

Case Study Report:
Accelerating Care and Treatment Outcomes for HIV+ Children
through Household Centred Economic Empowerment (HES)
Approach: A Social Security Perspective in Central Kenya

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ACRONYMS

AIDS: Acquired Immunodeficiency Syndrome

ART: Antiretroviral Therapy

CBO: Community Based Organization

CHV: Community Health Volunteers

CQIT: Community Quality Improvement Team

CT: Cash Transfer

GoK: Government of Kenya

HBC: Home Based Care

HES: Household Economic Strengthening

HH: Households

HIV: Human Immunodeficiency Viruses

HTC: HIV Testing and Counseling

IGAs: Income Generating Activities

OVC: Orphans and Vulnerable Children

PLHIV: People Living with HIV

SGBV: Sexual and Gender-based Violence

SILC: Savings and Internal Lending Communities

WASH: Water, Sanitation and Hygiene

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A. EXECUTIVE SUMMARY

Since January 2013 Cheer Up adopted a Household Economic Strengthening (HES) approach for the caregivers and out of school OVC under 18years. The HES approach was a socio-economic protection and stabilization intervention aimed at building the resilience and income of the households to enable them care for the OVC while also supplementing the Government of Kenya coverage of Cash-Transfer programme. Through HES interventions, CHEER UP had reached 216 Households. A total of 841 children were benefitting from HES intervention by end of the period (December 2016). A total of 65 HH caring for OVC received high-grade dairy cows, 120 HH received Merino sheep and 31 caregivers received support to start small businesses and start-up kits to boost their businesses. A total of 378 OVC Households were linked to SILC (Savings and Internal Lending Communities) while 26 Community Health Volunteers (CHVs) and 4 Home Based Care (HBC) Support groups (60 members with 106 OVC in their households) were reached with Income Generating Activities (IGAs) while mature OVC were reached with vocational technical skills. This was done in collaboration through entrepreneurship training and follow-up carried out by Equity Bank, Kimende Branch and CHEER UP Program staff. The innovation was implemented in Kiambu County, Central Kenya, where the innovation has been field tested.

HES approach is worth investing in for several reasons. It provides an alternative non-credit mechanism for the poor, who have always been left behind due to the vicious cycle of poverty and lack of access to services including HIV services. Unlike other innovations in improving access to HIV services, such as incentives for treatment, Testing or adherence, which proved ineffective and costly, HES is household-led, household-owned and household specific. Though the member targeted is the head of the household, the results and outcome are at household level. HES is contextualized and adaptive and seeks to respond to the needs of local business, rides on the people's capacities, interests, priorities and propensity to address their challenges in life, hence the higher success rate of HES initiative. HES approach is hinged on realities of the household through vulnerability assessments while targeting to address specific problems—health, education and general well-being. HES is a good will investment to the family, no debts owned, no repayments and it is truly pro-poor, marginalized and under-served who wouldn't have owned a business.

B. INNOVATION BACKGROUND

Cheer Up designed a community setup Household Economic Strengthening (HES) approach and fostered partnerships and linkages with public and private institutions for business growth, value addition, marketing and diversification. 216 households with HIV+ Children were supported with HES service delivery. A retrospective review of data was conducted in 2018 to compare outcomes and roles of HES while linking them to HIV prevention, care, treatment, and support outcomes for OVC for the period between January 2013 and December 2016.

CHEER UP is a Community Based Organization (CBO) that seeks to improve the quality of life to the OVC, their caregivers, people living with HIV/AIDS (PLHIV) and to poor marginalized households by providing Hope, Care and Support. This is achieved through awareness creation in responding to poverty, HIV and other public concerns among the most vulnerable people in the community and general public by transforming lives, empowering communities, providing leaderships, promoting collaboration with GOK and other stakeholders. Our activities are designed to foster behavior change and minimize risk on HIV/AIDS and other healthcare concerns geared to a resilient and thriving children and families.

The Household Economic Strengthening (HES) is implemented in selected households through a vulnerability assessment, applying the HES Toolkit Guidance. Targeting is done by the project staff and community through representatives implementing the project at the community level, usually through a Community Quality Improvement Team (CQIT) at the locational level. A pre-intervention vulnerability assessment is undertaken and the households that meet the criteria are supported to start income generating initiatives of their choice. Households, based on the Vulnerability Assessment (HHVA) scores, are categorized as less vulnerable, moderately vulnerable, highly vulnerable and extremely vulnerable. The determining factors of vulnerability revolve around availability of household assets, sources of income, savings, tenancy and type of housing, land ownership and sources of basic amenities like food, water, shelter, access to health among others. Less vulnerable households are linked to financial institutions for enterprise development, while moderately vulnerable households are provided with start-up stock for Income Generating Activities (IGAs) and business literacy. Highly vulnerable households are supported to join saving groups and upon stabilization and transitioning to moderate vulnerability, they qualify for IGAs support. Extremely vulnerable households are likened to social safety nets programs, the Kenya's Cash transfer (CT-*Inua Jami*) programmes. They are also expected to transition from extreme, through high vulnerability to moderate and qualify for IGAs over time. The moderately

vulnerable households receive a start-up stock after a market analysis (including value chain analysis) and trainings on business skills and literacy. The households receive continuous training and monitoring while they also maintain book records. These initiatives are monitored for a period of six months to evaluate their success and improvement.

In summary, HES is therefore, an effective way of improving HIV prevention, treatment, and care and support outcomes. Targeting the beneficiaries and health service providers with HES incentivizes the service delivery and provides a sustainable resilience-based approach in responding to HIV. The approach has been implemented as is ongoing. It's replicable and can be expanded for more outcomes.

C. ANALYSIS OF THE ISSUES, CAUSES AND FACTORS

The quest for sustainable income to meet household basic needs and ensure the wellbeing of the vulnerable people led to the birth of household economic empowerment interventions. But the main challenge was how to come up with a sustainable, household-based, participatory, long lasting impact Household economic approach. Household economic empowerment initiatives aimed at strengthening individual and family assets, improving household welfare, and preventing future exposure to the risks. Until 2010, programs providing services to vulnerable populations were faced with the challenges of sustainability, continuity and meaningful impact. First, most of the benefits counted as good impact, could not last beyond the project year. The beneficiaries counted as having improved their wellbeing could not be counted the subsequent year due lack of continuity and fall-off due to diminishing donor investment. The beneficiaries relapsed into emergence situation whenever no more services were forthcoming from the project. Services for vulnerable children and households were always in an 'emergency mode' with little investment in sustainability. Secondly, programs were faced with challenges of designing appropriate economic strengthening approaches that could address all diversities; resource-limited context, urban versus rural, the extremely poor versus the moderately poor, elderly caregivers, beneficiary participation, expert households versus the voiceless poor who were usually left behind.

D. RELEVANT THEORIES

Empowerment Theory

The theoretical orientation of household economic empowerment has equally been explained with varied perspectives in relation to the key variables. The empowerment theory, by Rappaport (1984) and with contributions from Zimmerman (1995), links individual well-being with the larger social environment. In theory, the mental health is connected to mutual help and the struggle to create a responsive and well-doing households and community. It compels us to think in terms

of wellness versus illness and competence versus deficits. In this theory at the household and community level, empowerment refers to collective action to improve the quality of life at the households and in a community in general. Organizational and community empowerment, however, are not simply a collection of empowered individuals, but rather those who require to be empowered.

E. IMPLICATION OF THE PROBLEM

Poverty increases the vulnerability to progression of HIV due to lack of access to essential services in health, nutrition and psychosocial wellbeing. While improved household income facilitates and empowers people towards health seeking behaviour, fights and lowers stigma, lack of income lowers peoples self-esteem and magnifies stigma. The Stigma is often manifested through deprivation, unwillingness and inability to afford basics of live. These easily provides a sad pointer that the inability to access the basic needs is due to HIV, when even if there are others who equally cannot afford the services and are not affected by HIV. Generating sustainable income to meet household basic needs and ensure the wellbeing of the vulnerable people while improving HIV prevention, treatment, and care and support outcomes is critical in ensuring a steady path to UNAIDS 90-90-90 goal.

F. HES AS AN INNOVATION SOLUTION

Economic empowerment enables health workers and adult beneficiaries to plan logistics and co-ordinate HIV care and support service delivery, while ensuring the quality of services. HES related economic wellbeing incentivizes and provides logistical convenience and ease of HIV prevention, care, treatment and support as it provided hope and reason to live a healthy and longer life without the ravages of HIV\AIDS. This rests on the philosophy that when PLHIV are able to overcome poverty, educate their children and access health like any other children in the community, the stigma perception is eliminated. HES provides a pathway where PLHIV can be resilient in the face of social-economic deprivation and lead to a healthy and well-being life.

i) *The development of the HES approach*

Around the same time key programs like USAID PEPFAR and governments including Kenya started thinking about sustainability, quality and continuity of programs. In 2012



joint 'guidance for Government of Kenya (GoK) 'Minimum Service Standards for Quality Improvement of children support programs' were rolled out to players in child care programs. The guidance standards called upon and provided a platform for partners to support economic strengthening at household level to enhance their ability to mobilize resources and build assets to cater for basic needs for children. The ultimate goal of the economic strengthening was to have improved and sustainable income to meet their basic needs and ensure the wellbeing of the children.

With this guidance and trainings provided, Cheer Up designed a household economic strengthening approach that encompassed element of quality, sustainability, continuity, contextual appropriateness and gainful income. In coming up with economic strengthening approach, Cheer Up considered all context; age and capacity of caregivers (most caregivers were elderly), local market chains for the goods, cost of sustaining the investment (labour, land, capital), level of participation by the children and the caregivers and risks. With technical support and mentorship from government departments, technical backstopping from project teams, the Household economic strengthening process, steps, criteria, monitoring tools were developed and implemented. The economic strengthening initiatives were reviewed against the processes, steps, criteria, tools and viability. At the time of development, the beneficiaries were oriented on the HES model. The beneficiaries were informed that the HES model was a 'one-off' investment aimed at ensuring sustainability of the households. They were informed that those household attaining economic stability will transition from the project to create room for others. Many embraced the HES approach while a number felt they will lose out on the support if they left the project.

The organization fostered partnerships and linkages with public and private institutions for business growth, value addition, marketing and diversification. The departments of business development, agriculture, livestock, and micro-finance and local banks provided short courses and services to the beneficiaries of HES.

ii) HES Foundation (Critical success factors for HES)

For HES to be effective and critical axis for improved HIV prevention, treatment and care outcomes (UNAIDS 90-90-90), the organization adopted the following approaches:

1. Whole-Market approach.

In this approach, it was required and emphasized that through HES as many other areas of HIV prevention, treatment and care as possible be integrated to ensure that HIV services were provided at the delivery point. Within HES initiatives, capacity building in income

generation integrated SGBV, adherence, treatment literacy, HIV risks reduction sessions and life skills to build both economic and social resilience. Stand-alone HES outcomes without articulation of HIV services were discouraged, for instance, growing savings without members knowing their OVC HIV status. Economic empowerment has enabled caregivers to build social connections, linkages and resilience while reducing risks to HIV.

2. HES as a pathway to addressing barriers to HIV Services

HES initiatives promoted those initiatives that directly addressed at least one of the services domains for the OVC and HBC in the households. HES was not only about accumulating income but improving access to HIV services. For instance HES through a dairy cow or nutrition garden provides nutrition for the consumption of the family directly while generating income from sale of milk and vegetables. A key element of monitoring and reporting on HES achievement focused on what HIV services were accessed by the households through HES. There was also deliberate effort to check if barriers to adolescent girls' education, prevention and accessing life skills were addressed through HES (girls out of school were more at risk of HIV infection). In monitoring, HES success were to be understood in terms of contribution to access HIV services while linking success to improved UNAIDS 90-90-90 outcomes.

3. Households Modelling.

The concept of empowering households to become model households thrust higher the progress in HIV outcomes. A model household was described as a household which has been reached with HES, is able to consistently access prioritized needs on time adequately for all its members. The idea of model houses was initiated to maximize and link resources to HIV outcomes. A requirement was made on 90-90-90 milestones to have been met or on path to be met before the household attains the status. The pursuit for harmonious confluence between HES outcomes and HIV outcomes, called for equal bi-directional efforts towards both outcomes. This greatly contributed to bi-directional achievement in HES and HIV outcomes. A household whose members were healthy, had known status, adhering well and virally suppressed, were able to attend to HES initiatives with progressive results, while vice versa a household thriving in HES will be able to access HIV prevention (reduced risks), treatment, viral load monitoring, and adherence.

iii. The 5 key implementation Steps

After developing the HES approach; process, tools, criteria and rationale, and for the economic strengthening approach to be effective, 5 key steps were followed.

a) *Orientation of project teams, CHVs and Quality Improvement Team members (QITS) on HES Approach*
First, the orientation of staff and community health volunteers (CHVs) on HES was conducted by the project. The HES toolkit was introduced with relevant tools.

b) *Pre-intervention vulnerability assessment*

The second step involved a pre-intervention vulnerability assessment which was undertaken and the households that met the criteria were supported to start income generating initiatives of their choice. Households, based on the Vulnerability Assessment (HHVA) scores, were categorized as less vulnerable, moderately vulnerable, highly vulnerable and extremely vulnerable. The determining factors of vulnerability revolved around availability of household assets, sources of income, savings, tenancy and type of housing, land ownership and sources of basic amenities like food, water, shelter, access to health among others. Less vulnerable households were linked to financial institutions for enterprise development, while moderately vulnerable households were provided with start-up stock for Income Generating Activities (IGAs) and business literacy. Highly vulnerable households were supported to join saving groups and upon stabilization and transitioning to moderate vulnerability, they qualified for IGAs support. Extremely vulnerable households were linked to social safety nets programs, the Kenya's Cash transfact (CT-*Inua Jamii*) programmes. They were also expected to transition from extreme, through high vulnerability to moderate and qualify for IGAs over time.

c) *Training of beneficiaries and business identification*

The third step involved training of beneficiaries selected for HES. They were trained on business literacy skills, stock management, profit calculation, savings, book keeping, reinvestment, budgeting and prioritization of household expenses versus budget. This was the time the beneficiaries made decisions on the type of Income Generating Activity they wished to engage in after clarity on profits, market analysis and intensity of skills, time, and labor requirement. These moderately vulnerable households received start-up stock of their preference after a market analysis (including value chain analysis) and trainings on business skills and literacy.

d) *Monitoring HES progress and performance against access to services*

The fourth step involved continuous training, business mentorship, monitoring to ensure the success of the IGAs and translation of profits into services. Households received continuous training and monitoring while they also maintained book records. These initiatives were

monitored for intervals of six months to evaluate their success, improvement and documented lessons learnt.

e) Post-intervention vulnerability assessment and exit

Through monitoring, households that had recorded remarkable progress in HES and services outcomes were identified for post-intervention vulnerability assessment. Using the same parameter as at initial assessments, progress was determined. Households that had achieved certain income levels and access to services including HIV services was impressive were earmarked for transitioning plan and for exit. After beneficiaries started recording success and prosperity, many beneficiaries started coming forward to request for consideration to be enrolled in HES initiative. The organization harnessed the pre-existing economic potential of the beneficiaries (some beneficiaries had knowledge and business skills). The HES model was reviewed and received feedback from stakeholders teams for improvement and continuous lessons shared for replication.

iv. Adaptation into Existing Health care and government structures

The HES innovation fits into the Government of Kenya and devolved county priorities. The innovations appropriately responds to the government call. This innovation therefore contributes to the National minimum service standard for QI guidance, essential actions and desired outcome. In reference to the Minimum Service Standards for Quality Improvement of Orphans and Vulnerable Children (OVC) Programmes; Kenya (2012) Guidelines define households economic strengthening as enhancing the ability to mobilize resources and build assets at the household level to cater for basic needs for OVC. The ultimate goal of economic strengthening service is households to have improved and sustainable income to meet their basic needs and ensure the wellbeing of the OVC (Republic of Kenya 2012). Minimum service standard dimension for quality no.5&6 emphasizes on sustainability and continuity of support. Partners are urged to ensure that interventions should guarantee continuous benefits to the households and lasts beyond the funding period. Under domain 2.7 Household Economic Strengthening; essential action no.3 calls for partners to 'initiate and facilitate successful economic strengthening for OVC households, informed by community action plans'. Under this, guideline 3.f.) Partners are called upon to build the capacities of households to identify and maximize avenues for income generation, investment promotion and asset building. The HES innovation is therefore well anchored in the GoK guidelines in regard to economic strengthening at household level. On the other hand, the Kenya AIDS Strategic Framework (KASF) 2014/2015-2018/2019 through the 4th Strategic Direction;

Strengthening integration of health and community systems; calls upon partners to 'Strengthen community service delivery system at national and county levels for the provision of HIV prevention, treatment and care services'. This 4th Strategic Direction in the framework provides an opportunity for partners in HIV response to integrate quality innovations that improve access to HIV prevention, care and treatment. The HES integration with HIV services at the household level aptly fits and contributes to the objectives of the national HIV response framework. The combination of HES and HIV response therefore contributes to the improving of access to HIV services.

v. Adaptation into Existing market structures

HES innovation is adapted to the local market contexts. The business selection (Income Generating Activity) is done by the recipient and is subjected to other factors that include local market value chains analyses, capacity of the beneficiary to engage in the business, viability, risks level, profit regimes, proposed business site, environmental and social stability. The innovation was implemented in Kiambu county, central highlands of Kenya. Majority of investments requested by beneficiaries and prioritized by the organization were dairy cows, merino sheep (wool and mutton) and general merchandize for outdoor vending. The county has a thriving dairy, mutton and wool sector, products while investments in dairy savings and credit organizations have higher potential for returns. The devolved Kiambu County Government has prioritized dairy, mutton and small-scale businesses as flagship domestic investments while addressing food security and nutrition. In addition, the county is transverse by the Great Northern Road from Nairobi to Northern Kenya, then Sudan. The roadside provides opportunities for vending in touristic items like curios, antiquity gifts, souvenirs and traditional craftworks. Beneficiaries invested in this highway vending. The innovation therefore contributes to production, food security, market development and general livelihood improvement priorities and policies for both the county and the country of Kenya. (*Right caregivers during stock-distribution*)



vi. Innovation Competitiveness and cutting-edge advantages

The innovation has no competition but has many opportunities for collaboration. Though there are other initiatives with a shared objective of improving livelihoods for households, the HES approach has no competitor. It is unique and different. The HES approach is unique in its priority and goal setting, targeting, identification of beneficiaries and business, investment terms and conditions, management of the process, beneficiary participation and the nature of outcomes. While HES targets the vulnerable and poor households with long term benefits geared towards definite priority goals (90-90-90, food security etc.), other economic strengthening initiatives are open to anyone and are for self-actualization business development and progress. In HES approach, the start-up stock for business was provided without repayment commitments so that the marginalized, underserved and poor can be reached, while other approaches provided credit mechanisms to those who meet the criteria and eligibility to borrow. HES's major commitment lies in seeing the members of households attain resilience and access services as they engage in business unlike other economic strengthening initiatives that are centered on credit-start-up stock payable in definite times without emphasis on services. In HES the benefactor monitors, support and ensures the success of the ventures unlike other approaches where there is no supportive supervision but inspection just in case of default in repayment. Lastly, there is deliberate requirement to link HES to health outcomes (HIV, nutrition, WASH) and protection issues.

vii. Innovation opportunities for collaborations and partnerships

HES approach is centered on collaborative partnerships and engagements. The first opportunity for collaboration is with the Cash-transfer (*Inua Jami*) program which targets households with orphans, widows and elderly persons above 70 years. These households will be supported to initiate HES approach for sustainability, resilience and continuity. Enrolment of these poor household onto the Cash-Transfer program will enhance HES initiative since the households will have capacity to initiate income generating activities. Secondly, the HES approach is popular among the HIV care and treatment groups as it is easier to implement with meaningful outcomes. Partnerships with Health facilities will foster bi-direction referral for HIV care management on one hand and economic empowerment on the other. At a point where people test positive for HIV, the linkage to HES initiative will bring hope and continuity.

G.INNOVATION OUTCOMES AND RESULTS

HES innovation has been tested with replicable and scalable outcomes. Between January 2013 and December 2016, through HES interventions, CHEER UP had reached 216 Households. A total of 841 children were benefitting from HES intervention by the end of the period. A total of 65 HH caring for OVC received high-grade dairy cows, 120 HH received Merino sheep and 31 caregivers received support to start small businesses and start-up kits to boost their businesses. A total of 378 OVC Households were linked to SILC (Savings and Internal Lending Communities) while 26 Community Health Volunteers (CHVs) and 4 HBC Support groups (60members with 106 OVC in their households) were reached with IGAs. This was done in collaboration through entrepreneurship training and follow-up carried out by Equity Bank, Kimende Branch and CHEER UP staff.

Main areas of results and impact

OVC care and support, HIV testing and treatment, HIV suppression and CHVs retention towards 90-90-90. A retrospective review of data at Cheer Up CBO was conducted in March 2018. The review sought to compare outcomes and roles of Household Economic Strengthening (HES) while linking them to HIV prevention, care, treatment and support outcomes for Orphaned and Vulnerable Children and their household affected by HIV/AIDS. This was conducted for the period between January 2013 and December 2016. Data in the HES, OVC and HBC HIV Care registers and tracking tools at Cheer Up databases was used. The review focused on HHs provided with HES, OVC enrolled on care and support project, OVC on HIV care and treatment, OVC tested with known status, HIV+ OVC retained on ART and their viral load suppression. The review also focused on adult PLHIV enrolled on Home Based Care program as well as caregivers and Community Health Volunteers who provided services to the OVC and PLHIV during the period. The review sought to identify the relationships and emerging roles and improved outcomes of HES and comparing them with outcomes on HIV prevention, treatment, care and support for OVC, caregivers, CHVs and adult PLHIV.

Result Area 1: HIV Care and support for beneficiaries through HES

Results showed HES had a significant and contributory role in increasing the number of OVC under care and support. HES played a key role in improving care and support services outcomes in education, health, psychosocial wellbeing, child protection, shelter improvement and food and nutrition. The increase in the HES households led to a corresponding improvement in care and support services for the OVC and their households. In general, the

number of OVC enrolled for care and support project increased by 40% (n=2,500) in 2013 to 3,500 in 2016. Out of these, 25% (n=3,500) of OVC lived and were supported in Households reached with HES. The number of Households caring for OVC increased by 31.4% (n=625) in 2013 to 821 in 2016. Out of the total 821 households, 216 households (26%) were initiated on Household Economic Strengthening interventions in the period. Out of these 216 Households reached with HES interventions, 176 (81%) were caring for HIV+ children under the project support. This represented 21% of all HHs caring for OVC on the project. There were 40 HHs (19%) who received HES but had no HIV+ OVC living in them. In the same period the number of CHVs caring for OVC and PLHIV increased by 50 % (n=20) and out of the 30 CHVs, 87% were provided with HES to facilitate their roles in HIV prevention, treatment, care and support in the community. The dropout rate for CHVs was 10% while 90% were retained. The high rate of retention of CHVs was majorly due to HES support. None of those who dropped had been initiated on HES. The results were an increasing number of OVC receiving services per domain, which increased with more investment in HES. See the success story of one of the beneficiary in Kiambu County (Source Cheer Up Program Report quarter 3 April-June 2016)

**All amount in Kenya Shillings is estimated at Kshs.100=1USD*

*Success Story 1: **HES made our lives better***

Mary, not her real name, is one of the caregivers taking care of two orphans, a boy and a girl. She joined Cheer-up Program in the year 2018 due to her 11-year's old daughter HIV positive status. Mary is also on care and treatment due to her HIV positive status. Her son is HIV positive.

Before being enrolled to the program, Mary had lost hope in life. Due to her low literacy level and her poor health, she was not able to provide for her family. Nonetheless she was not well informed on how to live with HIV AIDS neither taking care of her HIV positive daughter.

During one of the regular home visits by the program's Community Health Volunteer (CHV), Mary disclosed her status and agreed to be enrolled to the program. When joining the program, the young girl had a high viral load of 8543 copies. Viral load is the degree of the HIV virus in the blood stream, mainly caused by poor nutrition or lack of proper medication. The viral load is considered to be suppressed when it is less than 1000 copies. The high viral load indicated that the girl was at very high risk of contracting opportunistic infections related to HIV, mainly TB. This would lower her immunity leading to poor health that could easily lead to her premature death.

After being enrolled to the program, the Case Manager and the CHV visited the household to carry out vulnerability assessment and developed a case plan for the household. The

program and the caregiver highlighted the priority needs for the household. The issues on nutrition and follow up to ensure viral load suppression was ranked as the first priority. In addition, the household was considered to be supported with viable household economic empowerment intervention. The vulnerability assessment showed that Mary was interested in daily farming.

Later, the caregiver who had a small portion of land outside her house was helped to establish a kitchen garden to grow vegetables to ensure food security and access to nutritional food that would boost her children's immunity. The caregiver was also referred to the health facility where she accessed information on antiretroviral drugs. In addition, the caregiver was supported with a dairy cow to boost her economically.

It is now eight months since the household received the interventions. Through the program the mother and the daughter has been able to suppress the viral load through proper nutrition and the caregiver ensuring that medication is taken as prescribed and on time.

The cow produces 15 litres of milk per day. The household consume 2 litres per day and sells the 13 litres to the local cooperative at Kshs. 40.00 per litre. Thus at the end of the month, Mary receives about 15,000/=. This has enabled her to provide basic needs for the family and pay school fees for the children.

A beneficiary (The woman) admiring a dairy cow given by the project,

She also uses the manure from her cow shed to plant vegetables in her kitchen garden. This has reduced the money she could have used in buying fertilizer for the garden. After feeding her children with the produce from the kitchen garden, she sells the surplus to the neighbours, thus double income.

Result Area 2: HIV Testing & Counseling and treatment

In 2013, before Cheer up introduced HES intervention, the number of HIV+ Children on care and treatment was 90. This increased to 188 HIV+ OVC (109% from 90 in 2013) by end of 2016, through HES and targeted HIV Testing and Counseling (HTC). These 188 HIV+ children lived in 176



HHs (81%) of HES households and 21% of all HHs on the project. The proportion of children with known HIV status (Tested for HIV) increased from 28% (693\2500 in 2013 to 96% (3367\3500 in 2016) while those with unknown status reduced by 93% (Unknown status was 1807 in 2013 to 133 in 2016) at the end of the review period. All the 176 HHs with HIV+ OVC were reached with HES interventions and all the 188 HIV+ OVC in HES household had 100% adherence rate to treatment, with all referral appointments, scheduled health check-ups and drug uptake monitored and supported by caregivers and CHVs. **See success story 2** of one of the beneficiaries who accessed HTC.



*Success Story 2. **HES Intervention Changed my Life and Behaviour for the Better***

Jane Kimani {Not her real name} a single mother to 3 children, is one of the beneficiaries in Cheer Up Program. She is on care and treatment due to her HIV positive status. She was enrolled in the program in January 2016. By then she was an alcohol addict. This resulted to her poor health and extremely high viral load of 27,377 copies/ml. Consequently, her alcoholism behaviour and high viral load led to her inability to cater for the needs of her children as well as adhering to medication. The area Community Health Volunteer (CHV) discovered this during her regular home visits. She informed the program field officer who took the initiative of visiting the household and developed a case plan. During household vulnerability assessment which was conducted within the same month it was noted that the caregiver had passion on sheep rearing and requested the program to empower her since she was addicted to alcohol due to financial constraints and depression. Before being supported, Jane went through counselling sessions through Cheer up Program. She stopped taking alcohol, a behaviour she confessed was due to her hopelessness state. Later, she was later supported with 5 merino sheep amounting to Kshs.30,000 and regular monitoring was done. The beneficiary was also counselled by the case worker on behaviour change and she later reformed. Three of the merino Sheep are about to give

birth. She also uses the manure from her sheep pen to plant vegetables on a kitchen garden that the CHV helped her establish at her compound.

Jane says she now have hope in life. She completely stopped taking alcohol and joined a church. She is now adhering to ARVs and is attending her clinics continually. Her viral load is being suppressed. On the other hand, she is now up to her responsibilities of taking care of her children and providing the basic needs since she has a small piece of land where she is farming and selling vegetables compared to the time she used to take alcohol..

Result Area 3: Viral Suppression

Out of 188 HIV+ OVC in HES households, 173 (92%) HIV+OVC were virally suppressed (VL> 1000 copies per ml) while 15 (8%) HIV+ children were not virally suppressed (VL< 1000 copies per ml). All HHs with HIV+ children were reached with HES interventions. Of the 176 HHs reached with HES, 161 (91%) of HHs had children who attained viral suppression, while 15 (9%) had children not virally suppressed. Thus the HES households had the higher proportion of viral suppression, treatment adherence and monitoring for viral load compared due to a combination of HES and treatment initiatives. The 100% HIV testing rate (None of the HES HHs had children with unknown status) and 100% treatment adherence in HES households showed an effective role and strengthened and continuous CHVs support through HES. (See success story 3 below)

Success story 3. HES enabled a HIV+ Parent access health services and achieved viral suppression

Halima (not her real name) is one of our older OVC being supported by the project from Magina village in Lari constituency, Kiambu County. She was enrolled to the program with her other siblings in the year 2015 due to her mother's ailment as a result of HIV-AIDS. While conducting vulnerability assessment to the household, it was realized that she had acquired skills on hair dressing. With the skills she earned very little due to lack of the salon kits. She used to braid children's hair in the neighbourhood from her mother's house at a small fee of Kshs.50.00 per child. In good months, she used to earn between 500/- to Kshs. 1,500 per month. When she was given an opportunity during the HH assessments, Halima requested to be supported with salon starter up kits. Cheer Up purchased the kit worth Kshs. 30,000 which comprised of hair drier, brow dry, towels, shampoos, sink,

shower cape, hair oil, ear bands, hair combs, mirrors, small water tank, chairs, electric kettle and an apron.

Consequently, Halima opened a salon business at Magina shopping centre.

During the last visit we found that she now makes a profit of Ksh 10,500 per month. She uses the profit to pay school fees for her other

2 siblings, one in Form 1 and the other in Class Seven. She also assists her mother to access health services and for other basic needs for the household. Her mother's viral load is now suppressed and is not detectable. Halima has a vision of expanding her business so that other older OVC from the area can gain the skills from her business and that her other siblings will get the best education geared towards a thriving and resilient life.



Result Area 4: Community Health Volunteers (CHVs) retention

In terms of care and support, there were 20 CHVs caring and supporting the 2500 OVC in 2013. The number increased by 50% to 30 CHVs by 2016. A total of 26 (87%) out of the 30 CHV were also enrolled in HES alongside the OVC caregivers. The CHVs were able to respond to the needs of the HIV+ Children and PLHIV since they could generate own income and support their logistical needs and convenience. These point to the evidence that HES outcomes at individual household level, CHV level and PLHIV directly contributed to the improved HIV prevention, treatment and support outcomes for the beneficiaries. Mainstreaming HES in HIV prevention, treatment, and care and support is an effective way of improving HIV response outcomes. Targeting the beneficiaries and health service providers with HES incentivizes the service delivery and provides and leaves a trail of sustainable resilience-based, scalable outcomes and approach in responding to HIV. A combination of HIV Prevention, care and treatment initiatives with household economic strengthening enhances the 90-90-90 outcomes in terms of testing, treatment and viral suppression.

Success Story 4: HES Intervention enabled me to care for my Orphans



Alice Maringa [Not her real name] is a widow and lives with HIV virus. She joined Cheer Up Program in the year 2011. Her husband succumbed to TB, which was attributed to his HIV status some years back, leaving her with the burden of caring for her

four children single handedly. During one of our regular home visits, the CHV noticed how hardworking Alice was. Apart from recommending the program to pay school fees for her two children in high school, CHV also recommended her for HES intervention. Later, Cheer Up Program officer and the CHV visited Alice's home and conducted a vulnerability assessment. The assessment showed that the family would become economically stable if strengthened with HES. Her priority need after the assessment was sheep rearing. The family later was strengthened by being given five merino sheep, one ram and four ewes, worth Kshs. 35,000. During our last post-vulnerability assessment in November 2016, we found that the merino sheep had contributed to a great improvement in the family. The 5 sheep had reproduced to 11 sheep. Alice had already sold three sheep at a cost of 7,000/= per sheep amounting to 21,000/=. She spent 8,000 on paying school fees for her child in secondary school and opened a small kiosk with the balance. According to book keeping record she makes a profit of Kshs. 5000 per month from her kiosk. Her vision is to grow her small business from a kiosk to a bigger retail shop. She has also established kitchen garden where she is growing enough vegetables for her household and intends to be selling the surplus to her neighbours. Alice use manure from her sheep pen to plant the vegetables. Today, Alice, who was initially so much depressed due to her HIV status and the burden of bring up her four children as a widow, can now afford a smile. She now have hope in life. She is able to bring up her children with a lot of vigour and zeal. She thanks Cheer up program and the donor, USAID-Aphiaplus program for supporting her through encouragement, counselling and empowering her economically.

H. FACTORS LIMITING INNOVATION UPTAKE, IMPLEMENTATION AND AVAILABILITY

i) Limiting factors in HES

1. Higher number of beneficiaries qualifying and demanding HES support.

This is due to observed success among peers and this has attracted many caregivers who have expressed their wish and readiness to benefit from HES and transition from the project. The government officials and office of the local devolved structures have also been referring vulnerable people seeking support to the Cheer Up offices.

2. Indecision among the potential beneficiaries on the kind of income generating activity to invest in versus the potential for sustainability and continuity. Emerging markets of fast moving goods like plastics etc. have made the caregivers be undecided as most want to shun usual productive activities to hyped and risky retail businesses

3. Lack of skills versus eligibility criteria.

Beneficiaries who meet the assessment and eligibility criteria but lack basic entry skills to sustain a business that include illiterate and elderly caregivers, who require further orientation and pairing up with other literate family members as well as closer monitoring and support.

4. Mixed household Set up and organization.

Some caregivers are widows, returnee families that had relocated elsewhere but returned to the ancestral land due to political clashes, land feuds and dispossession, returnee-daughters (divorced) who do not own assets, land where they live and some economic activities like livestock may not be allowed on host family land.

ii) Innovations Response to the limiting factors

1. Higher number of beneficiaries qualifying and demanding HES support.

CHEER Up plans to start a revolving fund for successful beneficiaries (alumni chapter). Former beneficiaries will create a pool into which they will contribute voluntarily and these fund will be used to reach more beneficiaries beyond project support. Secondly, the organization plans to initiate a paired mentorship approach for HES. In this approach, beneficiaries who wish to undertake a HES intervention

and can have own alternative source of start-up stock, will after vulnerability assessment, be paired with an ongoing HES intervention beneficiary to enable them attain experience, skills, understand linkages and markets in the respective business. This way the number of HES beneficiaries will increase. All the paired beneficiaries benefit from monitoring, capacities and sensitization around health, HIV services and sustainability.

The organization strengthens partnerships with the Government of Kenya and other collaborators/partners in resource mobilization and linkages for cost effective HES services. The government has rolled out social security program targeting the disabled, aged persons and orphans with a cash transfer (CT). These households receive a monthly disbursement of Kshs. 4000 (USD 40). Most of these households lack sustainability and the Cash transfer amounts have had little impact to service access and delivery. Cases abound of missing men who disappear for days after pay-day only to return with nothing having spent all the monies. Using the HES approach, the organization will partner with the county government and promote the HES approach among the CT households to achieve sustainability and access services. Stakeholders have expressed readiness and willingness to adopt and replicate HES among the CT households, during joint monitoring and support supervision of households benefitting from HES. The project will similarly leverage on well-wishers to fundraise and support more household. Showcasing of HES achievements in exhibitions and promoting of the initiatives among voluntary and business sector will also attract potential benefactors to reach more people in the community.

2. Mixed household Set up and organization; lack of asset and land ownership;

The organization will reach out and mobilize the affected families to jointly support the HES initiative while accessing services. Diversification of business set-up to accommodate those that don't require or depend on family assets like business space or land. Outdoor vending, value-addition level business and small-scale businesses will be promoted among these families. Extended family and kinship that jointly own the resources will be sensitized to support and engage in the HES as a way of enhancing access to services.

3. Lack of skills

Before supporting the beneficiaries, the organization facilitates trainings on some basic skills in entrepreneurship/business to ensure high productivity and profitability. Where the main care giver is elderly or doesn't have the capacity or the propensity to learn a business skill, the organization will identify another family member who will be provided with skills on the selected income generating activity and record keeping. The organization will also implement a cascaded and graduated approach in capacity building. The organization will cluster the beneficiaries and provide initial training and the cluster members will cascade the learnt skills to their group members in a more relevant and appropriate context (language, environment, and site). Some beneficiaries will be supported through a graduated-capacity approach. They will be introduced to savings and loaning groups through which they will learn soft skills in savings, business sense and graduate to full HES support after some time. This will apply to organized groups of PLHIV, adherence groups and peer groups and caregiver groups

4. Indecision among the potential beneficiaries on the kind of income generating activity to invest in versus the potential for sustainability and continuity.

Emerging markets of fast moving goods like plastics etc. have made the caregivers be undecided as most want to shun usual productive activities to hyped and risky retail businesses. The organization will apply the Household Vulnerability assessment to guide on the most viable, sustainable business with lower risks.

I. CONCLUSIONS AND RECOMMENDATION

- i) *HES is effective in harnessing social protection to enable vulnerable children access HIV testing, treatment and care”*

The Household Economic Strengthening (HES) innovation being a type of social protection that responds well to the PAC innovation challenge statement 'Reaching All Children Harnessing social protection to enable vulnerable children access HIV testing, treatment and care'. HES innovation demonstrates a social protection approach that targets households with people and children infected or affected by HIV. The Innovation demonstrates how HES, a form of social protection, has contributed to the improved outcomes in the care, prevention, treatment, and viral suppression of HIV among the children and their caregivers, with evidence and examples over a period of time. HES is geared towards empowering households of PLHIV with ability to generate gainful income and capacities to access and uptake of health services. HES experiences are also centred on outcomes achieved through working with PLHIV households and provides direct and relevant experiences and evidences in demonstrating key objectives and elements of the social protection-sustainability, pro-poor, reliability, scalability, restorative social values and viability.

- ii) *HES Innovation is people-centred, ensuring privacy and the ability to not perpetuate stigma and discrimination associated with HIV.*

The basic intervention unit is the household. All health and HIV services outcomes are about all household members. Decisions on the kind of HES to be implemented depends on the family or household size, health status of family members and entire household capacities. A greater bit of the HES approach is the skills and social assets transfer to the family members to enable them manage own empowerment and health affairs. The vulnerability assessment sections highlights the status of people in the family and is the basis of decisions on the needs and priorities for interventions. HES innovation is people centered, it incorporates household members' collective interests, needs, capacities, preferences and contributions for success. External support only comes in the form of monitoring, supervision, mentorship, business literacy support and linkages for market,

extension services and business growth. In targeting the households for HES, the innovation ensures that the activities associated with the intervention doesn't perpetuate stigma, social alienation and avoids portraying the families as helpless. It begins with consent seeking and approval by the caregiver to participate in the innovation so that participation is through their acceptance and willingness. Issues that are highlighted at the beginning include information to the potential beneficiary that successful intervention will attract visitors, project staff, government officials who would often visit your household to learn and check on the progress of HES which may attract neighbourhood anxiety to which they consent there are no issues. For the children under 18 years in the household, they are too asked to assent to be part of the HES implementation, learning and documentation. Secondly all activities are carried out by teams who are trained in field etiquettes, sign confidentiality and non-discrimination and child safeguarding clauses to protect the dignity of the beneficiaries. Household visits are conducted in the homes of the beneficiaries for confidentiality issues. Thirdly the communities have been sensitized on anti-stigma issues through Quality Improvement teams. In addition, through the whole-market approach, many services are provided to different groups and types of people with varied needs to avoid manifest targeting or singling out certain people to be in need of a certain service. For instance home visits are usually organized to reach all the beneficiaries in the locality, with multiplicity of themes and services in HES, adherence, child protection, and sensitization on gender based violence. The organization has a mechanisms of ensuring the clients and recipients of HIV services are made aware of their rights (through sensitization, display of the service charters, clients rights at the office, confidentiality reporting-suggestion box and hotlines to report in case of violation of their rights or discrimination.)

iii) HES is replicable in a wide range of settings.

Some of the cross-cutting context into which HES can be replicated include in programs or initiatives that target vulnerable people, households with regular incentives such as monthly cash-transfers, provision of services on a regular basis and programs struggling with inadequate resources versus increasing needs for care and support. There exists opportunities to transform such support into HES innovation. This is on the philosophy that a program may not buy everything for every child every time, but a one-off HES investment empowers the families to take care of their own needs. In the Kiambu County where HES has been implemented, existing settings include the Government of Kenya social security program that operates a Cash-Transfer (CT)

Program called Inua Jamii that targets the Orphans and Vulnerable Children (OVC) households, People with Disability (PWDs, the aged persons and the Famine Relief program). These households receive a monthly disbursement of Kshs. 4000 (USD 40). Most of these households lack sustainability and the Cash transfer amounts have had little impact to service access and delivery. Cases abound of missing men who disappear for days after pay- day only to return with nothing having spent all the monies. Stakeholders have expressed readiness and willingness to adopt and replicate HES among the CT households, during joint monitoring and support supervision of households benefitting from HES. Secondly other projects supporting OVC with handouts and materials support in the region can be mobilized for HES innovation.

iv) HES Innovation is scalable:

There exists greater opportunities for scaling-up the HES interventions. Through the household vulnerability assessments conducted, many numbers of household that meet the criteria don't usually make it to the enrolment into HES program due to capacity and resources challenges. With more support, HES can be scaled up into more sub-counties and localities to reach more households and improve health outcomes. More opportunities for scale-up also exist in the networks and groups where the HES beneficiaries converge for savings, learning and loaning. Since the membership of these groups go beyond project beneficiaries , members of these groups can adopt HES and improve their access to income and services, including HIV prevention ,testing and treatment.

v) HES Innovation is affordable:

The HES approach provides an alternative non-credit mechanism for the poor, who have always been left behind due to the vicious cycle of poverty and lack of access to services including HIV services. The innovation starts with resource leveraging by the program, government or well-wishers outside the household and contributes little funds except the non-monetary contribution in terms of workmanship, time and space towards the investment. Where external source of funding is not forthcoming, HES is applicable at low –costs through start-small approach in which a family with as little as 10USD can be supported to invest and grow an investment under HES innovation by provision of technical capacities, vulnerability assessments, linkages and business literacy skills.

vi) HES Innovation is sustainable:

Compared with other economic strengthening initiatives, HES provides more sustainable outcomes. Due to its non-credit approach, it invests the initial power to engage in business to the caregiver without any debt obligations. Upon stabilization and

business, growth, the beneficiary is later able to borrow due to increase propensity for credit. This unique elements enable the caregiver to harness the economic potential from the first day of investment. Secondly from a programming perspective buying and providing every child and household on the program with everything they need brings about the challenge of sustainability as the funds regime end and no more support is forthcoming. The gist of Household economic empowerment initiatives is strengthening individual and family assets, improving household welfare, and preventing future exposure to the risks. Until 2010, programs providing services to vulnerable populations were faced with the challenges of sustainability, continuity and meaningful impact. This was due to emergency kind of approach in designing programs. The beneficiaries counted as having improved their wellbeing could not be counted the subsequent year due lack of continuity and fall-off due to diminishing donor investment. The beneficiaries relapse into emergence situation when no more services were forthcoming from the project. Secondly, HES is designed to such that the investment is appropriate to address all diversities; resource-limited context, urban versus rural, the extremely poor versus the moderately poor, elderly caregivers, beneficiary participation, expert households versus the voiceless poor who were usually left behind. This creates relevance and presence in each context, thus laying foundations for sustainability. Each individual in all these contexts can engage in appropriate HES with a higher degree of sustainability. HES approach has a management path that links income to service seeking behaviour. When people associate their good health, social services access, suppressed HIV and adherence, it gives more meaning to HES and creates a feeling of safeguarding the initiative so that the benefits can continue. Beneficiaries feel HES initiative is their lifeblood and it generates interest and commitment. This is the reason behind HES success and outcomes, and because HES is household centered and collectively owned, harmful decisions that could derail its progress are usually addressed at household level and individual decisions that can harm its survival do not make through. Lastly it is only in the HES approach that beneficiaries have made requests to leave active support since they can take care of their daily needs and access HIV treatment, care and support services unlike in other projects where beneficiaries are heavily depended on the projects and are unwilling to leave.

vii) HES Innovation brings substantive change in norms, technology and causal factors related to HIV:

Most HIV care and support, child care and protection programs still design initiatives that do not empower the beneficiaries. Against the higher number of beneficiaries and

limited resources, HES targets the right people and relieves the program of the continued need to support the households in all materials and services. HES approach therefore deviates from beneficiary dependency approach to beneficiary empowerment. HES has therefore potential to disrupt the traditional service delivery approaches used by most organization. HES has further potential to reverse the traditional trend in which programs have seemed to replace the principal caregivers and communities. The children and beneficiaries have 'temporarily belonged to the project' until the end of the projects. Cases of sick children and caregivers being hauled to the project office for treatment or services because they are 'children of the project' are very common. Empowered household will own up the responsibility and seek services at the nearest HES seeks to disrupt this trend and give the care and support of the children entirely to the households and the communities.

Illustration: An organization receiving a total grant of USD 50,000 for a period of 5 years to serve 200 Orphans can apply HES initiative and attain sustainability as below. The organization can reach 12 household (estimated 50 orphans) with HES at a total cost of USD 6,250 if each Household receives an average of USD 500 worth of business stock of their choice. This will see 12 households exit from the program sustainably each year and in 4 years all the households and the 200 orphans will have been reached with HES. The 5th year can be for monitoring and evaluation. The total HES costs for 4 years will be USD 25,000, half the total project cost for 5 year. This leaves the organization with extra funds for administrative and personnel and scale-up of the services as well as providing direct services as HES initiatives pick up and mature. This is unlike the usual approach where the programs keep on buying items and providing services each year while the children continue being needy and the increasing needs do not march the resources.

Cultural norms and manifestation of HIV/AIDS render the persons affected and infected with HIV alienated socially and debased. HES restore their status and provides an equal stratum for survival other than taking drugs. This is based on the orientation, to an extent due to effects of HIV, that poverty increases the vulnerability to the progression of HIV due to lack of access to essential services in health, nutrition and psychosocial wellbeing and vice versa. While improved household income facilitates and empowers people towards health seeking behavior, fights and lowers stigma, lack of income lowers peoples self-esteem and magnifies stigma. The Stigma is often manifested through deprivation, unwillingness and inability to afford basics of live. Wealthy PLHIV aren't

stigmatized as much the poor PLHIV. These easily provides a sad pointer that the inability to access the basic needs is due to HIV, when even there others who equally cannot afford the services and are not affected by HIV. HES related economic wellbeing incentivizes and provides logistical convenience and ease of HIV prevention, care, treatment and support as it provided hope and reason to live a healthy and longer life without the ravages of HIV\AIDS. This rests on the philosophy that when PLHIV are able to overcome poverty, educate their children and access health like any other children in the community, the stigma perception is eliminated. HES provides a pathway where PLHIV can be resilient in the face of social-economic deprivation and lead a healthy and well-being life and overcome societal associations and stigma that come with being sick and deprived due to HIV. PLHIV empowered with HES reclaim and resume their places in the society, restore their ambitions, aspirations and meaningful lives.

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H. Appendices

- **Minimum Service standard manual**



HES ASSESSMENT
FORM.doc

- **HES toolkit**

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