Striving for Scale and Sustainability in Microenterprise Development Programs

by John F. Else

Abstract: A challenge to United States microenterprise development is scale. After years of experience and learning, most programs still serve relatively few clients on an annual basis. Given the barriers to increasing scale and sustainability, we need strategies to achieve growth. This paper identifies strategies for growth in the field and identifies three areas of focus that are essential to increased scale and sustainability.

Scale has been the primary theme of the last two Annual Program Meetings of the Association for Enterprise Opportunity (AEO), the microenterprise trade association—and for good reason. While the field has grown in numbers over the years—the newest (forthcoming) directory will show contact information for 560 microenterprise development (MED) programs—only a small portion of those programs serve a substantial number of clients. Of the 560 MED programs listed in the new directory, 307 completed the questionnaire to provide data. Of the 307 programs reporting, only 41 percent (125 programs) served 100 or more clients during 2001. Only 19 percent (58 programs) served 250 or more clients in 2001.

There have been many discussions about how to “grow” the MED field. There are two strategies. One strategy is to encourage additional agencies to add MED services to their mix of services. Serious provision of MED services has tremendous organizational implications for the agencies in which they are
housed. Adding MED services to a social service agency is not equivalent to adding another social service. Nor is adding MED services to an employment and training agency equivalent to adding training courses for new types of jobs or jobs in another sector of the economy. The serious provision of MED services requires not only hiring an entirely different kind of staff, but also adding significant changes in the organizational culture and in its organizational structures. Another strategy is to encourage existing MED programs to grow in size, i.e., in the number of people they serve. While both of these strategies are important, this paper focuses on the issues involved in the latter—increasing the scale of existing MED programs.

Agencies with successful MED programs have hired staff who understand and are oriented to entrepreneurship and who run their programs in entrepreneurial ways. The agencies have invested considerable time and resources to develop staff and organizational capacities and build collaborative relationships essential to the MED infrastructure. Though multiple sources of services are often beneficial to people in the community, given the costs of developing MED capacity, it may not be efficient or effective for multiple agencies in small population areas to build that same capacity. Furthermore, whoever builds the MED capacity should have a clear intent to make MED a major initiative—an initiative to expand until it has the capacity to serve the population that needs the services. This requires a serious strategic plan to reach a reasonable scale.

What are we learning about the barriers to increasing scale and sustainability? What strategies are needed to achieve growth? We have identified three areas of focus that are essential to increased scale and sustainability:

1. Management by results—a need to focus on outcomes and efficiency (cost/outcome).

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2 Organizational culture, capacity, and structures that allow MED to flourish.
3 Strategies that increase capacities and outcomes (both resource development and strategies for increasing outcomes with existing resources).

**Managing for Results**

**Aiming for Outcomes: Mission, Goals, and Objectives**

The foundation for managing for results is an outcome-oriented mission statement and outcome-oriented goals and objectives. Though most organizations have strategic plans and there is considerable discussion about mission, goals, and objectives, confusion continues to prevail.

A mission statement needs to represent the vision of the world (or community) that the organization seeks to achieve or contribute to. It answers the “why” questions, for example, “Why are we doing what we are doing? What impact do we hope our work will have on the lives of the people we serve?” While the diverse organizations that operate MED programs have a wide range of missions, they usually focus on big-picture visions, such as the alleviation of poverty or the social and economic well-being of communities or specific target groups, such as women. Unfortunately, many mission statements simply describe what organizations do or the activities in which they are engaged, rather than the large-scale context of their efforts.

Similarly, goal and objective statements need to focus on outcomes. For example, one outcome might be the number of people whose businesses produce self-sufficiency levels of income for their families. Too often, statements describe “activities” or “inputs,” such as the number of training courses held, or “outputs,” such as the number of people who complete business plans or start businesses. Outputs are measures of progress toward outcomes; they are not true outcomes.

Thus the first step in managing for results is to have clear, outcome-oriented objectives that guide decision-making. As
they think about and plan each set of activities, a program staff
is challenged to ask, “How does this relate to our mission,
goals, and objectives? Will these activities help us achieve our
mission, goals, and objectives? Are there alternative activities
that are more likely to move us toward our missions, goals,
and objectives?”

Escaping Common Tendencies

In short, having clear missions, goals, and objectives enables us
to operate with what might be called a “business orientation.”
This orientation helps us to escape at least three common
tendencies:

• The tendency to focus on inputs (number of classes held), out-
puts (clients served, businesses started), and efficiency based on
outputs (cost per client served or cost per business started),
rather than on outcomes (number of people earning self-suffi-
ciency-level incomes) and efficiency based on outcomes (cost
per economically self-sufficient person).

• The tendency to focus on numbers rather than quality of out-
comes. There is a tendency to count the number of businesses
started or served rather than the quality of businesses. Many
programs report as successes “marginal” businesses that add
little to the family income, or may even drain income from
the family. Many, perhaps most, programs do not make dis-
 distinctions based on the quality of the businesses. Few organi-
zations, for example, measure their performance or success
on the basis of whether the businesses result in families
achieving self-sufficiency-level incomes—either the business
by itself or when “patched” with other income sources.

• The tendency to focus on additional funding as the only way
to increase the scale. Some would call this a “non-profit orga-
nization-orientation” and contrast it with a “business orien-
tation,” which would consider a full range of options for
increasing outcomes, including creative service strategies for
producing more with the same resources.

All three of these common tendencies must be overcome if
agencies are to manage for results.
Focusing on the Customer

Many microenterprise programs resemble businesses that focus so much on the products they “sell” that their businesses fail—either because they do not realize that competitors are finding less expensive ways to produce the same product (or achieve the same outcomes for the customers), or because they have not recognized changes in the composition or expectations of their customers. Managing for results requires awareness of customer needs and desires and flexibility to create products that meet needs or modify existing products to meet the changing demand. For example, programs may require a number of hours of training that exceed what clients find appropriate; or the training may not be frequent enough or be offered at convenient times; or customers may believe that they would move more quickly to their goal with a few hours of individual technical assistance rather than classroom training.

Managing for results also requires constant analysis of the context in which the work is done. For example, if the goal is businesses that provide self-sufficiency-level income, programs must identify the barriers that inhibit program clients from developing substantive businesses and must reshape their programs and products to respond to those barriers.

Focusing on Cost per Outcome

If M&E programs are to operate like the businesses they advise, they need to know the cost of their product—or the cost per outcome—and they need to have costs that are reasonable so that funders (another kind of customer) will think they are worth “buying.” For example, if the objective of the program is to create businesses that provide self-sufficiency-level incomes or to create full-time jobs with living wages, then the question is what does it cost to do that—what is the cost per outcome? Some programs have this data, but many do not.

Also, programs tend to justify their costs per outcome by pointing to all the apparent nonbusiness outcomes that occur: increases in self-esteem, increases in the quality of wage
employment that the participant subsequently obtains, and even the recognition that self-employment is not the best option. While these are important outcomes—and ones which many have described as byproducts of MED programs—they are not the outcomes for which most MED programs are funded. They will continue to be important byproducts of MED services, but focusing on quality outcomes and on costs and outcome will challenge staff to think smarter and to be continuously creative in strategies. Furthermore, the reality is that it is not practical to increase scale at the cost-per-outcome that many programs have. The best use of existing resources and the ability to attract additional resources require finding ways to reduce the cost per outcome.

Producing Reports for Program Management and Promotion
Finally, managing for results requires systems that collect the necessary data and produce regular reports on outcome and efficiency. In this way, managers will make decisions that move the programs toward their goals. The system must be capable of producing reports regularly—for program managers, agency administrators, funders, and policy makers. Program managers need simple reports that provide information on the progress toward goals and objectives and on the extent to which performance is improving. Funders need reports that help them determine whether to fund organizations making application and whether funded programs are achieving the goals and objectives they set forth in their applications. Policy makers need information that helps them assess the potential of MED programs and the costs per outcome in comparison with other self-sufficiency strategies. The most important and best quality information on the outcomes of MED programs is not what is usually considered “program data,” i.e., the data gathered at intake and at completion of the staff work. It is follow-up data, i.e., the measurement of outcomes at intervals after the customers are no longer receiving services, that provide a picture of how their businesses or business concepts
have changed. MED programs that emphasize lending find it easier to obtain such data because they often make multiple loans and so have access to tax returns in subsequent years.

Cultural, Capacity, and Structural Issues

Organizational Culture
The culture of an organization is critical to the growth of MED programs. A successful MED program requires an organization that is willing to take risks; is flexible enough to reshape policies, program designs, and operations to benefit the economic well-being of the people it serves; and is even willing to struggle with mission issues.

Some basic questions reveal the organizational culture of an agency. Does the organization understand what business owners and nascent business owners need? Is it a “learning organization” that constantly examines whether its products and strategies are meeting the needs of its customers and that is constantly testing new strategies in an effort to be more effective and efficient? Is it an organization that understands that serious community economic development requires access to credit—and aggressively seeks out resources to fill that need?

One test of the organizational culture and risk orientation is decisions regarding the provision of credit to low-income populations. For many social service organizations, this is such new and uncharted territory that executives and boards of directors are not willing to “make the leap.” In other cases, the agency agrees to establish a loan fund, but the loan fund is so restricted in size or in loan underwriting criteria that it fails to have any significant impact in the community.

Flexibility is another test of organizational culture. As noted above in the discussion of customer orientation, effective MED programs continually analyze their activities and outcomes to assure that they are providing the services that move customers quickly and effectively toward their goals. Furthermore, creative organizations analyze the market to predict the potential market for MED services and to determine
strategies that would enable the agency to serve a larger segment of that market. They are constantly learning and changing and testing to maximize the effectiveness of their work. This analysis includes examination of optional strategies for using the internal resources of the organization and the leveraging of potential additional resources that may be available in the community, including the use of volunteers and mentors, as well as potential linkages with other organizations.

Even the organizational mission is sometimes challenged as MED programs grow. Some agencies have initiated MED programs and been excited by their growth in size, budget, and importance within the agencies, only to discover that the growth creates dissonance and discomfort. In some cases, the dissonance is with the central mission of the agency. For example, some refugee service agencies have developed strong MED capacities and then learned that the capacity is underutilized if limited to the refugee communities (which represent only ten percent of the immigrant population), or that the next step in growth will require serving a larger population than the refugee community. Similarly, community action agencies develop capacities that are not available elsewhere in their communities and are challenged to expand the population to which the services are available beyond the target population of community action agencies. In both cases, the agencies face the dilemma of maintaining their mission (and thus limiting the scope of the MED program) or changing their basic mission.

Organizational Capacity

It takes time to develop the capacity for effective MED services. Many organizations start their programs using current staff members who may not have experience or expertise in microenterprise development. The agencies usually learn that they need to recruit and hire staff with business development expertise. Some agencies find that the salary scales they have traditionally used are not adequate to attract business development specialists, who function in a different job market. 2
Consequently, it often takes several years to have the appropriate staff.

MED programs must also establish relationships with various actors in their communities—other business development and economic development organizations (e.g., SBDCs, SCORE, and local and state economic development agencies), SBA, banks and community development credit unions, sectoral business associations, and state and business loan funds. Again, employment and training programs and social service programs may not have existing relationships with these organizations—or may need to change the nature of those relationships when it initiates a MED program. If the MED program includes a loan fund, this often represents an entirely new realm for the host organization.

In short, it requires considerable resources—and major adjustments on the part of the host agency—to create a MED program. It requires that the agency make an investment of time and energy, but it also requires that the agency be willing to make modifications to many aspects of its organization, from its basic mission to its salary structure to its operational procedures.

Organizational Structure

Structural issues are also common barriers to increase scale and sustainability. MED programs are often nested in organizations with more general missions—Community Action Agencies (CAAs), Community Development Corporations (CDCs), employment and training agencies, refugee service agencies, social service agencies, tribal governments, and women’s economic development organizations. While MED inclusion in agencies with broader purpose has been an asset to the field—in terms of geographical coverage of the services—it has also been a barrier to scale and sustainability.

One of the most common barriers to growth arises when the MED program does not have priority within the organization and thus does not receive the necessary attention from the agency leadership. Furthermore, developing the MED program
may conflict with other aspects of the agency’s work. For example, one MED program is partnered with a bank that does not provide some of the expected benefits. Though it would be in the self-interest of the MED program to change bank partners, that is not an option, since the bank has made a significant contribution to other initiatives of the agency. Another MED program is nested in a tribal government. Though the MED program could serve important functions for many in the tribe, it is not high on the priorities of the tribal government—and like other tribes, the turnover in tribal council members is so frequent that a sustained commitment is unlikely.

Many agencies are not willing to provide the autonomy that the enterprise and asset development activities may need. One of the most common examples of structural barriers relates to the MED program becoming a certified Community Development Financial Institution (CDFI). Certification requires that a majority of the staff and budget of the organization be devoted to financing activities. It is unlikely that many of the kinds of organizations in which MED programs are nested can meet that requirement. For example, since community action agencies are often multimillion-dollar operations that implement a wide variety of large-budget programs—such as Head Start, energy assistance, food assistance, and affordable housing—it is highly unlikely that financing could ever represent a majority of its budget and activities. The same is true for Community Development Corporations (CDCs), which often have large housing development and neighborhood business real estate development activities.

Yet these agencies often have greater organization infrastructure capacity than any other organization that serves the communities they serve. In these situations, the only viable strategy for the creation of a CDFI to serve the community is to create a subsidiary corporation that focuses exclusively on financial services. Two problems arise. First, such subsidiaries are natural extensions of some organizations but not of others.
Creating subsidiary corporations is common for CDCs that may create separate corporations for each large housing and business real estate development initiative—and creating a financing entity may represent a natural extension to those core activities. On the other hand, subsidiary corporations are less common for social service and employment and training agencies, and a financing subsidiary is a more alien concept. Second, subsidiary corporations involve a perceived risk that is difficult for some agencies, especially if financing has not been a core activity.

Strategies to Increase Capacities and Outcomes

If agencies agree to manage for results, they will need to have a clear analysis of where they want to go and how they will be most successful in getting there. They will need a clear focus and a set of priorities that will guide their actions. They will need careful analysis and deliberate decision-making. This paper discusses four of the many possible strategies: training and technical assistance; lending; intermediary models of service delivery; and linkages with mainstream funding sources at the state level.

Responsiveness and Efficiency in Training and Technical Assistance

For MED programs nationwide, training has been a major strategy. One reason for the training strategy is that it can accommodate many people at once and thus reduce the cost per participant. However, MED training has too often become an end in itself. MED programs often offer “introduction to small business” courses similar to those offered in community colleges, rather than presenting information as a means of developing a business plan for people who are ready to start or expand businesses. “Graduation” ceremonies seem inappropriate; they suggest that the accomplishment is the completion of the course. In contrast, if the intended outcome is business starts and expansions, it would seem more appropriate to have
mobile, individualized graduations—inviting the entire class to attend and celebrate each business opening or business expansion ceremony.

If the purpose of training is business plan development, participants should understand that every training session is taking them closer to completing the business plan, acquiring a loan, and opening or expanding their businesses. Training must be results focused. Rather than focus on what each participant needs to move quickly to completion of a business plan, the courses too often simply “cover” predetermined theoretical material. In short, the educational strategy follows a classroom coursework style, rather than a more adult pattern of learning what is needed when it is needed.

Furthermore, serious questions remain about whether training is in fact more “efficient” than individual technical assistance. If only 25 percent of those who participate in training actually start or expand businesses, it is arguable that it may be equally efficient to provide shorter training supplemented by one-on-one technical assistance to those who are more likely to achieve outcomes. It may also be more efficient to differentiate the various subgroups of program participants and thus use the more intense strategies (individual technical assistance) on those with higher probability of starting businesses. Less intense classroom training can be offered to subgroups where a lower percentage are likely to have such outcomes.

Most important, the first step with new clients should be an assessment that determines jointly how to move them quickly and effectively toward their individual goals—and that provides a menu of optional products to achieve that. Then a plan should be developed that will achieve that end.

Increased Lending Capacity and Access

A high percentage of customers approach MED programs because they are seeking business capital, and they perceive the program as an avenue to business loans. The capacity to enhance access to capital is critical to MED program success,
whether by providing loans or creating access to loans from other sources. With this goal in mind, some programs have aggressively sought to generate resources for that purpose. Increasingly, MED programs, even those that were historically “training led,” have concluded that it is important to create an internal lending capacity.

Lending creates access to credit for entrepreneurs who are not served by banks and other traditional lending institutions. However, some MED programs involved in lending create so many barriers to borrowing—through requirements for training and technical assistance, sophisticated business plans, collateral, co-signers, and other underwriting criteria—that customers lose interest and drop out before receiving loans. While MED programs must be concerned about repayment, they must also find creative ways to assess risk if the unbanked are to be served.

Another issue is whether MED agencies and their funders expect the lending component to be self-supporting. Unless the lending volume is exceptionally high (and maybe not even then), microenterprise lending, by itself, is unlikely to generate sufficient revenue to support the lending activity. If agencies expect the financing component to be self-supporting, they will be pushed into broader lending activities, such as larger business loans, housing development loans, and nonprofit facilities loans. While this is critical to the self-sufficiency of the financing capacity and may be beneficial to the communities the programs serve, it takes the organization in some new directions. Agencies need to study these implications carefully to determine whether this is the direction the agency wants to pursue.

Intermediary Models of Service Delivery
Agencies are often concerned about providing services to geographical areas that have no access to MED services. One option for achieving this at a reasonable cost is to use existing organizations to deliver services to the expanded geographical area while maintaining the lending capacity centrally. Since
this strategy uses existing institutions, it minimizes costs, while assuring quality control through centralized program designs, policies, procedures, training, and monitoring. The North Carolina Rural Economic Development Center represents one example of using this approach to serve a statewide constituency, and there is much to be learned from that experience.

Linkages with Mainstream Funding Sources at the State Level

Many MED programs have established strong relationships with state TANF (welfare) agencies and workforce development agencies to fund MED services to specific populations. This places the MED program into “mainstream” funding sources that have long funded other types of training services for welfare recipients, unemployment insurance recipients, and other unemployed people.

It is not easy to “break into” these systems. It often requires a long period of time to convince administrators that microenterprise (self-employment) should be one of the employment options available to these groups. Each agency has regulations that are often barriers to the self-employment option. For example, many TANF agencies follow the “work first” model, which requires that all recipients be employed first and considers training supplemental; in these cases, MED programs may need to negotiate an arrangement whereby potential clients could be employed in related businesses—ones that would teach them the intricacies of those businesses—while they develop plans for starting their own firms. This is only likely to be feasible, however, in businesses where the employers do not perceive potential new businesses as serious competition, and so they are not threatened by employing people who expect to start similar businesses.

Workforce development agencies also have barriers. The performance standards that measure the relative “success” of training programs is built on an employment model where the standards are employment at or above a specific salary within
ninety days of completion of training. Workforce agencies that meet or exceed these standards are rewarded with additional funding, while those that do not meet the standards receive reduced funding. Even workforce agencies that would like to provide the self-employment option are not willing to face the negative consequences that come if a self-employment program lowers its performance. There are ways, however, to circumvent the application of these performance standards to MED programs, which are inappropriate measures of the success of self-employment programs. For example, a certain percentage of workforce development funding can be reserved for a governor’s discretionary fund, whereby programs are exempted from the performance standards. The longer-term solution, however, is for the workforce development system to create separate performance standards for self-employment programs.

Conclusion

If helping people to become self-sufficient through self-employment is our goal, then increasing the scale and sustainability of MED programs is an important means. Such change requires a serious commitment of program staff, as well as the top leadership of the agencies in which they are nested. Increasing scale and sustainability requires willingness to take a more outcome-oriented approach to the work and to consider expanding the current program. However, the agencies and staff who are willing to make the commitment to growth will experience great possibilities, both for the programs and for the people they serve.

Notes

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partner agencies that are participating in this project. They are committed to struggling with the issues of scale and sustainability, and their insights have contributed to the learning of the ISED team and the MED field.


2. Some organizations have responded to this challenge by creating a separate salary schedule for their MED program that reflects the realities of the market from which they must recruit staff.