Can Savings Groups Facilitate Poor Women’s Access to Health Services?
Lessons from the Chitral Child Survival Project, Pakistan

I. Introduction

Over the past decade, Savings Groups\(^1\) have spread rapidly, as a way to introduce basic financial services to the rural poor. Diverse development practitioners have also embraced Savings Groups as an effective platform from which to launch non-financial programs and services. Yet little documented experience is available to guide such integrated program design. While Savings Groups can increase program participation, efficiency and sustainability, these benefits are balanced by the risk of over-burdening groups, siphoning off their resources, and compromising a cornerstone of their success – their autonomy.

In northern Pakistan, the Chitral Child Survival Project (CCSP) offers lessons for the integration of Savings Groups and other services. Implemented by the Aga Khan Development Network (AKDN) from 2009 to 2013, and funded by USAID and the Aga Khan Foundation (AKF), the CCSP successfully integrated Savings Groups into a program designed to improve maternal and neo-natal health\(^2\). CCSP increased women’s access to and use of a neo-natal continuum of care, with trained community midwives (CMWs) as the focal point. The bulk of project resources were invested in enhancing MNCH services at the community level, with one exception: Savings Groups, known in the Aga Khan network as Community-based Savings Groups (CBSGs), were introduced to help families manage the costs of the newly deployed cadre of skilled community midwives. Although CBSGs were new to Pakistan, AKF has promoted them in six other countries.

This program was the object of multiple research studies and evaluations testing the hypothesis that CBSG membership positively affects access to maternal and neonatal care. Most relevant to this discussion is the Research and Advocacy Fund (RAF) study\(^3\) which included interviews with 908 women who had given birth in the month prior to the study. It found that women with a family member in a CBSG were four times as likely to use the entire “continuum of care” (ante-

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1 Savings Groups are community-based informal institutions, typically with 15 to 25 members who save regularly and use their pooled savings to make loans among themselves; they maintain a small “social fund” to help members in emergencies, and, once a year, return all the members’ savings, plus a share of any money the group has earned through interest on loans. Then, typically, the group starts another cycle.

2 The CCSP was jointly implemented by Aga Khan Health Service, Pakistan, Aga Khan Rural Support Programme/Pakistan, Aga Khan Foundation/Pakistan, and Aga Khan Foundation/USA.

3 Role of Community Based Savings Groups (CBSGs) in enabling greater utilization of Community Midwives in Chitral District of Pakistan, funded by DFID’s Maternal and Newborn Health Programme – Research and Advocacy Fund (RAF), and implemented by Aga Khan Foundation Pakistan. The principal investigator was Dr. Qayyum Noorani.
natal, delivery, and post-natal) as women with no family membership. Table 1 summarizes some notable results:

<table>
<thead>
<tr>
<th>CMW services accessed</th>
<th>CBSG members</th>
<th>Non-members</th>
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<tbody>
<tr>
<td>Ante natal care</td>
<td>61.0%</td>
<td>27.0%</td>
</tr>
<tr>
<td>Delivery</td>
<td>26.0%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Post natal care</td>
<td>55.0%</td>
<td>24.0%</td>
</tr>
<tr>
<td>Continuum of Care</td>
<td>12.9%</td>
<td>3.1%</td>
</tr>
</tbody>
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In addition, the study found that, after the final multivariable analysis, only two variables correlated with use of the complete continuum of care to the standard of 5% confidence: CBSG membership of someone in the family, and whether the pregnant woman’s mother-in-law was the principal decision-maker regarding health care options for her daughter-in-law.

This document attempts to unpack these results, to tell the story of the CCSP and how groups of 20-women saving their pennies together supported the use of skilled maternal and neonatal care, making real progress towards behaviour change that will save lives. What happened in poverty-striken Chitral holds some surprises; the results should inform and inspire.

II. Project Overview: Problem to be addressed and proposed solution

In the northwest corner district of Khyber Pakhtunkhwa (KP) Province of Pakistan, bordering Afghanistan, Chitral District has some of the highest levels of maternal and infant mortality and morbidity in the country. The vast majority of births occur at home without a skilled birth attendant. Restricted access to health services, lack of preparation for emergency deliveries, insufficient birth spacing and lower rates of immunization all increase vulnerability of expectant mothers and newborns.

In Chitral District, the landscape alone presents huge barriers to accessing health services of any kind. Residents struggle to survive in extremely rugged, mountainous terrain (peaks up to 23,000 feet) where their scattered villages are located in deep, isolated valleys. In winter some are cut off from the rest of the country for as long as six months. Travel costs to distant health facilities are a large expense for poor families. Indeed, the average health expenditure per person per visit is about $25, half of which is spent on transportation. Eighty-two percent of deliveries in Chitral take place at home as compared to the national average of 65%\(^4\), and only 20% are assisted by a skilled birth attendant\(^5\) (well below the MDG goal for 90% of deliveries by a skilled birth attendant by 2015). While a home delivery is certainly a financial choice, it is also linked to cultural preference for the supportive presence of other female members of the family, special traditional foods prepared for the new mother,

\(^{4}\) Pakistan Demographic and Health Survey, 2006-2007
visits of well-wishers after the birth and associated ceremonies, and the traditional practice of keeping the mother and new-born in the home for the first 40 days after delivery.

Access to health services and knowledge of appropriate health care practices are further limited by poverty and cultural restrictions on women’s mobility outside the home, as well as low levels of female education and literacy; only 41% of women in Chitral have any schooling and only 32% are literate.

These constraints informed the design of the Chitral Child Survival Project (CCSP). Conceived as a 4 year project (October 2009 – September 2013), CCSP’s goal was to reduce maternal and neonatal mortality and morbidity in the district of Chitral. Its objectives, paraphrased for simplicity, were:

1. To increase the availability of, and demand for, trained Community midwives, responding to local preference for home delivery with skilled birth attendants.
2. To increase awareness of obstetric and neonatal complications, and use of Birth Preparedness and Complications Readiness plans (BPCR)
3. To improve the enabling environment for MNCH, including strengthened CMW referral linkages for obstetric and neonatal services.
4. To reduce financial barriers to accessing obstetric and neonatal continuum of care.

To accomplish these objectives, the CCSP introduced multiple interventions, two of which of stand out as innovative and potentially worthy of replication: To respect, but significantly improve, home delivery, it put in place a cadre of trained Community Midwives (CMWs) who offer a comprehensive package of maternal and newborn services in the community. To ease financial barriers to accessing care, it created CBSGs.

AKF and its partners designed CCSP as a public/private partnership: The project supported the Government of Pakistan’s Community Midwifery Initiative aiming to deploy 10,000 trained midwives across the country by 2012. The Pakistan Nursing Council provided both the course curriculum and accreditation for candidates passing their exams. On the private side, CMWs deployed in Chitral benefit both by existing health facilities put in place by AKRSP and AKHS/P over their many years of engagement in the district and new resources introduced by CCSP.

**III. Project Design**

*Community Midwives*

To deploy 28 Community midwives in Chitral, CCSP developed a package of training and support services. It collaborated with the government to establish the first Midwifery School in Chitral, accredited by the Pakistan Nursing Council (PNC) in February 2010. The PNC’s standard 18-month curriculum was followed by 6 months of practical training during which time CMW
candidates rotated among secondary health facilities to which they would be referring patients once deployed. During this practicum, the CMWs gained other valuable skills, such as suturing, that enhanced the services they could provide to the community (and the income they could earn).

Newly trained, the CMWs were deployed in Chitral between July and September, 2011. Delays occurred in conservative communities where more effort and time was needed to convince village leaders to accept the project, which some perceived as a threat to traditional or religious values. CCSP supported the CMWs in several important ways:

- **Stipend:** For the first year of deployment, CMWs received a stipend of PRK 2000/month (about $22 in 2011); during that period, CMWs were expected to develop their business and replace the project provided stipend with user fees.

- **Delivery station and toolkit:** The project contributed $250 to construct a ‘delivery station’ for each CMW where she could see patients and conduct deliveries, and provided a toolkit containing an infant weighing scale, antibiotics, essential medicines, Ambu Bag, disposable gloves, gauze, BP apparatus, stethoscope, fetoscope, first aid kit, delivery bag, family planning supplies and cotton rolls.

- **Village Health Committee (VHC):** A VHC was formed in each cluster of villages to build a strong enabling environment for the CMW. Consisting of elders, religious leaders, and other key stakeholders (including members of the long-standing Women’s Organizations, achieving representation by older women, i.e. the mothers-in-law who are so key to household health spending), each VHC was empowered to set a fee structure for the CMW’s services (posted in her delivery

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**Box #1: Criteria for Community Midwives:**
- female
- age 18-35
- grade 10 education
- preferably married
- resident in the location from which she is applying
station), mobilize resources for emergency transportation to a health center\textsuperscript{6}, and conduct community health events. Its broader purpose is to ground these improved MNCH services in the community, and ensure they continue after the CCSP closes.

- **Behavior Change Communication (BCC):** CCSP used market research data to design educational materials that would address gaps in knowledge about good maternal, neonatal and child health practices. The project produced pictorial flipcharts and pamphlets covering danger signs of pregnancy, delivery, post-partum and newborn care and trained dozens of local change agents (CMWs, VHCs, traditional birth attendants, lady health workers and local organizations) to use them. These change agents conducted trainings and distributed materials at frequent BCC campaigns, health days, and educational sessions in CBSG meetings.

In addition to these CCSP-sponsored resources, the CMWs had the support of a range of government health workers who had various levels of training and skills (see Box #). Their contribution to project goals has been to participate in BCC training, encourage use of CMW services, and send all pregnant women they know in the community cluster to the CMW for pregnancy-related services.

### Project Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>June 2009:</td>
<td>CMWs begin training at the Chitral Midwifery School</td>
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<td>May 2009:</td>
<td>CBSG training</td>
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<td>March 2010:</td>
<td>First CBSGs formed in Chitral</td>
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<tr>
<td>2010:</td>
<td>VHCs organized in each village cluster</td>
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<tr>
<td>2011:</td>
<td>Change agents trained in BCC</td>
</tr>
<tr>
<td>June 2011:</td>
<td>170 CBSGs with 3,232 members enrolled</td>
</tr>
<tr>
<td>July-Sept 2011:</td>
<td>CMWs deployed</td>
</tr>
<tr>
<td>Sept. 2013:</td>
<td>421 CBSGs with 7,988 members</td>
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</table>

\textsuperscript{6} The project’s geographic area consists of all villages within a two-hour driving radius of any one of the three tertiary care facilities offering Comprehensive Emergency Obstetric and Neonatal Care to ensure realistic referral linkages for the CMWs. VHCs identified emergency transport options and negotiated prices in anticipation of emergencies.
Community Based Savings Groups (CBSGs)

Where 59% of the population is classified as poor or ultra-poor as in Chitral, cost of care will invariably be an obstacle to access. In addition to the high price of transportation when medical evacuation is needed, families may also have to pay provider’s fees, bed charges for inpatient stay, medicines and other supplies. And, while CCSP was putting the infrastructure in place to encourage safe, at-home deliveries, its community midwife model could only be sustained over the long term with user fees. While quite reasonable and significantly less expensive than a hospital, CMW fees are higher than the traditional birth attendants, presenting extra cost to the patient.

From the outset, CCSP intended to introduce a financing mechanism that could address this obstacle. However, the creation of CBSGs was not its original idea. Project planners initially considered Chitral-wide risk pooling to ease the financial burden on the families requiring expensive emergency obstetric and/or neonatal care. Essentially a non-regulated insurance scheme, the plan presented challenges of local acceptance, dubious prospects of full cost recovery, insufficient capitalization to ensure payment of all claims, and a cumbersome administration of many small payments. Encouraged by AKF, the project eventually opted for an approach that was largely unknown in Pakistan -- the creation of CBSGs. (Rippey, 2013).

While the CMW candidates were in training, the Aga Khan Foundation laid the groundwork for CBSGs. It recruited and trained two field supervisors and a cadre of 27 village agents. Following the standard Savings Group model, staff assumed responsibility for CBSG formation and training in group policies and procedures and supervised each group regularly for the duration of the first 12-month cycle of weekly saving and borrowing.

CCSP formed the first groups in March, 2010. It did encounter some resistance: husbands’ refused to allow their wives to leave the house to attend meetings, some women objected to interest payments, and some reported that they could not afford a weekly savings deposit. Nevertheless, by the time it had stopped forming new groups in September, 2013, 421 CBSGs counted a total of 7,988 members.

Project managers assumed that loans, savings, or social fund contributions from CBSGs would finance MNCH services. While this did occur, how and why the CBSG membership positively influenced accessing MNCH services is about much more than money.

IV. What Happened and Why?

What happened in Chitral as the two project innovations intersected happened quickly. The CMWs only started working in the field during the third quarter of 2011 (July – September), with just two years left in the project period. Thus the relationship being tested only had two years to

7 To learn more about the Savings Group model, visit http://www.akdn.org/akf_beyond_financial_services.asp for a short video of AKF’s support for CBSGs. See also Nelson, Candace ed.; Savings Groups at the Frontier (2012)
achieve results. As stated earlier, CBSG members used CMW services at much higher rates than non-members and were four times more likely to use the entire continuum of care. Notably, these findings were obtained from research carried out largely during 2012, hence during the first 18 months of CMW deployment. If the same study had been conducted one year later, staff contend that the results would have been even more dramatic.

The results achieved might seemingly be due to two factors: 1) the profile of CBSG members, who were younger, more educated and had fewer children than non-members, and 2) their access to financing from the group.

However, multivariate analysis carried out on the RAF survey results negates the first assumption:

“The association of study participants’ socio-demographic characteristics including age of the participant, level of education of couples, occupation of women, number of alive children and household size by continuum of care through CMWs were found to be insignificant”, (RAF, p. 53)

And, RAF study data indicate that the financial contribution of the CBSG has been less important to the decision to access care than anticipated. Among the respondents in the RAF study, one third were either members of a CBSG themselves or someone in their family was (most often a mother-in-law or sister-in-law). Of these, 15.5% took a loan from the CBSG for MNCH services during their most recent pregnancy, and, in many of those cases, CBSG funds covered only a small part of the MNCH expenses; the largest share was paid by family members. In short, while some CBSG members used money from their group to pay for some of their expenses, the small percentage who did so is less than the differential use of discrete MCH services between members and non-members.

If demographic profile and money do not fully explain the positive influence that CBSGs exerted on the decision to access care, what does? Evidence points to a set of intersecting factors: financing, social empowerment and access to information. As designed, the CBSGs and the CMWs would have a privileged relationship, each supporting the other. This relationship proved mutually beneficial in several ways.

**CBSG financial role**

In this very poor district, the rates of saving and borrowing within the CBSGs are the lowest of AKF supported CBSG programs in seven countries. That said, many members regularly saved the maximum allowed by group rules, often because they kept the share value low to be inclusive of poorer members. More importantly they borrowed for diverse purposes more frequently than they did to pay for MNCH care. Among RAF respondents who were CBSG members, either directly or through someone in their family, 25% borrowed for household and business needs as

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8 In September 2013, the average savings per member was reported to be Rs. 1,500 ($15.22); a common share value was Rs. 10 ($0.09). (Rippey 2013)
compared to 15% who borrowed to cover MNCH expenses. This pattern of borrowing highlights a very critical and creative tension that occurred among project partners about the purpose of CBSGs.

Despite the fact that all parties involved with CCSP were working towards a common goal and gave the same mutually reinforcing messages about joining CBSGs and using the CMW, two different views about the purpose of the CBSGs led to intense and prolonged dialogue. One side, represented by AKHS/P, argued that CBSGs should function as health savings groups, earmarking funds saved for members’ health expenses. This line of thinking supported the overall project goal to improve health outcomes by introducing a community financing scheme that could help pregnant women pay for the care they need. The original project proposal stated:

“The two key innovations—training and deploying CMWs and implementing a community financing initiative—address the primary barriers of accessing skilled care by 1) bringing the services to the home—which eliminates the need to travel to a facility and also reduces the costs to the family, and 2) providing some financial cover for maternity care for families who would otherwise not be able to pay for EmONC services”. (Proposal Narrative; p.1)

Integral to the project design, the CBSG was selected as the financial tool to facilitate payment of health expenses.

The other view of CBSGs, led by AKF USA and AKF Pakistan, reflected a core principle of the Savings Group model – namely that group members can save and borrow for whatever needs or goals each person might have. Central to the success of Savings Groups is their autonomy; members govern their groups and choose what to do with their money. Rules imposed by external agents undermine the ownership that drives members to make their group strong. It is assumed first that members will save more when they can save for their own priorities, and second, that rules which restrict members from using their own money for those priorities will be broken, openly or not.

Advocates for each point of view worked long and hard to resolve this key issue. In the end, they agreed to the ‘generic’ purpose of CBSGs while maintaining their role as a conduit for information about MNCH, and specifically, CMW services. As the project evolved, CBSG members saved as much as allowed by the guidelines they established (i.e. share value and maximum number of shares that can be purchased at one time). Although fewer than half the members were active borrowers, they borrowed for diverse purposes, including, but not limited to MNCH expenses.

Thus, there are two dimensions to the CBSGs’ financial contribution to accessing a continuum of MNCH care: access to funds to cover expenses and maintaining dynamic groups. That members determine how to use the CBSG to manage their household financial needs strengthens their
ownership of and commitment to the group. Strong groups are effective in other ways – specifically, in empowering members to make their own decisions and in serving as platforms for other, non-financial activities – in this case MNCH education. It is also probable that the newfound ability to save is, in itself, empowering; confidence in one’s ability to save and replace household resources expended may ease the decision to spend money on MNCH care.

Social Solidarity and Empowerment

In keeping with Saving Group experience globally, CBSG members experience development that is both financial and personal -- a mixture of the pride in their accomplishments, solidarity with their friends, and confidence that comes with success. There are many stories in Chitral about CBSG members encouraging each other to pursue diverse opportunities (although most reported incidents were not related to accessing or paying for CMW care). In addition to being member-run financial institutions, CBSGs are women’s groups with an internal social dynamic of mutual support, and a strong common desire to improve their lives. Seen in that light, the role of CBSGs in education and mutual support seems inevitable.

But perhaps more specific to Chitral is the nature of CBSG membership there and how it influences decisions about health expenditures. Membership is a family affair; older women often sent younger daughters or daughters in law to join and represent them in the group. And effectively, educational messages and information disseminated to group members reached their extended families, especially the all-important mother-in-law who is the household administrator and decision-maker regarding care for pregnant daughters-in-law. The remarkable extent to which the family as a whole is considered the group member in Pakistan can be useful in understanding the impact that CBSGs had promoting access to care. Again, the RAF study found that the presence of a mother-in-law in the household as decision-maker was one of two significant variable exerting influence on the decision to access CMW care. That decision-maker is influenced by the CBSG, whether she herself is a member or not.

Information Dissemination

From the outset, CBSGs were intended as a venue and dissemination channel for BCC. In the complex web of communication of health and saving messages that the CCSP used, CBSGs played one of the central roles both for members and non-members alike\(^9\). The CMW attended many CBSG meetings to educate members. The impact of using the CBSGs as a platform to deliver health information was much broader than educating members in attendance at the meeting; as previously noted, the CBSGs facilitated the sensitization of the older generation to the importance of safe delivery.

A Mutually Supportive Relationship

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\(^9\) By June 2011, midway through the project, 165 BCC sessions had been conducted in CBSGs, reaching 3,075 women
These intersecting dimensions of the CBSG/CMW relationship made it a privileged one that facilitated another aspect of the CMW’s job – to market her services. Under pressure to replace her first-year salary with fees-for-service, the CMW had to both educate families about MCNH and market herself. CBSGs served as an important marketing channel for her, and an easy one to use because she was already attending meetings in her role as educator. That the CMW targeted her marketing to CBSGs helps to explain how CBSG membership surfaced as a significant variable in the decision to use CMW services.

Early in their deployment, CMWs experienced uneven acceptance, especially among residents of conservative villages who were slow to shift from the TBA to the more skilled CMW. They were slower to accept the CMW’s scope of expertise and skills. As one woman reported, the CMW is ‘better than nothing’. In addition, villagers Chitrak did not commonly pay other villagers for services, and in some communities, particularly those where AKRH/P or the AKRSP had not been engaged previously, CMWs struggled early on to collect their fees.

Against this backdrop, the CBSGs were a logical target for the CMW. The CBSG members were a receptive audience, open to learning about how to care for themselves during pregnancy. By design, the CMWs and the CBSGs had a mutually beneficial relationship that advanced project goals.

<table>
<thead>
<tr>
<th>Table 2: CBSGs and CMWs Working Together</th>
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<tbody>
<tr>
<td><strong>Benefits to CMWs</strong></td>
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<tr>
<td>• Market services to group vs. going door to door in rugged terrain;</td>
</tr>
<tr>
<td>• Having received so much information about MCNH, members are receptive, easier to talk to, more aware;</td>
</tr>
<tr>
<td>• CBSG members are source of referral to new clients</td>
</tr>
<tr>
<td>• Members prepared to pay for services</td>
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### V. Lessons Learned

That Savings Groups can educate, embolden and empower women to access better health care is an appealing idea. Emergent experience is generating ample anecdotes from numerous
countries about the power of Savings Groups to improve women’s access to and use of other development services. However, in northern Pakistan, the Chitral Child Survival Project built an integrated program from the outset that now offers evidence-based results confirming these observations. The program holds lessons that can inform not only MCNH efforts, but any development intervention that seeks to integrate financial and non-financial services.

1. **Understand the value proposition of the ‘offer’ and plan the program components to deliver that value.** CCSP understood the cultural importance of home birth and set out to make improved, safe home delivery a key part of its overall strategy to lower maternal and neonatal mortality and morbidity. Its approach was comprehensive (i.e. CMWs were supported by community education, leadership and finance), and it invested in quality. High standards were applied to the training of both the CMWs and the CBSGs, and their introduction in the field followed best practice.

2. **Make sure that everyone within the organization conveys the same messages.** Those engaged in delivering each program service must both understand and support the other service(s). That the AKHSP and AKRSP staff delivered the same messages to groups was a significant achievement which required many meetings and ongoing discussion between both agencies. CCSP built a positive relationship between CMWs and the CBSGs that was based on mutual benefit and choice instead of coercion, making it easier for each to promote the other with confidence.

3. **Do not compromise the autonomy of the group by telling members what to save or borrow for.** Although CCSP was a health project, the CBSGs it leaves behind are quite strong and likely to persist because they follow a key Savings Group principle assuring member control over the use of their money.

4. **Understand that members’ collective savings engenders mutual accountability which is the glue holding a CBSG together.** The cohesiveness of CBSGs makes them an effective platform for education and fosters peer support and encouragement. In Chitral, researchers found that the CBSG provides (1) finance; (2) a platform for messaging; and (3) mutual support to try new things. These three elements, together and individually, reinforce the uptake of health services. A health program will find it useful to create Savings Groups even if finance is not an issue, since the SG will help both messaging and mutual support.

5. **Acknowledge that CBSG membership is a family membership.** The official group member represents others in her family. This is important for message delivery: the woman of childbearing age does not need to be officially in the group in order to receive relevant health information, or group funds to pay for health services.

The CCSP ended with the strong probability that most of the Savings Groups, and most of the CMW’s, would continue functioning past the end of the project. This is an impressive accomplishment in an area so remote, so poor, and in some areas, so conservative.