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The Power of Financial Inclusion: Reporting on the Efficacy of Economic Strengthening Interventions in Sub-Saharan Africa

Fred M. Ssewamala, Ph.D., M.S.W.^{a,*}, Laura Gauer Bermudez, M.S.W., M.I.P.P.^{b,*}, and John Santelli, M.D., M.P.H.^c

^aWashington University in St. Louis, The George Warren Brown School of Social Work, St. Louis, Missouri

^bColumbia University School of Social Work, New York, New York

^cColumbia University, Mailman School of Public Health, Heilbrunn Department of Population & Family Health, New York, New York

Sub-Saharan Africa (SSA) is experiencing rapid economic development influenced by increasing access to technology and a profound economic resilience, despite often challenging conditions. As such, extreme poverty has declined significantly yet the absolute number of the region's poor is on the rise due to rapid population growth [1]. Financial hardship has consistently been associated with poor health outcomes, particularly for children and youth. The numbers of children and youth in SSA are surging, creating a demographic bulge and a challenge to multiple health and social systems. Indeed, while other regions of the globe have seen their youth populations stabilize, the number of youth aged 15–24 years is expected to continuously increase across Africa due to continued high fertility. The number of youth will more than double by 2055 and will contribute to Africa's increasing share of the global population, currently at 17%, to an estimated 26% in 2050 and as much as 40% in 2100 [2]. These trends underscore the rapidly changing nature of the global population, changes that can affect young people's health and well-being, particularly if poverty rates do not decrease. In 2014, the United Nations Children's Fund (UNICEF) estimated that 87 million children in low-resource contexts of SSA were experiencing at least four simultaneous deprivations, including lack of sanitation, poor vaccine coverage, contaminated water, and poor education quality [3].

At the same time, poverty affects the health of children and adolescents in less overt ways. Social exclusion, unemployment rates, and precarious education systems disproportionately affect those young people who continue to experience poverty. Likewise, poverty is often linked to gender discrimination, orphanhood, war, and forced migration. A lack of financial

* Address correspondence to: Laura Gauer Bermudez, M.S.W., M.I.P.P., and Fred M. Ssewamala, Ph.D., M.S.W. Columbia University School of Social Work, 1255 Amsterdam Ave, New York, NY 10027. lgb2123@columbia.edu (L.G. Bermudez); fms1@wustl.edu (F.M. Ssewamala).

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resources has also been associated with practices including child marriage, transactional or age disparate sex, and school separation, all of which put adolescent girls at risk of acquiring HIV [4–6]. Similarly, economic need is often cited as a primary driver of child labor, a practice that can have severe health and mental health implications for both boys and girls [7–9]. Furthermore, financial instability is often cited as the precipitating factor for caregivers placing children in child care institutions, the practice of which has been routinely associated with poor developmental outcomes for children as they age [10,11].

Adolescence is a unique period of change and development situated within a child's transition to adulthood. The physical and emotional changes can be difficult to navigate, even more so when families lack the financial means to meet their children's basic needs and young people themselves face multiple health and social disparities. Adolescence is also a critical time for determining the trajectories of young people. Left unaddressed, social and economic deprivations at the household and community level can perpetuate a cycle of intergenerational poverty, yielding negative repercussions for generations to come.

Within this frame, the second annual Global Perspectives on Adolescent Health and Economic Strengthening Conference, sponsored by the International Center for Child Health and Development (ICHAD), Columbia University Population Research Center, and Columbia University Mailman School of Public Health, Heilbrunn Department of Population and Family Health, was held at Columbia University's School of Social Work in May 2016, providing a forum for evidence sharing and dialogue on innovative economic strengthening research being carried out in SSA. The conference brought together academics, practitioners, donors, and private sector partners from the global North and global South to discuss the latest evidence in asset-based social protection interventions, methodological insights for researching adolescents, and consideration of special populations, such as migrant youth and children affected by HIV and AIDS. In this special issue of the *Journal of Adolescent Health*, we are honored to feature select manuscripts authored by our conference presenters and collaborators. These empirical papers, rigorously peer reviewed, examine the intersections between poverty and health outcomes for adolescents in SSA and provide recommendations on program design, costing, and methods for intervention research on economic strengthening moving forward.

In "Using a validated Child Depression Inventory to test the asset-effect hypothesis among Kenyan youth," Kagotho et al. [12] acknowledge the crucial need to understand the validity and cultural acceptability of mental health assessment tools in local contexts. To do so, they examine the psychometric properties of the 10-item Child Depression Inventory, a commonly used instrument to assess depression in children. The study employed a confirmatory factor analysis method to establish a reasonable depression measure. Using a latent construct method, this adapted eight-item instrument was then able to document a relationship between financial assets and mental health functioning among a sample of Kenyan youth involved in the YouthSave-Impact Study (N = 1,348). These findings support prior research in East Africa on the benefits of asset-building programs for adolescents and their subsequent positive effects on mental health functioning [13–15].

A limited body of research has documented the negative consequences of child labor on the physical, emotional, and mental health of children and adolescents. In this issue, Karimli et al. [16] have contributed, “Child labor as a risk factor for child health outcomes: Findings from an experimental study among ultra-poor households in Burkina Faso” which aims to add to this evidence base. The study employs a three-arm experimental design to examine: (1) the associations between child labor and health hazards and (2) the ability of a women-focused economic empowerment intervention (consisting of microsavings and seed grants) to reduce children’s exposures to health hazards. Overall, the study finds that at 12 months, children in the two treatment conditions: one focused exclusively on microsavings and seed grants and the second focused on microsavings, seed grants, and child protection awareness, report fewer superficial injuries or open wounds, dislocations, sprains, or strains, and less extreme fatigue, highlighting the potential for economic empowerment interventions, alone or as part of an integrated package of services, to reduce health hazards for working children [16].

Next, it is important to understand not only the effectiveness of economic strengthening interventions to improve health outcomes for young people but also their relative costs, information that is in high demand by local governments to determine feasibility of scale-up, often within significant budget constraints. In “Cost-effectiveness of a savings matched economic empowerment intervention for AIDS-affected adolescents in Uganda: Implications for scale-up in low resource communities,” Ssewamala et al. [17] employ a three-study arm cluster randomized clinical trial to examine the health and education outcomes associated with adolescent participation in a National Institute of Health–funded comprehensive economic intervention, Bridges to the Future. The primary features of this intervention were matched savings accounts, financial management training, and peer mentorship. The study is unique both for the dual examination of effectiveness and cost and for its sample population, adolescents who have lost one or both parents to AIDS (a particularly vulnerable group in the region). Adolescents in both treatment arms (receiving either a 1:1 or 1:2 match rate) demonstrated improved health, mental health, and education outcomes after 24 months, as compared with participants receiving usual care [17]. Furthermore, the cost component of the analyses found the higher match rate failed to yield outcomes that were significantly better than those obtained from the 1:1 rate, evidence of great utility to governments and other implementers interested in designing cost-effective asset-promotion interventions.

Finally, displaced populations face unique economic stressors due to a lack of access to livelihood opportunities and physical insecurity. Living arrangements can be temporary, and families are often uncertain as to how their basic needs will continue to be met on a day-to-day basis. In this issue, Stark et al. [18] present findings from the Creating Opportunities through Mentoring, Parental Involvement and Safe Spaces program, funded by the United Kingdom’s Department for International Development (DFID) and aimed at reducing the economic vulnerability of adolescent refugee girls residing in one of three project locations. The article, “Effects of a social empowerment intervention on economic vulnerability for adolescent refugee girls in Ethiopia,” acknowledges the ways in which economic need can drive health compromising practices, such as transactional sex, school separation (often leading to early marriage), and child labor. These behaviors can lead to complicated early pregnancies, sexually transmitted infections (including HIV), work-related injury and

illness, and poor mental health functioning. Thus, the authors argue that challenges to the health of displaced female adolescents can be viewed as partially rooted in economic deprivations. In an examination of the Creating Opportunities through Mentoring, Parental Involvement and Safe Spaces program's social empowerment intervention, which included mentor-facilitated curriculum on topics such as safety, healthy relationships, and financial planning for adolescents and their caregivers, the authors found that the economic vulnerability of participating adolescent girls remained unchanged after 10 months of program implementation [18]. Although more research is needed, this finding points to the potential limitations of awareness-raising and training programs to affect the economic drivers of health compromising behaviors for adolescent girls and reinforces the notion that such interventions are likely more effective if they offer tangible economic benefits such as access to capital or linkages to financial institutions.

Taken together, the articles featured in this special issue contribute to the growing evidence base on economic strengthening interventions for adolescents in SSA. It is our hope that researchers will continue to test the effects of economic interventions on health outcomes for young people and that this evidence is translated into policies and practices to improve health via poverty reduction strategies.

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