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Economic Strengthening Programs for HIV/AIDS-Affected Households: Evidence of Impact and Good Practice Guidelines

As responses to the HIV/AIDS epidemic have matured, and persons with HIV are able to live longer given proper care and treatment, greater attention is being paid to creating economic strengthening programs for affected communities and households. *Economic strengthening initiatives* are a portfolio of strategies and interventions that supply, protect, and/or grow physical, natural, financial, human, and social assets. They are an important component for policymaking that can enable HIV/AIDS-affected households to cope with the effects of the epidemic, and preserve viable livelihoods to sustain basic food, water, shelter, health, education, and social needs (Conway and Chambers in Allen 2005).

Donors and practitioners are implementing multisectoral programs that integrate health, economic strengthening, educational, and protective services. While financial and food assistance for HIV/AIDS-affected households has increasingly been integrated into local support for chronically ill and poor household members, there has been little systematic evaluation of these interventions. Thus, little is known about crosscutting interventions that combine health, economic development, and social protection. The kinds of programs that work best, for whom, and why is still largely unstudied. This primer, which draws on the report *Economic Strengthening Programs for HIV/AIDS Affected Communities: Evidence of Impact and Good Practice Guidelines* (Stene, et al. 2009), examines two key questions:

1. *To what extent are economic strengthening interventions improving the wellbeing (financial, nutritional, health status, school enrollment) of people living with and affected by HIV/AIDS?*
2. *How can programs measure and assess impact of these interventions on households?*

To answer these questions, we review evidence of the influence that economic strengthening programs have on communities affected by HIV/AIDS. We describe the economic approaches, and illustrate how such programs can help mitigate risk and benefit vulnerable groups. We offer recommendations to practitioners wishing to incorporate economic strengthening approaches to benefit the wellbeing of households affected by HIV/AIDS.

1. RESEARCH CHALLENGES AND METHODOLOGY

Despite the increasing integration of economic strengthening components into HIV/AIDS support programs, little or no empirical data on impact are available. With the exception of the more rigorously evaluated microfinance programs, the impact of enterprise development, market linkages, health education, and cash or food transfers on HIV/AIDS-affected households is not known.

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The multifaceted relationship between HIV/AIDS and the economic standing of a household make direction, impact, and causality difficult to isolate. This complexity is exacerbated by the fact that economic strengthening interventions often target entire households, while public health and clinical HIV/AIDS interventions target individuals.

To shed light on the relationship between economic strengthening programs and individual and household wellbeing, this study disaggregates economic strengthening impacts by six commonly cited variables: financial status, nutritional status, health outcomes, health spending, school enrollment/educational spending, and attitudes and knowledge about HIV/AIDS. The research methodology comprised two primary components:

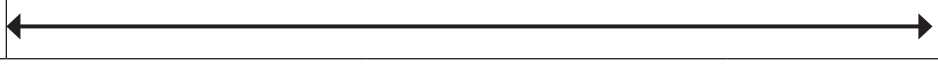
1. Desk-review of published literature and "gray" materials from donor agencies and partners working in the sector; and
2. Key informant telephone interviews with 24 representatives working across the sector from donor agencies, implementing organizations, field staff, independent consultants, and researchers. Although most interviews were done with head offices that have global field presence, informal interviews were also conducted in Ethiopia.

2. WHAT ARE THE TYPES OF ECONOMIC STRENGTHENING ACTIVITIES?

Experts in the field generally conclude that there is *a continuum of economic strengthening programs that includes three principal approaches: social assistance, asset growth and protection, and income growth.*

The range of economic strengthening approaches is amenable to meeting the dynamically changing needs of HIV/AIDS-affected households. Social assistance refers to safety-net-type programs (e.g., cash or food transfers). Asset-growth and protection services include savings and insurance. Income-generation initiatives work through mechanisms such as vocational training and microfinance, as well as linking clients to value-added opportunities identified by market research

Table 1. Continuum of Economic Strengthening Programs

Approach	Social Assistance *Supply relief assistance and support*	Asset Protection & Growth *Restore or maintain economic resources*	Income Generation *Strengthen or increase economic resources*
Services	• Asset and cash transfers • Food aid • Social pensions • Public works	• Group and individual savings • Insurance services • Legal services to protect vulnerable groups	• Business loans • Skills training • Income-generating activities • Market linkages
Focus	***Most vulnerable*** *Unable to engage in economic activity*	***Vulnerable*** *In transition. Generally need some assistance to avoid falling into most vulnerable group*	***Somewhat vulnerable*** *Stable but poor*
Illustrative Target Group	• Elderly caregivers • Poor women or widows • PLWHA at the symptomatic stages	• All caregivers (women, elderly, and poor households) • Youth • PLWHA	• Caregivers with productive capacity • Youth • PLWHA with productive capacity
			

Sources: Adapted from Donahue (2005); James-Wilson et al. (2008)

and analysis. The approaches are most effective when tailored to the level(s) of vulnerability of households and/or individuals in a specific target group. Needs therefore should be assessed, and matched to the approach that is most appropriate to the target group.

Factors leading to vulnerability and wellbeing vary widely by target group. The needs of people living with HIV/AIDS (PLWHA), for example, are very different from those of orphans and vulnerable children (OVC) left behind by the disease. In addition, vulnerabilities and productive capacity change over time, as household members care for the sick, invest in medical care, or regain productive capacity with improved access to essential medicines.

A combination of individual needs – including the household's ability to provide food, shelter, education, and other essential elements of life to its members – must therefore be taken into consideration when designing economic strengthening programs to support HIV/AIDS-affected households (Table 1).

Social Assistance Programs

Social assistance programs are intended to provide a first line of relief for households that are the *most vulnerable* (extremely poor households that are unable to engage in productive activity and that have no other source of viable revenue stream). This may include elderly caregivers, persons who are AIDS-symptomatic, or others whose time is consumed by caring for the ill or other dependents. Such programs typically consist of asset transfers by governments and/or donors, with *cash transfer programs that take into consideration local food prices* increasingly seen as the most effective means to offer subsistence to destitute households.

Cash transfers may be *conditional*, whereby beneficiaries are obligated to participate in training, education, or health services to qualify for the grant, or *unconditional*, where no obligations are put on the beneficiaries. That said, unconditional grants might be tied to voluntary, complementary services.

Asset Protection and Growth Programs

Asset protection and growth programs are generally aimed at the *very vulnerable;* those in transition who are either recovering or declining from an economic shock. Groups in this category include HIV/AIDS-affected households and may target caregivers, youth or the chronically ill who still have productivity capacity. These programs often comprise *savings and/or insurance schemes,* which are critical for families to cope with unexpected crisis (e.g., drought, crop failure, illness, or loss of household income earners) while continuing to afford essential goods and services over the long term. Legal protection and services for widows, children, and other groups subjected to discrimination or lack of access to credit and viable market opportunities also are included in this category.

Savings and insurance services can be both formal and informal. Each comes with different operational costs, reach, accessibility, and sustainability ramifications that should be considered during the program design. Commonly used savings and insurance services include:

- Group savings products, such as Accumulating Savings & Credit Associations (ASCAs)
- Individual savings products, such as Child Savings Accounts (CSAs)
- Microinsurance, which can target the poor, allows households to pool funds and plan for risks
- Commercial insurance products, which are starting to penetrate low-income markets by working through existing microfinance institutions or NGOs

It is worth noting that for *all poor households*, when available, savings and insurance services are an appropriate and necessary form of financial protection.

Income-Generation Programs

Income-generation programs work to bolster the productive capacity of *somewhat vulnerable* (those that are stable but financially poor) households, which may include caregivers, youth, and PLWHA with productive capacity. These programs are diverse in their objectives and approaches, and may include financial services, business loans, job training, and market linkage assistance. While these types of services generally require significant capacities, skills, and motivation by participants, they have the potential to build economic resilience to cope with crises and reduce risk over time. Some examples are:

- Small business loans
- Community-based savings and loan groups (including ASCAs)
- Regulated microfinance institutions
- Income-generating programs/loan services tied to vocational and skills training in a particular trade
- Technical assistance to identify income generation opportunities based on market analysis and research.

3. WHAT ARE THE IMPACTS OF ECONOMIC STRENGTHENING PROGRAMS? KEY FINDINGS BY ECONOMIC APPROACH

This review disaggregated the evidence of impact of economic strengthening programs on HIV/AIDS-affected households.

Social Assistance/Cash Transfer Schemes

Social assistance/cash transfer programs have a number of positive impacts on the wellbeing of HIV/AIDS-affected households, particularly on (i) improvements in food consumption, (ii) some reduction in child labor, and (iii) small increases in health expenditures. Among the poorest households, which may spend up to 80 percent of their income on food, nutritional status is among the first and most responsive indicators to cash transfers (Adato and Basset 2007). As Box 1 illustrates, the benefits of improved nutrition – which social assistance can foster – to HIV/AIDS prevention and care are multifaceted.

Box 1. Nutrition and HIV/AIDS

Improved nutrition is vital for preventing and managing illness. Improved nutrition can prevent infections that, in particular, leave women more vulnerable to HIV/AIDS infection. Nutrition is also vital to antiretroviral therapy (ART), as the drugs cannot work as effectively among the malnourished (Gillespie and Kadiyala 2005). Studies have also found that ART adherence and nutrition counseling services – critical to ensuring compliance with the drug regimen – can complement cash transfer interventions that reach significant numbers of families affected by HIV and AIDS. Though targeting by HIV/AIDS status is not advised, adding complementary economic services to HIV/AIDS treatment programs may be one way to discreetly reach PLWHA (Adato and Basset 2007; Schubert 2007).

Even small grants can lead to dramatic impacts on young children's nutritional status and cognitive growth and development. In Malawi and Zambia, grants of just US$10-13 per month to households raised reported satiation from 42.6 percent to 65.2 percent, and marked a 10.5 percent point reduction in being underweight among children under five.

Although cash transfers exhibit only a very small effect on school enrollment, they may have a larger effect on reducing absenteeism among children already enrolled. In the Zambia, Kalomo cash transfer program, reports from 2005 indicate that absenteeism decreased from 40 percent to 24 percent (Schubert 2005).

Based on experiences with programs piloted in Kalomo District, Zambia (1,000 households) and Mchinji, Malawi (3,000 households) (Box 2), social assistance/cash transfer programs can be large in scope, amenable to national scale-up, and integrated into poverty reduction programs. Cost and coverage estimates for national scale-up are:

- US$16 million to reach Zambia's 200,000 most destitute households.
- US$42 million to scale up Malawi's "Mchinji Cash Transfer Program" to the 250,000 most destitute households. This program would benefit more than 1 million people, including 650,000 OVCs.

Box 2. The Mchinji Pilot Social Cash Transfer Scheme

The Mchinji Pilot Social Cash Transfer Scheme in Malawi is an example of a cash transfer effort that has been designed to reach HIV/AIDS-affected families within a broader mandate of reaching the most vulnerable. Funded by UNICEF and the Global Fund to Fight AIDS, TB and Malaria, the scheme was launched in 2006 by the Malawian Government to reduce poverty and hunger in extremely poor households. Preliminary baseline data indicated that 70 percent of the households were HIV/AIDS affected, either having to care for OVCs or the chronically ill, or had had an AIDS-related death in the household (Schubert 2007).

The Scheme also set out to increase school attendance and improve the health, nutrition, and protection of OVCs. Under the program, households receive US$4-13 based on the number of persons in the household, with a bonus of between US$1.5 and US$3 offered for children who attend primary and secondary school, respectively. By 2007, the Scheme reached 3,000 households and had plans for scaling up to 28 districts and 250,000 households by 2015. At the one-year follow-up impact study, households reported that they had achieved significant increase in productive assets, necessities, and livestock. They also reported fewer missed meals, fewer days without adequate food, and greater food diversity. Households reported greater demand for health care and higher health care expenditures. Incidence of reported illness declined by 7.9 percent among adults and 10.9 percent per month among children.

The Scheme has also instituted linkages to early childhood development services for beneficiaries by working with community-based organizations and child protection workers, and it has instituted channels to provide home-based care to PLWHA, including ART adherence support, counseling, and psychosocial support (UNICEF 2007).

Asset Protection and Growth – Savings and Insurance Schemes

As with social assistance, there are few evaluations on how savings and insurance schemes directly affect vulnerability to HIV/AIDS. When available, evidence is generally correlative but not causal. Savings, for example, generally correlated with increased confidence, participation in social networks, and overall attitudes among those affected. Savings schemes appear able to produce dramatic self-reported nutritional gains, but less conclusive evidence in terms of health care expenditures. School enrollment among children in assisted houses grew a statistically significant, yet small 4 percent among boys, and improved attitudes about future schooling among OVCs.

Based on CARE's extensive experience with savings and loans schemes (having served over 1.9 million people), there is high demand among poor households for safe and flexible savings plans and particularly insurance products. The poor often first draw on their savings to cope with economic shocks, before selling off productive assets such as larger livestock or business capital (Donahue et al. 2001). Assessments performed on CARE's Village Savings and Loan (VS & L) schemes in Zimbabwe and Mozambique showed that women's participation resulted in increased ownership of assets and consumption of major food groups and use of health services among the household members. Evidence also showed increased stability to participant's businesses. Families caring for OVCs were also better able to cope after participating in the scheme.

An important finding that might influence policymakers designing economic strengthening programs is that savings and insurance schemes are frequently seen as less risky than microfinance/loan programs. This is often the case among young women, who may view the burden of borrowing and repaying loans as highly stressful (Cohen and Sebstad 2006). Thus, programs aimed at generating new, sustainable income streams among poor households may be more successful if they are structured toward savings/asset protection rather than taking on new financial obligations.

One challenge to consider in launching large-scale, formal savings schemes is the cost to managing them. For example, by one CARE estimate, it could cost US$500-1,000 per household to implement the program (vs. $60 for an informal, client-managed savings scheme that reached 50,000 in Zimbabwe in 2004). When savings schemes are scaled up, the cost of replication and client ability to self-manage the funds should be considered as key factors to sustainability and program replication.

Income-Generation Schemes – Microloans, Vocational Skills Building, Market Linkages, and Value Chain Programs

Within the income-generation domain, microfinance initiatives have the most established link with HIV/AIDS mitigation behaviors and attitudes, particularly among women (Kim et al. 2006). Market linkage and value chain programs have not been thoroughly evaluated for reducing HIV/AIDS risks and vulnerability, although vocational skill building has demonstrated some improved self-confidence. This is a particularly important finding for programs designed to reach young women and girls, who may not yet possess the skills and maturity to manage the stressors associated with loan management, repayment, or commitments to group lending schemes (Kim et al. 2008).

There are also a number of positive findings related to women's participation in microfinance programs with educational components, including improved food consumption, especially among OVCs living in the household.

- A microfinance program studied in South Africa (SHAZ), which included an educational component about empowerment and domestic violence, revealed that intimate partner violence declined by 55 percent (from 10 percent to 4.5 percent) among the 430 participants compared to matched controls (Kim et al. 2008).

Income generation and skill building have also been found to improve women's empowerment as demonstrated through improved self-confidence and authority to negotiate household decisions (Cheston and Kuhn 2002).

- One study found that adult female participants reported a 24 percent decrease in their levels of unprotected sex, which research attributes to increased confidence in negotiating safer sex practices. Moreover, other members of these women's households reported increased communication about HIV/AIDS and a 60 percent increase in voluntary counseling and testing for HIV (Simanowitz 2008).
- Health care utilization can also increase dramatically among households with a microfinance participant. In Project HOPE's microfinance programs in Mozambique and Namibia, for example, OVCs reported an increase in health care utilization from 39 percent to 94 percent during the last three times in which medical care was needed (Bronson 2008).

Moreover, one of the benefits of microfinance programs is that they can have a broad scope and lend themselves to scale-up.

- Project HOPE's microloan business program in Namibia and Mozambique reached households where 45,000 OVCs lived, improving their economic status and quality of life.
- Similarly, the Image Program – involving microfinance, gender, and health-related education – reached over 40,000 women in South Africa.

While there is much evidence suggesting that microfinance can lead to empowerment and reduced vulnerability, some studies have noted unintended negative consequences. These consequences are indirectly associated with microfinance initiatives, and more directly linked to perceived challenges to traditional gender norms (Jewkes 2002). Microfinance programs, and more broadly all economic strengthening programs, should be aware of this potential problem.

Furthermore, the cost of implementing microfinance schemes can be high due to the expensive nature of many small transactions and higher still if extensive educational and other supportive services are added. Thus, this study recommends that further research be done on ways to combine microfinance with existing health programs cost effectively. Often, it may be more cost and quality effective to establish cross-sector alliances to achieve these goals.

4. CROSSCUTTING RECOMMENDATIONS FOR IMPLEMENTING ECONOMIC STRENGTHENING PROGRAMS

Several key recommendations can be made for the implementation of future economic strengthening programs:[1]

1. Avoid targeting based on HIV/AIDS status because of the difficulty in *accurately* reaching affected families, *stigma* that such targeting may result in, and *equity concerns* with basing transfers on HIV-status alone rather than considering other types of vulnerabilities, such as old age, disabilities, or other illness (Adato and Basset 2007; Schubert 2007). Geographically targeting services in high HIV prevalence areas is one way of reaching the most vulnerable HIV/AIDS-affected households, without excluding the chronically ill, malnourished, and other vulnerable households. Blending services for HIV/AIDS patients can discreetly target PLWHA (Schubert 2007; Miller and Tsoka 2008).
2. Involve a variety of specialists from the initial phase of designing multisectoral programs to define an approach that reflects best practices in different sectors. Rather than directly providing loans, health sector initiatives should identify strong partners that have a core competency in financial service delivery. Be aware of partners' priorities and spend time defining mutual objectives, outcomes, and approaches before beginning implementation (Miller and Tsoka 2008).
3. Assess intrahousehold dynamics to ensure optimal use of benefits. Research suggests that interventions targeting women-headed households and elderly (generation-gap) households that are also labor and food constrained can have positive effects on children's nutrition, health care, and health status. Other intrahousehold dynamics and special needs (such as care for a chronically ill family member) may also affect how resources are spent within the household. Programs should assess impacts (in education, nutrition, and health care access) on the specific groups they wish to reach. Consider services that complement the economic intervention (such as transport vouchers to ensure medical care access) to maximize improvements on household wellbeing (Schubert 2005, 2007; Devereux et al. 2007; Booyson 2004; Case 2001; Case et al. 2005; Aguero et al. 2007; Samson et al. 2001).

   Implementers should be mindful of unintended consequences that may arise with economic strengthening approaches. Consider integrating local support systems with economic strengthening programs to help clients manage stressors associated with the program. These stressors may include changes in intrahousehold power dynamics, gender roles, or community and familial pressures on the beneficiary (Jewkes 2002, Cheston and Kuhn 2002).
4. Assess and design economic interventions that are appropriate to the household's skill level and productive capacity (cash transfer or savings programs may be more appropriate when skill level and productive capacity is limited). Consider opportunity costs to participants (e.g., transport, time away from work, the need to care for the chronically ill) when designing economic interventions that require significant inputs from participating clients (James-Wilson et al. 2008).
5. Link economic strengthening (particularly for the most vulnerable) to complementary services to ensure the effective use of resources. Access to support services

[1] For program-specific recommendations, see the full report (Stene et al. 2009).

including health care, counseling, and adherence to ART and other family welfare services are critical for all economically vulnerable families – especially those affected by the multiple impacts of HIV and AIDS. Economic programs that are conditional upon mandated services, however, should not be implemented unless access and supply of the given service are evaluated. Among PLWHA, ART adherence can complement cash transfer interventions that reach significant numbers of families affected by HIV and AIDS (Adato and Basset 2007; Schubert 2007).

6. Map existing economic strengthening programs to understand opportunities, gaps, and potential partnerships. Consider the existing safety nets available to vulnerable groups. Identify and build on economic interventions available to target households. This includes national-level social assistance programs to agencies involved in economic development work. This may reveal that beneficiaries of a health program are already participating – or eligible to participate – in a national cash transfer effort (James-Wilson et al. 2008). Errors of exclusion can be quite high among safety net programs, particularly when providers and/or households do not understand eligibility criteria and application procedures. An evaluation of disability grant coverage in South Africa found that only 20 percent of eligible HIV and AIDS affected, female-headed households received the cash transfers (Booyson, 2003). Awareness-raising, outreach and application assistance among targeted households may increase coverage among these vulnerable households.

7. Periodically re-evaluate clients' changing needs to ensure that the economic strengthening approach continues to be appropriate. As clients' financial and health situations improve, they may be able to graduate from one economic strengthening approach to another (Hashemi et al. 2006). If health or economic shocks mount however, shifts toward safety nets and supportive services may be necessary.

Programs should assess the environment of available programs, to foster linkages to the services available in a community. This requires building and maintaining partnerships from different sectors, which can draw on each other's core expertise and improve standards of professional practice (James-Wilson et al. 2008).

8. Ensure that implementing partners have the capacity to administer services regularly, reliably, and at a level sufficient to meet the essential needs of all household members. Generally, the size of the transfers has been found to correlate with the level of impact – though even small transfers have been shown to have strong impact (Devereux et al. 2005).

9. To increase the success of group savings and loan schemes, encourage participants' self-selection into solidarity savings groups. Participant-managed, informal savings schemes that allow members to establish their own lending terms can be much more cost effective to implement and replicate. Factors that boost repayment include no outside access to capital or donations, ensuring that loan earnings are kept within the savings group, and limiting loan use for productive and consumptive purposes. With more formal schemes, ensure that savings are kept in reliable institutions (ideally by regulated deposit-taking institutions) that can provide loan services to clients when sufficient capital has been saved (James-Wilson et al. 2008).

10. Ensure that insurers working in communities with a high prevalence of HIV and AIDS mitigate risk by expanding the size of risk pools to include different risk groups. Qualified insurers should use actuarial data to price their insurance products, and design benefit packages and levels of coverage based on willingness to pay. All group members within a certain parameter set by the village or town should buy coverage to prevent self-selection by the sick, aged, or other high-risk groups. Ensure that members are able to contribute a premium on a regular basis, and

encourage only institutions with the capacity to assess and manage risk to undertake insurance services (McCord 2007; Chandani 2008).

5. CONCLUSIONS

Families and communities affected by HIV/AIDS experience a complex and long-wave shock, often leading to devastating health, social, and economic consequences. The impact of health-centered HIV/AIDS programs can be expanded and sustained when coupled with economic strengthening interventions. A plethora of small- and larger-scale multisectoral initiatives are being tested to improve access to medical treatment and care *and* mitigate the financial impacts of the epidemic on vulnerable individuals and households. Though empirical evidence of impact is still limited, the available evidence points to positive correlations between participation in economic safety-net programs, savings facilities, and income-growth programs, with improvements in household welfare. Where programs have intentionally introduced education, social support, and confidence-building skills training, they exhibit some reduction in risk behaviors that can increase vulnerability to the HIV/AIDS transmission.

There is enormous need and potential to continue forging partnerships between health and economic strengthening programs to counter the sheer scale and impact of the HIV/AIDS epidemic. Health-focused programs should consider the broader safety nets of individuals deemed most vulnerable, such as caregivers in the households, extended families, and communities. Effective partnerships with economic strengthening programs will build on these existing safety nets to ensure that vulnerable livelihoods are protected over time.

Depending on their economic vulnerability, individuals and families can benefit from different economic strengthening programs. Households that are not able to engage in productive activities generally require relief or *social assistance* services such as cash transfers that provide for their basic needs around food, shelter, health, and education. *Asset protection and growth* services can help to stabilize families by preventing the loss of their asset base and provide the initial capital and business confidence to consider growing income. Activities that are centered on *income generation* can help to diversify the economic activities in which a family is involved and strengthen their longer-term resilience to crises. Programs should carefully match the capacities of different individuals and groups with the appropriate type of economic strengthening support; for instance, the elderly may require ongoing cash subsidies to care for children in the household, adolescents may require access to savings and vocational training services to build their financial base and confidence, and women may chose to access business loans to start a new enterprise.

It is essential that all multisectoral programs assess the local health and economic context, including services available from partner organizations and government. Practitioners should engage partners from different sectors at the program's conception stage to follow best practices of different professions and carefully design programs that match the needs of the clients with appropriate services. Given the need for further research and evidence of impact in this area – and the challenges in instituting monitoring and evaluation systems that capture outcomes and changes across sectors – it is critical to invest upfront in building integrated monitoring and research frameworks that draw on expertise from different disciplines.

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Banyan Global
Dillon, Allman and Partners, LLC
Family Health International
Forum One Communications
IntraHealth International
O'Hanlon Health Consulting
Population Services International
Tulane University School of Public Health and Tropical Medicine

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