LEARNING BRIEF

CATHOLIC RELIEF SERVICES

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

PHOTO FOR CRS BY LAURA POHL

Mlumun Shachia took out a SILC loan of N10,000 (about $23) to buy chicks, which she resold, earning her a profit of N8,000 (about $25).

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.[1] 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.[2] Of Nigeria's 17.5 million vulnerable children, an estimated 7.3 million have lost one or both parents.[3] An estimated 9% of all children are orphaned or vulnerable, and 95% of these receive no medical, psychosocial, material, or school-related assistance.[4] Household poverty not only affects the wellbeing of children, but also increases their vulnerability to HIV.[5]

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

pool their money into a fund, from which they can take out loans with a reasonable interest rate, throughout a pre-determined cycle (typically 8–12 months). At the end of the cycle, funds are re-distributed to members. This proven model[6] offers poor households opportunities to save within their own communities. Members share increased social capital as they engage in joint decision-making and action.

SMILE actively promoted uptake of SILC among caregivers by facilitating a working relationship between the 232 trained Field Agents (FAs) and its community volunteer (CV) cadre. FAs trained CVs on the SILC methodology. CVs then used their customary home visits to sensitize and encourage caregivers to join SILC groups, while providing other OVC services at the household level. These targeted, individualized household-level messages were reinforced during open mobilizations where FAs promoted SILC to the community at large. As SILC messaging included entire communities, vulnerable caregivers were able to join community-wide SILC groups and avoid the potential stigma of "SMILE-beneficiary-only" groups. FAs then provided training to each new group and supported them throughout their first cycle.

To better understand how SILC participation affected the ability of caregivers to meet the basic needs of their children, SMILE carried out a mixed-method study. A household survey was conducted among primary caregivers and OVC enrolled in the program.[7] Conventional survey data were enhanced by the introduction of the SenseMaker methodology to elicit the perceived effect of caregiver participation in SMILE on different domains of child wellbeing.. SenseMaker is a participatory data collection method designed to explore complex processes from multiple perspectives. Respondents reply to a prompt question and share an experience. SMILE beneficiaries were asked to describe a concrete example where their ability to care for the children in their homes in the past year was improved or worsened. Upon sharing this, respondents answered a series of questions providing additional meaning to their story. SenseMaker was applied to 475 caregivers in Benue and Nasarawa states.

THE BEST THING THAT HAPPENED TO ME IN THE LAST YEAR IS SILC

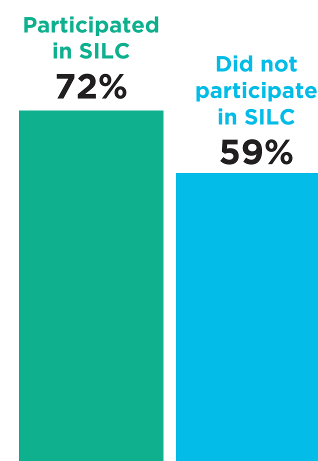
"THE INTRODUCTION OF SILC REALLY HELP [SIC] ME A LOT BECAUSE AS [A] MEMBER OF THE GROUP I CONTRIBUTED MONEY AND ALSO RECEIVED LOAN WHICH I USED TO START A SMALL BUSINESS WHICH IMPROVE MY FINANCIAL STATUS. WE WERE ABLE TO PAY OUR CHILDREN'S SCHOOL FEES FROM THE INCOME WE GENERATED." —FEMALE CAREGIVER, BENUE

RESULTS

Between August 2015 and September 2017, 1,148 SILC groups were formed, engaging 24,794 members (17,985 women and 6,809 men), which included SMILE beneficiaries and other members of the community. The groups accrued total assets of nearly N146 million (approximately US$406,000) by the end of September 2017. Nearly 20% of these groups have now graduated, shared out their savings and dividends, and continue to operate successfully without SMILE program support in subsequent savings cycles.

FIGURE 1

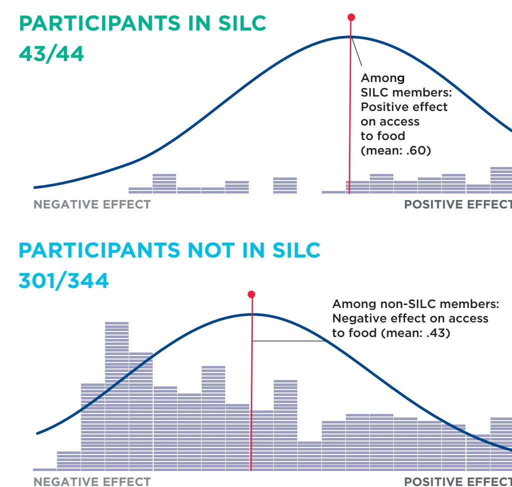
School advancement in children 10–17 by caregiver participation in SILC^



^Controlling for caregiver education, wealth quintile, State, area of residence, number of children in the household.

FIGURE 2

Access to food by SILC participation



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[8] indicated that OVC caregivers who participated in SILC in Benue and Nasarawa were 2.4 times more likely (95% CI: 1.42-4.03; $p<0.01$) 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 ($p<0.01$) times greater for beneficiaries participating in SILC vs. those who were not part of a SILC group. After adjusting for socio-demographic 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).

OUR ACHIEVEMENT

"I AND MY HUSBAND [SIC] ARE NOT AS HEALTHY PHYSICALLY, BUT WE DO FARM AND THE CHILDREN USED TO HELP US. THINGS CHANGED WHEN WE SOUGHT FOR LOAN FROM THE SILC GROUP AND WE GOT A GRINDING MACHINE, THIS GIVES THE MUCH NEEDED FINANCE TO TAKE CARE OF OUR CHILDREN'S NEEDS."

—FEMALE CAREGIVER, BENUE

FIGURE 3

Percentage of caregivers reporting past-12 month HIV testing by participation in SILC and receipt of HIV referral in Benue and Nasarawa states (n=711)

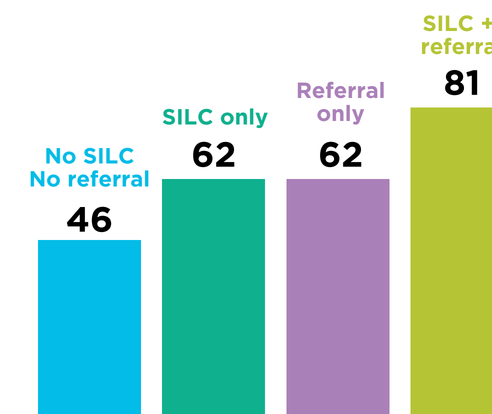
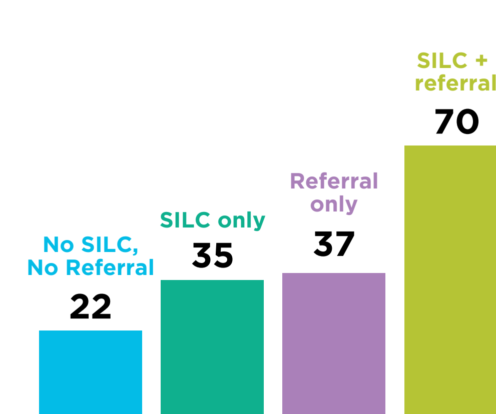


FIGURE 4

Percentage of caregivers who know their child's HIV status by participation in SILC and receipt of HIV referral in Benue and Nasarawa states (n=962)



*Controlled 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 and child sex.

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.[9] 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.

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1 World Bank. 2016. Poverty and Shared Prosperity 2016: Taking on Inequality. Washington, DC: World Bank. doi:10.1596/978-1-4648-0958-3.

2 UNAIDS. 2016. Country Fact Sheet, Nigeria. Retrieved on December 15, 2017 from http://www.unaids.org/en/regionscountries/countries/nigeria

3 National Agency for the Control of AIDS (NACA). 2014. Global AIDS Response Country Progress Report. Retrieved on November 28, 2017 from https://naca.gov.ng/nigeria-garpr-2014/

4 National Population Commission (NPC) Nigeria and ICF International. 2014. Nigeria Demographic and Health Survey 2013. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.

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.

6 CRS. Lives and Livelihoods: How savings groups transform lives. Retrieved on Nov. 21, 2017 from https://www.crs.org/our-work-overseas/program-areas/microfinance/silc-road/impact

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.

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