



ASPIRES EVIDENCE BRIEF SERIES: BUSINESS SKILLS AND ENTREPRENEURSHIP TRAINING AND HIV OUTCOMES

Introduction

Economic factors are linked to HIV risk behaviors, as well as outcomes, at every stage of the HIV care and treatment cascade. The ASPIRES project conducted an extensive review of the literature on these linkages to produce an evidence brief series highlighting how different household economic strengthening (HES) interventions may affect HIV prevention, testing, links to care, retention in care, and antiretroviral therapy (ART) adherence.

Business skills and entrepreneurship training is an economic strengthening approach that builds the skills of participants to start and run their own businesses. Evidence suggests that when combined with other health and/or economic strengthening (ES) interventions, entrepreneurship support may help improve HIV prevention, HIV testing and linkage to care, as well as adherence to anti-retroviral therapy (ART).

Briefs in the Series:

Unconditional cash transfers	Conditional cash transfers
Individual savings	Group savings
Financial education	Income generation
Vocational/technical training	Business skills & entrepreneurship
Employment support	

What do we know?

HIV PREVENTION AND RISK REDUCTION

ASPIRES identified nine articles - a few tied to the same study - that aimed to assess how interventions with business skills and/or entrepreneurship training components affected HIV prevention/risk reduction. The studies varied in terms of design quality and analytical rigor with four ranking high, one medium/high, three medium and the last low.

In Nairobi, Kenya, Erulkar and Chong [1] conducted a high-quality longitudinal study to assess changes in vulnerabilities and risk behaviors of 444 out-of-school adolescent females age 16–22, split between Tap and Reposition Youth (TRY) intervention participants and matched controls. The TRY intervention combined business management training with reproductive health, group savings, and individual microcredit. At program exit (after < 1 year to 3 years), 80.3% of the intervention group were able to refuse sex with their partner, compared to 71.6% of control group, which was a significant difference, though in both arms this was a decrease from baseline values. The intervention group was significantly more likely to insist on condom use compared to control (61.7% vs. 49.3%).

In Durban, South Africa, Jewkes et al [2] conducted a high-quality time-series proof-of-concept study to assess the effects on HIV risk, intimate partner violence (IPV), economic, and social outcomes of training 232 out-of-school youth aged 17-34 on HIV, gender equality, and violence prevention combined with employment or business development support. After 58 weeks, the experience of sexual IPV by females dropped significantly from 9.8% at baseline to 3.6%, though there was no change in self-reported perpetration of sexual IPV by male participants. There were positive but not statistically significant changes in condom use at last sex and engagement in transactional sex for females, but no change in these metrics for males.

In Ulaanbaatar, Mongolia, Witte et al [3] conducted a randomized controlled trial with 107 female sex workers (FSW) aged 18+. Sexual risk outcomes were compared for a group of these FSW who received HIV sexual risk reduction sessions (HIVSRR) alone and a group receiving HIVSRR plus financial education, a 2:1 matched savings account, and business development and mentorship support. After six months, the number of sexual partners was reduced for both groups, but the difference was 22% greater for those receiving the “plus” package. Although both groups reduced their number of unprotected sex acts, the difference was again greater for the plus package recipients - they were 3.72 times more likely to report not having unprotected sex with paying partners the prior 90 days.

In their 2016 article, Tsai et al [4] built upon Witte et al data from Mongolia by investigating violence (physical and/or sexual) that FSW experience from paying clients in the past 90 days between the HIVSRR and HIVSRR+ groups. No significant differences between groups were found for any violence from paying clients. In 2018, Tsai et al [5] conducted a high-quality feasibility study testing the efficacy of HIVSRR+ in reducing the sexual risk of women engaged in sex work. Results indicated that HIVSRR+ recipients were significantly more likely to report no income from sex work, compared to the HIVSRR group. Therefore, it is unsurprising that HIVSRR+ FSW were also significantly less likely to report sex work as their main income source.

In Nairobi, Kenya, Odek et al [6] conducted a medium-quality pre/post study with 227 adult FSW (no control) to assess if/how sexual risk behaviors were affected by adding group microcredit, business skills training, and savings promotion to an existing program of peer-mediated STI/HIV prevention and care education and condom promotion. After two years, the mean number of sex partners in the preceding week changed from 3.26 to 1.84, a significant difference. Condom use with casual sex partners remained high at both survey points (93.8% to 95.4%) while consistent condom use with regular partners increased significantly from 78.9% at baseline to 93.5% at end line. In addition, 45.4% of participants reported stopping sex work.

Goodman et al [7 and 8] implemented a medium-quality stratified-random, cross-sectional survey with households headed by vulnerable children and youth (aged 13 to 25) in Meru County, Kenya, to examine associations between sexual initiation, condom use and number of sex partners with participation in a three-year empowerment program that combined cash transfers, psychosocial support, health education and microenterprise development services. Program participants received vocational training, group income-generating activities (IGAs) and business start-up kits. They also received weekly group trainings on business, health, hygiene, and agriculture. Some received cash transfers. Differences between three cohorts (those involved for 4 months, over 1 year, and over 2 years) were examined. Female participants with longer exposure to the intervention were found to have fewer sex partners and greater condom

use at last sexual encounter, both significant findings. Among male participants there was no significant difference in number of sexual partners or condom use.

Dunbar et al [9] surveyed 50 adolescent, female, out-of-school orphans in Chitungwiza and Epworth, Zimbabwe, before and after the Shaping the Health of Adolescents in Zimbabwe (SHAZ!) pilot, which combined life skills education for HIV prevention, business training and mentoring, and access to microcredit. Results indicated no significant change in condom use. The study was unable to compare pre/post data for sexual violence and forced sex.

HIV TESTING (HTS) AND LINKAGE TO CARE

Two articles were found which looked at how enhancing business skills or entrepreneurship may affect HTS and linkage to care. The high-quality Jewkes et al study discussed above found that over the course of the intervention the proportion of male participants reporting HTS uptake increased, but there was no significant increase for female participants. Authors hypothesized that this result may stem from female HTS levels already being much higher than male, likely because antenatal HIV testing is common in South Africa.

In rural Malawi, Galvao [10] conducted a longitudinal, nonequivalent control group study with 600 intervention participants and 300 nonparticipants to evaluate the effects of a four-component intervention on health outcomes, including HIV vulnerability and HTS uptake. The intervention integrated HIV education and gender empowerment with provision of sustainable agriculture training, access to savings and lending groups, and support to local government structures. At 36 months, intervention participants were more likely than controls to report HTS uptake, leading to increased HIV case finding, both statistically significant findings.

RETENTION IN HIV CARE AND ADHERENCE TO ART

Four articles of varying quality were found which examined the relationship between retention in HIV care and adherence to ART and enhancing business skills or entrepreneurship. In southern Uganda (Rakai, Masaka, Kalungu & Lwengo districts) Bermudez et al [11] employed a high-quality two-arm, cluster-randomized trial to better understand the impact of an economic empowerment intervention on adolescent (n=702) adherence. Both control and treatment group received a bolstered standard of care, which included adherence sessions and support, but the treatment group also received a matched savings account package that included workshops on financial management and business development. Although viral load differences between the two groups existed at baseline, they were not statistically significant. However, differences found at 24-months were significant. Results suggest differential change over time across the two groups with intervention group participants improving.

In Ethiopia, Bezabih et al [12 and 13] used a medium-high quality cross-sectional design to compare PLHIV who did and did not participate in an ES component of the WFP Urban HIV/AIDS Nutrition and Food Security project. All ES participants received a series of business and financial management trainings and joined Village Saving and Loan Associations (VSLAs), which helped them to save, take loans and invest in different business activities. Weekly/bi-weekly VSLA meetings were used as discussion forums on topics such as business skills, ART adherence, positive living, and nutrition. ES participants were encouraged to start businesses as individuals or by organizing themselves into group businesses. Controlling for socioeconomic

and demographic variables, participation in ES activities significantly increased the odds of having good ART adherence by a factor of 2.4 and 5.6 (the two measures used were the Visual Analogue Scale and the AIDS Clinical Trials Group adherence baseline questionnaire, respectively).

In Cali, Colombia, Arrivillaga, Salcedo, and Pérez [14] conducted a medium-quality pre/post study (no control) with 48 literate, low-income, adult, female PLHIV who had been on ART for 6+ months to assess the effect of the IMEA intervention - microcredit and entrepreneurship training, microenterprise implementation support, and treatment adherence workshops - on health outcomes and business formation. After 15 months, IMEA participant ART adherence increased significantly, from 16.5% to 52.5%.

In Lundazi District, Zambia, Masa [15] conducted a medium-quality pre/post study with 101 economically poor adult PLHIV on ART to evaluate the effects of the Health and Wealth Program on food security and adherence. The program included cash, business training, access to individual savings, financial education, health training, and adherence counseling. A control group received adherence counseling only. After one year, when controlling for baseline adherence, program participants who received the broader package of support were more likely to report optimal adherence compared to control, but the result was not statistically significant.

What does this Mean?

In considering this evidence base, it is important to note that many of the studies identified and summarized in this brief compared a control group receiving only HIV-related services to a group receiving that standard of care plus an additional package of ES-focused support that included business skills and entrepreneurship training among other components. Because of this approach of offering several ES and/or social components together, it is not possible to determine the specific role such training alone played in achieving any positive results. The studies were not set up to differentiate attribution by program component. The current evidence base can only support business training as part of a multi-component package. Additional research to explore whether and how business training contributes to a multi-component economic strengthening package would be valuable to help determine if the cost of offering business skills training is justified by improved outcomes.

With these limitations in mind, most of the nine studies highlight clear, positive trends in HIV prevention on key topics such as condom use, IPV, and number of sexual partners. Positive results were also observed in a much more limited evidence base for HTS. The four studies looking at how multi-component packages containing entrepreneurship training affect PLHIV adherence all clearly demonstrate positive results. There were null results, but no negative ones. This appears to indicate that it is feasible to include business skills and entrepreneurship training in a comprehensive package of interventions intended to improve HIV outcomes. In many low-income contexts, such training is a logical intervention for implementers to incorporate when aiming to affect economic outcomes, as it should enable participants to better utilize existing or provided resources to stabilize or enhance their economic situation.

For more information on the studies included in this brief, reference the ASPIRES systematic review on ES interventions to address HIV outcomes [16-18].

Sources

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