyoumdjian, Watt, & Mbwambo, 2010). Due to entrenched gender norms that provide men with the power and control within relationships to determine the conditions, such as the timing, the level of protection, and the consensual nature, of sex with their partners, men in sub-Saharan Africa are key targets for HIV and gender-based violence (GBV) prevention efforts (K. Dunkle et al., 2003; K. L. Dunkle et al., 2006; Jewkes et al., 2006; Martin et al., 1999; Noar & Morokoff, 2002; Raj et al., 2006).

We continue to lack knowledge on how to access and engage young men at risk for HIV and perpetration of violence. Clinic based approaches may not be effective at reaching young men under the age of 25 years because young men access health services at disproportionately lower rates than females in part due to traditional masculine gender norms (Galdas, Cheater & Marshall, 2005; Nyamhanga, Muhondwa, Shayo, 2013). Worksite and school based approaches may also not be the most effective approach, because many young men most at risk are not in school and not formally employed (Stroeken et al., 2012). Intervention strategies to engage men are also lacking, particularly those that address the structural determinants of risk. Unemployment has destructive physical and mental health effects on men (Bartley & Ferrie, 2010), and the stress associated with men's inability to meet their roles as economic providers for their sexual partners and their families creates enormous strain for men, and leads to conflict between partners (Krishnan et al., 2010; Sivaram, Latkin, Solomon, & Celentano, 2006). Despite the detrimental effects of unemployment on men's health, men have been overlooked in some poverty alleviation efforts, such as microfinance. Microfinance extends small loans to poor individuals to start or support small business enterprise. A growing body of literature shows that beyond poverty alleviation, microfinance programs can lead to positive health outcomes (Leatherman & Dunford, 2010; Morduch & Haley, 2002; P. M. Pronyk et al., 2006). The most striking example of positive health effects resulting from a combined microfinance and health intervention is from the Intervention for Microfinance and Gender Equity (IMAGE) study in South Africa. Women in this trial who received small loans and attended biweekly health sessions reported significantly less domestic violence, greater uptake of HIV counseling and testing, and greater HIV-related communication with partners than women in the control arm (P. M. Pronyk et al., 2006). Women are generally the beneficiaries of microfinance because they have traditionally demonstrated better overall repayment and greater investment of these resources and profits in household needs (Armendáriz & Roome, 2008; D'espallier, Guérin, & Mersland, 2011). However, a growing number of microfinance organizations are committed to making loans to men (Accion, 2009) and research has demonstrated positive health effects of microfinance with men, including greater use of contraception and reduced depressive symptoms among men in a South Africa study (Fernald, Hamad, Karlan, Ozer, & Zinman, 2008; Khandker, 1998).

Microfinance programs have increasingly incorporated a health focus in their programs because the microfinance groups offer a platform to reach individuals, and can leverage

groups to effect change (Leatherman & Dunford, 2010). In the IMAGE Study, for example, women's microfinance groups provided opportunities for mentorship and information exchange, resulting in greater solidarity and collective action among the intervention participants (Paul M Pronyk, Harpham, Busza, et al., 2008). This work suggests that social capital generated through microfinance may have positive spillover effects for preventing HIV Microfinance is successful in part because the model relies on groups to hold individuals accountable for the repayment of their loans The success of microfinance programs capitalizes on the accountability of groups or networks of individuals. Interventions designed not only to change the behavior of individuals but also to work with social networks to promote behavior change are likely to result in sustained change because they tap into naturally existing structures (DiClemente & Wingood, 2003; Jemmott & Jemmott, 2000; Kelly, 1999). Social networks serve as an important context for shared peer norms related to HIV and provide opportunities for social influence processes to occur naturally (Kelly, 1999). Adolescents, in particular, are influenced by the behaviors and norms of their peers (DiClemente & Wingood, 2003; Jemmott & Jemmott, 2000). One social network intervention among gay men in the US that engaged network leaders to promote behavior change showed a 30% reduction in network members' sexual risk behaviors (Kelly et al., 1991). Social networks can also be sources of social capital, defined as perceptions of reciprocity, solidarity and trust within a network (Kawachi & Berkman, 2000). Social capital may be channeled into collective action around HIV, including information sharing and changing social norms (Campbell et al., 2013). In a study of young women in South Africa, more social capital was associated with lower HIV prevalence and higher levels of condom use (Paul M Pronyk, Harpham, Morison, et al., 2008).

Our group conducted formative research in Dar es Salaam to identify the venues where young men engaging in high-risk sexual behavior socialize. Through this formative research we identified camps, which we have described in previous publications (Yamanis et al., 2013; Yamanis, Maman, Mbwambo, Earp, & Kajula, 2010). Camps are enduring social groups of mostly men, with a median of 32 members and an average lifespan of 8 years (range 4–13 years). Through our formative research we identified, mapped and collected data on 71camps within one ward (equivalent of US census tract) of the city. Some camps have physical structures that demarcate their location, while others use public spaces, such as the side of a building, to establish their camps. Camps require membership and have elected leadership. Most members we interviewed belong to one camp and come every day for several hours to socialize. There were many ways in which members of the camp supported one another in emotional and more tangible ways, such as providing money in the event of a death in the family. There was also a substantial amount of health risks that occurred among camp members. The young men's median age of first sex, 16.3 years, was lower than the national estimate of 17.7 years, and the proportion who had multiple partners in the past year (47 %) was higher than the national proportion for their age (26 %) (National Bureau of Statistics (NBS) [Tanzania], 2004; Yamanis et al., 2013). Furthermore, the six month cumulative prevalence of concurrency among sexually experienced youths was 42% (Yamanis et al., 2013), substantially higher than other studies of male youth in sub-Saharan Africa that ranged between 20 and 38 % over time periods of past 12 months and past 3 years (Carter et al., 2007; Harrison, Cleland, & Frohlich, 2008; Mah, 2010; National

Bureau of Statistics (NBS) [Tanzania], 2004; Steffenson, Pettifor, Seage III, Rees, & Cleary, 2011). A total of 41% of men who were sexually active reported perpetrating physical violence against a partner in the past 6 months. We used what we knew about camps as a platform to launch this pilot HIV prevention intervention that combined microfinance with health leadership training and promotion. This combination intervention is innovative in that it addresses both social and structural determinants of HIV risk for an underserved, hard-to-reach and at-risk group of young men in Sub-Saharan Africa. The primary purpose of this paper is to describe the feasibility and acceptability of the pilot intervention.

Methods

Of the 71 camps we identified in our formative work, we selected three camps that had existed for more than a year, had fewer than 40 members and reported that they had some previous experience with business enterprise for this pilot study. Two of the camps we selected had existed for 7 years and the third camp existed for 9 years. While camps primarily consist of male members, some camps, including two of the three that were part of this pilot also had some female members. Since we conceptualized this intervention as one that would have camp-level effects, all camp members, men and women were invited to participate in the intervention.

The pilot intervention had two components, a microfinance component and a peer leadership component. The two intervention components leveraged the facts that the camps had cohesive social networks of primarily young men that met regularly in fixed locations, there were clearly identified leadership structures to these networks, and the networks showed signs that they were entrepreneurial, running businesses within the camps. The two components of the intervention were piloted in the same three camps from February, 2011 through August, 2011.

Microfinance

We conceptualized the microfinance as both a mechanism through which we could reach men and provide them with skills in business training and management, something that they said they wanted during the formative work, as well as an intervention that could build social capital within these social networks. To be eligible, the camp members had to be 15 years or older and a registered member of the camp. All camp members who were interested in participating submitted brief business concept proposals. The proposals were evaluated for feasibility, how likely the business could be initiated with the resources provided, and creativity, the extent to which the proposed business filled a particular market need in the area. We extended invitations to participate in the microfinance to 30 camp members with the most promising business ideas across the 3 camps (10 in each camp). Twenty-two of the 30 camp members who were invited to participate initiated loans, including 18 men and four women

We partnered with a microfinance organization in Dar es Salaam to implement the microfinance component. We used standard principles and practices to guide the microfinance including (1) *Business skills training:* Camp members received a one-week business training workshop. The training focused on how to generate viable business ideas,

how to assess markets, how to start and scale up businesses, how to manage businesses, and how to deal with common challenges in business. A key part of this initial training was teaching the participants about microfinance and the conditions of microfinance loans, so that they could make informed choices about their participation. We also conducted booster training sessions for loan recipients two months after they received the loan. *(2) Formation of loan groups:* Camp members were asked to form groups with four other camp members for the purpose of receiving the loan. Each camp member within the group received an individual loan. While loans were paid to individuals, the groups were accountable for repayment of all group members' loans, such that if one member missed a payment, the other members of the group repaid on his behalf. *(3) Applications for loans:* Individuals applied for a loan by completing a loan application that included details on the planned business, information on group members, and evidence that the individual had 12.5% of the loan in savings. (*4) Distribution of the loans.* After successful completion of the application, camp members received an initial loan of $100 USD at 18% interest, with a 6 month repayment deadline. (5) *Weekly repayment sessions:* The camp members met with a loan officer on a weekly basis with their group to repay their loan principal plus interest in installments of roughly $4.50. All members were expected to attend these repayment sessions. *(6) Ongoing access to credit*: Since ongoing access to incrementally larger loans is a key feature of microfinance, camp members were eligible for a second loan in the amount of $200 USD after successfully paying back the first loan.

Peer leadership component

The second component of the intervention was a peer health component that identified and trained the peer leaders within the camps as health promoters for behavior change. This intervention component built on the fact that it is possible to identify leaders within the camps who are respected and trusted by their peers. We used the following steps to implement this component: *(1) Nomination of leaders:* To identify peer leaders we held a meeting with camp members and asked them to identify qualities of leaders, and then to each identify, through a confidential process, up to 5 camp members within the camp whom they felt best demonstrated these qualities. Example of leadership qualities identified by the men included trustworthiness, caring and sincerity. We aggregated the data from the nominations to identify 10 individuals within each camp who received the most peer nominations. We approached these 10 individuals and invited them to participate in the health training. All of the peer leaders that we approached agreed to participate. *(2) Training:* Peer leaders participated in an initial one-week training and two, single day booster training sessions held two and five months later. The trainings were facilitated by the coauthor (LK) who is a master's trained psychologist with expertise in training for counseling in this context. The training provided the leaders with knowledge to address myths and misconceptions related to HIV transmission and prevention, condoms, violence and multiple sexual partnerships. A major component of the training was building skills in effective communication for social influence. Through role playing and demonstrations, leaders learned how to engage their peers in conversations about sensitive topics, how to identify and address barriers to practicing safe sex, how to counter negative viewpoints, how to use 'I' statements when talking with their peers about behavior, how to be better listeners, and how to model positive behavior choices for their peers. The training module on gender-

based violence included several interactive activities that were designed to help the peer leaders clarify their own attitudes and values related to gender, violence and power and to help the leaders understand how violence affects women's health and well-being. Booster training sessions were an opportunity to review information covered in the initial training, and discuss success and challenges that the health leaders faced in implementing the strategies among their peers. Peer leaders received a modest allowance for the training days to cover costs associated with transportation to get to and from the training venue and to cover the cost for work time that was missed. *(3) Implementation of the communication and social influence strategies:* Once the leaders were trained, they were asked to implement the strategies they learned among peers in the camps. They were asked to incorporate the material they learned in the training into naturally occurring conversations that they were having with members of their camp. They were given diaries to record the frequency and type of conversations that they had with peers.

Data collection

We collected observational data on the training sessions, meetings with peer leaders, and monitoring data on loan repayment and health conversations of the leaders. We developed semi-structured tools for the observations that outlined general information we wanted to gather about each activity. We trained a staff member in how to use these tools to record the data. He recorded data by hand and then all data was entered for analysis. His notes consisted of a summary of what he observed and what he learned through discussions of the camp members at the activities he attended.

Observations of training sessions and boosters for microfinance and health leadership training—The study staff member took notes during the initial and booster training sessions for the microfinance and health leadership training. The notes documented the content of the training sessions, as well as questions and concerns raised by the camp members at these sessions.

Observations of business implementation—Among the 22 microfinance participants there were 18 viable businesses to observe. The same staff member visited these businesses, and took notes using a structured observation tool. He made one visit to all the businesses, and a second visit to 16 of these businesses. He took notes on the type of business that was being conducted, the location of the business activities, evidence that the business was happening, information on whether the business involved other people, challenges that were faced by the camp member running the business, where the camp member obtained products for his/her business, and his impression of the success of the business.

Observations of repayment sessions—The study staff member took notes from 20 weekly loan repayment sessions. The observations were documented on a semi-structured tool that included information on who attended the repayment session, reasons for non-attendance, whether loan was repaid and reasons for non-payment of loans. The notes also included details about challenges discussed and suggestions for improvement.

Observation of peer health leaders—The data collector took notes at the meetings with the leaders in each camp. Observation notes included details on who attended the meetings and reasons for non-attendance. Trained health leaders were asked to record each week the number and type of conversations that they had with peers, and these logs were collected at each meeting. Leaders reported on the conversations that they had with peers at the regular meetings. Notes from each meeting with health leaders included a detailed example of one or two conversations that the leaders reported having with their peers, and challenges of implementing the strategies.

Loan repayment data—We tracked loan repayment amounts collected at each session. If repayment was not made, we collected data on reasons for non-payment, and balance remaining on the loans.

Data analysis

Loan repayment data and observational data were analyzed principally by two authors (SM and PB). Notes from the training sessions, repayment sessions and meetings with the leaders were summarized. Key themes were identified through the use of matrices to display and compare details about the implementation, and challenges that were faced in both intervention components. Repayment rates were calculated based on total amount and number of loans disbursed and total amount and number of loans repaid.

Results

Microfinance implementation

Twenty-two camp members received the loans, including 18 men and four women. The average age of loan recipients was 23 years, (range 17–36 years). See Table 1 for a description of participants and a summary of intervention activities.

Types of businesses that the youth initiated—The types of businesses that the youth initiated with their loans fell into three categories: sale of clothing, sale of food, and service. Of the 18 viable businesses, ten of the youth used their loans to sell clothing including second hand clothes, shoes and handbags. Six of the youth invested their loans to develop food businesses including preparing and selling fries, boiled eggs and samosas. Three of the youth invested their loans in a service enterprise including video rental, rental of a pool table and carpentry.

Repayment rates—The initial loan was provided to camp members on February 11, 2011 and repayment started two weeks later. The regular repayment sessions continued every week thereafter through August, 2011. One of the men died during the intervention pilot, and two men disappeared. We learned that one of the individual who disappeared was imprisoned for petty theft in another ward. Of the 19 remaining loans, 18 paid back the first loan in full. The one man who was not able to complete the payment became sick during the pilot period, and this prevented him from developing his business. Among the 18 individuals who paid back their first loan in full, 15 of these individual applied for and received the second loan of $200., including 4 women and 11 men. For the second loans, the

microfinance participants became regular clients of our partner microfinance institution and the duration of their loans exceeded our study period. Thus we did not collect data on the repayment rates of the second loans.

Success and challenges of microfinance—For the camp members who were able to repay the loan, the requirement to repay in small increments and the support of the loan officer were important factors in their success. We noted a trend in that youth who had more business experience were able to pay back the loan in full more quickly. There were a number of challenges that camp members faced in developing their businesses and paying back their loans. First, several participants used their loans to enhance an existing family business. It was difficult for these camp members to estimate the proportion of business profits resulting from their investment versus the contribution of other members of their family, particularly, if the person they engaged in business with was an older member of their family like a parent. It was also difficult for these participants to question business decisions made by family members even when they felt those decisions may not have been in the best interest of the family business. Second, camp members who engaged in business with friends experienced challenges, similar to those experienced with family businesses. Third, another business related challenge that some participants faced was the poor selection of businesses to launch. Some of them ended up changing their business plan during the course of the pilot because they found that the market for their original business was saturated in their area. In addition, we noted variable attendance at repayment sessions over time. In several cases, camp members gave their repayment amounts to friends to pay back at the repayment sessions on their behalf, not attending the sessions themselves. When we probed to understand why this was happening, we were told by many participants that they felt like they could not afford to be away from their businesses during prime business time to attend these sessions. Finally, several participants complained that the size of the initial loan was too small, and did not enable them to invest in sufficient capital to start a business.

Peer health leadership implementation

A total of 30 peer-nominated health leaders were selected from the three camps, 26 males and 4 females with an average age of 24 years (range of 15–40 years). They all participated in the first training session. One of the camp leaders died during the pilot study and one disappeared (these two individuals also participated in the microfinance), leaving us with a total of 28 health leaders whom we followed. Fifteen of the camp members who participated in the peer leadership component also participated in the microfinance component including 13 men and 2 women.

Success and challenges of peer health leadership—Meetings were held with the leaders in each camp every 2–3 weeks to discuss success and challenges. The most common topic of conversation that leaders reported having with peers was condoms. We provided the leaders with condoms to distribute, and the distribution of condoms became a trigger for discussions that they had with their peers. In many cases, they showed their peers how to use condoms properly. They answered questions about whether condoms were safe and reliable, and whether they reduced pleasure during sex. Another common topic of the conversation was sexual partnerships. Peer leaders reported talking to their peers about selecting partners

that they could trust by choosing partners that were known to family or friends so that their reputations could be cross-checked with people the young men knew, communicating with partners, and fielding questions about the perceived faithfulness of partners and how this affected their ideas regarding concurrency. A third topic of conversation that many leaders engaged in with their peers was HIV testing. They talked to their peers about the importance of testing with their partner. The leaders developed a slogan, which we printed for them on t-shirts that said “You cannot test with your eyes only.” The slogan on the t-shirt led to many conversations about the importance of knowing your partner, not relying on physical appearance to assess whether the partner was infected or not with a sexually transmitted infection including HIV, and the importance of HIV testing with partners. Leaders reported very few conversations with peers about GBV. Three leaders recorded conversations that they had with their peers about cases of rape in their community. There were no leaders who recorded conversations about gender power more broadly.

Discussion

Through this pilot we demonstrated the feasibility and acceptability of a combined microfinance and peer leadership intervention with social networks in Dar es Salaam. We discuss the experiences of the youth with this combined intervention and highlight the lessons learned. We addressed many of these issues when refining this intervention prior to our ongoing cluster-randomized trial of the intervention within 60 camps across four wards of Dar es Salaam.

Feasibility and acceptability of the microfinance and peer leadership intervention

Camp members in this pilot were able to meet the loan requirements including depositing savings and documenting a clear business idea. Eighteen of the 22 camp members who initiated loans (81.8%) paid back their loan in full, and 15 of these 18 camp members (83%) successfully applied for a larger, second loan. Given the interest shown by youth in camps, we do feel an intervention like microfinance could be a useful mechanism to reach and engage this population. There are few other examples in the published literature of microfinance among youth. In another feasibility study of microfinance with adolescent girls in Zimbabwe, the SHAZ! study, the loan repayment and business success was poor among the adolescent girls. By six months only 6% repaid in full, and 20% had partially repaid (Dunbar et al., 2010). The investigators on this study attributed poor microfinance results to the overall poor macroeconomic context of Zimbabwe at that time, as well as lack of adequate support for the young girls to succeed. It is likely that the group accountability that is built into the design of microfinance worked effectively within the camp networks in our study, and may have contributed to the camp member’s success with managing their loans. In terms of the peer leadership component, the leaders who were nominated by their peers were engaged and enthusiastic about the training that they received. They attended the training sessions, asked questions, raised important challenges in the booster training sessions, and demonstrated an interest in the program and in their role as health leaders.

Challenges that limited the implementation of microfinance and health leadership

We offered 30 camp members the opportunity to participate in the microfinance, and 22 initiated loans and participated. The structure of the loan requirements were the primary barriers to participation among the eight individuals who did not initiate loans. This included, for example, the small size of the loans and the requirement for savings prior to loan initiation. The loan recipients faced challenges that may be unique to youth. Youth who invested in a family business talked about the challenges of being able to clearly delineate what part of their profit earned was theirs, and accessing the funds from the profits to pay back the loans. They also referred to challenges associated with making decisions about the family business when it was under the control of another relative. Two of the four young men who defaulted on loans did so because of health reasons. We did not design our tools to collect and report on loan performance throughout the pilot period, thus we are able to report final repayment rates for the group, but cannot provide more details on the repayment process. For the peer leadership component, the implementation was hampered by the fact that leaders felt comfortable talking about some issues such as condoms and multiple partnerships more than other issues such as violence and power in relationships. The conversations they had with peers were often very didactic and informational. The conversations about condoms and sexual partnerships may have been easier for the peer leaders to initiate because these topics are often covered in HIV prevention initiatives through mass media, so they are familiar to people, and the topics lend themselves to more didactic and informational conversations. Conversations about power and violence may be more challenging because they are not commonly addressed in mainstream HIV prevention programs, and they are deeply rooted in cultural norms about gender and conflict in this context. We were primarily interested in conversations that peer leaders had with other members of their camp, and thus did not assess the reach of these leaders outside of the camps.

Implications for the design and implementation of current intervention trial

Lessons learned from this pilot have directly informed the design and implementation of our current intervention trial. To increase uptake of the microfinance intervention in on ongoing trial, we facilitated camp meetings to explain the loan structure and to explain the business skill training. To optimize the timing for the repayment sessions, we are convening some sessions during non-prime working business hours and groups have the option to impose penalties on their members who show up late to these sessions. The initial training now covers more explicitly the challenges relating to initiating business with family and friends. In terms of the peer leadership component, we have built in more time during the training of peer leaders to discuss and clarify some of their own beliefs and opinions about power, control and violence. We spent more time raising awareness among the leaders of the ways in which power and control is closely tied to other forms of risk in relationships. Finally, we designed this intervention with these two components because we believe that together they address the social and structural determinants of behavior for both HIV and partner violence, both leverage the social capital within these existing networks, and both require group trainings and then enforcement by the group. In the larger trial we will have the capacity to look more systematically at the combined effect of the two intervention components on behaviors. The primary outcomes for the larger trial are STI incidence and perpetration of

physical or sexual violence against female partners. We are measuring hope and future orientation as mediators of the intervention's effects. We are also collecting data on all social ties within each camp at multiple waves of data collection. We will have the opportunity to use social network analysis methods to provide a more nuanced understanding of the adoption of the microfinance intervention as well as the discussions with peer leaders about HIV and gender-based violence within the camp social networks. Using these complete network data, we will also be able to assess if and how our combined intervention affects social network structure (e.g. density and cohesion), as well as how relationships between camp members affect changes in social norms and adoption of protective behaviors over time.

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Table 1

Information on participants and pilot intervention components

Microfinance	
Number of first loans disbursed ($100)	22
Age of loan recipients	Mean: 23 years, Range 17–36 years
Gender of loan recipients	18 men, 4 women
Number of first loans repaid	18 (14 men, 4 women)
Reasons for first loan non-repayment	1 death, 1 illness, 2 disappeared
Number of second loans disbursed ($200)	15 (11 men, 4 women)
Peer Leadership	
Number of peer leaders	30 (1 died and 1 disappeared)
Age of peer leaders	Mean: 24 years, Range 15–40 years
Gender of peer leaders	26 men, 4 women
Number of peer leaders who were also loan recipients	13 men, 2 women