LEARNING BRIEF

Tangible benefits to child wellbeing seen among households participating in Savings and Internal Lending Communities (SILC)

Sustainable Mechanisms for Improving Livelihoods and Household Empowerment (SMILE) is a five-year (April 2013–December 2018) cooperative agreement between Catholic Relief Services (CRS) U.S. Agency for International Development (USAID). CRS Nigeria leads the SMILE consortium which includes ActionAid Nigeria and Westat. SMILE is designed to improve the wellbeing of 500,000 orphans and vulnerable children (OVC) and 125,000 caregivers in Benue, Kogi, Edo, and Nasarawa states and the Federal Capital Territory, Abuja. Household economic strengthening, HIV and health services, child protection, psychosocial support, and education are some of the core services delivered to targeted priority populations. Nearly 50 local civil society organizations received sub-grants to strengthen their technical capacity and to deliver high-quality services to OVC and their caregivers through trained community volunteers.

BACKGROUND

Although Nigeria has Africa’s largest economy, gross disparities in wealth distribution and access to basic services remain critical drivers of poverty. Nigeria has the second-largest population of poor worldwide, with 86 million people living under the international US$1.90-a-day poverty line. Poverty is a leading cause of child vulnerability, and many poor households are unable to meet the basic needs of children in their care. Exposure to shocks or unplanned expenses force caregivers to rely on negative coping mechanisms such as skipping meals, pulling children from school to earn income, transactional sex, or selling productive assets.

Nigeria also bears the burden of having the second largest number of people living with HIV in sub-Saharan Africa, with 2.9 million people infected. Of Nigeria’s 17.5 million vulnerable children, an estimated 7.3 million have lost one or both parents. An estimated 9% of all children are orphaned or vulnerable, and 95% of these receive no medical, psychosocial, material, or school-related assistance. Household poverty not only affects the wellbeing of children, but also increases their vulnerability to HIV.

To ensure vulnerable households have more reliable income sources to meet the basic needs of children in their care, SMILE employed multiple economic strengthening interventions including savings and internal lending communities (SILC); financial education; agribusiness, vocational, and apprenticeship training; agriculture value chain development; and linkages to public and private sector schemes. An examination of SMILE’s SILC strategy, described below, revealed a positive relationship between caregiver participation in SILC and their perceived ability to meet the basic needs of their children. Importantly, positive HIV-related outcomes were also demonstrated, especially around knowledge of child and caregiver HIV status.

SMILE’S SILC APPROACH

SILC is a grassroots, savings-led microfinance methodology that enables households to protect their assets, improve cash flow, and increase income. SILC groups are composed of 15–30 community members who self-select based on trustworthiness and commitment. Members
Analysis of the household survey and SenseMaker data demonstrated the positive association of SILC participation and three key areas: OVC school progression, caregivers’ perception of access to food, and caregivers’ knowledge of their own and their children’s HIV status.

1. Children of SILC participants were more likely to progress in school. SMILE survey data showed that, after controlling for demographic factors, the probability of progressing in school from one grade to the next was 13 percentage points greater for children whose caregivers participated in SILC relative to children with non-participating caregivers (Figure 1).

2. SILC caregivers perceived better access to food. From the SenseMaker analysis, more SILC participants (67%) perceived they were able to provide food to their families compared to non-SILC participants (30%, p=0.05). SILC members were more likely to indicate that they had access to food compared to caregivers who had not joined SILC (Figure 2).

3. Caregivers who participated in SILC were more likely to have tested for HIV in the past year. Multivariate analysis indicated that caregivers who participated in SILC in Benue and Nasarawa were 2.4 times more likely (95% CI: 1.42-4.03; p=0.001) to have tested for HIV in the past year and know their status compared to caregivers who did not participate in SILC. Analysis revealed that among OVC caregivers who participated in SILC and received an HIV testing referral, HIV testing in the past year was 35 percentage points greater than OVC caregivers who received neither service (Figure 3).

The same analysis revealed that SILC participation and a referral for HIV testing resulted in a 19-percentage point increase in HIV testing in the past 12 months compared to caregivers who simply received a referral. This finding demonstrates the potential reinforcing value of complementary activities that only a comprehensive OVC program can provide. Finally, far more SILC participants (85%) have ever tested for HIV and know their status than non-SILC participants (72%; p=0.001).

Membership in SILC was strongly associated with knowledge of children’s HIV status. The odds of knowing the child’s HIV status was 2.37 (p=0.001) times greater for beneficiaries participating in SILC vs. those who were not part of a SILC group. After adjusting for sociodemographic and other characteristics, the greatest benefit was derived by children whose caregivers both participated in SILC and received a referral. They showed a 33-percentage point increase in knowledge of their children’s HIV status compared to caregivers who received a referral only (Figure 4).

The study found that SILC participation led to improved school progression, better access to food, and increased knowledge of children’s HIV status. These findings highlight the potential of SILC as a comprehensive approach to support vulnerable children and their caregivers.
CONSIDERATIONS FOR FUTURE PROGRAMMING

The data presented above suggest that caregivers and their children may derive multiple benefits from SILC participation, including having access to resources to meet basic needs. Donors and implementers seeking to reduce child vulnerability should consider the following:

- Comprehensive OVC programs need access to adequate financial and human resources to support high-quality SILC programming.
- SILC programming is most effective when layered with child-focused interventions, enabling caregivers the benefits of increased knowledge and skill, confidence, social capital, and income. This compounding effect outperforms stand-alone interventions.
- Purposeful, structured collaboration and coordination between SILC FAs and OVC program CVs may improve access to SILC (and its benefits) for caregivers.
- Additional research is needed to better understand the linkages between SILC participation and uptake of HIV testing and services for caregivers and children.

CONCLUSION

SMILE recognizes that the cycle of poverty can be broken only by tackling the interrelated factors and circumstances that sustain it. The SMILE team acknowledges that simply providing access to savings and loans will not lift vulnerable families out of poverty unless the threats of illness, lack of education, and poor nutrition are addressed simultaneously. However, the results of SMILE’s SILC intervention underscored the direct relevance of a reliable savings and loans scheme and demonstrated its positive effect on caregivers’ perceived ability to meet their children’s basic needs. Furthermore, SMILE’s integrated, complementary activities may have mutually reinforcing effects, most notably on the strong uptake of HIV testing among caregivers (and their children) where participation in SILC reinforced and expanded the effect of the referral mechanism.

5 Drimie and M. Casale. 2009. Multiple stressors in Southern Africa: the link between HIV/AIDS, food insecurity, poverty and children’s vulnerability now and in the future. AIDS Care, 21: sup1, 28–33.
7 Multi-stage cluster sampling was used to select a representative sample of OVC and primary caregivers in each of the five SMILE states. This brief presents survey results of primary caregivers (n=1,170) and OVC (n=1,762) in Benue and Nasarawa states only.
8 Multivariate analysis adjusted for participation in health education activities, wealth quintile, state of residence, urban/rural residence, caregiver education level, caregiver HIV knowledge, and caregiver attitudes towards PLHIV.
9 Note that these results should be viewed in light of several limitations. Both the household survey and SenseMaker were cross-sectional, limiting our conclusions about the temporality of the relationships uncovered. Given that SMILE participants self-select into SILCs, we cannot definitively conclude that the associations between SILC participation and our outcomes of interest were not due to other unmeasured causes. Additionally, the data are based on self-report and subject to social desirability and recall biases.