ECONOMIC STRENGTHENING FOR VULNERABLE POPULATIONS

Protection: Savings Groups

KEY POINTS

- → Evidence that savings groups (SGs) reach large numbers of people through low cost and sustainable technical assistance has created a growing interest in how SGs could be used as a platform for other development interventions.
- → Emerging research shows that households participating in SGs see positive impact in the following areas: creating savings, balancing savings and spending, and expanding working capital.
- → Linking SGs to efforts to increase adherence to antiretroviral therapy (ART) and retention in care leverages existing investments and supports sustainable, community-led structures to reach those most in need.
- → Savings represents a promising means to help overcome the most common barriers to accessing HIV and AIDS care and treatment: transportation costs, food insecurity and income loss associated with time off for care and treatment.

This product is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of FHI 360 and do not necessarily reflect the views of USAID or the US Government.

LIFT II is a PEPFAR-funded Associate Award under the FIELD-Support LWA, a cooperative agreement between USAID's Microenterprise and Private Enterprise Promotion Office and FHI 360 and its consortium of 24 development partners. Learn more about FIELD at: www.microlinks.org/field-support.

For more information on LIFT II, please visit our website: www.theliftproject.org

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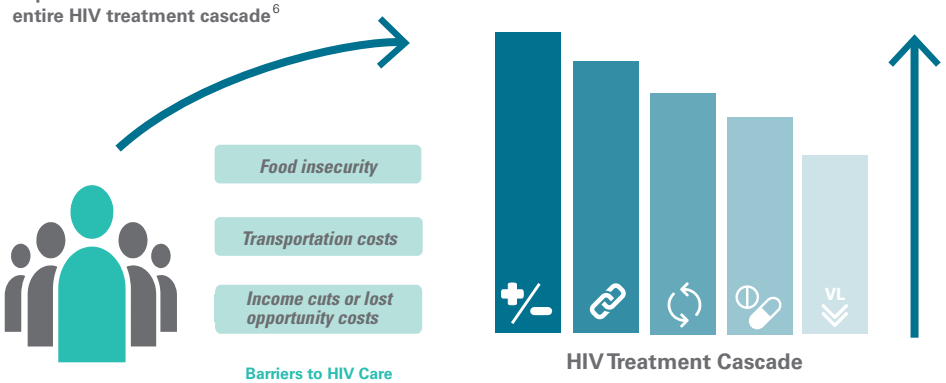
INTRODUCTION

Savings-led microfinance has introduced savings, lending and insurance services to financially isolated communities. Data from the Savings Groups Information Exchange (SAVIX) estimates that savings groups (SGs) provide more than 7 million people across the world, mostly in Africa, with access to financial services.[1] The evidence base clearly shows that SGs contribute to balance household savings and spending during periods of minimal earning and facilitate payment for unexpected individual and community emergencies; however, evidence is more limited in relation to the capacity of SGs to alleviate poverty or incorporate vulnerable households and youth into these groups. Most recent work and emerging research has centered on Savings Group Plus (SG+) models, which utilize SGs as a platform to introduce additional development interventions—health messaging, nutrition services, etc.—to ensure greater ART adherence and retention in care or link participants to additional financial services, such as health insurance or health savings accounts. Emerging evidence from studies of specific interventions that combine SG and health demonstrates the potential of SGs to increase adherence and retention in HIV care.

Relationship between SGs and ART adherence and retention in care: A 2015 study conducted in Cambodia found a statistically significant relationship between receiving a loan from a SG and ART appointment adherence compared to those who participated in SGs but did not get a loan.[2] Another study to assess effectiveness of combined interventions in microfinance, entrepreneurship and adherence to HIV treatment (IMEA) for women with HIV/AIDS and living in poverty in Colombia showed statistically significant increases over 12 months in the four key variables studied: knowledge of transmission and prevention of HIV, knowledge of HIV treatment, adherence to ART, and self-efficacy for work. Adherence to ART showed the largest increase from 16.5% to 52.5%.[3] A similar study in Peru examined an intervention integrating ART, SGs and psychosocial support. After two years, participants in the intervention group reported higher adherence to ART—79.3% vs. 44.1%.[4] A study by CARE in Côte d'Ivoire found that participation by people living with HIV (PLHIV) in SGs not only mitigated the negative socio-economic impact of HIV and AIDS, but also increased access and adherence to treatment. Access to SG loans allowed participants to pay for medical and household expenses and also reduced stigmatization of PLHIV as they were perceived as economic contributors in their community.[5]

USING ECONOMIC INTERVENTIONS TO PROMOTE ENGAGEMENT, ADHERENCE AND RETENTION IN HIV CARE

Targeting interventions to overcome barriers to care improves outcomes on the entire HIV treatment cascade[6]



[1] Data from http://savingsgroups.com.

[2] Daigle GT, et al. (2015). System-level factors as predictors of adherence to clinical appointment schedules in antiretroviral therapy in Cambodia. AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV, 27:7, 836-43.

[3] Arrivillaga M, et al. (2014). The IMEA project: An intervention based on microfinance, entrepreneurship, and adherence to treatment for women with HIV/AIDS living in poverty. AIDS Educ Prev, 26:5, 398-410.

[4] Muñoz M, et al. (2010). Matching social support to individual needs: A community-based intervention to improve HIV treatment adherence in a resource-poor setting. AIDS Behav 2011, 15:1454-1464.

[5] Holmes K & Winskell K. (2013). Understanding and mitigating HIV-related resource-based stigma in the era of antiretroviral therapy. AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV, 25:11, 1349-1355.

[6] The HIV treatment cascade is a model that outlines the stages of medical care for people living with HIV towards the goal of viral load suppression. More information can be found at https://www.aids.gov/federal-resources/policies/care-continuum/.

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FORTHCOMING RESEARCH & FURTHER READING

Outcomes from ongoing studies will further serve to expand the evidence base for linking savings to HIV care.

→ **Zambia:** The Futures Group, funded by PEPFAR, is conducting a three-year longitudinal, quasi-experimental study in Zambia with intervention and comparison groups. The study applies a multi-stage cluster sampling approach to compare 1,000 SGs with a control group in a neighboring community. The study will assess the impact of caregivers' participation in SGs on children's food security and examine how participation in SGs changes household decision-making dynamics, children's nutritional status, access to health and school services and household expenditures. The study results will identify effective approaches to implementing SG models, promoting economic security for OVC households, and improving children's access to health care, education and nutrition.

WHAT LIFT CAN DO

Given current changes in the global community's approach to achieving an AID-free generation, LIFT can work with current USAID Missions, US government agencies and host country governments or savings providers to:

→ Identify high volume clinics and work with community health workers to **link PLHIV systematically and confidentially to SGs** in their communities, providing a means for clients to save for costs associated with care and treatment or health emergencies and encouraging better adherence to ART;

→ Improve **geographic targeting** to support ART adherence by backing the formation of new SGs in communities that do not have these services readily available; and

→ Support host country governments to **promote more systemic interventions**, such as insurance and savings health accounts, that can help translate knowledge gains into behavior change.

The effects of SGs on HIV prevention: Not only do SGs improve the economic status of participants, but evidence shows that they also lead to increased use of contraception and increased empowerment of women. A study of the Intervention with Micro Finance for AIDS and Gender Equity (IMAGE) project in South Africa found a 55% reduction in self-reported physical or sexual intimate partner violence in women who received a combined microfinance and life skills training intervention.[7] SGs have also been used to deter sexual transmission. A study in Mongolia demonstrated that a matched savings program for asset building paired with financial literacy and small business development achieved a 36% sexual risk reduction in female sex workers over five years.[8] Findings are consistent with similar interventions in India and Kenya; however, unique to this study is that the outcome was achieved solely through savings.

The use of social funds to finance health expenditures: A randomized controlled trial examining SG programs in Ghana, Uganda and Malawi found that group insurance funds are used on an ongoing basis to finance health emergencies. In Ghana, 41% of the social funds were used for healthcare and 33% for funerals; in Malawi, 66% of funds were spent on healthcare and 25% on funerals; and in Uganda, social funds were primarily used for healthcare—and 18% of the SG loans were also used to pay for health-related expenses.[9] A study conducted under the Savings for Change program in Mali also found that payment of medical costs were not only part of social fund expenditures but also among the most common uses of the SG loan funds.[10]

Integrating SGs to improve food security: Data from a longitudinal study in Mozambique showed that SG involvement resulted in an additional 0.47 months of food sufficiency among participating households compared with matched controls.[11] Furthermore, participants that took part in SG+ showed even higher levels of food security than those that participated in SGs alone. While the findings illustrate the potential of SGs to improve food security, it is noted that additional interventions are needed to alleviate chronic nutritional challenges.

Evidence shows the prevailing trends in combining SGs with health and life skills and their potential as a collective intervention; however, significant gaps remain that limit our ability to draw specific conclusions about the associations between SG interventions and health outcomes. Moving forward, there is a need for continued investment in research that explores how and to what extent SGs can lead to improved health, particularly related to influencing behavioral changes that promote outcomes associated with HIV and AIDS care, treatment and adherence.

SUMMARY OF EXISTING PROMISING FINDINGS

STUDY	COUNTRY	RELEVANT OUTCOMES
Daigle et al. 2015	Cambodia	This observational study of PLHIV participation in ART programs found that receiving an SG loan was associated with on-time ART appointment attendance.
Muñoz et al. 2013	Peru	This study found that HIV+ adults enrolled in a program integrating ART, microfinance and psychosocial support had higher rates of ART adherence after two years.
Arrivillaga et al. 2013	Columbia	This study of an intervention combining microfinance, entrepreneurship and adherence for women living in poverty showed increased adherence to treatment over 12 months.
Witte et al. 2015	Mongolia	This study demonstrated a 36% HIV risk reduction in female sex workers achieved through a structural intervention focused on savings as alternatives to income from sex work over five years.
BARA & IPA 2013	Mali	This study of women participating in SGs found that health expenditures were among the most common use of loan funds after food and business activities.
Holmes & Winskell 2013	Côte d'Ivoire	Findings from this study of HIV+ SG participants suggest that increased economic independence has contributed to changing perception of PLHIV and reducing resource-based stigmatization as well as increasing access and adherence to ART.
Karlan et al. 2012	Ghana, Malawi, Uganda	This study found that social funds were being used on 40-60% of the time to finance emergency health expenses.

[7] Arrivillaga M & Salcedo JP (2014). A systematic review of microfinance-based interventions for HIV/AIDS prevention. AIDS Educ Prev, 26:1, 13-27.

[8] Witte S, et al. (2015). Efficacy of a savings-led microfinance intervention to reduce sexual risk for HIV among women engaged in sex work: a randomized clinical trial. American Journal of Public Health, 105:3, e95-102.

[9] Karlan D, et al. (2012). Impact assessment of savings groups: Findings from three randomized evaluations of CARE village savings and loan associations programs in Ghana, Malawi and Uganda. New Haven, CT: Innovations for Poverty Action (IPA).

[10] Bureau of Applied Research and Anthropology (BARA) of the University of Arizona and Innovations for Poverty Action (IPA). (2013). Final impact evaluation of the Savings for Change program in Mali, 2009- 2012.

[11] Brunie A, Fumagalli L, et al. (2014). Can village savings and loan groups be a potential tool in the malnutrition fight? Mixed method findings from Mozambique. Children and Youth Services Review 47 (2014), 113-120.

This publication is part of a practitioner oriented technical note series featuring economic strengthening interventions. It provides an overview of cash transfers and vouchers as consumption support in the household vulnerability continuum of provision-protection-promotion. Additional briefs address program elements, implementation and M&E. LIFT II matches beneficiaries with appropriate household economic strengthening (HES) activities based on three categories of vulnerability.