



# **THE ROLE OF FINANCIAL SERVICES IN THE ECONOMIC EMPOWERMENT OF AIDS-AFFECTED HOUSEHOLDS**

A REVIEW OF PRACTICE AND OPTIONS IN KENYA

A report on the role of financial services in the economic empowerment of AIDS-affected households

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For Financial Sector Deepening Kenya

**This report was commissioned by FSD Kenya. The findings, interpretations and conclusions are those of the authors and do not necessarily represent those of FSD Kenya, its Trustees and partner development agencies.**



The Kenya Financial Sector Deepening (FSD) programme was established in early 2005 to support the development of financial markets in Kenya as a means to stimulate wealth creation and reduce poverty. Working in partnership with the financial services industry, the programme's goal is to expand access to financial services among lower income households and smaller enterprises. It operates as an independent trust under the supervision of professional trustees, KPMG Kenya, with policy guidance from a Programme Investment Committee (PIC). In addition to the Government of Kenya, funders include the UK's Department for International Development (DFID), the World Bank, the Swedish International Development Agency (SIDA) and Agence Française de Développement (AFD).

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## Abbreviations

<b>AED</b>	Academy for Educational Development	<b>FFH</b>	Freedom From Hunger
<b>AIDS</b>	Acquired Immune Deficiency Syndrome	<b>FIELD</b>	Financial Integration, Economic Leveraging, Broad-Based Dissemination Support project
<b>AMAP</b>	Accelerated Micro-enterprise Advancement Programme	<b>FSD</b>	Financial Sector Deepening Programme
<b>AMREF</b>	African Medical Research Foundation	<b>GBCC</b>	Global Business Coalition on AIDS, Malaria and Tuberculosis
<b>APHIA</b>	AIDS, population and health integrated assistance	<b>GBV</b>	Gender-based Violence
<b>ART</b>	Anti-retroviral therapy	<b>GTZ</b>	German Agency for Technical Cooperation
<b>ASCA</b>	Accumulating savings and credit association	<b>HAI</b>	Health Alliance International
<b>BOM</b>	Banco Oportunidade de Moçambique	<b>HAART</b>	Highly Active Anti-retroviral Therapy
<b>CARD</b>	Center for Agriculture and Rural Development	<b>HIV</b>	Human Immunodeficiency Virus
<b>CBO</b>	Community-based Organisation	<b>IFC</b>	International Finance Corporation
<b>CIC</b>	Cooperative Insurance Corporation	<b>IGA</b>	Income-generating Activity
<b>COPE</b>	Community-Based Orphan Care Protection and Empowerment project	<b>IGVGD</b>	Income Generation for Vulnerable Groups Development programme
<b>CSR</b>	Corporate Social Responsibility	<b>IMAGE</b>	Intervention with Micro-finance for AIDS and Gender Equity project
<b>CT-OVC</b>	Cash Transfer Programme for Orphans and Vulnerable Children	<b>KAIS</b>	Kenya AIDS Indicator Survey
<b>DFID</b>	UK Department for International Development	<b>KAPB</b>	Knowledge, Attitudes, Perceptions and Behaviours Survey
<b>DTM</b>	Deposit Taking Micro-finance institution	<b>KDA</b>	K-REP Development Agency
<b>EMG</b>	Emerging Markets Group	<b>KDHS</b>	Kenya Demographic Household Survey
<b>FAHIDA</b>	Family Health Integrated Development Assistance	<b>KSh</b>	Kenyan shilling
<b>FAT</b>	Facing AIDS Together curriculum		

## Abbreviations

<b>MAHP</b>	Micro-finance and Health Protection Initiative
<b>MED</b>	Micro Enterprise Development
<b>MFI</b>	Micro Finance Institution
<b>MIA</b>	Micro Insurance Agency
<b>NACC</b>	National AIDS Control Council
<b>NASCOP</b>	National AIDS and Sexually Transmitted Diseases Control Programme
<b>NCCK</b>	National Council of Churches in Kenya
<b>NHIF</b>	National Hospital Insurance Fund
<b>OVC</b>	Orphans and Vulnerable Children
<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>PLWHA</b>	People Living With HIV/AIDS
<b>ROADS</b>	Regional Outreach Addressing AIDS through Development Strategies
<b>ROSCA</b>	Rotating Savings and Credit Association
<b>SACCO</b>	Savings and Credit Cooperative
<b>SMEP</b>	Small and Micro Enterprise Programme
<b>STI</b>	Sexually Transmitted Infection
<b>TTI</b>	Temporary and Total Incapacity
<b>UNICEF</b>	United Nations Children's Fund
<b>USAID</b>	United States Agency for International Development
<b>VCT</b>	Voluntary Counselling and Testing
<b>VSL</b>	Village Savings and Loan

## EXECUTIVE SUMMARY

Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) has had a profound impact on the economic livelihood strategies of households in Kenya, particularly poorer households. Although the AIDS prevalence rate has declined over recent years to 7.8 percent, from 10 percent in the mid-1990s, due to prevention and behaviour-change campaigns as well as mortality, an estimated 1.3 million people are still living with the disease, and approximately 1.1 million children have been orphaned because one or more parents died from it. Combined with the fact that close to half the population of Kenya lives at or below the poverty level, interventions that bolster safety nets are critical, particularly for the poor and those made economically vulnerable by AIDS.

Starting in the late 1990s, researchers began chronicling the ways in which people living with HIV/AIDS (PLWHA) and AIDS-affected households coped with the economic impact of increased health emergencies. Based on this research, economic development and health practitioners worked to develop strategies to mitigate that impact. Among these strategies were financial sector solutions, particularly for those institutions that serve people at and below the poverty level. Since the new millennium, financial service providers of all types have begun to take a more active role in the fight against HIV/AIDS, but their responses to the pandemic have varied depending on their client orientation and their business model.

Banks, particularly the larger, global banks, have addressed the ways in which HIV/AIDS has affected their staff (and thereby their bottom line) through the development of workplace programmes that protect their employees, but also through corporate social responsibility (CSR) initiatives that reach out to the community. Seeing AIDS' devastating impact on poor and vulnerable non-poor clients, micro-finance institutions (MFIs) have adjusted their operations, policies, and practices in the face of higher client dropout numbers, dissolution of loan groups, increased delinquency and default, and liquidation of savings. Indeed, MFIs' response has been the most multifaceted. It has included efforts to get prevention awareness information and training in the hands of clients; the development of new and modification of existing loan and savings products (including the terms and conditions surrounding loans and mandatory savings); and the adoption of credit life and health insurance products for PLWHA and those affected by HIV/AIDS. These interventions have been carried out through partnerships and stand-alone activities. More recently, health organisations that are focused on HIV/AIDS prevention, treatment, and care of PLWHA and orphans and vulnerable children (OVC) have focused more of their energy on the economic strengthening of these individuals and households who have become more vulnerable economically because of AIDS.

In Kenya today, a variety of activities are under way to address the economic and financial constraints felt by HIV/AIDS-affected households. Financial service providers and health organisations alike have spearheaded these activities, and are making small inroads in empowering people made more

vulnerable by HIV/AIDS. DAI assessed these initiatives for the Financial Sector Deepening (FSD) Programme Kenya in July 2008. FSD's interest is in identifying market-based initiatives that contribute to the prevention of HIV transmission and mitigate its economic impact.

This assessment report catalogues the variety of forward-thinking and emerging best practice interventions being implemented by financial service providers (including banks, MFIs, savings and credit cooperatives (SACCOs), payment companies, facilitators, network organisations, and insurance companies), health organisations, and donor and government social safety net programmes. The assessment also captures innovations taking place internationally and regionally that could inform and enhance future opportunities to support the AIDS-affected in Kenya. Finally, from the assessment and, in particular, from discussions with 69 individuals that are part of organisations working in Kenya, we have identified a set of opportunities in which investment could be made to meet the financing constraints of AIDS-affected households.

The following are areas in which significant impact on HIV/AIDS-affected communities could be achieved and where further support could be provided<sup>1</sup>:

- Support for the creation of workplace programmes for MFIs and SACCOs; Support for the development of affordable health insurance that allows broad access to health services and simplifies the payment or reimbursement of these costs;
- Support for the development of contractual child savings mechanisms that allow families and guardians to save for children - either for education (secondary or beyond) or for longer-term asset accumulation;
- Support for the development of agricultural loan products that allow households to invest in labour-saving types of agriculture;
- Support for the development of supplementary or consumer loan products that allow PLWHA to pay for transport and other non-treatment costs of getting treatment;
- Support for initiatives of the Government of Kenya/United Nations Children's Fund (UNICEF) OVC cash transfer programme that 1) either add on additional non-financial and financial services to bolster the skills and savings capacity of older youths who will graduate from the programme or 2) add in new payment options for paying out cash and extend access to the formal financial system to less-served communities;
- Support for financial education mechanisms that build greater financial literacy and address issues of concern to the AIDS-affected - namely,

<sup>1</sup> Note: Not all of these opportunities fit with FSD's overall strategy. These opportunities and options have been presented as areas of need. From this list, a more refined set of recommendations has been made to FSD for its internal engagement.

legacy planning, legal rights with respect to inheritance, joint title registration among spouses, and the rights of children; and

- Creation of an entity or initiative that brings together economic development actors (including financial service providers) with health organisations for regular discussions, information sharing, and partnership opportunities and that acts as a clearinghouse for innovations.

Supporting AIDS-affected communities with valued-added financial services that help them better mitigate the risks and constraints associated with AIDS is at the frontier of expanding service provision - a frontier that is not currently being reached by the market. Initiatives that seek to work at this frontier, and to bring the market there by making appropriate use of subsidies and investments, will have the greatest impact on reducing the long-term economic vulnerability caused by the AIDS pandemic.

## Chapter 1

# INTRODUCTION

HIV/AIDS has had a profound impact on the economic livelihood strategies of households in Kenya, particularly poorer households. From an epidemiological standpoint, the poor are no more vulnerable to contracting HIV than wealthier populations. However, their limited assets, lack of skills, and lack of social capital contribute to their increased risk behaviours for transmitting the virus and to their inability to economically cope with the disease in the short and medium term. Combined with the knowledge that of the 34.7 million Kenyans, an estimated 46 percent are living on less than a dollar per day<sup>2</sup>, and the economic reality of Kenya's AIDS-affected population is harsh. Although the AIDS prevalence rate has declined from 10 percent in the mid-1990s to 7.8 percent today, due to prevention and behaviour-change campaigns as well as mortality, an estimated 1.3 million people are still living with AIDS, and approximately 1.1 million children have lost one or more parents to the disease. Everyone is affected on some level.

Although the picture may seem bleak, over the past decade many national and international organisations have become actively involved in the fight against AIDS. Increasingly, these organisations are trying to address the issues surrounding the increased economic vulnerability of households and individuals affected by HIV/AIDS. In Kenya, since 2003 alone, approximately \$1.53 billion<sup>3</sup> has been provided by international donor organisations to slow the spread of AIDS, provide treatment to people living with HIV/AIDS for free or at a lower cost, and support the many households and individuals affected by the disease with health, social, economic and other interventions<sup>4</sup>.

In July 2008, the Kenya FSD Programme conducted a study to assess the prospects for and attempt to define a market-based approach to developing financial services in Kenya to contribute to the prevention of HIV transmission and to mitigate the economic impact of HIV/AIDS. Set up in early 2005 to support the development of financial markets in Kenya as a means to stimulate wealth creation and reduce poverty, the FSD Programme had previously not analysed the economic issues surrounding HIV/AIDS, although it had recognised the vast resources being provided to support HIV/AIDS-affected households, particularly those at or below the poverty line. For FSD to play a longer-term role in this arena, it would need to demonstrate the ability to have an impact at scale and be guided by strong evidence of what works in Kenya and has worked internationally.

As part of the assignment, FSD contracted a DAI researcher to interview a variety of organisations working directly or indirectly in financial services, with AIDS-affected populations, beneficiaries of social protection programmes,

other donor organisations, and insurance providers to get a full view of what is happening (and not happening) in this arena in Kenya and abroad. The researcher considered a variety of financial products and services that could be provided to people living with HIV/AIDS (PLWHA) and other AIDS-affected populations, and new programming areas that financial service providers and others could take on to fill some of the current gaps where services are not currently being provided.

A note on the limitations of this study. The first constraint is that of time; it was conducted in July 2008 during a three-week assignment to Kenya. The researcher focused primarily on financial service providers, including facilitators of informal savings and loan schemes, banks, MFIs, SACCOs and insurance companies, health and AIDS organisation that address economic strengthening and livelihoods as a component of a larger health or care and support programme, social protection programmes, donors supporting HIV/AIDS programming and, to a lesser extent, Kenyan governmental entities engaged in supporting programmes and organisations at this nexus. This report provides a sampling of what is happening in Kenya with respect to financial and other services provided to AIDS-affected – perhaps the tip of the iceberg – but it does not seek to capture everything.

The second constraint is that the study was designed to focus on financial sector solutions to the economic vulnerabilities of PLWHA, rather than across-the-board market development solutions, of which financial services would be one important component. However, at the conclusion of this assignment it is the belief of the author that support to PLWHA and AIDS-affected households will have the most impact when it provides comprehensive market support, ranging from integration of PLWHA/AIDS-affected into value chains to identifying potential financial products and services that better serve this niche. To the extent possible, I have included examples of Programmes that FSD and others could consider that put financial services in a context supporting broader market development and economic support efforts.

Also considered as part of the study are examples of successful financial institutions and HIV/AIDS support organisations' innovations in other countries and regions that have bridged this gap. These examples show how organisations have:

<sup>2</sup> Kenya Institute of Public Policy Analysis predicted rates 2005–2006.

<sup>3</sup> This includes more than \$1.3 from the US Government/President Emergency Plan for AIDS Relief (PEPFAR), £45 million (\$87.6 million at the current exchange rate) from DFID, \$70.8 million from the Global Fund and approximately \$70 million from various initiatives of the World Bank. Note: World Bank funding is disaggregated based on different time period, and thus is an approximation of what was spent during the period 2003–2008.

<sup>4</sup> The experience in Kenya mirrors what is happening globally. Bernstein and sessions of the Center for Global Development report that funding to combat HIV/AIDS in low- and middle-income countries has more than tripled since 2001, from \$2.1 billion to an estimated \$8.9 billion in 2006. In fact, globally the funding to combat HIV/AIDS in low- and middle-income countries has more than tripled since 2001, rising from \$2.1 billion to an estimated \$8.9 billion in 2006.

- Addressed HIV/AIDS depending on their orientation (with either a social/health or a risk management lens);
- Addressed AIDS workplace issues (such as absenteeism, increased health/benefit costs, and training costs) that affect both the staff and the bottom line by developing successful wellness programmes;
- Managed client constraints (such as increased delinquency in the repayment of loans or defaults, drop-outs, and changing product/service needs) by adopting new or modifying existing products or technologies and by listening more closely to their clients'/beneficiaries' needs;
- Taken advantage of opportunities for partnership and collaboration with other financial institutions and health and AIDS support organisations to better serve people made (more) vulnerable by AIDS and moved them to being more economically self-sufficient; and
- Targeted explicitly (or have not targeted at all) HIV/AIDS-affected populations, and what the impact has been on the organisations or their focus on commercial viability or long-term sustainability.

This document consists of four chapters. Chapter One gives an overview of the nexus between HIV/AIDS and financial services. Chapter Two provides some examples of successful and innovative or “emerging good practice” programmes from other AIDS-affected countries and regions that link financial services and HIV/AIDS. Chapter Three provides a snapshot of the activities, programmes, products and partnerships currently being offered and implemented for PLWHA and the AIDS-affected in Kenya. Finally, Chapter Four provides some recommendations and options for initiatives that could be undertaken to better serve this group.

Note: a list of acronyms and abbreviations has been provided in the front to deal with the “alphabet soup” that is made when you bring together health and financial service topics. Additionally, the end of this report contains a glossary of terms encompassing both technical topics.

## Chapter 2

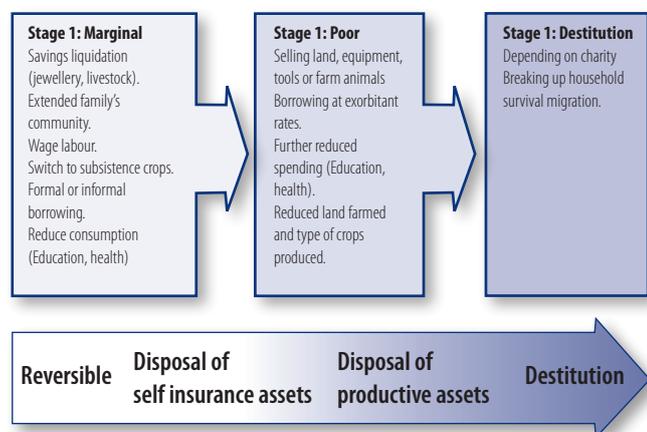
# THE NEXUS BETWEEN HIV/AIDS AND FINANCIAL SERVICES

Starting in the late 1990s, researchers began chronicling the way in which PLWHA and HIV/AIDS-affected households coped with the economic impact of increased health emergencies (see Figure 1). The patterns of household coping strategies were logical and followed a similar progression from country to country. Poorer households first reduced their spending, liquidated their savings, borrowed from family and friends, took on additional wage labour, switched to producing subsistence crops and, if they had access to finance, borrowed more from those sources. As the health crisis continued and as medical and nutritious food costs increased and productive members of the household grew sicker and needed hospitalisation, costs and pressure escalated. This meant that households sold off productive equipment and farm animals, borrowed from riskier sources (such as money-lenders), further reduced their engagement in business and in farming, and, as a last step, sold land. Some households fell into destitution, having to rely on charity for basic needs. In even more dire cases families were broken up, and children were given to whoever could care for them.

How HIV/AIDS-affected individuals and households fared economically depended on where they started before the infected individual contracted HIV/AIDS and succumbed to the illness. One factor was whether they had access to financial services, including micro-finance (see Figure 2). If a household was better off, the fall was not so far and the pressure not as great. If they had access to finance, social protection programmes (which are often outside the reach of the poor), or access to risk mitigation strategies such as insurance, they did not fall as far.

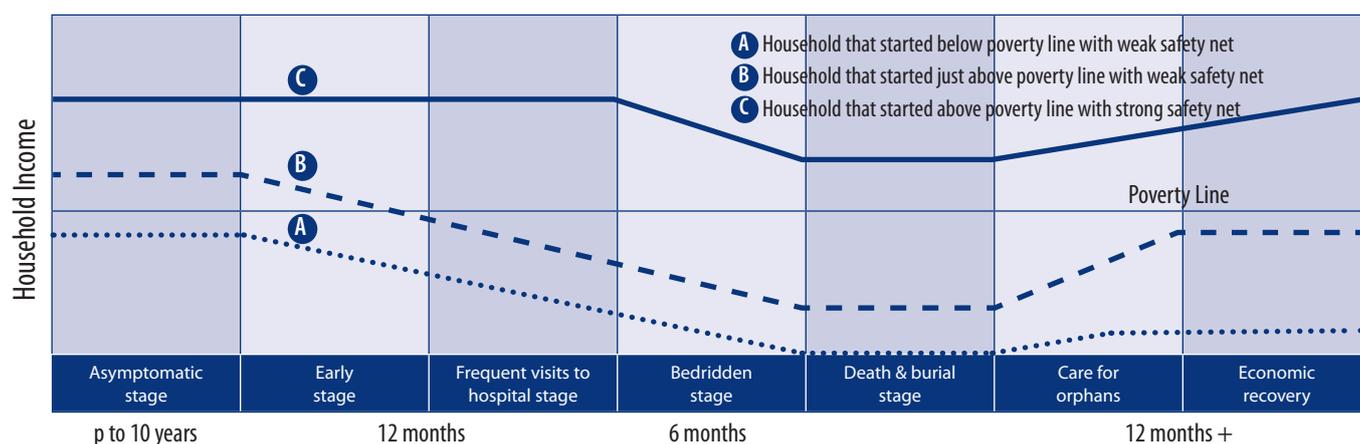
Financial service providers, both formal and informal, responded differently to the crisis. In 2000 and 2001 two studies highlighted the challenges of HIV/AIDS for financial service providers. The first, a UNAIDS study on the impact of HIV/AIDS on MFIs, highlighted some of the emerging strategies that MFIs were using to address the crisis both internally and on their clients. The second study, completed by MicroSave Africa, is titled HIV/AIDS: Responding to a Silent Economic Crisis Among Micro-finance Clients in Kenya and Uganda. It focused on the coping strategies of vulnerable households, but provided interesting insights into the impact of the pandemic on financial service providers and the opportunities facing them, reporting an increased reliance on informal strategies such as rotating savings and credit associations (ROSCAs) and accumulating savings and credit associations (ASCAs) to meet the needs of affected households. Both studies pointed to the need for financial service providers to refine products to make them more flexible for clients - for example, by allowing clients access to savings without incurring a penalty or having to drop out of the institution, allowing for "rests" between loan cycles, and allowing more flexible loan terms such as less frequent repayment periods. Both studies pointed to the need to adopt new financial products, including savings, insurance, emergency, and school-fee loans. Both also pointed to the need for linkages and partnerships with other financial and non-financial service providers that can provide health, prevention, and other services to clients affected by HIV/AIDS.

**Figure 1: How households cope with the economic shocks associated with AIDS**



Source: DAI

**Figure 2: Safety nets: Reducing the economic impact**



Adapted from Donahue, Jill, Kamau Kabbucho, and Sylvia Osinde. HIV/AIDS: Responding to a Silent Economic Crisis Among Micro-finance Clients in Kenya and Uganda. MicroSave Africa, September 2001.

More formal financial service providers, such as banks and insurance companies, the focus on HIV/AIDS has been from either a workplace or a corporate social responsibility standpoint. These are often medium-sized or large companies, employing hundreds or thousands of staff. They see the impact of AIDS on their bottom line through the increase of indirect costs associated with productivity drops or increased absenteeism or of direct costs such as health, funeral, and insurance costs<sup>5</sup>. They have also been encouraged by organisations such as the Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria (GBC) to take a more aggressive stance on HIV/AIDS and see value in increased corporate social responsibility programmes that target the HIV/AIDS-affected (and add brand value to the bank). Similarly, GBC has used the brand recognition of these large banks and their voice to influence others to address HIV/AIDS-related issues.

Among GBC's 200 members are close to 20 of the largest international banks, insurance companies and investment houses, which over the past seven years have become outspoken mouthpieces for action to address the three diseases, sharing knowledge gained on the front lines and harnessing the skills and expertise of their firms to fight the spread of these scourges. In general, financial service providers have not been as engaged in addressing the prevention of HIV/AIDS. While some have offered HIV/AIDS awareness information to clients (in partnership or on their own), they have been less engaged with the extended communities on this topic. Instead, many health and development organisations have begun initiatives around economic strengthening of HIV/AIDS-affected that address directly or indirectly prevention. Perhaps the most successful are those that address the risk factors that influence behaviour and shape risk environments and situations. These factors include<sup>6</sup>:

- **Asymmetrical sexual relations.** The chance of being exposed to the HIV virus increases when a small number of women have unprotected sex with a larger number of men, or visa versa. Epidemiological models have shown that this asymmetry has increased the spread of AIDS.
- **Movement.** The movement of people (for labour or other reasons) has contributed to the widening of the AIDS pandemic and rising infection rates in areas or among groups previously not affected.
- **Inequalities.** Social, economic and gender inequalities particularly around sexual relations and geographic disparities that affect decisions on movement, contribute to the risk of exposure to the HIV virus.

To the extent that service providers (financial, health or development) can address and mitigate against these factors, the more successful the organisation will be in preventing new HIV infections in the medium and long term.

## 2.1 THE ENGAGEMENT OF DONORS AND FUNDERS

Since the late 1990s, a few donor organisations and funders that support and invest in financial services/micro-finance and in health activities have begun to address the role and needs of their efforts within this nexus. These donors/funders include the U.S. Agency for International Development (USAID) and U.S. Department of State's President's Emergency Plan for AIDS Relief (PEPFAR), AfriCap, the International Finance Corporation (IFC), and to a lesser extent the German Agency for Technical Cooperation (GTZ), and the World Bank. Many of the others have been slower to engage. Some that have not been engaged may be too "siloed" in terms of their funding for financial sector development and health to address it. Others, particularly those that focus on financial sector development, are uncomfortable with targeting AIDS-affected individuals and households because they are risky, are seen as less credit-worthy or are considered best suited to be recipients of charity or beneficiaries of social protection programmes. Still others are uncomfortable with the topic of AIDS because it conjures up images of immoral behaviour that they believe should not be discussed in the workplace. Finally, other donors and funders see financial services as simply part of a larger array of economic strengthening and livelihoods tools that should be applied to this group, not a separate intervention.

### 2.1.1 Targeting HIV/AIDS-affected populations and the role of subsidy: Differing perspectives on financial services and health organisations

Irrespective of where one sits in this discussion, the issue of targeting and responding to the needs of PLWHA and HIV/AIDS-affected persons becomes tricky on many levels. First, despite the tendency to lump people together using terminology such as "PLWHA" or "AIDS-affected", this group is in no way homogeneous. It ranges from HIV-positive adults actively engaged in vibrant enterprises to young, orphaned children and their guardians/caregivers to disinherited widows to women who engage in transactional sex to support themselves and their families. The needs of these individuals for financial products and health and care services vary greatly.

Second, the way in which organisations refer to this group is different; health organisations refer to beneficiaries, financial service providers to clients. This distinction speaks to the lens through which the organisations view members of the target group; one as recipients of charity, the other as users of services.

Third, health organisations target individuals based on that person's health or vulnerability status in order to successfully distribute drugs, undertake clinical research, provide care or disseminate awareness and prevention information. Financial service providers, by contrast, target clients based on their ability to take up products and services; banks are interested in and comfortable targeting medium and large businesses and middle- and upper-income individuals because they can be assured low risk; commercially oriented MFIs

<sup>5</sup> This is especially true in southern Africa where prevalence rates are greater than 20 percent.

<sup>6</sup> These factors are discussed in detail in the IFPRI FCND Discussion Paper No. 157 HIV/AIDS, Food Security and Rural Livelihoods: Understanding and Responding by Michael Loevinsohn and Stuart Gillespie, September 2003.

**Table 1: Segmentation of AIDS-affected groups by service provider, risk and subsidy characteristics, and demand for products and services**

Target group	Risk characteristics	Subsidy characteristics	Demand for products and services
PLWHA as viewed by financial service providers	<ul style="list-style-type: none"> <li>▪ Diminished productivity</li> <li>▪ Un(der)employment</li> <li>▪ Loss of livelihood</li> <li>▪ Diversion of funds to health expenses</li> <li>▪ Potential for early mortality</li> <li>▪ But with greater access to ARTs, living longer and more productively</li> <li>▪ Viewed as highly risky, (though may not be if they have access to ARTs)</li> </ul>	Varies; those that explicitly target PLWHA provide loans at below-market interest rates (medium subsidy). Those that do not target PLWHA do not subsidise them	Savings, health insurance, life insurance, business/ agricultural loans, emergency/ medical savings
PLWHA as viewed by health organisations	<ul style="list-style-type: none"> <li>▪ HIV status may not be known</li> <li>▪ With status unknown, may continue to transmit disease</li> <li>▪ Undernourished</li> <li>▪ Limited or no access to or knowledge of good nutrition or ARTs</li> <li>▪ Unable to support self and household</li> <li>▪ High likelihood of depression and other psychological stress</li> <li>▪ Poor coping skills</li> <li>▪ Higher likelihood of alcohol/substance abuse</li> <li>▪ Increase in risk behaviours</li> <li>▪ Stigma and discrimination</li> </ul>	In general, high levels of subsidy to provide treatment, care and support services	Access to ARTs, voluntary counselling and testing (VCT), food/nutritional support, basic household commodities/ clothing, preventative health services, social support, income supplements, skills development and business training, legacy planning/ memory books, loans for income-generating activities (IGAs) at below-market interest rates, group savings
OVC (includes child-headed households, girls under age 14 and youths aged 14–18) as viewed by financial service providers	<ul style="list-style-type: none"> <li>▪ Underage; cannot enter into contractual relationships</li> <li>▪ Lack of skills/ business experience</li> <li>▪ May be considered high risk takers</li> <li>▪ High risk for loans; costly investment for savings</li> </ul>	<ul style="list-style-type: none"> <li>▪ Do not provide loans, so no subsidy</li> <li>▪ Costs associated with mobilising savings; low marginal cost</li> </ul>	Child savings for health/ education, long-term asset accumulation, health insurance
OVC (includes child-headed households, girls under age 14 and youths aged 14–18) as viewed by health organisations	<ul style="list-style-type: none"> <li>▪ Limited or no access to education due to gender</li> <li>▪ No or limited access to/use of healthcare, especially preventative healthcare</li> <li>▪ High likelihood of depression and other psychosocial stress related to loss of one or more parents</li> <li>▪ Increased risk of gender-based violence (GBV)</li> <li>▪ Stigma and discrimination</li> <li>▪ Higher likelihood of alcohol and substance abuse</li> <li>▪ May engage into commercial sex work to support self/other family members</li> <li>▪ Due to socio-economic status may be more prone to vulnerability and thereby infection</li> </ul>	In general, high levels of subsidy to provide treatment (if required), care, and support services	VCT and psychosocial support, access to ARTs if required, food/nutritional support, basic household commodities/clothing, preventative health services, pre-school fees, secondary school fees, school uniforms, life skills development, home health care capacity-building training, access to prevention activities
Widow(er)s (including disinherited) as viewed by financial services providers	<ul style="list-style-type: none"> <li>▪ May have limited business skills/business acumen</li> <li>▪ Assets may have been stripped at death of spouse</li> <li>▪ Viewed as medium to high risk</li> </ul>	In general, do not target; no subsidy	Savings, health Insurance, IGA loans, life insurance
Widow(er)s (including disinherited) as viewed by health organisations	<ul style="list-style-type: none"> <li>▪ May not have access to or knowledge of good nutrition or ARTs</li> <li>▪ May be unable to work to support self and household</li> <li>▪ May suffer from depression and other psychosocial stress</li> <li>▪ May be caring for multiple children/OVC</li> <li>▪ Limited time for livelihood because of need to care for OVC or sick household member</li> <li>▪ Higher likelihood of alcohol and substance abuse</li> </ul>	In general, medium to high levels of subsidy to provide treatment (if required), care, and support services	VCT and psychosocial support, access to ARTs if required, food/nutritional support, basic household commodities/clothing, preventative health services, pre-school or secondary school fees for OVC, linkages to AIDS support organisations, training in home-based health care, skills development and business training, empowerment training, informal group savings and loans for IGAs

Target group	Risk characteristics	Subsidy characteristics	Demand for products and services
Caregivers/volunteers/ community health workers/ mentors as viewed by financial service providers	<ul style="list-style-type: none"> <li>▪ Have limited time for livelihood because are caring for family member or other AIDS-affected persons</li> <li>▪ May have limited business skills/business acumen/business to invest in</li> <li>▪ Risk profile medium to high</li> </ul>	Varies; those that explicitly target this population provide loans at below-market interest rates (medium subsidy). Those that do not target, do not subsidise	Savings, health insurance, business loans, medical savings or IGA loans, life insurance
Caregivers/volunteers/ community health workers/ mentors as viewed by health organisations	<ul style="list-style-type: none"> <li>▪ Limited or no access to or knowledge of good nutrition or ARTs</li> <li>▪ May have limited business skills/business acumen</li> <li>▪ High likelihood of depression and other psychological stress</li> </ul>	Medium levels of subsidy depending on whether they are part of an affected household or working with additional households; controversy over stipends and other payments made to this group to take on additional care responsibilities	Training in good nutrition, provision of basic household commodities, access to preventative health services, skills development and business training, stipend/in-kind payment for volunteer work, informal group savings and loans for IGAs; sometimes cash or productive assets for start-up businesses
Commercial sex workers as viewed by financial service providers	<ul style="list-style-type: none"> <li>▪ Low skills/business acumen</li> <li>▪ May be viewed as immoral because economic view of household not known</li> <li>▪ Risk profile high</li> </ul>	Are not explicitly served, except in rare programmes that have largely failed	Savings, health insurance, IGA loans, life insurance
Commercial sex workers as viewed by health organisations	<ul style="list-style-type: none"> <li>▪ Maybe most economically vulnerable; willingness to trade sex for basic needs</li> <li>▪ HIV status may not be known</li> <li>▪ With status unknown, may continue to transmit disease</li> <li>▪ Undernourished</li> <li>▪ Limited or no access to or knowledge of good nutrition or ARTs</li> <li>▪ May be caring for OVC</li> <li>▪ May have limited business skills/business acumen</li> <li>▪ High likelihood of depression and other psychological stress</li> <li>▪ Increased incidence of GBV</li> <li>▪ Stigma and discrimination</li> <li>▪ Limited access to prevention programmes because of stigma</li> <li>▪ Higher likelihood of alcohol and substance abuse</li> </ul>	In general, high levels of subsidy to provide treatment (if required), care, and support services	Access to ARTs, VCT, food/nutritional support, basic household commodities/clothing, preventative health services including condom negotiation, skills development and business training, legacy planning, empowerment training, behavioural change, informal group savings and loans for IGAs; sometimes cash or productive assets for start-up businesses
Grandparents/elderly care- givers as viewed by financial service providers	<ul style="list-style-type: none"> <li>▪ May be beyond productive years/unable to engage in hard labour</li> <li>▪ Risk profile high</li> </ul>	No subsidy, are not targeted for services; some institutions exclude people over the age of retirement (60–65 years old)	Savings, IGA loans, life insurance
Grandparents/elderly care- givers as viewed by health organisations	<ul style="list-style-type: none"> <li>▪ May be caring for multiple children/OVC</li> <li>▪ Inability to care for self and OVC</li> <li>▪ May be beyond productive years/unable to engage in hard labour</li> <li>▪ Limited mobility</li> <li>▪ Increased prevalence of other ailments (hypertension, diabetes, etc.)</li> </ul>	Medium to high level of subsidy depending on the economic position of the household and the number of OVC being cared for	Food/nutritional support, basic household commodities/clothing, preventative health services, income supplements

target those individuals at or below the poverty line whose viable ongoing businesses can repay short- and medium-term loans; even socially oriented MFIs may often target women below the poverty line who have some capacity to make small payments toward a small, short-term loan. While institutional financial service providers target, they do not always target the most vulnerable.

Finally, even when health and financial service organisations share similar ideas about serving vulnerable clients or beneficiaries, they target them differently, think about subsidy differently and do not share the same views on sustainability. Financial institutions, particularly those that try to serve poorer markets, have long thought about the role of subsidy – when it is appropriate and for how long. In general, the industry belief is that some subsidy (or investment) is good so long as it leads to longer-term sustainability. Subsidy becomes the sunk cost incurred to achieve a larger purpose.

For health organisations, however, the role and use of subsidy is more opaque and its link to sustainability is perhaps more controversial. In some instances, a small upfront subsidy will yield larger cost savings over time. For example, incurring costs for prevention awareness to decrease the transmission of HIV limits the much larger costs that would be spent on treating people who do develop AIDS. But despite attempts to use subsidy to develop the private health care market, there is broad recognition that health is a public good and that in order to get broad access to it, service provision, particularly to lower-income groups, needs to be subsidised in order to reach everyone. Thus, private institutions are subsidised to deliver services that the state normally would deliver, and lower-income households get free access. With

HIV/AIDS, this issue of subsidy and sustainability has an added dimension at the international level. In the recent debate about PEPFAR reauthorisation, there has been a lot of controversy over the continued subsidisation of the delivery of anti-retroviral therapies (ART) to the third world, particularly sub-Saharan Africa. Once people are in treatment, there is a moral (not to mention public health) obligation to continue to treat. This added dimension further complicates the issues surrounding subsidy and sustainability.

In short, the issues do not go away. Donors/funders need to recognise where and how to subsidise, and what role the financial sector has in financing the challenges of the AIDS pandemic. Do you subsidise the buyer or do you subsidise the supplier? Should a financial institution deliver subsidised financial services to AIDS-affected households that might yield a positive economic rate of return (compared to financial) by reducing health costs in the future? What kinds of distortions would such subsidies, driven by health organisations, bring to the financial sector. While AIDS-affected households and individuals might be the new frontier of financial service provision, there may still be some upfront subsidy (investment) required to bring the market there.

Table 1 seeks to capture how both financial service providers and health organisations view various AIDS-affected/infected groups. It also suggests the types of services that are currently being provided or could be provided by each group, the level of subsidy involved, and where the intersection is. It is in this space that financial sector activities and products for PLWHA and the AIDS-affected can be jointly and individually undertaken.

## Chapter 3

# REVIEW OF INTERNATIONAL EVIDENCE

### 3.1 THE STATE OF THE FIELD

Since the 1990s, a broad array of organisations have been providing financial services and working with AIDS-affected communities. The next section provides an overview of the variety of HIV/AIDS and financial service interventions currently taking place in countries that are similar to Kenya in terms of their level of economic development, the pervasiveness of HIV/AIDS and other factors. These interventions and lessons provide insight into how to best incorporate HIV/AIDS strategies into financial sector support programmes or other types of programming. These examples do not attempt to catalogue all that is currently being undertaken there, but merely provide a sampling of innovations that are being piloted or integrated into day-to-day operations. It provides descriptions of the various programmes, their structure and activities and to some extent lessons learned. Many examples include one or more interventions that are important in reaching HIV/AIDS-affected populations. Broadly speaking these interventions have been characterized into the following categories:

**Prevention messaging:** Programmes adopted by financial service providers or others whose aim (primary or secondary) is to share information about the transmission and epidemiology of HIV/AIDS as a way to create awareness and educate people so that they will be galvanized to modify risky behaviours and prevent the spread of the virus. These messages may be presented in one-off training courses, in literature or other forms of communication or may be part of longer term, workplace programmes that address HIV/AIDS and other health issues.

**Workplace programmes: minimalist versus comprehensive:** Workplace wellness programmes offered by financial services providers that are a combination of educational, organisational, and environmental activities designed to support behaviour conducive to the health of employees in a business and their families. They consist of health education, screening, and interventions designed to change employees' behaviour in order to achieve better health and reduce the associated health risks. Minimalist programmes tend to only address HIV/AIDS, while comprehensive ones focus on a broad array of health issues, including but not limited to HIV/AIDS.

**CSR activities:** (Also called corporate responsibility, corporate citizenship, responsible business and corporate social opportunity). Programmes adopted by organisations that consider the interests of society by taking responsibility for the impact of their activities on clients, suppliers, employees, shareholders, communities and other stakeholders. This responsibility is seen to extend beyond the statutory obligation to comply with legislation but has organisations voluntarily taking on activities to improve the quality of life the local community and society at large, in this instance around the issue of HIV/AIDS.

**Training and tools:** Training courses and tools developed by or for financial service providers to increase their awareness of HIV/AIDS or change their own

business processes vis-à-vis HIV/AIDS, the AIDS-affected and the society at large.

**Financial products:** Loans, Savings, Insurance, and Training: Products offered by financial service providers that are tailored directly or indirectly to benefit HIV/AIDS infected or affected groups. These products include a variety of loans, savings and insurance products, as well as business training.

**Other non-financial services:** Services offered by financial service providers or others – either as a stand alone or in conjunction with financial services – that provide training or tools (business, HIV/AIDS awareness, other) to HIV/AIDS-affected populations and businesses.

**Partnerships:** Programmes undertaken in partnership with an AIDS or health service organisation to extend service provision beyond the core competencies of the financial service provider.

**Behaviour change:** Programmes or activities that seek to transform or modify individual, community and environmental influences on behaviour. In the context of HIV/AIDS, this refers to programmes that attempt to prevent new HIV/AIDS infections or re-infections, or to change hygiene and nutrition habits.

**Economic strengthening:** Programmes and activities that help families/caregivers and OVC meet expanding financial responsibilities to care for ill family members or additional OVC who join the household. (See page 25 for further description).

**Cash transfers:** Programmes aim to reduce poverty of AIDS-affected, such as OVC through the direct provision of cash to the beneficiary group.

**Cash transfers with add-ons/add-ins:** Cash transfer programmes that provide add on programmes to link beneficiaries to other market based services such as savings or micro-finance, or programmes that link beneficiaries to the financial system simply by the mechanism of payment (point of sale device, smart card or other mechanism). (See text box on page 28 for a more thorough discussion).

Table 2 at the end of this chapter provides a summary matrix of the different interventions by programme/organisation. Many organisations are achieving multiple goals or are undertaking multiple activities.

#### 3.1.1 Prevention messaging as part of financial service provision

Numerous non-health organisations have experimented with using different techniques to include messages of AIDS awareness and prevention in their day-to-day operations. A number of micro-finance organisations (either institutional providers or facilitators of informal savings and loans) use the

technique directly or indirectly as part of their approach to serving more vulnerable populations. In both examples provided below, AIDS awareness and prevention messaging is provided either to all clients as part of the package of financial and non-financial services received from the organisation or is provided opportunistically when group cohesion and trust is formed.

### **World Relief/Freedom from Hunger Facing AIDS Together curriculum, global**

In 2002 World Relief and Freedom from Hunger jointly produced the Facing AIDS Together (FAT): HIV/AIDS Prevention and Care training curriculum. The FAT curriculum is a group-based curriculum designed to raise awareness about HIV/AIDS. Designed with group-based lenders in mind, particularly those who ascribe to the credit plus approach, the curriculum walks individuals through basic concepts about HIV/AIDS, technical information regarding transmission and prevention; local statistics on AIDS prevalence; and how to communicate with family members (spouse and children) about AIDS. The curriculum is implemented in 12 half-hour sessions as part of a group loan meeting. The curriculum has been rolled out in many countries by World Relief, Freedom From Hunger, and World Vision, among others, and has been adapted for use by churches and for youth peer educators. Although the curriculum directly addresses the need to get more knowledge out to poorer, less educated audiences who may not have access to such information from other sources, adopting the curriculum has posed numerous challenges for implementing MFIs, including:

- The expulsion of good clients from groups because of their HIV status, due to the perception that HIV is a death sentence ;
- Increased job responsibilities for the loan officer, including the need to provide ongoing psychosocial support to HIV-positive clients, collecting repayments after offering the course, and social or cultural discomfort after presenting graphic information associated with the transmission of HIV, particularly to older clients;
- Limited ability of loan officers to communicate more sophisticated technical information about HIV/AIDS because they are not trained as health communicators; and
- A higher cost structure for the MFI to cover the education component.

### **CARE'S VSL programme, global**

Developed by Care International in Niger in 1991, the village savings and loan (VSL) model is a savings-based approach that has proven on a very large scale that it can substantially fill the gap where other institution-based financial service providers cannot. By intermediating small local pools of capital to satisfy household cash-management needs it provides immediately sustainable and profitable savings and credit services to people who live in places where banks and MFIs do not have a presence.

While the focus of the programme is ostensibly on savings and credit, the model is most powerful at getting people to think and be self-sufficient economically. Over the course of six meetings, groups learn to form their groups; define a purpose; elect officials; design their system of savings and credit, including policies and procedures; and practice running savings and credit meetings. Once this process is completed, groups can begin to save and to lend, supervised over a period of 9 to 12 months by Care field staff who ensure that the groups can function independently thereafter. Experience in Africa has shown that more than 95 percent of groups continue to operate independently once their formal relationship with Care has ended.

As the trust of group members of one another continues to build over time, so does their ability to break down barriers and talk about real issues. The feeling of “we’re investing together” brings the groups together and allows them to broach often-taboo issues even in mixed-gender groups. This trust has allowed individual members to disclose their HIV status to one another, discuss issues surrounding mother-to-child transmission of HIV, issues of inheritance and disinheritance, and children’s rights, among other taboo or mundane topics. Some groups use the forum to document family histories through the creation of “memory books” which can act as an informal will and communicate a dying parent’s wishes for his/her children. Care field staff can also use the forum to add in additional training on AIDS prevention and stigma reduction.

Care has used the VSL model worldwide, including in 16 countries in Africa, two in Latin America and two in Asia, with almost 1 million active participants worldwide at present. Other international organisations, such as PACT, Plan International and Catholic Relief Services, have adopted the model. Care has found that this model is particularly effective in reaching women who have been marginalised from mainstream society.

### **3.1.2 Workplace HIV/AIDS and wellness programmes**

According to the GBC, which is one of the biggest global organisations mobilising support from the international business community in the campaign against HIV/AIDS, banks in particular have taken a great interest in HIV/AIDS as a workplace issue<sup>7</sup>. A few of the top African banks and their approaches to workplace issues are highlighted here.

#### **Standard Chartered's global living with HIV programme**

Standard Chartered is among the global banks that has made an extraordinary commitment to HIV/AIDS. This commitment is evident in Standard Chartered's Living with HIV programme, a “global policy aimed at protecting basic human rights, promoting health of (its) employees and keeping the business costs associated with HIV/AIDS to a minimum”.

<sup>7</sup> Of the GBC's 200+ corporate members, 10 percent are banks, insurance companies and investment management firms

The programme has four focus areas:

- Raising awareness of its 70,000-plus employees through training;
- Educating the community about the prevention and treatment of HIV;
- Being a thought leader in HIV/AIDS; and
- Sharing knowledge with other organisations.

For its own workplace programme, Standard Chartered has put into place an employee peer education programme where employee peer educators, called HIV champions, conduct face-to-face HIV/AIDS awareness sessions. Employees volunteer to become champions and are trained on how to communicate effectively to other staff members. This training is adapted to fit the local cultural context and norms. Standard Chartered estimates that it has approximately one peer educator for each 150 employees, or close to 465 peer educators globally.

The Clinton Global Initiative has given the bank support to educate one million people about AIDS over the next three years. Standard Chartered seeks to reach these people by sharing with them their employee peer-educator model with businesses and organisations interested in partnership. It also has a free-of-charge e-learning module available on its website.

In partnership with the AIDS Business Coalition Tanzania, the bank is rolling out the “Living with HIV” programme to SMEs in Tanzania. Based on the experience, the bank will roll out an SME-focused workplace programme in other countries as well.

### **Standard Bank, South Africa**

Standard Bank, a South Africa-based financial services company, was recently honoured by the GBC for its integrated HIV/AIDS management programme that was rolled out in 2002. Under this programme, considered to be the most comprehensive in Africa, the bank regularly educates its staff about AIDS and provides needed services for treatment and care. The programme incorporates HIV/AIDS into its corporate wellness programme that reaches nearly 40,000 employees in 16 African countries. Standard Bank’s programme began with a Knowledge, Attitudes, Perceptions and Behaviours (KAPB) survey of employees. It then added AIDS to its Life-Threatening Diseases Policy, which focuses on protecting staff from discrimination and has trained managers and wellness champions (peer educators) in the banks on HIV/AIDS. Finally, the bank provides free access to a variety of AIDS-related health services including VCT in onsite clinics, subsidised special care programmes for HIV-positive employees, and ongoing education and awareness programmes. Standard Bank’s internal research suggests that keeping senior staff and management healthy is having a large positive impact on the bottom line, saving 300,000–750,000 rand annually (\$40,000–\$100,000). (Note: all dollar amounts are US dollars unless otherwise specified.) Its temporary and total incapacity (TTI) benefit enables individual employees to receive 75 percent of their salary

for up to 24 months for the time it takes them to recover; in 2007, almost a quarter of all TTI cases were HIV-related.

### **ABSA Group Limited, South Africa**

ABSA Group Limited, now majority-owned by Barclays, is one of South Africa’s largest financial service organisations, serving a range of personal and corporate clients. Under its fiduciary services arm, ABSA health care consultants provide a variety of services and tools related to company management of HIV/AIDS. These include:

- HIV/AIDS management solutions, which include helping employers develop their strategy and policy for addressing AIDS in the workplace, actuarial prevalence modelling, KABP surveys, HIV/AIDS education and awareness programmes, VCT, and services for HIV-positive employees to obtain access to care, advice, and treatment;
- Actuarial integrated information reports, which take company -level actuarial data and help the company understand the interaction between absenteeism rates, disability rates and usage of health and wellness benefits as a means to improve their health and wellness interventions and investment in these areas;
- Consulting services on medical schemes to allow employers to understand the specific legislative and policy changes that have taken place in the South African health insurance system; and
- Healthcare and corporate wellness strategy development.

### **IFC against AIDS: Workplace programming as a condition of investment**

The mission of IFC Against AIDS, an internal support programme, is to protect people and profitability by being a risk management partner, HIV/AIDS expert and catalyst for action in places where HIV/AIDS is threatening sustainable development. Approximately 80 percent of its work, however, is focused on IFC investments and getting investee companies to make a corporate commitment in the fight against AIDS. As of June 2008 IFC was working with 27 companies in Africa and six in India on HIV/AIDS-related projects that are linked to more than \$1.1 billion in investment and \$18 million in advisory services. For example, in August 2007 IFC rolled out plans to work with Blue Financial Services, a pan-African consumer finance provider, to implement a pilot HIV/AIDS awareness and prevention programme in Botswana, South Africa and Zambia.

The programme targets local communities and small companies, helping them protect businesses and preserve jobs by managing the business risks associated with AIDS. A similar programme has been rolled out with the K-REP Group in Kenya (see Chapter 3).

### 3.1.3 Tools and training for financial service providers

#### *AfriCap's partners in action*

In 2005 AfriCap Micro-finance Fund formed a working group on HIV/AIDS to identify key issues in MFI HIV/AIDS risk management. Made up of professionals from a variety of organisations, including MFIs, not-for-profits, donor and multilateral organisations, consulting firms, and insurers, the working group helped guide the completion of a risk management framework and set of tools for MFIs in countries with generalised AIDS epidemics. The guide *Partners in Action: Financial Institutions, Health, HIV and AIDS Risk Management* includes several tools to help MFIs with risk management and touches on medical, epidemiological, financing and insurance issues; cultural issues like stigma, workplace issues, and legal, political and policy issues.

The risk management guide is now available in an online format for reference at [www.micro-financerisk.org](http://www.micro-financerisk.org) and also refers the user to other existing resources, tools and expertise. So far, however, only Zambia has a comprehensive hyperlinked list of different resource organisations available for partnerships, including financial service providers (banks, MFIs, leasing and insurance companies), hospitals, hospices, health centres and clinics, other AIDS support organisations (including those that provide VCT, care and support, and services to OVC), governmental entities addressing AIDS, associations of PLWHA, donor-funded programmes and ecumenical groups. Additional resources are currently being sought from the Bill & Melinda Gates Foundation and other donors to support the development of other country-level resource and partnership pages.

#### *Defining options curriculum and assistance to Mozambican MFIs*

In 2000, DAI through the USAID-funded microenterprise best practices project developed a three-day training course<sup>8</sup> to help MFIs consider the bottom-line and institutional implications of HIV/AIDS. The course was designed to assist MFIs in developing strategies to adjust management and other internal systems, prepare staff, better understand their changing market and clientele base, and respond more effectively. Designed for managers and board members of MFIs, the *Micro-finance and HIV/AIDS: Defining Options for Strategic and Operational Change* course focuses on how MFIs in countries with medium to high HIV prevalence rates can effectively address challenges of working with HIV/AIDS-affected communities. The course promotes the formation of strategic alliances with local AIDS support organisations, monitoring the financial impact of HIV/AIDS on an MFI's portfolio, refining products to meet changing financial needs of clients, and changing workplace policies to address employee rights and benefits related to HIV/AIDS, as well as other staff employment issues. The training materials drew heavily from research

conducted by MicroSave, Family Health International, a UNAIDS study on the role of micro-finance in the fight against HIV/AIDS, and other best practice materials used in micro-finance.

The course was piloted in Harare, Zimbabwe, in October 2001 with a group of 40 MFIs. An updated version was rolled out between 2004 and 2005 (with funding from another USAID contract, Accelerated Microenterprise Advancement Programme [AMAP] Financial Services Knowledge Generation project) in Ethiopia, South Africa, Kenya, Rwanda and Mozambique. Local trainers and health educators were used to conduct the workshop and serve as resources to institutions seeking additional help in crafting HIV/AIDS strategies. To the extent possible, national-level micro-finance associations were used both to organise the training and to provide regular forums for discussion and work. Finally, DAI and ECIAfrica created a companion guide to the training course, *Micro-finance and HIV/AIDS: Tools for Making Institutional Changes in Response to HIV/AIDS* to help institutions implement activities.

The response to the course was generally positive at each of the trainings, but the longer-term outcomes were less impressive. Many MFI attendees simply did not have the time, expertise or funding to make many of the changes suggested in the curriculum. The response led DAI to sponsor a pilot initiative in Mozambique in collaboration with ECIAfrica and the Mozambican Micro-finance Facility managed by Mennonite Economic Development Associates (with funding from AMAP and CIDA). Under the initiative, seed funding was provided to four diverse MFIs that had attended the training, developed detailed action plans and sought assistance for tailored one-off AIDS-related activities. To these MFIs<sup>9</sup>, the consortium provided additional training and some limited technical assistance and funding. The pilot initiative was also crafted as a learning exercise where the MFIs met at the beginning and intermediate stages to share knowledge and ideas and at the end of the pilot presented to a larger group of stakeholders, including health organisations, governmental entities engaged in AIDS prevention, treatment and care, and other financial service providers. Among the lessons learned were:

- MFIs may require short-term technical assistance and funding to implement AIDS mitigation strategies. However, MFIs can accomplish sustainable results with minimal external support when channelled into well-designed mitigation activities.
- MFIs should seek to establish strategic partnerships with ASOs, government agencies, and other MFIs with mutually compatible goals and objectives. Such partnerships enable institutions to focus on their areas of expertise while allowing their clients to benefit from a complement of financial, social, and health services that help them deal with the effects of AIDS.

<sup>8</sup> The original course was three days. It has since been expanded to four to allow for institutions to develop actions plans within the training environment.

<sup>9</sup> The selected MFIs included a bank, a ROSCA facilitator, a women's cooperative and a small credit association.

- Donor and government funding is often “siloed” through programmatic channels that focus only on the health and social aspects of HIV/AIDS mitigation or on economic development. A more holistic approach to addressing HIV/AIDS mitigation will clear the way for more collaborative partnerships and funding that will enable institutions, including MFI, to address the social, health, and economic impacts of HIV/AIDS on affected communities<sup>10</sup>.

### 3.1.4 Product innovations

#### *Loans for women affected by AIDS: Trust banks*

Opportunity International (OI) has been one of the leading micro-finance networks to address HIV/AIDS. Since the late 1990s, OI has been piloting and innovating its product and service delivery to include prevention and awareness education and training for clients (see Banco Oportunidade de Moçambique), insurance provision (see Micro Insurance Agency) and in its trust bank model. Trust banks, a variation on village banking, are actively targeted at the most vulnerable populations, especially women made more vulnerable by HIV/AIDS. OI affiliates target help a variety of clients to form trust banks, including unemployed women (who can access loans instead of “bartering their bodies”), young girls, AIDS widows and the caregivers of OVC affected by HIV/AIDS. Trust banks are made up of 30–40 women who meet weekly to repay loans and accumulate savings.

#### *Micro-insurance and health coverage - Advances with respect to HIV/AIDS*

Managing AIDS-related health emergencies requires a variety of strategies and solutions. One product and risk management strategy that has been widely explored over the past ten years is the provision of micro-insurance to poor households. Micro-insurance encompasses a range of products, including life insurance (term life, funeral coverage and credit life), health insurance, agricultural insurance (crop or livestock) and property. Although the majority of the poor fall outside of traditional insurance and social protection (the coverage of health disability or unemployment by the State where it exists at all), a number of organisations have emerged that are focused on providing life, health and agricultural insurance, with life and health insurance increasingly covering HIV/AIDS and the opportunistic diseases associated with it.

For more than a decade, provision of life insurance, particularly funeral expense and credit life, have been widely available to lower-income households who are clients of micro-finance institutions or members of SACCOs. Both products have become part and parcel of the loan products offered by these institutions because in the case of credit life, they protect the institution as much as the borrower. More recently, studies have revealed the real need and demand for

health protection – ranging from minor or chronic illnesses to accidents – as households are crippled by out-of-pocket expenses. According to estimates by the WHO, World Bank and IMF, out-of-pocket spending accounts for 93 percent of private spending on health and more than 60 percent of total health spending in low-income countries. In sub-Saharan Africa, roughly half of all health spending is out of pocket<sup>11</sup>.

Micro-insurance is defined as the protection of the poor against specific risks in exchange for regular premium payments proportionate to the likelihood and cost of the risk involved.

Source: Churchill, “What is Insurance for the Poor?” in *Protecting the Poor: A Micro-insurance Compendium*, 2008

In the formal sector, comprehensive coverage for HIV/AIDS often comes at an added cost in insurance premiums, but covers counselling services, ARTs, regular CD4 counts and viral load testing, ongoing treatment of opportunistic infections and in-hospital care. Despite the high upfront costs, it is generally seen as more cost-effective to treat in the early phases of AIDS than to wait to pay for treatment of opportunistic infections and more frequent hospitalisation as the disease progresses; people who get access to treatment earlier on can manage it better, and thereby manage the costs.

A few organisations are starting to provide more comprehensive micro-health insurance coverage. In addition to working to get the cost of premiums down to a level that is affordable for the poor, they are working on more efficient back-office systems and on improving the quality of health services provided, particularly in rural areas. Others are adding on health services to the financial and non-financial services that they already provide.

#### *Micro-insurance agency*

A wholly owned subsidiary of Opportunity International, the Micro Insurance Agency (MIA) was launched in 2005 to provide a range of affordable insurance products tailored to the needs of the poor and with a specific focus on improving the service side to clients. MIA's products include credit life, term life, funeral, livestock, property, weather index and health insurance. None of its products exclude people from coverage due to their HIV status because the cost of monitoring and screening outweighs the benefits. Its focus on back-office systems has meant that MIA has been able to reduce claims payment times to less than a week (where traditional insurers can take up to six months), has implemented cashless systems for health insurance claims, and interceded on behalf of clients in life insurance claims, identifying other acceptable forms of verification where death certificates cannot be provided. MIA is expanding

<sup>10</sup> Since this time, PEPFAR in particular is funding more activities that cross both health and economic development.

<sup>11</sup> Gottret and Shreiber, World Bank, 2006. McCord and Noble, Micro-insurance Note #6: Health Insurance, USAID, June 2007.

its footprint rapidly due to funding from the Gates Foundation, has wholly owned subsidiaries in Uganda, Ghana and the Philippines, is working in seven additional countries, and is planning for two additional subsidiaries in 2008.

### **MicroCare Health Limited, Uganda**

In 2000 MicroCare, a not-for-profit organisation, was created out of a Community Health Financing Micro-insurance Initiative in Uganda and has grown to become Uganda's largest provider of group health insurance, serving both the formal and informal sector in rural and urban areas. MicroCare provides health coverage to many people excluded from existing schemes and covers a wide range of health services, including treatment for HIV/AIDS (added in 2005) and malaria, water-borne diseases, and maternal-child health. In 2007 it became the main Ugandan insurer to more than 85,000 clients (primarily sourced through MFIs) and its network covers more than 170 approved clinics and hospitals in most Ugandan districts. It now has the commanding position in the market, with annual revenues in 2007 topping 2.9 billion Ugandan shillings (\$1.6 million), up 121 percent from the previous year.

Part of its success has been its ability to manage costs using real-time monitoring of receipts and expenditures and its ability to reduce fraud by putting into place electronic fingerprint recognition systems and smart cards that carry the photo of the client and up to 10 dependents. Policyholders are covered for outpatient treatment, for which they do not have to pay high user fees, and as a result they seek earlier treatment for health problems. They also do not need to self-medicate, risking drug complications or interference (in the case of HIV-positive users) nor waste resources on ineffective treatments. Finally, with access to so many clinics and hospitals, users do not need to waste time procuring health services. MicroCare's development strategy has favoured community dialogues, as each scheme is negotiated at the local level.

Although initially donor supported, MicroCare has been operating with minimal donor funding since 2006. In 2008 MicroCare will launch in Zambia and has plans to expand into other East African countries.

### **Rwandan mutuelles**

Community-based health mutuals (mutuelles de la santé) have been rolled out nationwide in Rwanda, using a national solidarity funding structure where public and donor funds are channelled to the district level to supplement local pools of household contributions. An estimated 70 percent of the population, including vulnerable groups, receives health coverage through the system including care and provision of ARTs. Preliminary assessment results suggest that the inclusion of PLWHA within the schemes has resulted in only limited incremental costs as long as ARTs continue to be provided or paid for by donor funds. The issues that remain to be addressed are whether users of the mutuelle are truly getting access to high-quality health services.

### **The Health Insurance Fund and Hygeia Nigeria Ltd.**

The aim of the Health Insurance fund, incorporated in the Netherlands in 2005, is to make general health and HIV/AIDS insurance available to currently uninsured people in Africa by using and upgrading the existing private healthcare infrastructure working in conjunction with the public sector. While access is the main focus of the fund, it recognises that it must also make significant investment in healthcare delivery infrastructure and improve quality standards. With funding from the Dutch government, the Fund launched its first insurance scheme in partnership with Hygeia Nigeria Ltd. in Nigeria in early 2007, targeting 115,000 market women, farmers and their families in Lagos and Kwara. A second scheme is being explored in Tanzania.

### **Micro-finance and Health Protection Initiative, Global**

Managed by Freedom From Hunger (FFH) and supported by the Gates Foundation, the Micro-finance and Health Protection (MAHP) Initiative does not target PLWHA and the AIDS-affected per se, but is trying to develop a number of interesting health partnerships for MFIs. Three MFIs affiliated with FFH are working through MAHP to link their clients to healthcare providers and pharmaceuticals. Although one of the partners, CRECER in Bolivia, is not specifically AIDS-related, it has linked with mobile doctors who provide health education as well as preventative and diagnostic services to clients in rural areas. Similarly, the Center for Agriculture and Rural Development (CARD), an MFI in the Philippines, is creating linkages with healthcare providers to include affordable access to primary care and is exploring a franchise network for the distribution of affordable drugs. While these are not AIDS-specific examples, they show promise to organisation looking to address issues of preventative health which could help clients get access to needed VCT, ARVs and psycho social support before they are hospitalised with AIDS.

### **3.1.5 Child savings**

A number of child sponsorship organisations such as Save the Children and Plan International are currently looking to develop child savings programmes on a large scale, in some cases with funding from PEPFAR and other health donors. The intent is to both make the business case to commercial banks globally that targeting youth and children can be a good mechanism for building early, loyal clientele who will stay with the bank through adulthood, while at the same time working with children and their families and caregivers to build assets early, which evidence suggests allows them to earn more later in their adult lives<sup>12</sup>.

### **SUUBI project, Uganda**

One experiment, the Suubi project conducted in Uganda by a researcher from the Centre for Social Policy of Washington University (USA) attempted

<sup>12</sup> Conley, 1999; Boehm and Schlottman 2001.

to refine and test the feasibility of child savings for secondary education among orphans. The objective of the project was to see how incentives could positively enhance the ability of orphaned children and their guardians to save as well as enhance their ability to develop longer-term financial planning skills. Working in conjunction with Centenary Bank, the programme tested two groups of orphaned children on their savings habits, one reinforced by the match of a payment each time the child or his/her guardian saved, the second not. While the incentives had the desired effects for the group that received the match, boosting not only individual savings but also their longer-term ability to accumulate assets, there were some cautionary results from the programme. The primary one was that particularly for the most vulnerable, some care must be taken to ensure that households do not divert resources for basic needs to savings, which risks further compromising the welfare of the child. Nonetheless, the results of this and other global experiments with child savings suggest that the potential for child savings is huge. The main question remains: can the business case of extending child savings to lower-income youth and children be made? And can this model be adapted to extend to children made vulnerable or orphaned by AIDS? What kinds of incentives are required to make contractual savings products of this nature work for the clients over time?

### 3.1.6 Partnership approaches to linking AIDS and financial services

#### *Finca and John Hopkins' life savings partnership programme - Malawi*

In 2005 the Bill and Melinda Gates Foundation funded a 16-month partnership between FINCA International and the Bloomberg School of Public Health at Johns Hopkins University (USA) with the objective of bringing HIV and AIDS prevention message to clients of FINCA's village bank network in Malawi. The intent was to deliver information on how to remain HIV-negative, reduce HIV-related stigma and provide information on healthy living, as well as support

to those that are infected. Among the positive outcomes identified by the programme where that participation in the programme resulted in:

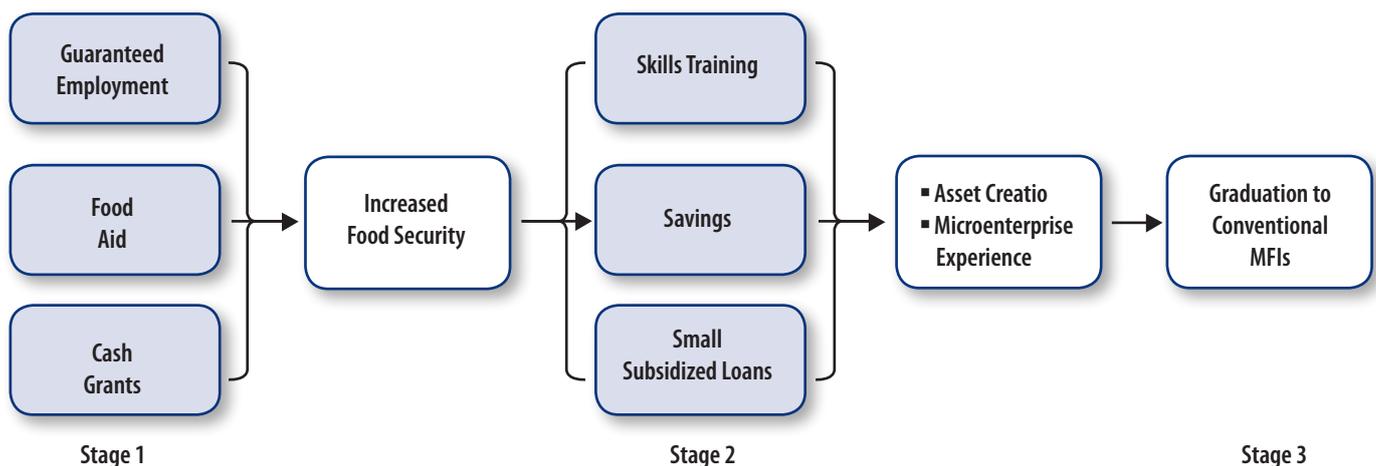
- Greater retention of village bank members compared with village banks that did not participate in the programme;
- Greater knowledge about HIV/AIDS transmission and prevention;
- Fewer stigmatising beliefs about the cause of HIV/AIDS;
- Improvements in self-efficacy to reduce the number of sexual partners and use condoms;
- Greater rates of HIV testing; and
- Increased discussions about condom use with partners.

Village banks appear to be a good mechanism for distributing health information to people vulnerable to HIV/AIDS because they provide a safe forum for discussion.

#### *Banco Oportunidade de Moçambique and Health Alliance International*

In Mozambique, the Banco Oportunidade de Moçambique (BOM), an affiliate of Opportunity International, and Health Alliance International (HAI) were able to set up a mutually beneficial partnership that allowed BOM to receive high-quality awareness and prevention education training for its clients from HAI AIDS educators. HAI AIDS educators came to meetings of BOM's clients and provided AIDS awareness and prevention training at no additional cost to BOM, except the cost of the trainer's transport. For BOM this meant not having to go beyond its core competencies in financial services to develop the AIDS-related training curriculum in-house or provide training to staff on AIDS messaging and communications. In turn, HAI's interest was in identifying vulnerable target groups with whom it could share prevention messages as part of its PEPFAR-funded project; it was a plus that it was able to "count" BOM clients as part of its prevention-level indicators.

**Figure 3: Sequencing - from safety net programmes to financial services**



### 3.1.7 HIV/AIDS and financial service programmes focused on behaviour change

#### *IMAGE project*

The Intervention with Micro-finance for AIDS and Gender Equity (IMAGE) project, a community-based structural intervention for HIV/AIDS prevention, was founded in 2001 in conjunction with the Small Enterprise Foundation, the University of Witwatersrand, the London School of Hygiene and Tropical Medicine, and the South African Department of Health's Rural AIDS and Development Action Research Programme. The IMAGE loan programme functions much like other micro-finance programmes – group loans with bi-weekly repayments using a group guarantee. The intent of the programme is to provide business loans to rural women so that they can increase their earning power and economic empowerment and can become more vocal at home, in particular to confront their husbands about infidelity and condom use. IMAGE aims seeks to influence factors that predispose individuals to HIV infection and gender-based violence by targeting the environment in which they occur.

Two years ago, IMAGE began a study to see if providing micro-finance loans to women could indeed reduce their risk of infection by making them less financially dependent on men and more able to negotiate safer sex. The study was done in two phases: In Phase One, the target group was selected from the poorest group of women in the community and offered small loans to start businesses. This group was also given 10 one-hour compulsory training sessions as part of the loan repayment meetings. Topics included HIV, sexual violence, gender inequality and communication skills. Eight hundred sixty participants were compared with a control group of women who did not receive the intervention. The results were assessed based on a number of factors: economic well-being, empowerment, intimate partner violence and HIV-related variables. After two years, the study showed:

- An increase in household asset value, together with a trend towards a higher savings rate; no differences in school enrolment or food security were noted;
- With respect to empowerment, the only significant change was related to communication with household members; women who participated in the scheme did not show greater self-confidence or communication with a partner than the control group;
- Intimate partner violence was significantly reduced (55 percent); and
- With respect to HIV-related factors, unprotected sex with a non-spousal partner decreased significantly. Participants were also more likely to access VCT services and reported higher levels of HIV-related communication. However, the incidence of HIV showed no significant decline over the period.

Although the results are interesting, there remains a limited body of evidence

surrounding economic and gender-related activities on HIV vulnerability, and change in risk behaviour is still quite small. This posed a dilemma for similar programmes trying to emulate this study.

#### *World Bank anti-AIDS experiment*

In 2008 the World Bank, in partnership with the William and Flora Hewlett Foundation, the Population Reference Bureau and the Spanish Impact Evaluation Fund, will launch a \$1.8 million trial to counsel 3,000 men and women aged 15–30 in southern rural Tanzania over a three-year period, paying them on the condition of periodic testing proving that they had not contracted HIV. The proposed payments of \$45 are equal to a quarter of the annual income of some participants. The intent of the programme is to test the use of cash as an incentive to stay negative. The programme is considered by many NGOs, health organisations and donors to be highly controversial and “a long shot”<sup>13</sup>. This experiment builds on other efforts to use conditional cash transfer programmes to serve vulnerable groups and, in this case, to change behaviour.

### 3.1.8 Economic strengthening programmes targeting PLWHA, OVC, caregivers and HIV-negative youth

Economic strengthening refers to a variety of activities that help families/caregivers and OVC meet expanding financial responsibilities to care for ill family members or additional OVC who join the household. It refers to a variety of activities that support the myriad of strategies that asset-poor people use in order to get by – selling surplus food, petty trading, operating/owning businesses and getting paid by others for work. Poorly designed economic strengthening programmes are often jump started with a one-time or short-term injection of funds, combined with assets or skills training and lack the linkages to markets and market relationships that can help households over the long haul. For economic strengthening activities for the AIDS-affected to be effective, they need to be market-driven and contextually relevant, and some combination of the following must be available:

“The landscape of rural development is littered with failed attempts to promote employment through short-lived supply-driven interventions. Leading culprits are training schemes for unmarketable skills, poorly managed revolving loan funds and the handout of every (un)productive asset from cows to sewing machines. The urgency to mitigate the economic impact of HIV/AIDS should not be an excuse to repeat these mistakes”.

Source: A quote from a Springfield Centre report for the UK Department for International Development (DFID), Helping to Harmonise and Align Support for Kenya's Response to HIV/AIDS, March 2007

<sup>13</sup> Financial Times, UK, April 26, 2008

Table 2: Financial service and other interventions that support the AIDS-affected

Organisations/Programmes	Prevention messaging	Workplace programmes: Minimalist	Workplace programmes: Comprehensive	CSR activities	Training/ tools	Financial products: Loans	Financial products: Savings	Financial products: Insurance	Non-financial products: Training	Other non-financial services	Partnerships	Behaviour change	Economic strengthening	Cash transfers	Cash transfers with add-ins/ add-ons
Micro-finance and Health Protection Initiative, Global						X	X	X		X Access to pharmaceuticals					
SUUBI Project, Uganda							X				X				
FINCA/JHU Life Savings Partnership Programme, Malawi	X								X		X				
Banco Oportunidade de Moçambique	X								X		X				
IMAGE Project, South Africa	X					X	X		X		X				
World Bank Anti-AIDS Experiment, Tanzania	X													X	
COPE Project, East Africa													X		
ROADS Project, East African Transport Network	X											X	X		
IGVGD, Bangladesh										X Payment network	X			X	X
All-Pay, South Africa														X	
SEEP Network, HAMMED Online Toolkit	X				X					X Case studies, tools					
USAID MicroLINKS Tools	X				X					X Reports, research, tools					

- Relevant and affordable business services that are available, especially in rural settings;
- Financial services and systems that work for poorer people;
- Agricultural (or livestock) extension services for small farmers and to ensure food security; and
- Reformed policies and practices of local authorities that enable, not constrain, the informal sector's ability to engage in economic activities.

The projects below demonstrate some of the broader economic strengthening initiatives taking place today for AIDS-affected communities. Some of these are more market-driven, and others are learning the hard lessons of past failed rural livelihood schemes.

#### ***COPE Project, Mozambique, Rwanda, Tanzania and Uganda***

The Community-based Orphan Care Protection and Empowerment (COPE) project, an Africare project funded by PEPFAR and managed by the Emerging Markets Group (EMG), a US-based consulting firm, is working at various levels with children and their caregivers in four countries – Mozambique, Rwanda, Tanzania and Uganda – to improve the welfare of OVC. While Africare provides the health- and education-focused services, EMG works with OVC and caregivers on increasing access to high income-generating activities that have high growth potential in the market. Examples of some of COPE's successfully linked groups are a group in Uganda that is selling dried fruit to the UK, a group in Mozambique selling vegetables to a local college and a group in Rwanda selling baskets to Macy's in the United States. The key focus of COPE is bringing AIDS-vulnerable groups into value chains with local, regional or export potential. Critical steps in this process include facilitating linkages for OVC and caregiver groups to larger firms that can provide better access to the market, ensuring that the groups can meet the business needs and standards of the larger firm, where appropriate getting the larger firm to facilitate credit for equipment (such as fruit dryers), and encouraging groups to cooperate formally or informally so that they can jointly address constraints.

#### **3.1.9 The ROADS project: SafeTStops and Life Works**

USAID's Regional Outreach Addressing AIDS through Development Strategies (ROADS) programme began in August 2005 with the intent to reduce HIV transmission, improve care and reduce the impact of HIV along the major transport corridors in East Africa. The programme attempts to link mobile populations and communities along the corridor to prevention, care, treatment and other support services as well as test pilot interventions. The ROADS project is based in Nairobi but operates in Burundi, Democratic Republic of Congo, Djibouti, Ethiopia, Rwanda, Sudan, Tanzania and Uganda. Among its two key sub-projects are the SafeTStop Initiative and the Life Works Initiative.

With the community behind them, ROADS builds partnerships along the

transport route, particularly in high-prevalence areas and at border crossings, to bring direct HIV and AIDS services to communities, truckers and other mobile populations along the route. The programme has set up SafeTStop-branded "safe centres" in which truckers and transport workers can stay, get medical and health services and get information. Among the ongoing initiatives is to put IT systems into these stops which can be used for a variety of things, including maintaining health records of SafeTStop users and members.

If SafeTStops works to intercede on the health and prevention side, Life Works addresses the economic side of the puzzle. Life Works' main mission is to create employment for vulnerable populations along that transport corridor by scaling up existing businesses, starting new enterprises, and offering incentives to large and multinational companies to outsource production to these communities. Life Works targets primarily low-income, at-risk women, older orphans, and vulnerable youth and community care providers that are already participating in the SafeTStops initiative. For Life Works, enterprises that are scaled up or created must meet some basic criteria: they must be labour-intensive, market-driven, low-capital, geographically/culturally acceptable, and not part of complicated value chains but instead be able to employ low-skilled workers. In Kenya, Life Works is working on two projects: mushroom production in Busia and home textiles in Mariakani. Unfortunately, the two programmes combined only provide a livelihood and income to 200 women and orphans.

Life Works managers readily admit that they have learned from their mistakes and that scaling up is a high priority. For example, targeting or recruiting based on health or social status does not yield strong business results. Income-generating activities (IGAs), particularly those undertaken by the most vulnerable, often fail because individual do not have the business management capacity needed – for example, do not know how to manage accounts or get access to finance. Thus, earned income goes to pay for basic needs, not for reinvestment in the business. Also, IGAs need to be market driven, and this means primarily local and regional markets. Unfortunately, Life Works and others have had "pie-in-the-sky" expectations of selling goods created by the AIDS-affected (and branded as such) in foreign export markets, hoping to cash in on the social aspects of these products. However, much of this has ended up being "one off" in nature due to the fact that relationships with foreign buyers are maintained by the NGO, not by the producers themselves, thereby limiting the development impact. Life Works also has struggled with the question of subsidy—where to subsidise and when. NGOs are not in the business of setting up and managing businesses and therefore need to adopt market principles in helping the local entrepreneurs and service providers move into set-up and management, not doing it themselves. Finally, among the biggest hurdles along the transport corridors are changing the policy and bureaucratic impediments that slow border crossings. When truckers wait for days on end at borders to clear customs, risky behaviour ensues. If border delays could be minimised, not only would goods flow more freely across

borders, but the spread of HIV/AIDS would be slowed as well.

### 3.1.10 Graduating clients from social safety net programmes through add-ons and add-ins

A variety of programmes has been and is being developed around the world that enhances social transfer programmes that are providing cash and other in-kind commodities to extreme vulnerable beneficiaries. These programmes are either “add-ons” of financial and non-financial services to the existing social protection programme with the aim of “graduating” beneficiaries from grant or other commodities to longer-term but market-based sources of financial services, or they are “add-ins” of a payment mechanism that through their use, integrates the beneficiary into the financial system.

“Add-on” approaches are more common and have been piloted in places like Bangladesh, Haiti, Ethiopia and other places known for their extreme poverty. Add-on approaches use stepped sequencing to ensure that beneficiaries/clients are able to use cash, food aid, guaranteed employment to become food-secure (Stage One) and then add skills training, savings, and small, sometimes subsidised loans over a specific time period to allow individuals to slowly accumulate assets and gain business experience (Stage Two) before graduating them to more formal sources of finance and business development services (stage 3). Figure 3 below depicts the sequencing used in many “add-on” schemes.

“Add-in” approaches are also starting to become more common as countries and financial institutions adopt new telecommunications technologies such as point-of-sale devices, biometrics and cell phones to speed up payment processes and lower costs. Experimentation with “add-in” approaches to making social safety net payments has taken place in South Africa, Brazil and Mexico, among other developing countries where payment infrastructure is a bit more advanced. Both “add-in” and “add-on” approaches are being to link AIDS-affected communities into the formal financial sector.

#### **ADD-ON: IGVD, Bangladesh**

The Income Generation for Vulnerable Groups Development (IGVD) programme, run by a specialised unit within BRAC, a Bangladeshi MFI, targets destitute rural women to whom the government and the World Food Programme is providing free grain for 18 months. The programme works with them to set up savings groups and give training to develop IGAs. Once the women have saved some and been trained, groups can access microloans to start their IGAs. The full cost of the initial loans for IGAs are subsidised with grants received by the programme. Initial review of the data in 2006 shows great impact. Of the 1.6 million participants, two-thirds have graduated from the grain programme and are accessing traditional micro-finance at BRAC. In recognition of this, BRAC was honoured with the prestigious Gates Award for Global Health. Again, while not specifically AIDS-focused, this programme

presents a model for other organisations to emulate.

#### **ADD-IN: Allpay’s Sekulula (It’s easier) card, South Africa<sup>14</sup>**

In 1997 Allpay Consolidated Investment Holdings, then a business unit of ABSA bank, was established when it bid for a project for the automated payout of social security grants in the Free State Province of South Africa. Since then the company has been set up as a separate subsidiary which specialises in cash payment of grants rolled out. In 2003 it rolled out the Sekulula Debit Card, a basic transaction bank account product is specifically targeted at recipients of social grants, such as pension and other social welfare payments, in South Africa. Allpay uses advanced technology and biometric fingerprint verification to make cash payments to South Africa’s most needy and vulnerable citizens and in some of the most remote areas of the country where there is little or no electricity or telecommunication infrastructure. Allpay now makes a wide variety of social payments for the government and NGOs, including NGOs that specialise in home-based care, HIV counselling and general HIV/AIDS health.

#### **Add-on versus add-in approaches to enhancing cash transfer programmes**

Most beneficiaries of cash transfer schemes spend the bulk of their cash grants on basic necessities (clothing, food, education, and healthcare). However, many may desire to save a small portion for planned or unplanned events that require larger sums. With some cash transfer programmes, organisations have worked with beneficiary groups to add on or add in programming. “Add-on” approaches involve the provision of additional financial services such as micro-savings or credit to which beneficiaries can access after receiving grants. “Add-in” approaches involve the design of a payment instrument which itself fosters integration of the beneficiaries into the formal financial system.

Source: Bankable Frontier Associates, Scoping Report on the Payment of Social Transfers Through the Financial System, DFID UK, July 2006

The Sekulula account has no minimum balance requirement. The governmental agency providing the social grants currently covers the fees on the account on behalf of the beneficiary. As of December 2007, the Sekulula account was being used by 683,576 beneficiaries in four provinces of South Africa.

### 3.1.11 Other resources and fora linking HIV/AIDS and financial services

A number of web-based resources are now available that provide research, tools, training courses and case studies on financial services and HIV/AIDS.

<sup>14</sup> See Case study prepared by Inspiris for InWEnt/World Bank Institute Eleventh International Business Leaders Forum, 2006

**SEEP network: Hamed working group and online toolkit**

In June 2008, the SEEP Network, a network of NGO micro-enterprise practitioners, put their HIV/AIDS and Micro-Enterprise Development (MED) guide online and set up a broader working group open to health professionals, micro-enterprise development practitioners, policymakers and donors. The guide aspires to be a go-to resource for practitioners working at this cross-section. Its current format includes the SEEP network's guidelines on MED and HIV/AIDS; a community directory; resources, including tools, case studies and other information; a calendar; job opportunities and a platform for community discussion. The online guide can be accessed at <http://communities/SEEPnetwork.org/hamed>.

**USAID'S microlinks**

USAID has been one of the leading donors supporting initiatives that cross HIV/AIDS/health and financial services. Since the late 1990s, USAID has supported research on the intersection of HIV/AIDS and micro-finance, starting first with

the Microenterprise Best Practices project and more recently with the AMAP Financial Services Knowledge Generation project and the Financial Integration, Economic Leveraging, Broad-based Dissemination (FIELD) Support project. Through these projects a variety of publications were developed. Most recently, USAID has supported the development of a short technical note series under AMAP that address thematic issues succinctly, such as the microNOTE series on AIDS and micro-finance, which covers partnerships, savings, insurance, workplace programmes, and the role of donors and funders, as well as a guide to the economic strengthening of OVC under FIELD. All of these publications are available at [www.microlinks.org](http://www.microlinks.org).

Chapter 4

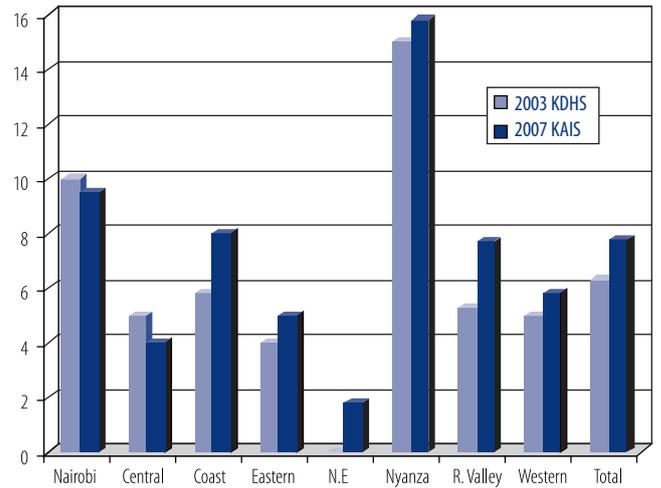
# REVIEW OF THE KENYA EXPERIENCE

## 4.1 HIV/AIDS IN KENYA

Although the AIDS pandemic in Kenya is believed to be on the decline after peaking in the late 1990s with an overall HIV prevalence rate of 10 percent in adults aged 15–49, HIV/AIDS continues to be a huge challenge for Kenya. Substantial regional variations in HIV infection, low levels of HIV testing, differences in infection within couples, and continued epidemics of other sexually transmitted infections (STIs) remain important challenges to control and manage. Kenya’s HIV epidemic is complex and dynamic, and many factors have influenced how the prevalence rate has risen and fallen over the past few years, including mortality due to AIDS-related illnesses, greater access to treatment and care, and new infections. The 2007 Kenya AIDS Indicator Survey (KAIS) Preliminary Report<sup>15</sup> includes new up-to-date information about HIV infections, including information on the scope and distribution of HIV in adults, an estimate of the incidence of HIV through laboratory testing, and the socio-demographic and behavioural risk factors related to HIV and other STIs.

<sup>15</sup> The Kenya AIDS Indicator Survey (KAIS) Preliminary Report was released on July 29, 2008. It contains some basic statistical data on the shifts in prevalence, but speculation on the causes of these shifts will be left to the final report, expected to be released in January 2009.

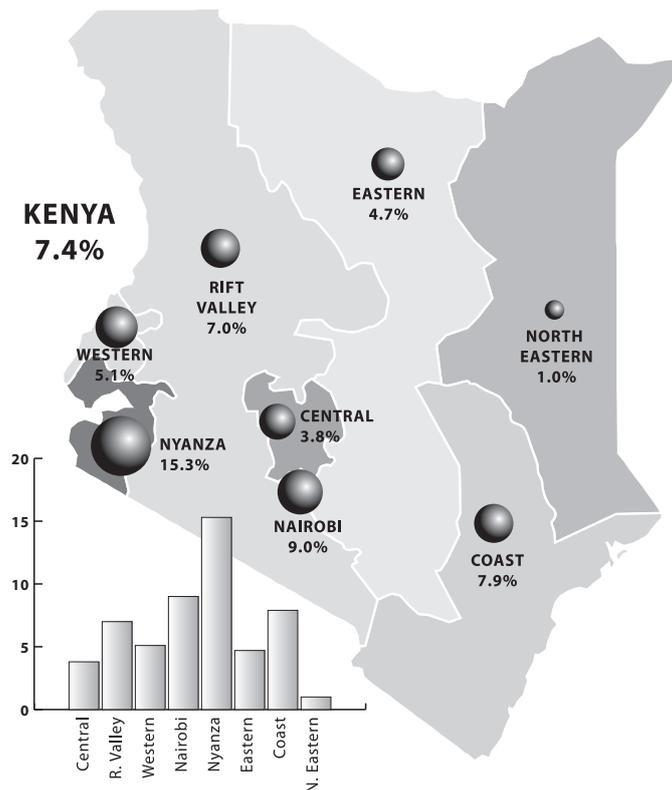
Figure 5: HIV prevalence among participants 15–49 years old in the KAIS 2007 and KDHS 2003, by province



Source: Kenya AIDS Indicator Survey, 2007 Preliminary Report

The 2007 results showed that 7.8 percent of Kenyan adults age 15 to 49 are infected with HIV, the virus that causes AIDS, up 1.1 percent from the 2003

Figure 4: Map of AIDS prevalence by province in Kenya



Source: KAIS 2007

survey. According to the survey, approximately 1.4 million Kenyans are living with AIDS (see Figure 4).

Geographically, the prevalence rates have also changed from 2003 to 2007. Aside from Nairobi and Central provinces, all provinces experienced a bump up in prevalence. The pandemic in Nyanza continues to be twice the national average (see sidebar), suggesting the limited influence of prevention, treatment and care efforts in the province. Figure 5 depicts changes in the prevalence among participants 15–49 years old in the 2007 KAIS compared with the 2003 Kenya Demographic Household Survey (KDHS).

#### **AIDS and Nyanza: Why is prevalence so much higher?**

Nyanza province continues to lead Kenya in terms of the prevalence of HIV/AIDS there. A number of retrogressive cultural practices are behind the spread, including:

- Casual and transactional sexual practices perpetuated by times of sporadic but high liquidity among the fisherman and an influx of poor women looking to sell or transport fish;
- Different cultural expectations about sexual partners; (fisher) men can have sex at random, while women must have a beach “husband” to be assured a good supply of fish and other favours;
- Negative attitudes towards condom use;
- High consumption of alcohol and drugs;
- Certain continued cultural practices, such as wife inheritance irrespective of health status or the number of widows that a man may already have.
- Lack of male circumcision practices (which when combined with female physiological characteristics make women more susceptible to the virus);

Because the province has been so hard hit, solutions to addressing the AIDS crisis in Nyanza need to be big and focus on the economic as much as the behaviour-change aspects.

Source: IPAR Study 2004

In terms of urban versus rural prevalence, the rural areas in which three-quarters of Kenyans live still have a slightly lower prevalence rate (7 percent) than urban areas (9 percent).

Data on AIDS prevalence by income quartile was not available from the KAIS preliminary report, but undoubtedly this would also add a very important dimension, particularly with respect to gender (see sidebar).

The good news is that progress is being made in terms of testing and treatment, but slowly. Compared with the KDHS in 2003, 36 percent of Kenyans have been tested for HIV at least once, up from 14 percent in 2003. Testing for HIV is an important step toward knowing one’s status (though not a 100 percent guarantee, since repeated exposure to HIV can mean less accurate information about one’s status). ART coverage, based on the measurement of CD4 cell counts below 250, is also up substantially since 2003, but not to the point where everyone who needs ARTs is on them. In fact, according to the KAIS, only 35 percent of the estimated 250,000 people who need ARTs and know their status are on them. Another 2 percent need ARTs, know their status and are not on them, while another 63 percent need ARTs, do not know their status and are not on them. This latter group presents the biggest challenge going forward.

Despite the need to get more people on ARTs, the increased access to them has changed the profile of AIDS. With more people getting treatment and getting the nutrition and rest they need to live healthily, more people are living longer and more productive lives. This positive example is turning what seemed to be an early death sentence a decade ago into hope for many more people, and has shifted the public view of AIDS from one of a large-scale catastrophe to one of a manageable chronic disease.

#### **4.1.1 Government and donor responses to AIDS**

Unfortunately, health statistics do not capture the new vulnerability felt by those infected and affected by HIV/AIDS. As in other severely impacted countries, this vulnerability to HIV/AIDS at an individual level has translated into a slowing of Kenya’s economic development. Recognition of how HIV/AIDS is undermining economic development and poverty reduction has thus become a main focus, not only for the Government of Kenya’s National AIDS Control Council (NACC) but also for the many national and international organisations working there. The achievement of core poverty reduction objectives – increased household food security, higher household income and more resilient livelihoods – underpins two of the three Kenyan National HIV/AIDS Strategic Plan priority areas as well. The priorities are these:

- Prevention of new infections;
- Improvement in the quality of life of people infected and affected by HIV/AIDS; and
- Mitigation of socio-economic impact.

NACC was formed in 1999 to lead the national response and serve as the governmental coordinating body. This leadership included managing the multi-sectoral approach to AIDS, providing policy direction and mobilising resources. NACC’s location under the Office of the President is a demonstration of the government’s commitment to HIV/AIDS and allows it input and

### Paying attention to gender: Some staggering statistics and facts about AIDS and women in Kenya

Geographic data on AIDS in Kenya does not present the full picture; a gender snapshot on the other hand speaks volumes.

- A higher proportion of women than men are infected with HIV (8.7 percent versus 5.6 percent) or 3 out of every 5 infected are female.
- Women age 15–64 are more likely to be infected than men in both urban and rural areas with 10.8 percent of urban females compared to 6.2 percent of urban males and 8.2 of rural women versus 5.5 percent of urban males.
- There is a high correlation between income and age that puts younger women at higher risk. Teenage women ages 15–19 are five times more likely to have HIV due to consensual, unsafe sexual relationships with men 5 or more years older who because of their age and higher income level (compared with teenage men) can negotiate for unsafe sex. (Dupas 2006)
- Women with higher education levels have significantly lower prevalence; 10 percent for women who have only primary school education versus 4 percent for those who have university –level education. (KAIS 2007)
- Because of cultural and traditional mores, women are more limited than men in the economic roles they can play. Also decisions about the ownership of assets, title to legal property (such as land) and decisions about inheritance are left to male tribal elders to decide. As a result of these inequalities, though most women are given property rights under the law, customary law supersedes, often leaving women without decision-making authority in the event of the death of her spouse and thus, the potential of being inherited or disinherited or dispossessed.

(Ellis et al 2007)

influence into broader economic development initiatives, such as the Economic Recovery Strategy. From the Government of Kenya side, NACC now sits at the head of a complex web of organisations, sub-networks, forums, organisations and donors engaged in the national response.

Donor funding contributes significantly to NACC as well as the web of organisations. In the past five years, international donors, led by the US Government's PEPFAR, have funded significant portions of the work of NACC and the National AIDS and Sexually Transmitted Diseases Control Programme (NAS COP) of the Ministry of Health. These investments have included strengthening public health and mission hospitals, supporting NAS COP's capacity to establish comprehensive care centres that offer VCT and medical

management services, working with the Government of Kenya to develop and disseminate policies and guidelines on HIV counselling and testing, ART treatments and treatment for opportunistic infections, support for OVC, and, finally, engaging new partners and leveraging additional resources to offer new and innovative programmes but also to enhance sustainability and address some of the socio-economic factors compounding the AIDS pandemic<sup>16</sup>. Particularly in this latter area of economic strengthening, more and more donor programmes are being developed, tested and rolled out each day

#### 4.1.2 The nexus of HIV/AIDS and financial services in Kenya

Kenya boasts a wide range of financial service providers, including 43 licensed commercial banks, two mortgage finance companies, approximately 40 MFIs, an estimated 3,000 SACCOs, and thousands of informal group-based ROSCAs and accumulating savings and credit associations (ASCAs). Geographically, these organisations are spread throughout the country, although no comprehensive data exists on branch/institution location by province except for bank branches, where penetration is very low (see Figure 6)<sup>17</sup>.

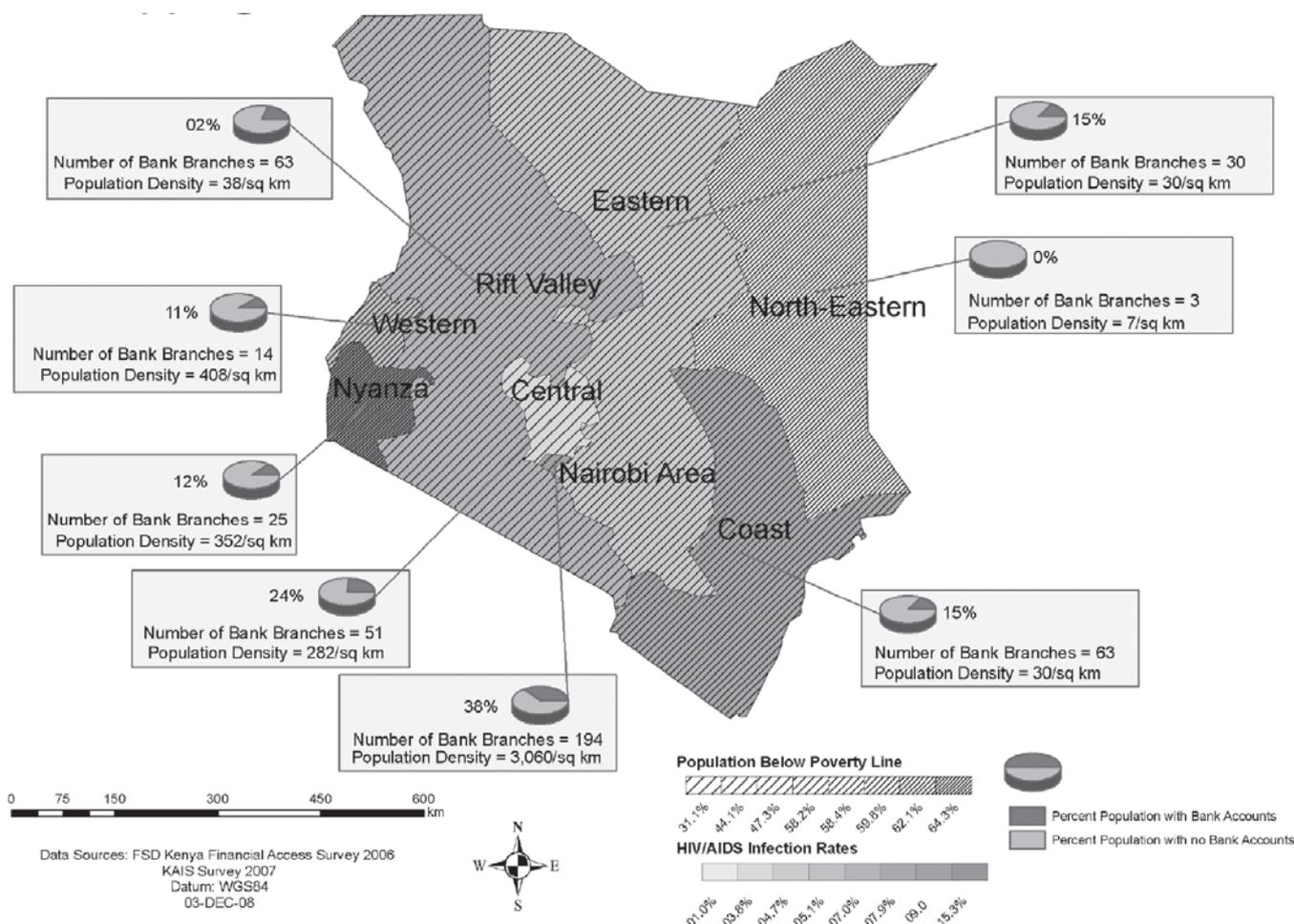
Since the start of the new millennium, these institutions have made varying inroads into addressing AIDS directly and indirectly as it impacts them as institutions, impacts their staff and impacts their clients. The MicroSave report HIV/AIDS—Responding to a Silent Economic Crisis, which catalogued some of the few responses in Kenya at that time, demonstrates the progress that has been made. Since this report was published many of its recommendations have been implemented, particularly around financial product innovation. Institutions have become flexible (while still maintaining financial rigor, discipline and a double bottom-line focus); they have created new products such as micro-insurance (both health and life) and different non-business loans for clients (emergency, school fee and health premium loans); and some have forged partnerships with business, AIDS and home-based care support organisations. These innovations are happening in both targeted and non-targeted ways. A variety of good and less good practice programmes and institutions crowd the landscape. The coming section will document some of the better practices of organisations operating in this sphere, as well as critique others.

What remains is the continued need to mind the trends in access, product delivery and consumer needs and attitudes. Despite decades of donor support and investment in financial services, particularly in more rural areas remains low. The 2007 Financial Access Survey, which measured access to and the demand for financial services as well as product usage and information about

<sup>16</sup> 2007 Country Profile: Kenya, the President's Emergency Plan for AIDS Relief

<sup>17</sup> Note: The Financial Access Survey conducted in 2006 collected significant data on the characteristics and habits of users of the financial system. However, it did not compare this data with that of suppliers of finance by province.

Figure 6: Mapping HIV/AIDS prevalence and financial access



demographics, livelihoods, and income, continues to highlight gaps - gaps that appear to mirror some health trends with respect to AIDS. For example:

- Women, who are disproportionately affected by HIV/AIDS due to their gender and economic status, are similarly limited by their lack of access to financial services. In fact, 52.9 percent of women are considered financially excluded, meaning they do not have access to banks, bank-like institutions or informal mechanisms such as ROSCAs<sup>18</sup>;
- Seventy-four percent of youth are excluded from any form of financial access, and 82 percent have never had a savings product of any kind;
- Products such as insurance have very low penetration in Kenya; only 5.9 percent of the population has use insurance products, with higher incidence in urban areas (12.8 percent) compared with in rural areas (3.6 percent);

- Geographically, there does not appear to be a correlation between high prevalence or incidence of HIV/AIDS and lack of financial services. However, Nyanza Province, a province with both a high HIV prevalence and poverty rate, continues to be underserved with banking services<sup>19</sup>. While anecdotally the researcher was told of the recent (2006-2008) increase in bank branches and banking services set up to serve the fishing communities, particularly in Kisumu, it was also noted that many of the banking facilities are far off the beaches, suggesting they may not be truly serving this high risk population<sup>20</sup>. Figure 6 provides province level data on banking services mapped with HIV/AIDS prevalence and poverty.
- Finally, the top three reasons cited for savings were to meet household needs (49 percent), for education (37 percent) and for emergencies, including burials and medical reasons (35 percent).

<sup>18</sup> Financial Access in Kenya: Results of the 2006 National Survey, October 2007.

<sup>19</sup> Note: The Financial Access Survey provided only geographic data on bank branches, not on branches/offices/points of service for other financial service providers.

<sup>20</sup> More research will be needed to map the location of bank and other financial institution branches and services to prevalence in primary, secondary and tertiary cities in Kenya.

All of these statistics and others point to ongoing opportunities for the financial sector to expand access to its services, including to AIDS-vulnerable populations.

## 4.2 FINANCIAL SECTOR APPROACHES TO ADDRESSING HIV/AIDS

A number of organisations within the financial services community are actively involved in addressing HIV/AIDS as both an economic and social crisis in Kenya. Examples of programmes, activities and products undertaken in Kenya and lessons learned are provided in the below section. The examples are grouped by type of financial service provider (bank, MFI, SACCO, facilitator, network organisation) and by products/interventions. Not surprisingly, the response to AIDS has been similar to many other countries in the region, except that partnerships have been less prevalent, products such as health insurance and savings are not as widely available, and little has been done at a higher level to coordinate the economic activities of the private and health sectors. Table 3 at the end of the chapter attempts to catalogue some of the more successful examples of organisations and programmes that have been working at this nexus in Kenya.

### 4.2.1 The banking sector: Workplace programmes and CSR

The Kenyan banking sector, like other banking sectors, views HIV/AIDS through either one lens or two: either it is a workplace risk management issue that must be addressed by putting into place a programme addressing HIV/AIDS for staff, management and their extended families (and sometimes communities), or it is viewed as a corporate social responsibility (CSR) issue through which activities can be undertaken that have no impact on the bottom line (and in fact may be implemented as part of the bank's foundation or charitable activities) but enhance the bank's image and brand locally and internationally; or both. In this section some of the specific HIV initiatives of Kenya's larger banks are highlighted.

#### **Barclays Bank**

Barclays' approach to HIV/AIDS has been through the lens of protecting its staff. In 1998, Barclays rolled out a comprehensive HIV workplace programme in many of its African affiliates. In 2004, this programme was transformed into a broader wellness programme that includes HIV/AIDS as well as other health and lifestyle issues that impact the company's productivity. The wellness approach provided to be much more successful for the bank, given the stigma surrounding AIDS, and as a result, Barclays has been able to get higher staff participation in its wellness initiatives than it would have had they been HIV-specific. Barclays' wellness programme in Kenya currently covers 4,000 full-time employees and 4,000 contract employees.

The wellness programme has three distinct pieces: 1) an HIV/AIDS workplace programme, 2) employee assistance and 3) core health management. The programme covers all employees and their registered dependents (including children up to age 25 that are still living at home). The programme also covers them for one year beyond the date of termination, which was felt to be extremely important for retired individuals.

Many of the services associated with its wellness programme are outsourced to different health organisations and individuals. This allows employees to access services on a confidential basis; Barclays only obtains statistics on use from the service provider, with no names attached. Barclays offers weekly seminars to its employees on a variety of health issues, and regularly offers VCT services to employees and their dependents in its branch offices. This has helped to build employee confidence in the workplace programme and to believe in the confidentiality of the services offered. Barclays spends between 80 and 100 million shillings annually on this programme.

Although Barclays' programme has been internally focused, the bank has been a big supporter of community efforts to fight HIV/AIDS through its wellness programme and as part of its CSR efforts. Its wellness adviser is interested and willing in working with other financial institutions and MFIs in helping them set up workplace programmes and identify appropriate partnerships. On the CSR side, Barclays has worked with Pathfinder International, an international AIDS NGO, to provide vocational training to 32 OVC and empower youth through the creation of IGAs. Barclays has also sponsored the International Women's AIDS run two years ago, and regularly provides free seminars to schools and other educational institutes.

#### **K-REP Bank**

In June 2008 IFC announced its intention to help the K-REP Group, which includes K-REP Bank Limited, K-REP Development Agency, K-REP Fedha Services and K-REP Advisory Services, to implement a corporate HIV/AIDS programme for its more than 900 employees. IFC will invest \$77,000 in the programme, complemented by an additional \$150,000 from K-REP. Led by IFC Against AIDS, the work with K-REP reflects a new trend by IFC to give management support to its investee companies to take a proactive stand against HIV/AIDS. IFC support will help K-REP launch a workplace HIV/AIDS programme and increase staff awareness of the disease. The company will also provide employees with confidential access to VCT services and extend free medical care to those affected and their dependents.

#### **Equity Bank**

Like many other banks in Kenya, Equity views HIV/AIDS-affected communities through more of a CSR lens than through a business lens. Its Equity Group Foundation has recently initiated a partnership with the Meru Hospice to provide loans to PLWHA. Equity managers believe this kind of CSR offers beneficial brand enhancement for the bank.

On the business side, Equity is running a strong insurance business for its middle- and upper-income clients through its working relationship with British American Insurance. Despite attempts to partner with the National Hospital Insurance Fund (NHIF) to offer lower premiums to its micro-finance clients, its offers have been rebuffed – leaving its clients underserved in this area.

In other areas, Equity is working with FSD and DFID on the hunger safety net cash transfer programme. This programme will provide cash instead of food aid to destitute pastoralist households in northern Kenya. Through the FSD Kenya-managed tender, Equity Bank was successful in its bid to set up the point-of-sale/card-based payment network for this cash transfer programme. At the time this was being explored, FSD, DFID and others were also discussing the possibility of setting up a similar payment network for the OVC cash transfer programme. Such a programme could link new groups (OVC, guardians, caregivers and single parents) into formal financial services that they previously did not have access to.

#### 4.2.2 The micro-finance sector

To date the direct response of the Kenyan micro-finance sector to the AIDS pandemic has been quite limited. A few MFIs have experimented around the edges with providing services directly to AIDS-affected populations, but predominantly they have not directly targeted this population for products and services. Instead, some of their product offerings, such as health insurance coverage, cover clients affected by AIDS indirectly. In discussions with MFIs about their interest in this segment, the response has been mixed. The majority interviewed prefer not to target AIDS-affected groups<sup>21</sup>.

This group views HIV/AIDS as any other chronic disease that must be managed and believes that drawing attention to it only goes to further the stigma associated with it. Others MFIs view it as a potential group to target, but believe that AIDS-affected/infected individuals cannot (and perhaps should not) pay full market interest rates for products and services. Finally, others, particularly those planning or preparing for transformation to micro-finance deposit-taking institutions, believe this is a place for donor funding, but not the focus of commercial micro-finance. This group recognises the need for services to be extended to this group, as well as the need to integrate them back into society, but also realises that more needs to be done to combat stigma.

In this section, a number of the product responses will be highlighted, as will the specifics of any organisation or programme that targets PLWHA/affected communities directly or in some cases indirectly.

<sup>21</sup> A caveat to this comment. This researcher was only able to meet with a handful of MFIs and chose to meet the larger ones, serving greater numbers of clients. Not coincidentally, many of these institutions are preparing to transform into regulated micro-finance deposit-taking institutions.

#### *Direct MFI business loans to PLWHA and the AIDS-affected*

Only a small number of MFIs have chosen to provide loans directly to AIDS-affected populations. Those that target this segment have developed the Programmes or loan products that are variations of their standard loan product, bear a lower (below-market) interest rate to the end client, but are covered by credit life insurance and may be more lenient on issues of delinquency and default. The fact that few MFIs are actively serving this market niche is not a surprise, and still less surprising is the fact that those that are commercially driven (and seeking to transform into regulated deposit-taking MDIs) do not have the interest except as a CSR activity. Others are simply uncomfortable with targeting, due to the stigma attached to AIDS.

#### *K-REP Development Agency's FAHIDA programme*

Only the K-REP Development Agency (KDA) Family Health Integrated Development Assistance (FAHIDA) Programme, begun in 2001 with pilot funding of \$300,000 from USAID, has instituted a large savings and credit scheme for HIV/AIDS-infected and -affected persons. The initial pilot, which began in Western Kenya, Mombasa and Nairobi<sup>22</sup>, has since been expanded to Thika, Nakuru, Garissa, Embu, Meru, Nyeri, Kilifi, Malindi, Kwale, Kisumu, Rachuonyo, Nyando, Busia, Bungoma, Kakamega, Buteria and Mumias. The programme actively uses USAID's AIDS, Population and Health Integrated Assistance (APHIA) II Implementing Partners to identify clients who are already getting treatment and care for its savings and loan programme.

K-REP recognised that the ability of poor households to cope with the economic and financial impact of HIV/AIDS greatly depended on the economic resources available to the household before, during and after the disease affected them. Because micro-finance has been shown to help households smooth consumption, improve household income flow and increase food security, KDA felt it had an important role to play in getting PLWHA and affected individuals back on their feet.

KDA provides clients with access to group saving and loans. Groups made up of 15–50 self-selected individuals meet weekly to make payments on group-guaranteed loans and collect small savings. Partner AIDS CBOs provide other social and health support to these groups, and occasionally group meetings are used to provide business training. FAHIDA's initial group loans tend to be smaller (5,000–15,000 KSh), shorter term than other MFIs (6–12 months) and carry an interest rate of 13 percent (plus a 1 percent application fee).

Since 2001 FAHIDA has provided loans to a total of 12,770 clients. Its current outstanding portfolio is KSh77.8 million<sup>23</sup> for a few thousand active clients<sup>24</sup>.

<sup>22</sup> The programme was originally set up for Western Kenya, but was extended to Mombasa and Nairobi-Thika with subsequent tranches of subcontracted funding from USAID partners, the Christian Children's Fund and Pathfinder. In total, the original programme received about \$1,000,000 from USAID and its partners.

<sup>23</sup> Statistics are current as of May 31, 2008.

<sup>24</sup> Unlike other MFIs which promote the number of active clients, KDA presents its statistics in terms of total numbers served. The difference between the two suggests a very high dropout rate from the programme.

Targeted clients include PLWHA, caregivers, mature OVC (18 years or older), volunteer community health workers, widow(er)s, and commercial sex workers. Community health volunteers are also covered, as they often fit into one or more of the above categories. FAHIDA believes one of its key achievements has been the demonstration that PLWHA/AIDS-affected can repay loans and actually save at a higher rate than the average micro-finance client<sup>25</sup>. However, the PAR >30 days measure still remains higher than the industry average for micro-finance at 12–15 percent<sup>26</sup>, but delinquency is also not treated with the same level of attention as in other MFIs. FAHIDA's non-payment rate is approximately 10 percent<sup>27</sup>.

Additionally, it has been able to negotiate the provision of credit life insurance on these loans for an additional charge of 0.75 percent. This insurance covers the loan in the event of death and pays a nominal funeral expense up to 10,000 KSh. More recently, KDA has been able to provide the NHIF/Cooperative Insurance Corporation (CIC) medical coverage for programme members and their extended family to cover inpatient hospitalisation. However, to date there has been little uptake of the product. Although no comprehensive study has been conducted to see why there has not been more uptake, a short discussion by the researcher with a client suggested that there was greater need for other medical services and the price point may be too high for the most vulnerable clients<sup>28</sup>.

In 2007, FAHIDA received an additional \$4.8 million from USAID/PEPFAR to expand the programme. This funding will allow it to expand the programme to all provinces and from 6 to 16 offices, allow it to roll out the health (*afya*) coverage, and allow it more administrative costs to conduct client impact assessments and set up better management information systems that allow it to better track and compare costs by office. KDA believes this new funding will allow the programme to expand its outreach (its goal is to reach 35,000 AIDS infected/affected clients), achieve financial sustainability and demonstrate more broadly that this market segment is indeed bankable. Although KDA was actively working with USAID's APHIA II partners, it was unaware of larger initiatives to strengthen economic opportunities for the AIDS-affected. It also had no active plans for linking more successful clients into more mainstream micro-finance offerings or in expanding its product offering to these clients. Moreover, not all the APHIA II health organisations have been supportive of the product. Issues have arisen over delinquency in that a couple of the health organisations have been opposed to making AIDS-affected people repay loans.

<sup>25</sup> The higher savings rate was mentioned anecdotally. To date, KDA has not done extensive surveying to this end.

<sup>26</sup> This was the average prior to the Kenyan elections in December. After that period, many MFIs have had large numbers of non-payments due to the post-election violence and destruction.

<sup>27</sup> FAHIDA states its repayment rate is 90 percent. How this is measured is unknown to the author.

<sup>28</sup> Note: the client was part of a loan group in the Mathari area of Nairobi, one also greatly affected by the post-election violence and destruction. Many clients were greatly impacted financially and are still trying to rebuild their businesses.

### **Small and Micro Enterprise Programme (SMEP)**

SMEP has been providing business loans to PLWHA/AIDS-affected populations for almost a decade now. Through its founder, the National Council of Churches in Kenya (NCCCK), SMEP was subcontracted to provide the financial part of a project that supported marginalised women, including those affected by HIV/AIDS. NCCCK brings the women together, trains them in different IGAs, and provides them with financing for these businesses. In total SMEP has worked with about 200 women through four of its branches in Mombasa, Nakuru, Nairobi and Kisumu. Loans were provided at an interest rate of 1 percent. Women “graduated” from this scheme and then set up their self-financing merry-go-rounds (informal savings and loan schemes) that allow them to save and receive loans. NCCCK paid for SMEP's administrative costs.

According to SMEP's CEO, the organisation has done some very serious thinking about HIV/AIDS, especially how it affects staff and clients in Nyanza and Western Provinces. Several clients have died from AIDS-related illnesses. This is partly why the organisation began providing life insurance to staff and credit life insurance and health insurance to clients.

In terms of its standard business loan product, SMEP does offer business and other training as part of its group loan product. However, it has never actively used this forum to do health or HIV/AIDS awareness training. If it has been done, it is only in cases where the branch managers and loan officers have been more creative. While SMEP does not actively exclude HIV-positive individuals from business loans, it does not target them either or make efforts to reach out to this community; all economically active people can become clients of SMEP.

SMEP has not done any active surveying or research to find out if individuals are being dropped from groups due to issues related to stigma. That said, it has begun making its products more flexible, which may help clients that are affected by HIV/AIDS. For example, clients can “opt out” for a period of time to access savings or partial savings and then rejoin their loan group at a later time. SMEP also offers emergency loans in addition to business loans for those that require them. These loans are often taken for health-related crises.

#### **4.2.3 Medical coverage/health insurance**

In addition to credit life insurance, which many of the largest MFIs provide as a part of any loan they make, a number of organisations are beginning to offer health insurance. This health insurance tends to cover the high costs of inpatient hospitalisation in addition to some funeral and death benefits. None of the MFIs is yet providing comprehensive medical coverage.

### **NHIF/CIC health insurance coverage for inpatient hospitalisation**

In late 2007 and in 2008, a number of MFIs – including the SMEP, Kenya Women Financial Trust (KWFT), FAULU, the Kenya Agency for the Development of Enterprise and Technology (KADET) and K-REP Development Agency, among others – have begun marketing and selling a new health insurance coverage provided by the Cooperative Insurance Company (CIC) and NHIF. The product provides three-in-one coverage: 1) comprehensive medical coverage of in-patient hospitalisation, 2) personal accident coverage and 3) a funeral expense. The insurance covers the client, his/her spouse and all children up to age 21 for an annual premium payment of 3,650 KSh, or 10 shillings per day, for in-patient hospitalisation in government and mission hospitals; HIV and AIDS-related infections are not excluded. Funeral expenses of up to 30,000 shillings are also covered.

As of July 2008, only about 9,800 MFI clients had bought the coverage. While CIC and NHIF are happy with the growth – particularly since April, when things returned to normal after the post-election crisis – they had expected to have at least 35,000 clients by June 2008. Instead, they will probably get to that number by December.

From the MFIs' perspective, the coverage is good but doesn't begin to address all the medical coverage needed by clients. One MFI relayed that the coverage has frustrated its clients who – for example – want to take their children to the doctor for treatment, but since the children don't need to be hospitalised they are not covered. While this coverage is a good first step, it isn't the most needed health coverage and for AIDS-affected people, this type of coverage alone might be a deterrent to getting the needed treatment for earlier, lesser opportunistic infections that are also less costly to cure.

From the insurance perspective, there is great concern that people will overuse insurance, particularly as the end of the coverage period comes nearer. Insurers also voiced opinions that medical providers inflate their bills. As a result, there has been little work to date within the industry to look at providing this coverage at a lower price point for lower-income clients.

While this kind of health coverage may not be the ideal product, at least three of the MFIs (KWFT, FAULU and KDA) also provide financing to pay for the health insurance premiums as a way to help clients get access; loans for premiums are charged at the same standard rate as other business loans.

### **Jamii Bora's medical coverage**

Jamii Bora has had no specific focus on PLWHA or AIDS-affected households. According to one of its managers, it does not discriminate on the basis of the health status of an individual, nor does it target those with health ailments.

Anyone – irrespective of health status – can become a member of Jamii Bora. That said, Jamii Bora has been very active in putting medical coverage for its members into place. The organisation self-finances this coverage, and has negotiated with more than 50 public hospitals in Kenya. For this coverage, Jamii's members pay 1,200 KSh per annum (30 KSh per week) for inpatient medical coverage. This "insurance" covers the member and any children under 18 years old up to 4 children<sup>29</sup>. Outpatient costs are paid by the clients.

Jamii Bora's medical coverage is completely self-financed. It began offering this coverage in 2001 without any kind of comprehensive feasibility study – just the knowledge that its members needed such coverage. Illness was the most common reason cited for loan non-repayment.

According to the insurance manager, the programme has been well received by its clientele. Although no exact figures were given, an estimated 60 percent of its 180,000 clients currently pay for the medical coverage and the premium appears to sufficiently cover the costs. When asked about coverage of outpatient costs, Jamii Bora's insurance manager noted that they had not looked into this because outpatient costs were difficult to monitor, nor could Jamii Bora have control over which health providers its clients would see.

## **4.3 OTHER FINANCIAL PRODUCTS AND SERVICES TO ASSIST THE AIDS-AFFECTED**

MFIs are starting to provide a variety of other products and services that can positively impact PLWHA and AIDS-affected households. These products include emergency loans, loans for education/school fees, child savings accounts, and non-financial services such as training on health and AIDS prevention. Some of these products do provide the flexibility that AIDS-affected households need; in some cases, this group continues to be excluded from access because they have economically fallen too far and are considered high risk.

### **4.3.1 Emergency loans**

Many of the MFIs provide emergency (*tatua*) loans for their clients for hospital and other medical bills, among other emergencies. These loans run concurrently with other business loans that clients may have, but are for shorter terms (generally three months). Among the organisations providing emergency loans are KWFT, SMEP and FAULU. While these loans provide added flexibility for clients, including the AIDS-affected, not all clients can qualify for them. In cases where clients have abstained from loans for a period of time and/or have liquidated their mandatory savings, they may not be able to take these emergency loans. Thus, these emergency loans are truly only useful for those who haven't yet exhausted other means. Also, these loans may not be available on a regular basis or to cover non-treatment costs associated with getting health treatment, such as to cover the cost of transportation.

<sup>29</sup> Spouses are not covered unless they become a member, and children over the age of 18 must pay an adult rate.

### 4.3.2 Education/school fee loans

Many MFIs are now providing loans for education or school fees. These loans are provided as a second loan to any business loans taken out by clients and are generally shorter in term and for smaller amounts than the business loans. The extent to which these loans are being made to guardians and caregivers of OVC is unknown. These loans provide added flexibility for guardians and caregivers, allowing continuity of education for children while the caregiver works. Further innovation could be done by MFIs and other financial service providers to develop savings products that allow families and guardians to save up for education, particularly secondary education, where girls are more likely to drop out far in advance of the need to pay out the school fees.

### 4.3.3 Other loans

One MFI that will transform this year to a deposit-taking micro-finance institution (DTM) has plans to have its non-profit foundation arm focus more on working with AIDS-affected populations. This MFI hopes to launch a loan product for caregivers, where strong repayment will pay out a rebate that can be saved for children.

### 4.3.4 Child savings

Child savings accounts are currently being offered by a number of the banks in Kenya (Equity, K-REP bank, Kenya PostBank, Kenya Cooperative Bank and KCB), in part because MFIs cannot legally offer regulated voluntary deposit services<sup>30</sup>. At least one transforming MFI is interested in exploring child savings. This MFI conducted a market survey last year and results indicated that among its client base, savings for their children's future is a high priority for clients. One of the main purposes for child savings would be to fund education, particularly secondary/boarding school and university. Although this MFI will transform to a DTM in the coming year and begin with what it described as very "vanilla" savings products (basic savings and time deposits products), it is planning expansion into child savings in the coming years. This expansion may include experimenting with group savings models, as well as promotions and awards to promote savings. This MFI believes financial education will be a key to its success.

### 4.3.5 Awareness and prevention training for clients

Many of the group-lending MFIs in Kenya offer business training as part of their core product offering (integral to any loan offering). A number of the MFIs, including SMEP, FAULU, and others, have occasionally offered training on non-business topics, particularly in cases where a loan officer suggested it. For example, FAULU developed a basic curriculum around AIDS in house. It recognises that in order to roll it out on a larger scale it has to put resources behind it and train trainers. Additionally, many of its loan officers are young – often younger than the clients. Because of traditional values and the traditional

relationship between the young and old, many of the younger loan officers would feel awkward in sharing the information. As a result, it has been rolled out haphazardly.

### 4.3.6 MFI workplace programmes

Very few MFIs have attempted to put into place a comprehensive AIDS workplace or employee wellness programme, despite having hundreds of staff members who could be infected and are certainly affected by the disease. SMEP admits to having provided education seminars in the past that covered topics such as HIV/AIDS. Its management now believes the information is common knowledge among staff members, at the same recognising that stigma issues remain. A similar remark came from a manager at Jamii Bora – that the staff knows the information. Of the MFIs interviewed, only Faulu wished to undertake something more comprehensive – a workplace programme that focused on getting prevention education out to both staff and clients.

In terms of staff health and wellness benefits, most MFIs provide medical coverage for their staff members that provides access to private hospitals, and pay a funeral expense of up to 50,000 KSh. How well the insurance covers HIV/AIDS is unknown. One organisation was looking into more comprehensive coverage for their staff that would explicitly cover HIV and AIDS-related illnesses. The premium for this insurance comes at a higher cost.

### 4.3.7 Kenyan SACCOs

Like other financial service providers, very few SACCOs have addressed HIV/AIDS-affected clients directly. Most SACCOs do not target the AIDS-affected, but being member-based institutions provide financial and non-financial services to all their members. As a result there are no specific financial products that address AIDS, with one exception (see WOCCU below). Instead, SACCOs serve AIDS-affected people that are among their membership (and who are not necessarily open about their status) with business loans, school fees loans and short-term emergency loans to cover medical bills in much the same way that other financial service providers do. SACCOs also offer child savings. In some instances affected/infected members have set up self-help groups outside of the SACCO structure, and KUSSCO has encouraged the SACCOs in which they are members to provide them loans for medicine or good nutrition or link them with access to subsidised food. SACCOs can do this without worrying about defaults, because all loans are covered by credit life insurance.

KUSSCO, the umbrella organisation for SACCOs in Kenya, admits that despite claims from some at general meetings about the increase in member deaths from AIDS, SACCOs have not been proactive in addressing the risks in the workplace or among their membership. Also, despite the fact that the NACC provides funds to cooperative organisations to create awareness programmes, many SACCOs know that these are one-time funds and have not taken the initiative to obtain them. Neither KUSSCO nor individual SACCOs have explored partnerships with AIDS support organisations to make this happen.

<sup>30</sup> However, DTMs will be able to offer a variety of deposit products.

Instead, KUSSCO has organised Education Days for groups of SACCOs at the provincial and sometimes local level where HIV prevention, re-infection and discrimination against infected/affected staff members have been among the topics covered. This education session is generally led by an outside AIDS educator or doctor, and paid for through KUSSCO's annual budget. One KUSSCO manager admitted that it has been hard to convince people that they need to know about HIV; she feels Kenya is saturated with information and that people feel they know it, even if that is not the case. She gave an example of a teachers' SACCO in Western Province, where risky behaviour may inadvertently be promoted by making teachers travel into town where they have to stay the night in order to collect their salaries. Anecdotally this is thought to increase the chances for transmitting the virus, despite campaigns by the government to include AIDS prevention/deterrence messaging ("AIDS kills") directly on the pay slips.

#### ***WOCCU's mitigating the economic impact of HIV/AIDS programme through SACCO restructuring***

The World Council of Credit Unions (WOCCU) programme, with funding from the US Department of Agriculture (USDA), is implementing a programme for AIDS-affected populations in a much different way from other organisations in Kenya. The programme has three components:

- Increasing the financial sustainability of and modernising four SACCOs in Nyanza Province through the provision of stabilisation loans;
- Working with farmer groups and SACCOs to increase agricultural lending and to get access to agricultural business development services, including training in labour-saving and conservation technologies; and
- Providing loans and livelihoods support and training to caregivers, PLWHA and OVC.

The third component entails forming partnerships with groups of caregivers (selected by WOCCU, not by a CBO) and incorporating PLWHA to work on business ideas together. To these groups, group loans are provided for group business initiatives. Business initiatives are predominantly agriculture focused, but with a specific interest in labour-saving crops and farming techniques. These labour-saving crops and farming techniques include fruit trees, palm oil production, bee-keeping, kitchen gardens, ruminants, and medicinal herbs, among others, and are meant to recognise the time limitation of caregivers and the energy/strength deficiencies experienced by PLWHA managing their chronic illness.

In addition to the group business components, WOCCU is trying to get groups to develop partnerships with schools for feeding programmes, among other programmes, as a way to give back to the community. Unlike other economic strengthening programmes that work with AIDS-affected groups, USDA does not want WOCCU to providing any other health services or goods. USDA wants them simply to focus on the livelihoods side.

A few of the partner SACCOs have also developed sensitivity and awareness training programmes. Walimu SACCO has developed a peer educator programme for its members, and is hoping to roll it out to other SACCOs on a fee-for-service basis. Walimu is also setting up a foundation that will provide scholarships for secondary school.

#### **4.3.8 The facilitators**

##### ***CARE Kenya's GSL programme***

Like its VSL programmes in other African countries, Care International has multiple programmes in Kenya that set up group savings and loan (GSL) programmes, particularly in Kibera in Nairobi and in the Kisumu area targeting the fishing community on Lake Victoria. As in other countries, Care does not target PLWHA or AIDS-affected communities per se, but instead works with extremely vulnerable community groups to build their own savings and loan funds for the group<sup>31</sup>.

These groups do not need to include existing entrepreneurs, but focus on getting people to think first about savings and then on how to improve their economic position. Care knows that many of its groups already include a variety of AIDS-affected groups, including caregivers of the sick and orphans, youth and vulnerable women, who are often pulled out of existing businesses to provide care and are simply looking for survival strategies. By forming a group savings and loan, Care helps them to build both the social and the financial support and empowerment that they desperately need.

One Care Kenya GSL programme is working with older women who care for between two and five OVCs. The group receives a one-time cash injection to start a small IGA<sup>32</sup>. They are then tasked with identifying one older OVC to groom to manage the business. As a result of the GSL, this group also is able to discuss issues surrounding children's rights, wife and child inheritance. Because the model is a powerful tool for behaviour change, groups become empowered over issues of child and wife (dis)inheritance. In traditional society, where male community leaders often determine the disposition of the family when the male spouse/father passes a way, a woman voicing her opinion that she will not be inherited has had powerful consequences and has kept families together.

GSL groups also often set up their own social funds that may provide additional funds to a family overburdened with medical bills or other emergencies. These funds are, however, given to members, not lent. Occasionally group members also save, with other beneficiaries – namely, their children – in mind.

<sup>31</sup> Care has discovered through trial and error that targeting only creates greater stigma for the group.

<sup>32</sup> In general Care does not make cash injections into groups.

### 4.3.9 Associations/networks of financial service providers

#### *Association of Micro-Finance Institutions (AMFI)*

Although serving as the organiser of a 2005 training using the Defining Options methodology, AMFI has in the past not been particularly focused on HIV/AIDS as an issue. However, with changes in leadership in recent years, its director is now quite keen on undertaking a number of initiatives with respect to HIV/AIDS. As the board member of a local AIDS CBO that supports orphans and widows, he has approached the Ford Foundation about helping him mainstream HIV/AIDS into micro-finance, but was turned down for budgetary reasons. Having recently attended a HIVOS-sponsored training in Dar es Salaam, AMFI plans to focus on:

- Sensitising MFIs to the social factors of working with AIDS-affected clients, and specifically training loan officers to deal with the health and financial ramifications of HIV/AIDS;
- Helping MFIs develop special products for the AIDS-affected, including short-term credit, medical insurance, loans for agricultural and nutritional support (possibly through urban/kitchen garden programmes);
- Creating a network or platform for sharing information about AIDS support organisations so that MFIs have a resource to turn to for information and partnerships; and
- Working with MFIs to do lending for start-ups and BDS training.

AMFI is very interested in bringing member of the micro-finance community together in the coming weeks to discuss some of these plans.

#### **KUSSCO**

As mentioned above, KUSSCO is not currently providing anything more than ad hoc information to member SACCOs on HIV/AIDS. It does not currently have a workplace or wellness programme for its 130 employees.

## 4.4 HEALTH SECTOR APPROACHES TO ECONOMIC STRENGTHENING OF AIDS-AFFECTED POPULATIONS

Below are examples of the some targeted and untargeted economic strengthening and market development initiatives that are seeking to make an impact on the spread of HIV/AIDS. The quality and real impact of these programmes varies greatly; as of yet there has been little quantitative econometric research on the impact of different approaches (and therefore also on the role of subsidy) that could shed light on what works best under what circumstances<sup>33</sup>. Some organisations explicitly target the AIDS-affected with the hopes of providing quality services to them, but miss the mark. Others do not target the AIDS-affected but work on broader economic strengthening

that may change the economic and risk profile of individuals and households to keep them from increasing their risk of contracting AIDS.

### 4.4.1 African Medical Research Foundation's (AMREF'S) Kibera community-based health care programme and revolving fund

The African Medical and Research Foundation, a large African-based, multi-dimensional medical research and health organisation, has been working since 1998 to improve health and socio-economic conditions in Kibera, specifically Laini Saba and Mashimoni. The programme is focused on providing promotive, curative, and preventative services to the community in the Kibera slums. It currently has six components: 1) a clinical component that provides direct health care through a clinic, 2) a programme focused on TB, 3) a water and sanitation programme, 4) a personal hygiene and sanitation programme, 5) a programme for distribution of ARTs and 6) micro-finance. The micro-finance fund, recently registered as the Kibera Community Trust, in particular came into existence because according to AMREF no other financial service providers were interested in providing financial services to the slum community. The whole project currently works with 100,000 persons; the micro-finance programme works with approximately 1,500 clients.

The micro-finance programme was started with seed capital of 10 million KSh from AMREF and the Shell Foundation UK, 5 million of which has gone for loan capital. The local community has also contributed an additional 5 million KSh in voluntary savings. The fund is using a Grameen replica model to provide loans and savings services to this community. AMREF sees this as a fund for the community. In addition to loans and savings, clients receive business management training from AMREF and AMREF-identified facilitators. Loans range from 5,000 to up to 150,000 KSh with 1 percent per month flat charged, which still reflects a below-market interest rate in Kenya.

Although this loan fund is meant to complement the medical services, the fund's clients are not necessarily the same as those receiving medical services, so in many ways it has missed the mark of truly serving health-compromised households. Additionally, the longer-term viability of this programme is in question once donor funds no longer pay the subsidy for the programme. AMREF is considering registering the fund with the government and hiring someone to manager it full time, assuming they can figure out how to cover the cost. A more appropriate strategy might be to partner with an existing MFI and have it take over the portfolio, while maintaining a partner link to AMREF for medical services.

<sup>33</sup> Econometric studies that focus on the impact of different economic strengthening approaches such as was done by IMAGE in South Africa and ones undertaken by the IFPRI/International Service for National Agricultural Research (ISNAR)'s RENEWAL programme (Regional Network of HIV/AIDS, Rural Livelihoods and Food Security) offer a good start to increasing the body of empirical evidence out there on what works and what does not.

#### 4.4.2 Academic Model for the Prevention and Treatment of HIV/AIDS (AMPATH)

The Academic Model for the Prevention and Treatment of HIV/AIDS (AMPATH) operating in Western Kenya uses a systems-based approach to HIV prevention and treatment that links clinical care, research and training. It promotes and fosters a multi-sectoral approach to HIV control that complements the existing health infrastructure by preventing new HIV infections, but also works to improve the quality of life of people living with and affected by HIV by mitigating the social and economic impact of HIV and TB. The programme, which currently works with 60,000 HIV-positive people, provides treatment and health services in more than 18 sites in rural and urban areas, but also has a variety of initiatives to deal with the socio-economic issues as well. These initiatives include:

- The Family Preservation Initiative, which focuses on keeping families together and self-sufficient, particularly when one spouse has died, the other is sick and there are multiple children to be cared for. The programme focuses on income security, specifically providing job skills and micro-finance for IGAs. The initiative also fosters farm cooperatives.
- The HAART<sup>34</sup> and Harvest Initiative, which provides food and nutrition to malnourished AMPATH patients receiving treatment for approximately 6 months to get people healthy and back on their feet. In 15 of AMPATH's sites, it has set up a sustainable food programme with demonstration farms that enable subsistence farmers to improve their agricultural output while also gaining access to treatment and prevention information. The programme has created a system which allows successful farmers to market their excess produce, generating additional incomes for their families.
- The OVC programme, which provides basic for basic physical and psychological needs for extended families left to care for orphaned children. The programme is providing school fees, school uniforms and clothing for needy orphans.

#### 4.4.3 The Academy for Educational Development (AED) Speak for the child project

The Speak for the child project began in 2000 in Nyanza, Western and Coast provinces, with the aim of providing basic health, nutrition and psychosocial care of young children orphaned as a result of AIDS. Supported by the Elton John Foundation and the Children's Investment Fund Foundation, the programme focuses its initiatives on three groups: children under 12, older children and their caregivers, although community mentors or volunteer caregivers are also a big focus of the programme since they deliver many of the services to

<sup>34</sup> HAART refers to the first protease inhibitor anti-retroviral therapy developed in 1996 that has radically changed the mortality and morbidity of infection due to HIV. HAART stands for highly active anti-retroviral therapy. Since the use of HAART became common, the incidences of both AIDS cases and deaths from AIDS have declined dramatically.

OVC households. Programme beneficiaries are targeted through local CBOs. Households are given some basic household-level commodities (blankets, bed nets, soap, and water purification products), access to basic preventative health services such as immunisations, vitamin A and de-worming, and, where most needed, food supplements for those on ARTs or malnourished. AED has also set up service agreements with schools, health clinics, and pharmacies to cover preschool fees, medicines, and immunisations.

A big focus of the programme is training community mentors to support caregivers who may be older orphans, single parent households or often grandparents. These mentors are usually part-time caregivers themselves (some may also be HIV positive), but who agree to look after additional households for a stipend<sup>35</sup>. For Speak for the Child, mentors care for between 30–32 orphans from 15–18 households. Mentors are trained to provide various aspects of support including preventative health, psycho-social support, nutrition counselling, and problem solving and to train the caregivers. In some instances, this means setting up kitchen gardens, taking the BMI of children, providing food supplements if needed and providing preschool fees.

Households generally stay in the programme for two years; the first year is focused on the child, the second year on the caregiver with the aim of ensuring that caregivers ultimately can manage their children. This latter focus has two elements: psycho-social support and then assistance in setting up group-based income-generating activities. A number of the CBOs have set up an incentive fund to provide some funding to groups of caregivers and mentors that have set up IGAs. According to the programme managers, not many from this group are able to access formal financial services including micro-finance. One of the biggest hurdles (and a future hurdle for orphaned children) is lack of a national ID card or birth certificate. Although some organisations are working on the margins of this, not many are working on getting legal documents for this community.

#### 4.4.4 Africa Now village bank partnership and support to fisherfolk

Africa Now is an Oxford-based NGO that works to address rural poverty by working with small scale farmers and promoting ethical trade. In Kenya Africa Now works primarily with small holder producers to produce more and get it to markets—local and export. As part of its work with the fishing community in Nyanza, Africa Now is working with KDA to set up village banks to respond to local financial service needs. The village banks work with fisherman and

<sup>35</sup> The issue of mentor or volunteer stipends is a thorny one that was raised over and over again by multiple health organisations. Some organisations believe that because these individuals are “volunteers” they should not be paid; others pay them directly but do not treat them as staff which is likely to be in violation of the current labour law. Both groups complain that when community health workers are not being compensated, they do not provide the care services beyond their immediate households. The fact remains that the concept of volunteerism may mean something different in communities where people are underemployed and struggling to meet their own basic needs and organisations need to recognize this.

women's groups to support their economic activities. With the prevalence in Nyanza well over 15 percent, a high percentage of clients are HIV-positive or are part of AIDS-affected households. The 7 village banks currently serve about 12,000 clients and have an outstanding portfolio of 8 million shillings.

More importantly through their work with local communities, particularly women, Africa Now's work has had an impact in terms of changing the dynamics of the economics, equity and power among men and women engaged in commerce around fishing. For example, where women previously were not directly involved in the fishing industry; they did not work in the beach management units, did not fish, nor did they own boats. As part of its gender mainstreaming, Africa Now has worked to help women become boat owners and have paid jobs within the beach management units. As a result, some women have been able to move away from the dynamics of exchanging sex for the first cut of fish in order to survive.

#### 4.5 OTHER PROGRAMMES FOR THE AIDS-AFFECTED

##### 4.5.1 UNICEF/Government of Kenya cash transfer programme for OVC (CT-OVC)

Starting in 2004, the Ministry of Gender and Children and the Ministry of Home Affairs (MOHA), in conjunction with UNICEF, has been implementing a cash transfer programme (CT-OVC) to protect and assist OVC who are mainly made vulnerable by AIDS – and, most importantly, keep the families together. Targeting HIV status, however, is not a criterion for involvement in the programme. UNICEF's role has been to provide the necessary technical assistance to the Department of Children's Services on the design, implementation and evaluation of impact. The programme began by supporting 500 OVCs in three districts (Nairobi, Garissa and Kitale) and was quickly scaled up to 3,000 households in 13 districts. Cash transfers of 1,500 shillings monthly were made to targeted beneficiaries through the district-level children's officers, who delivered the cash to OVCs and their designated recipients on a bi-monthly basis.

Phase Two of the programme, launched in June 2006, provided additional financial support from the Government of Kenya, UNICEF, DFID and SIDA. The aim of Phase Two is to provide cash transfers to more than 30,000 OVC in 37 districts over the life of the programme. In Phase Two a number of programmatic changes have been made. First, different cash transfer mechanisms are being employed, including using the post office system in seven districts to distribute bi-monthly cash payments<sup>36</sup>. By looking at different payment mechanisms, the programme could test both the cost and security issues associated with making the payments<sup>37</sup>. Second, conditionality is being applied in some

districts to compare usage of health and school facilities; penalties will be applied for non-compliance. Third, a clearer geographic targeting process has been used to give priority to areas with a higher poverty and HIV/AIDS prevalence rate (assuming this will yield the highest number of OVCs).

Phase Three of the programme is geared to come online in 2008–2009, with the aim of reaching more than 100,000 OVC. The Ministries of Gender and Children and MOHA also aim to establish a pooled financing arrangement between the Government and various donor partners that will allow for the most effective channelling. As time has gone on, the Government has continued to put more money in the programme; in 2008 it is contributing close to 550 million shillings. The hope is that the Government will continue a phased expansion of the programme (as other donors exit over the next 10 years) and the programme will eventually reach at least 30 percent of the poorest and most vulnerable OVCs.

Additionally, in Phase Three partners such as UNICEF also want to experiment with add-on activities that provide additional social or other benefits to the children. To date the discussion has focused on adding awareness messaging and potentially creating linkages with other health and child welfare organisations such as World Vision, but these had not yet been undertaken. Yet programme managers did share concern over what happens to children/youth once they graduate from the programme. They admitted this was a thorny issue. However, this may also open up an opportunity for programming that transitions youth from social protection to employment or business opportunities once they turn 18 years old and graduate from the programme. Herein lays a potential link to financial services, namely savings.

Opportunities may also exist for add-in approaches to financial services. For example, when probed about the payment mechanism for this cash transfer programme and the potential of exploring other payment systems whereby the funds are transferred to a bank account held in the name of the child or his/her named recipient or some other smart card- or cell phone-based mechanism that might take advantage of lower-cost payment facilities, UNICEF and Ministry officials were somewhat sceptical. While they were interested in exploring other cash delivery mechanisms and admitted interest in Safaricom's M-Pesa programme as a delivery channel, they also expressed worry that these systems may somehow have an inflationary effect in the local market. For this reason programme managers are paying close attention to the roll-out of the Hunger Safety Net Programme in Northern Kenya in which DFID and FSD are involved, FSD on the contracting of Equity Bank to undertake the creation of a card-based payment network. Either way, add-ons and add-ins to this programme may be possible in the short and medium term.

##### 4.5.2 Gold Star Network

Launched in 2006 as a partnership of Family Health International and the Kenyan Medical Association, the Gold Star Network is an HIV care and treatment

<sup>36</sup> The post office system in Kenya has more than 500 branches and thus, has deeper penetration into rural areas than other banks or government offices do.

<sup>37</sup> Note: UNICEF was clear to point out the hidden costs associated with having district children's officers make the cash payments, including the need for security, petrol and even graft.

programme developed with the intent of keeping HIV-infected workers well and productive using the private healthcare system. The Gold Star Network works at two levels: 1) it works with private medical providers to upgrade and assure high-quality HIV treatment and care services to Gold Star members and 2) it signs up and administers the programme to private sector company members. The intent of the programme is to ensure that private services are available alongside the highly subsidised HIV treatment and care services offered through public sector health facilities. Network members gain access to HIV test-kits, medicines and quality ART drugs (branded and generic) at low prices. The Network is currently active in Nairobi, Nakuru and Mombassa.

Gold Star has a keen interest in working with a health insurance providers to cover the cost of these services for Gold Star network companies. Ideally, the partnership would effectively work as health or disease management organisation. This could also entail work on a larger health payment system that is smart card-based. Additionally, it would like to work with the Kenyan government to upgrade health services provided by less costly medical providers, such as clinical assistants, nurses and pharmacists.

#### **4.5.3 Sustainable Health Enterprise Foundation**

The Sustainable Health Enterprise Foundation, or SHEF (formerly HealthStore Foundation) is a US-based not-for-profit foundation that seeks to improve access to essential drugs, basic healthcare and prevention services for children and families in the developing world using business models that are scalable, maintain standards and achieve economies of scale. SHEF uses

a micro-franchise model to enable Child and Family Wellness (CFW) branded pharmacies and local clinics, CFWshops™, to provide access to the drugs and healthcare people need that treat the diseases that cause 70–90 percent of the illnesses and deaths in rural communities. In 2000, SHEF launched the CFWshops in Kenya. As of July 2008, the network has grown to 65 drug stores and primary care clinics owned and operated by Kenyan nurses and health workers in rural areas, serving well over a million clients.

CFWshops are able to maintain high-quality standards by incorporating simple clinical and business procedures into their franchise system. One example is the patient register in which each franchisee records every transaction and treatment. CFWshops franchisees undergo a rigorous, four-week training programme that teaches the basics in record keeping, procedures, product standards and pricing. Those that do not comply have their status revoked. SHEF has plans to expand to 225 locations which will reduce the treatment cost per patient to under US \$1 per year. IFC is supporting this expansion through its Grassroots Business Initiative.

SHEF is exploring implementing Voxiva's data management system throughout its franchise network. The Voxiva system will allow franchisees to feed data into a central data base via cell phones, PDAs or laptops. It is also looking a third party payment system to help finance the use of the franchise network. Ideally, franchisees will be reimbursed for the cost of drugs and services through a combination of patient co-pay and third-party reimbursement. This health insurance coverage is being discussed with USAID, among other donors.

Table 3: Financial service and health interventions in Kenya that serve the AIDS-affected

Organisations/Programmes	Prevention messaging	Workplace programmes: Minimalist	Workplace programmes: Comprehensive	CSR activities	Training/ tools	Financial products: Loans	Financial products: Savings	Financial products: Insurance	Non-financial products: Training	Other non-financial services	Partnerships	Behaviour change	Economic strengthening	Cash transfers	Cash transfers with add-ins/ add-ons
Barclays	X		X	X											
K-REP Bank	X	X													
Equity				X											
KDA						X	X	X	X		X				
SMEP				X		X	X	X							
FAULU				X				X							
KWFT				X				X							
WOCCU						X	X	X		X Assistance with group economic activities			X		
Jamii Bora								X							
AMFI					X										
KUSSCO															
Occasional															
CARE Kenya GSL	X					X	X		X	X Empowerment training					
Africa Now											X		X		
AMREF						X									
AMPATH	X					X	X			X	X	X	X		

## Chapter 5

# OPPORTUNITIES FOR FINANCIAL SECTOR INITIATIVES

Despite the presence of many different programmes and organisations that address HIV/AIDS through financial service or financial interventions, there is currently no programme or organisation that takes a comprehensive or exclusive look at how the financial sector can contribute to the prevention of HIV transmission or the mitigation of its impact on clients. Instead more focus has been placed on the economic strengthening of AIDS vulnerable populations, in which financial services is one tool that can contribute to building the household's safety net. Additionally, donors are pushing organisations they support to ensure that economic strengthening are market driven and ultimately mainstream PLWHA and AIDS-affected clients. Achieving this will mean that the private sector and other non-health development organisations will need to begin systematically mainstreaming the AIDS-affected into their programming. This does not necessarily mean targeting them exclusively for services, but instead figuring out ways to address the constraints that hamper their ability to access financial and other services.

With respect to the role that the financial sector can play a role in responding to the pandemic, the list of options in any context is narrow. There is, unfortunately, no magic bullet to solving the financing dilemma. Instead, responses will include a mix of the following options.

1. Strengthening the overall capacity of the financial service provider to continue to provide services by ensuring it can manage its portfolio risk and can manage the impact of the pandemic on its own staff (which in turn impact the institution with increased staffing costs, and lowered productivity and morale);
2. Strengthening the capacity of financial service providers to understand the changing market through market research, so that they can develop and promote financial products that address the constraints felt by AIDS-affected households and help them to manage their own household responses to the pandemic—all while not undercutting the long-term sustainability of the provider (and thereby access to services by the client);
3. Where appropriate, improving the basic services needed to bolster the safety nets of the poor. From a financial sector perspective this may be limited to facilitating payment systems which ease the payment of cash transfers or medical bills; and
4. Where appropriate, building an informed clientele that understands the products and services that can be obtained and the risks and benefits of each.

In Kenya each of these above options has already been addressed to some extent, but further investment can be made in implementing these options on a more systemic level. First, this should be in workplace programmes. The financial service providers with the deep pockets, namely banks have already done this. Next up should be the development of workplace programmes for institutions that work with poorer clients, namely the MFIs and SACCOs.

Second, investment should be made in developing new or improving existing financial products, especially insurance and savings, but also loans for agriculture, and consumer loans. This list includes:

- Affordable health insurance products that allow access to broader health services not just catastrophic hospitalisation coverage and the payment network that simplifies the payment or reimbursement of these costs;
- Contractual savings mechanisms that allow families and guardians to save for children—either for education (secondary or beyond) or for longer-term asset accumulation;
- Agricultural loan products that allow households to invest in labour-saving types of agriculture; and
- Supplementary or consumer loan products that allow PLWHA to pay for transport and other non-treatment costs of getting treatment;

Third is the need to improve basic services to build and bolster the social safety nets of the poor. From a financial sector perspective, this means finding ways to make payments simpler, easier, cheaper and faster. This could include add-in programmes for existing social protection programmes, such as the OVC-CT programme or health payment systems to improve the processing or facilitate the payment of medical bills (as an add on to improved health insurance coverage).

Fourth, much more work needs to be done to improve overall financial literacy, including that of the AIDS-affected. Financial service providers, governments and donors need to give added consideration on how to improve formal and informal financial education such that people understand the basics of personal and business finance.

Finally, there is the need to create a more formal nexus between health and market development actors (including financial service providers) in which information, ideas, and innovations are shared, and where partnerships can be formed to address overlapping constraints.

In the coming section these options will be detailed as well as the challenges and questions that need to be addressed in order to be successful.

## 5.1 WORKPLACE WELLNESS PROGRAMMES FOR MFIs AND OTHER FINANCIAL INSTITUTIONS

Although Kenya has a generalised AIDS pandemic, it does not have the high prevalence rates seen in Southern Africa (20 percent or more), where the disease has had a major impact on business in terms of cost and loss of productivity. Thus, workplace wellness programmes are not as well developed as in those countries. Nonetheless, workplace programmes have proven to be a good tool to reach employees, their families and sometimes the surrounding communities with positive health messages, including HIV prevention. This study revealed that a number of organisations, namely MFIs and SACCOs

but also some banks, have not set up workplace programmes to address the needs of staff members and their families with respect to HIV/AIDS (or other health issues). For organisations that employ hundreds of employees, this is an oversight and an opportunity.

In Kenya a number of organisations exist that can provide assistance to financial service providers in setting up workplace programmes. The Kenya HIV/AIDS Business Council has a new programme targeting SMEs (the size of many of Kenya's MFIs) to assist them with programmes that can be effective but also not extremely costly. Similarly, Standard Chartered and Barclays offer support to businesses in designing, rolling out and mentoring other financial institutions in the creation of workplace wellness programmes and peer education models at no cost. They also see this as having a big impact on how these institutions directly or indirectly serve AIDS-affected populations. Finally, the Gold Star Network is signing up a variety of private sector employers to provide access to a variety of HIV/AIDS resources (VCT, ARTs, and other support) through private hospitals.

The workshop set up by FSD and this author brought a number of these groups together (Barclays, Gold Star Network, the Kenya Private Sector Business Council, GBC, KUSSCO and AMFI) to discuss the possibility of developing workplace Programmes using AMFI and KUSSCO as aggregators of larger groups of MFIs and SACCOs. There appears to be great interest in doing this and sufficient low-cost support to do so. The key challenges and questions for them in developing new workplace programming include:

- Can the programme cost be low enough for SME (such as for many SACCOs and MFIs)?
- Can these network bodies attract MFIs and SACCOs to forums and workshops to first sensitise them to the need and then work with them to develop them in-house?
- Should new workplace programmes be designed as part of larger employee wellness initiatives or as stand-alone HIV initiatives?

## 5.2 PRODUCT DEVELOPMENT: AFFORDABLE COMPREHENSIVE HEALTH INSURANCE

Affordable, comprehensive health insurance that covers outpatient and inpatient medical treatment particularly for lower-income clients, is lacking in the Kenyan marketplace. While such comprehensive coverage does exist in the upmarket for employees insured under company-paid insurance schemes, these insurance schemes are generally provided at an additional premium and at a price point that is much higher than the majority of the market is able to pay. And while the recent roll-out of inpatient coverage by CIC and NHIF is certainly a good start, it is not adequate to address lesser health emergencies and illnesses that require treatment but not hospitalisation, and it is certainly inadequate for addressing preventative health. Studies from other countries,

for example, have demonstrated that lack of access to outpatient services only drives up in hospital costs.

The workshop organised by the author and FSD at the close of this assignment revealed not only a lot of interest in the topic, but also brought together different players actively working on the development of low-cost comprehensive insurance. At the workshop, the insurance providers AON and CIC as well as representatives of the Gold Star Network were able to meet with a USAID health adviser who briefed them on their interest in investing in a new social health insurance product or health management initiatives that could be rolled out to lower-income populations at an appropriate price point. Through this initiative USAID is also considering how to link the insurance to a third party healthcare provider. Among the candidates under consideration is the Sustainable Health Foundation, which is actively developing its franchising model of nurse owned and managed, fee-for-service health clinics in rural Kenya.

In attempting to create this product, insurers, health organisations and donors will need to consider the following complicated challenges and questions:

- What will the insurance cover and what will be excluded? Will this comprehensive coverage include counselling services, the provision of ARTs and regular CD4 counts and viral load testing? Will it cover the household, the family and/or the individual? Will it cover death and indemnity?
- Are these benefits and exclusions likely to positively influence the adoption of the product by low-income clients?
- What is the appropriate premium level for low-income households? Can costs be contained so as to make this product attractive to commercial insurers to provide? Can resources be mobilised from other sectors, including the national government, to speed up the development of this product?
- Can this comprehensive insurance provide access to quality healthcare, particularly in rural areas? Is the government willing to refine and approve quality control standards such that lower cost health clinics can be covered by insurance?
- Can payments be streamlined and reimbursement policies efficient such that low-income clients can participate even when they lack the cash flow? Can this initiative be linked into other payment mechanisms that lower the cost of payment and simplify the process for clients?
- Can moral hazard, adverse selection and fraud be minimised?
- Can some kind of financial education be provided to allow clients to understand the product?

### 5.3 PRODUCT DEVELOPMENT: CHILD SAVINGS ACCOUNTS

With the numbers of orphans increasing each day, the need for products in which parents and guardians can invest in the short, medium and long term is important. While a number of MFIs and SACCOs have already developed loans for school fees which are predictable expenditures for their clients, more could be done to develop contractual savings products that allow for the regular accumulation of lump sums to pay for school fees at the secondary level or for other events. This product would be particularly important for girls who are more likely than boys to not attend when financial pressure is put on the household. Past studies in Kenya have indicated that clients would find this an attractive product if 1) it were linked to another liquid savings account that could be used in the event of an emergency (or the ability to borrow against it) and 2) if there were adequate returns on the savings<sup>38</sup>.

Developing such a product has its own challenges and questions.

- Can products be designed to meet the short-, medium- and long-term needs of the children in mind?
- Can the business case be made to banks to develop such products, knowing this type of product is often a loss leader?
- Can financial education about the importance of savings be delivered to the long-term benefit of the child and guardian?
- Can the product be adequately protected from any parent or guardians who may choose to divert the funds to other events down the line that do not benefit the child?
- Can national policies be influenced to encourage the uptake of child savings or provide incentives (tax, direct transfers) to families and households that save for their children?

### 5.4 PRODUCT DEVELOPMENT: LOANS FOR LABOUR-SAVING AGRICULTURE

Many of the organisations working on increasing food security and strengthening the economic position of AIDS-affected households recognise the need for the AIDS-affected, particularly PLWHA and caregivers, to use their time and energy wisely. Both caregivers and PLWHA may not be able to commit their entire days and weeks to tending to businesses or agricultural activities because they spend their time caring for the sick or children, or must conserve energy to live healthier if they are undergoing treatment. Labour-saving agricultural activities range from kitchen gardens to fruit trees, mushroom production, bee keeping, and palm oil production. Initiatives that identify both appropriate agriculture and market opportunities for expansion, such as has been done by COPE, WOCCU, Life Works and others may be good

partners for linking into newer value chain finance initiatives being explored by donors and financial institutions. For example, in Uganda the COPE project was able to get the exporter to extend credit for fruit dryers to initial groups of AIDS-affected people who supplied them the dried fruit. Subsequent groups who joined the programme were asked to save first before being extended credit.

A number of value chain finance initiatives are currently underway in Kenya, including some attempts to finance fruit trees. Linkages between these initiatives and ongoing economic strengthening activities could afford some unique opportunities and provide economic benefits to AIDS-affected groups. These are also not without challenges and questions, many of which remain on the non-financial side:

- Can detailed market analyses be done to ensure that the opportunities are real and at the market? For example, are the small producers to whom finance would be provided food-secure and thereby able to sell excess instead of consuming it? Is there sufficient volume for sale?
- Can buyer/exporters be leveraged to build credit histories for small producers who have not accessed credit before (for example, through reverse factoring or other schemes?)
- Is there sufficient access to value added/embedded services that will ensure that products meet quality, phyto-sanitary and other standards required by the market?
- Can longer-term relationships be built by AIDS vulnerable groups with buyers and exporters? Can smaller firms cooperate to collectively meet the demand required by buyers and exporters?
- Can initiatives be linked into large land tenure initiatives to sort out land ownership for smaller producers over the long term?
- Can financial institutions sufficiently hedge against the risks associated with the specific agricultural activity, using insurance or other hedging devices?

While the financing of labour-saving agriculture, could be interesting and is needed among some groups, many of the larger questions need to be sorted out before finance could be provided.

### 5.5 PRODUCT DEVELOPMENT: LOANS TO COVER NON-TREATMENT COSTS OF ARTS

With access to ARTs, good nutrition and improved health lifestyles, PLWHA can and are living productive lives. The death sentence that was AIDS ten years ago has changed as individuals are living for ten, fifteen and even twenty years longer than originally anticipated. In Kenya, particularly in larger urban areas such as Nairobi, Kisumu and Mombasa, access to ARTs through public and mission hospitals is strong and growing. In secondary cities access is

<sup>38</sup> Donahue, HIV/AIDS - Responding to the Silent Economic Crisis Among Micro-finance Clients in Kenya and Uganda, 2001.

also expanding. However, for people living in peri-urban and rural areas, the key issue to accessing this free treatment is the non-treatment costs, namely transport. Although these transport costs are infrequent, particularly once treatment has begun and the drug regimen is adhered to, initially these costs could be great for poorer and more rural individuals.

One option is for financial institutions to consider covering transport costs as part of a supplemental or consumer loan. As one World Bank expert noted, the actuarial analysis can be done to support this and show that the risk is low.

The big challenges with the development of this product include:

- Is this product developed for a broader population seeking coverage of a variety of non-treatment-related health costs?
- How does one price it? The same or higher than your standard business loan?
- What documentation is required for verification and does the requirement alone result in greater stigma toward the PLWHA? How does a financial institution verify the risk vis-à-vis the individual client? How can the financial institution know the clients' health profile or drug adherence regime? How can the financial institution mitigate the potential risks of moral hazard and adverse selection?
- Will insurers underwrite the credit life associated with this product?

## 5.6 LINKING THE OVC SOCIAL SAFETY NET PROGRAMME TO FORMAL FINANCIAL SERVICES

The Government of Kenya/UNICEF cash transfer programme for OVC offers a unique opportunity to link children and their guardians into more permanent types of financial services, namely savings. "Add-ons" to social safety net programmes are currently being experimented with in other countries in sub-Saharan Africa, albeit not specifically for AIDS vulnerable populations. UNICEF and the Government of Kenya have indicated an interest in exploring "add-ons" to the existing programme, initially in the form of awareness training.

Through this opening programming and products could be developed, for example, that allow older youth to access training (business skills, empowerment and financial education), mentorship opportunities and contractual savings that would them and their guardians to save small sums toward an end goal at the end of a 18–24 month period. This type of add-on could better prepare youth for their graduation from the cash transfer programme at age 18.

"Add-in" elements to the programme—that is, elements linking beneficiaries and their named recipients into other payment mechanisms may also allow for new exposure and experience with more formal financial services through a bank or even a cell phone provider, such as M-Pesa. Again if this payment

mechanism were linked to longer-term, formal savings, it might provide an opening for developing long-term savings habits<sup>39</sup>.

Developing an "add-on" or "add-in" programme would need to address a number of key challenges and questions:

- How would the additive programme be coordinated with the Government of Kenya/UNICEF? Can current programme managers be convinced of the added value to the programme?
- How would the additional services (financial and non-financial) be provided and managed and against what objectives?

## 5.7 IMPROVING FINANCIAL LITERACY

The ability of individuals to make appropriate decisions on how to manage their personal and business finances, plan and create budgets, save and invest, use credit wisely and manage risk is important to all individuals but especially to those who have fewer resources and with greater vulnerability. The costs associated with AIDS – for illness, hospitalisation, better nutrition, caring for additional children and with the responsibilities at the end of life to bury the dead and provide for those left behind – are enormous. Not nearly enough is being done to address the understanding of these issues by AIDS-affected households. With greater financial literacy comes the possibility to empower and enhance an individual's social system, to develop a positive attitude toward institutional finance and a willingness to adopt beneficial new services and technologies.

There is both interest in and need for financial service providers, governments, economic development practitioners, health organisations and communities to enhance financial education initiatives. For the AIDS-affected, these initiatives should also address issues of legacy planning, legal rights with respect to inheritance, joint title registration among spouses and the rights of children, and with the recognition that this will and needs to change cultural norms and traditions in tribal communities in order to protect women and children in particular. These initiatives could be done in partnerships. For example, VCT clinics who are often the first to help clients cope with new knowledge and acceptance of their HIV status could partner with financial service providers (either through community outreach initiatives or CSR activities) to offer regular or embedded seminars on financial coping, planning and education.

## 5.8 PROMOTING LINKAGES WITH HEALTH ORGANISATIONS

The FSD workshop highlighted a big concern of both health and financial service providers alike: the absence of an organisation or initiative that links both the health organisations and economic development organisations

<sup>39</sup> The author recognizes that at this time one cannot formally "save" using M-Pesa or other cell phone money transfer providers. How this savings would be linked with a more secure deposit-taking institution would need to be explored further

(including financial service providers) together. As a result, new activities, initiatives and innovations tend to happen in isolation instead of building upon the comparative advantages and strengths of the other. Numerous organisations expressed interest in regular seminars and workshops that bring the two groups together and that share information on how to link health security, livelihoods and food security to larger economic strengthening and private sector initiatives. This level of information sharing and coordination is lacking at the programmatic level, and at the donor and governmental level. With the formalisation of this nexus, partnerships could be built, new programmes could be designed that allow different partners to provide their expertise appropriately and the AIDS-affected could be better served at each stage of the progression of their disease. A formalisation of cooperation between the two spheres could improve and broaden both market-based service provision by better informing service providers of the trends and also bolster and build new and existing CSR initiatives.

Irrespective of the form or structure this coordination took and how it was supported (by the government, donors or the private sector, or a mix), this entity could act as a clearinghouse of ideas and knowledge—where knowledge can be shared, partnerships can be built and best practice culled and disseminated to a broader audience.

Such an initiative could also take on the responsibility of developing the Kenya resources for AfriCap's online risk management guide. As has been done for Zambia, the Kenya page could be developed to link together both health and private sector players, including financial service providers, business support organisations, and insurance companies. Combined with regular workshops in which these organisations could learn about each other, this information could expand opportunities for partnership.

## 5.9 CONCLUSION

Supporting HIV/AIDS-affected communities with quality and demanded financial services is without a doubt at the frontier of expanding service provision. How this is done—in a targeted or non-targeted way, as part of larger donor driven market development initiatives or by initiatives developed and led by the public and private sectors working together—remains an open question, if only because more evidence needs to be accumulated and slow progress has been made in all of these areas. The role of subsidy and investment

also remains a difficult question at this frontier given the health side of it is comfortably subsidised and less concerned with the longer term financial sustainability of health-oriented interventions (barring some exceptions related to payment of volunteer health care workers). For the time being, the gray area of where to subsidise and where not remains large, particularly as programme design decisions remain with health donors and practitioners in absence of consultation with economists, financial sector experts, economic development practitioners and the private sector.

Programme implementers – both in the health sphere and in the financial services sphere -- need to apply more critical, market based thinking to solving economic issues faced by HIV/AIDS-affected groups. This thinking needs to apply economic rigour, be evidence –based (not trend driven) and be focused on achieving scale – scale much larger than the tens or hundreds of beneficiaries that some recent high profile economic strengthening and financial service interventions have reached (including some catalogued for this study). The substantial increase in donor funding to combat HIV/AIDS (and the ongoing entitlement that goes with it) should not be the latest excuse to spend millions and reach few.

The recommendations presented in this chapter represent a solid sampling of activities and interventions for which limited subsidy can be provided to either link AIDS-affected groups into market-based financial service activities or bring market-based financial products and services to them. Moreover, all of them have the potential to reach large numbers of HIV/AIDS-affected individuals and households . . . and the sooner, the better.

# GLOSSARY OF FINANCIAL SERVICE AND HIV/AIDS TERMINOLOGY

**Adherence:** Refers to how closely a treatment regimen is being followed. In this case, adherence refers to HIV and taking anti-retroviral drugs. Where a person does not adhere to their treatment regimen, there is a chance that the body will develop resistance to the drug and the drug may not work as well anymore.

**AIDS Service Organisation (ASO):** An organisation that provides care, education, and/or other services to people with HIV/AIDS.

**ART (Anti-retroviral therapies):** ARTs are the newest drugs that can reduce the buildup of HIV in the body and slow the progress of the disease. People with HIV usually take a combination of two or more ARTs. ARTs are also referred to as anti-retroviral (ARVs) in some instances.

**ASCA - Accumulated Savings and Credit Association:** An informal group where savings of members accumulates instead of being given to one member every collection day (as in a ROSCA). Loans can be provided from the collection of mobilised savings. ASCAs may be time bound or they can last indefinitely.

**Asymptomatic:** Without signs or symptoms of disease or illness (for example, the patient does not complain of any symptoms). Most people who are HIV-positive are asymptomatic for 5–10 years or more.

**CD4:** A protein present on T-helper cells in the body. Counting the level of CD4 proteins via a laboratory test can help practitioners learn how strong a person's immune system is. The test is used in combination with the viral load test which measures the amount of HIV in the blood. Both tests are used to predict staging of HIV and help determine the proper medical treatment a patient requires. The number of CD4 cells we have is called the CD4 count. The lower the count, the more likely one is to show signs of illness. A low CD4 count is less than 200 and is usually considered the time to start ART treatment.

**Credit with education:** In this model micro-finance institutions offer credit and savings to groups of individuals. The institution takes advantage of regular group meetings to offer clients additional information and training. This is also referred to as “credit plus”.

**Economic strengthening:** A term often used by practitioners targeting OVC and other AIDS-affected people. In addition to some types of micro-enterprise development or income-generating activities, economic strengthening may also include cash transfers, vocational training and workforce development, and legal services.

**Facilitator:** An international or local institution that uses public funds to promote the development of specific activities, often informal credit and savings or value chain development.

**Financial systems approach:** The development of institutions, regulations and the industry to promote broad expansion of the financial systems to income poorer people.

**HIV/AIDS-affected:** Affected clients include not only the infected, but those who care for the sick, have lost family members, experienced a decline in income due to the illness or death of a household member, care for AIDS orphans or provide care within their communities to other families, children and households.

**Incidence:** The number of newly diagnosed cases during a specific time period. This differs from prevalence, which refers to the number of cases (new or not) on a certain date.

**Income-generating Activity (IGA):** Used in a variety of ways. Sometimes this term is used to refer to micro-enterprises. In other instances it refers to the income creating activities of self-employed, very poor people. Often it refers to group enterprises.

**Living positively:** People who are infected with HIV can live well for many years. Living positively is a kind of treatment that includes a healthy diet and other health-seeking behaviours, hopeful attitudes, and prevention of additional exposure to HIV or transmission of HIV to others. People living with HIV/AIDS should eat nutritious foods, avoid alcohol and tobacco, and get plenty of rest and exercise. Getting support and comfort from family, friends, and religious advisors also prolongs and improves life.

**Market development approach:** An approach to enterprise promotion which focuses on developing private sector markets for goods and services to make them more inclusive and beneficial to specific groups of enterprises and people. Includes both value chain development and commercial business services.

**Micro-finance** is the provision of a broad range of financial services (credit, savings, insurance, payments, etc.) to low-income clients. **Micro-credit** refers to small loans offered by banks or other financial service providers. Micro-finance is the preferred term given that the term micro-credit implies that credit (loans or debt) is the only financial service that is relevant. For those affected by AIDS, micro-credit may be less relevant than savings and insurance.

**Micro-insurance:** The protection of the poor against specific risks in exchange for regular premium payments proportionate to the likelihood and cost of the risk involved.

**Opportunistic infection:** Refers to an infection caused by organisms that do not affect a person with a healthy immune system. Some opportunistic infections experienced by people with advanced HIV infection include

*Pneumocystis carinii* pneumonia, histoplasmosis, viral and fungal infections; and some types of cancers.

**PEPFAR:** The US President's Emergency Plan for AIDS Relief, a \$15 billion fund initiated in 2003 by President George Bush to address prevention (10 million people), AIDS and OVC care and support (7 million people) and treatment (2 million people) over 5 years. PEPFAR was reauthorised in July 2008 for 48 billion for the next five years.

**Prevalence:** The proportion of people with HIV or AIDS present in a population at a specific time. Prevalence includes people who have just been infected as well as people who have been infected for a long time.

**Prevention of mother to child transmission:** Mother-to-child transmission is when an HIV-positive woman passes the virus to her baby. This can occur during pregnancy, labour and delivery, or breastfeeding. Without

treatment, around 15–30 percent of babies born to HIV-positive women will become infected with HIV during pregnancy and delivery. A further 5–20 percent will become infected through breastfeeding.

**ROSCA - Rotating Savings and Credit Association:** An informal saving and loan group where all members contribute equally and receive the collection of funds once per cycle on a pre-scheduled basis (for example, weekly with a distribution schedule set by lottery).

**VCT (Voluntary Counselling And Testing):** VCT is three-step process: receiving pretest counselling and information about the HIV test; taking the HIV test; and receiving post-test counselling to discuss test results and next steps.

# LIST OF INDIVIDUALS AND ORGANISATIONS CONSULTED DURING ASSIGNMENT

- **Academy for Educational Development**  
Lisa Kimbo, Regional Representative, Betty Juma, Chief of Party, Speak for the Child Project Kenya, Byron Radcliffe, Senior Vice President and Director for Development and Planning
- **Africa Medical Research Foundation (AMREF)**  
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- **Africa Now**  
David Otieno, Country Representative, Pamela Agunda, Project Officer, Kisumu
- **Association of Micro-finance Institutions (AMFI)**  
Ben Nkungi, CEO
- **AON Insurance Brokers**  
Joseph Kirono, Assistant Consultant
- **APHIA II Nyanza Project**  
Maryjane Musungu, Community Care Adviser
- **Assured Insurance Brokers Ltd**, Anne Rama, Managing Director
- **Barclays Bank**  
Joseph Wafula, Wellness Adviser
- **Care Kenya**  
Ngugi Chege, Assistant Country Director, Rosemary Mbaluka, Alan Logendo, Nelly Otieno, Project Manager COSAMO, Boaz Omondi, Assistant Field Officer—COSAMO, Sylvester Obare,
- **Department for International Development (DFID) Health Unit**, Tony Daly, Health Adviser
- **DFID Social Protection Programme**  
Ada Mwangola, Social Development Adviser
- **Engender Health**  
Dr Job Obwaka, Country Director and Albert Kombo, Deputy Project Director (Kisumu)
- **Equity Bank**  
Allan Waititu, Director, Projects and PMO
- **Family Health International**  
Dr Charles Thube, Gold Star Network Project, Susan Kimani, Gold Star Network, Vincent Odiara, Gold Star Network, Gail Goodridge, Director of the ROADS Programme and Chris Degnan, Senior Programme Associate, Life Works Partnership Trust
- **Global Business Coalition on HIV/AIDS**  
Tuberculosis and Malaria, Julie Chege
- **FAULU**, Lydia Koros, Managing Director and Pauline Githubu, Company Secretary,
- **International Finance Corporation (IFC)**  
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- **Jamii Bora**, Jack Kinuthi, Manager Insurance
- **Kenyan AIDS NGOs Consortium**  
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- **Kenya HIV/AIDS Private Sector Business Council**  
Dr Hellen Magutu
- **Kenya Network of Women with AIDS (KENWA)**  
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- **Kenya Women Finance Trust (KWFT)**  
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- **Kenya Union of Savings and Credit Cooperatives (KUSSCO)**, Rachel Wafula, Manager, Risk Management Services
- **K-REP Development Agency**  
FAHIDA Programme, Anne Gathuku and Aleke Dondo, Managing Director, Jimmy Riobo, Loan Officer
- **Ministry of Gender, Children and Social Development**, Samuel Ochieng, Senior Children's Officer and MIS Coordinator
- **Office of the President**  
National AIDS Control Council, Regina Ombam, Head Strategy
- **PACT**, Lisbeth Loughran, Regional Director, Grace Mwangi, Technical Specialist, WORTH Programme
- **President's Emergency Plan For AIDS Relief (PEPFAR)**  
David Haroz, Senior Associate for External Relations and Policy
- **Small and Micro Enterprise Programme**  
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- **UNICEF**, Carlos Alviar, Cash Transfer Programme Officer
- **United States Agency for International Development (USAID) Office Of Population and Health**  
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- **World Council of Credit Unions (WOCCU)**  
Lin Johnson, Finance and HIV/AIDS Manager

## OTHER PROFESSIONALS CONSULTED

- **Consultative Group to Assist the Poorest (CGAP)**, Evelyn Stark
- **DAI**, Bill Grant, Practice Manager, Agriculture and Agribusiness
- **HIVOS**, Peter Bas Shrieken, Programme Officer Financial Services and Business Development
- **MicroCare Zambia**, Carolijn Gommans
- **Office of the Global Coordinator/PEPFAR/US State Department**, Lauren Murphy, Michelle Maloney-Kitts
- **Save the Children**, Lisa Parrott, Regional Technical Adviser
- **USAID**, Nhu-An Tran, Allyn Moushey
- **World Bank**, Vijay Kalavakonda, Financial Markets for the Social Safety Net

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## WEBSITES

Standard Chartered ([www.standardchartered.com](http://www.standardchartered.com))

Health Insurance Fund ([www.HIFund.nl](http://www.HIFund.nl))

AfriCap risk management guide ([www.micro-financerisk.org](http://www.micro-financerisk.org))

SEEP Network's HIV/AIDS and Microenterprise Development (HAMED) community of practice and online guide (<http://communities.SEENetwork.org/hamed/node/903>)

USAID microlinks ([www.microlinks.org](http://www.microlinks.org))





