

Jacqueline's Journal

Kenya

September 29 - October 2, 2008

Monday, September 29, 2008

NAIROBI, KENYA

Our CAO/General Counsel Ann MacDougall arrived last night, ready for just five days in Nairobi. Our goals are straightforward: to spend time with our small but growing team and focus on the consequent strengths and growing pains; to meet with key investees as we always do and troubleshoot where we might be useful, and to touch base with our advisors who bring so much to all we do.

The flights were uneventful and relatively easy, and it feels good to be back in Kenya. The last time I was here was during the riots in early January. Times were tense then, and thousands were killed across the country in ethnic clashes, causing a precipitous decline in the key drivers of economic growth, such as tourism. General confidence in the country suffered really, just as the country was turning a corner and beginning to make real strides. Things calmed down in March; a coalition government is in place and the country has been slowly rebuilding itself, though it isn't clear yet whether the wounds that were exposed were dealt with at all or, more likely, just covered over with the thinnest veneer which makes the country vulnerable going forward.

Kenya's population lacks good, accessible and accountable health systems, especially in more rural areas.

PCEA KIKUYU EYE HOSPITAL

In the morning, we drive through the endless snarl of Nairobi traffic to reach a longstanding private hospital run by Presbyterian missionaries. Immediately we are struck by how beautiful and clean the waiting area is. People sit on benches in the open air surrounded by manicured lawns and well-tended gardens; a kiosk sells sandwiches and sodas; and people of all ages wait quietly, some watching the outdoor television that is tuned to sports.



Kenya has been slowly rebuilding after the clashes in early January.

Near the waiting area is a small window where the Ksh.200 (\$2.60) consultation fees are collected before doctors meet with patients. Apparently, this is the normal fee for low-income people (though in many SHF clinics, patients are asked to pay half or a quarter of that fee), and drugs are paid for as needed. I ask a woman what she thought of the fee, and she answers that it is "steep but ok."

Along one of the wings, we meet with Dr. Kibata, an expert in diabetic retinopathy, a much-needed specialty given the high and growing prevalence of diabetes in Kenya. Dr. Kibata, a young man in his thirties with a calm and generous manner, greets us warmly despite the fact that he sees about 50 patients per day. He tells us that he loves the public nature of his work in this place where all people feel they can come. "Even those with little or no money tend to come and find the fees from other family members or from the community. It is just how things are done in Kenya," he tells us. Indeed, his desire to see change stemmed not from the pricing of healthcare delivery in Kenya, but from the population's overall lack of awareness about health issues, as well as the absence of good, accessible and accountable health systems, especially in more rural areas.

He explains that Ksh.200 is the average cost at most public hospitals, and that people are willing to pay ten times more to receive care at private clinics and higher-end hospitals. This amount is even more reasonable, he said, when considering that surgery can cost much more than that, whether you are rich or poor. "We need to focus most of all on prevention," he said. "Treatment is too expensive under any scenario." We would soon discover



At PCEA, doctors are not permitted to charge side fees; rather, prices are transparent.

that an emphasis on prevention would be a common theme on our trip.

“Just yesterday,” he tells us, slowly shaking his head, “a 52-year old engineer who works in Somalia found his way here after much too much travel. Because his condition had not been caught early enough, he had already gone blind. Like others here at the hospital, he had to wait maybe eight or nine hours to see the doctor. I listened to this man’s story and after I examined him, I had to tell him that there was nothing I could do to cure his blindness. He had waited too long before seeking help. You know, too many diabetics don’t understand the connection between the disease and the chance of blindness. If only he had come in earlier, I could have helped him.”

According to Dr. Kibata, some 200,000 people have diabetes in Kenya, and this number is projected to increase to half a million in the next few years. According to the government, 10 percent of people over the age of 35 will be diagnosed with the disease. “We have to find a way to do something about this, not just the disease but the impact on people’s eye health and ability to see,” says Dr. Kibata.

PATRICK HENFREY, ABE

We meet Patrick for a long lunch to discuss some of the challenges faced by this artemisinin-producing company in which Acumen Fund has a significant equity stake. We’ve been working with Patrick, a part-time resident of Kenya with a love of this land and its people. Patrick and his partners have put their lives and their savings into ABE, a venture that purchases Artemisia leaves from farmers in Kenya, Tanzania and Uganda and extracts pure artemisinin, which is then sold primarily to Novartis for encapsulation into Coartem, one of the best known artemisinin-based combination treatments (ACTs) for treating malaria.

Our investment in ABE is one of several we’ve made to support local supply chain development for critical goods solving problems in Africa. Because artemisinin is so key to solving the malaria pandemic, we’ve been thrilled to see the continent’s leading producer take root in East Africa. The company currently produces more than 20 tons per year and contributes significantly to worldwide production. This vision of building a supply chain that starts with the creation of valuable opportunities

for low-income farmers, generates significant revenues for the local economy, and also provides an essential drug to treat malaria is powerful, and we’re proud to be part of it.

But the going is tough, especially in these markets so dependent on a few major buyers. In the past year, ABE has contended with a couple of major challenges. First, the worldwide price for Artemisia declined considerably, reducing margins for both farmers and the company itself. Second, generics arrived on the scene -- exciting from the perspective of end-users, but detrimental to ABE’s profit margins. This was compounded by the company’s dedication to manufacturing socially responsible product, ensuring high standards and fair wages to the farmers. Finally, at the same time that world demand seems to be growing, the World Health Organization appears to be reducing its level of orders from private companies (though I couldn’t confirm this with anyone). The overall impact of all of these forces on this local African manufacturer takes its toll in squeezed margins as well as a loss of jobs.

ABE is fighting through this difficult patch and reminds me of the complexity of providing incentives for local entrepreneurship around public-driven products. International agencies can create or destroy specific market segments nearly overnight, and there is a case to look at protecting local companies by transitioning them to serve a greater spectrum of needs. ABE is already looking at the prospect of selling artemisinin to generics producers, while also considering developing additional product lines and continuing to hone its capacity to produce the highest level of artemisinin for its continuing relationship with Novartis. We leave the conversation knowing we would meet IPS, one of our co-investors in ABE, later in the week to discuss how we can work together to best support this important work.

Tuesday, September 30, 2008**NAIROBI, KENYA**

Morning comes early today, especially given the long night of watching CNN, transfixed on the failure of the U.S. Congress to reach an agreement on the financial bailout of the banking crisis and the resulting sheer drop in the Dow Jones. Countless people are watching their pensions and savings decline, though it seems most Americans are against the bail out. What worries me most is how interconnected we are, and how the effects of this decision will impact not only ordinary citizens, but people all around the world who are losing so much faith in the U.S. economy.

A butterfly flaps its wing, a mortgage holder fails to pay, and, meanwhile, the global economy churns and the price of oil rises and along with the price of food. People everywhere are affected; mortgage holders default, confidence starts waning throughout the financial sector, the the world system begins to teeter. Through it all, the complexity is so great that there are no silver bullets to turn the situation around.

Nthenya, Ann and I meet again with Dr. Kibata over coffee outside his smart private office close to downtown Nairobi. This time, he is wearing a gray v-neck sweater, instead of a lab coat, and is clearly intelligent, full of life and committed to changing the face of diabetes-related eye care in Kenya and across Africa. I begin by asking him to tell us his story. "I'm the youngest of five brothers," he said. "We were brought up near Nyeri, in Central Kenya. My parents were educated by missionaries and they, in turn, imparted a sense of social responsibility on all of us. They also made sure all of us were educated and raised to be good citizens."

When he was 21, his mother died of cancer, and a year or so later, his father suddenly went blind. Though the family knew he was diabetic, they didn't understand the relationship between diabetes and blindness. Lacking sight and health and missing his wife desperately, Kibata's father died a year later, leaving his son determined to do something about the disease.

As much as he's a doctor, Kibata is also highly entrepreneurial. After medical school, he won a scholarship to earn a masters degree, and was sent to an insolvent hospital in western Kenya for his training. He then applied for and won a second scholarship, this time to South Africa, and got a job afterward that sent him to Tanzania. There he worked with an organization that was highly influenced by Acumen's former investee, Aravind, an extraordinary Indian eye hospital that prices surgery on a sliding scale and currently serves more than 1.5 million people a year – sustainably.

We return to our conversation about how to make healthcare and, in his case, eye care accessible. Again, Dr. Kibata emphasizes the importance of awareness even over price. "Look," he said, "I'm not going to turn anyone away, but most people in this country have

the expectation that they should pay something for healthcare." His vision is to establish a more upscale private clinic and use part of the proceeds to run mobile clinics that will provide awareness – and testing – to people who live in more rural areas outside Nairobi. His prices would be fair, and much lower in those areas.

We tell Kibata that we think he is a superstar, and that there is a critical role for him to play in bringing the highest quality services to Kenya. At the same time, we discuss different approaches to delivering services to the poor. There might be elements of an Aravind-like approach that actually integrates pricing and sustainability into the business itself, so that the charity component – the mobile units – does not depend on profitability, but instead is built into the overall business itself.

MERIDIAN

After seeing Dr. Kibata, we visit another one of our health investments, Meridian, a for-profit business focused on providing quality, compassionate healthcare to both the middle and lower classes. Drs. Wambugu and Ndiba greet us at our hotel, and we pile into their two cars to visit an existing clinic and one that is set to launch the very next day. I drive with Dr. Ndiba, a lovely Kenyan with a wife and a nine-year-old daughter, whose dream has always

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been to deliver high quality healthcare in his native country, rather than be part of the brain-drain the country has been experiencing with so much of its medical talent.

We raise this question of pricing and how to reach all levels of society. Dr. Ndiba sighs, saying that "the aid game" had so distorted healthcare that it is incredibly difficult to build a system that: 1. inspires the best talent to work in Kenya; 2. assures people of quality care; and 3. is financially sustainable. "Seven or eight years ago," he said, "A good doctor might earn \$100 a month from a government job. That same doctor would now earn ten times that amount, but they would be working in inefficient systems with poor quality drugs and little accountability and that isn't inspiring either." So they set up private practices on the side, ignoring their public work. It thus becomes difficult for truly private practices set on providing true quality care to function and have a real chance to grow.

Indeed, the aid game is everywhere in Kenya. Ann says that at our hotel she overheard people talking about bednets and HIV at

one table and maternal health at another, all in the context of donor programs. We wonder how many expatriates at the hotel restaurant were there to give charity and how many were there to invest. We assume the mix went overwhelmingly to the former. Throughout the week, we hear that grants are needed by most enterprises to even compete in the marketplace. This can't be healthy for the long-term growth and sustainability of solutions, especially as the problems facing the country are growing more and not less complex. Big grants continue to put all decision-making to a few individuals who may or may not know on-the-ground realities of a people or a place. The question for the world must be how to build sustainable systems while also dealing with people's immediate needs.

Meridian uses a sliding scale for how it charges consultation fees. At its most expensive clinics (Yaya, the Mall & Nation Centre), the company charges Ksh.1000 (about \$14); at Donholm, half that amount. In even lower-income areas than Donholm, the company intends to charge Ksh.200. Dr. Ndiba insists that low-cost, high-quality generics can lower the price of treatment even further and insists on them for the lower-income areas. Unfortunately, many high-income people, he said, are so used to believing that all generics are counterfeit that they ask to pay for brand names and believe the medical treatment to be of inferior quality if it is too inexpensive.

We drive to Buru Buru, the site of Meridian's newest clinic, which is scheduled to open the next day. Located in a building attached to a privately run market for about 100 shops, Meridian hopes to have not only a built-in clientele, but one that it can monitor and support over time. They project that each doctor will see around 40 patients a day. The next clinic to open will go further down-market, and Drs. Ndiba and Wambugu are focused on how best to reduce costs while still providing quality service. They

are considering lowering the consultation fees even further for the very low-income neighborhoods, in addition to using clinical officers (as opposed to doctors) to screen patients. In many instances, clinical officers have more experience than younger, inexperienced doctors and can take care of most ailments, referring only the more serious cases to doctors. This hub-and-spoke business model is not wholly unlike that of Medicine Shoppe.

We talk for a long time about what it would take to significantly increase Meridian's truly low-income client population. Dr. Ndiba believes the company will get there over time, in large part through building a trusted healthcare brand in Kenya. He

overwhelmingly on supporting primary healthcare. In the '90s the focus shifted dramatically to HIV/AIDS. Now, the world is crazy about malaria. But with this current financial crisis, will the donors stick to finding real solutions til they have done what they said they are doing? I know with Meridian that we are here for the long-haul. We will figure this out so Kenya has local solutions to local problems. And then we'll inspire others in other countries. But it means we must deal with a mix of income levels and a mix of diseases as well."

I take it that Dr. Ndiba disagrees with the world's focus on eradicating malaria. "Look," he said. "That is a good, laudable goal. But how are they intending to do

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restates that low-income people pay about \$1.30 at government "free clinics," which typically have few or no doctors available and offer a lower quality of care. Waiting times tend to be very long and corruption continues to be endemic. For these reasons, determining how to deliver healthcare to all people through private market mechanisms is a major commitment of the Meridian team, according to Dr. Wambugu.

I ask Dr. Ndiba what Meridian's five-year goals are. He answers eloquently that they intend to create a nationwide network of clinics. He hopes Meridian will one day be listed on the stock exchange and seen as a model that can serve low-income people with high-quality, affordable care. I push hard on why he isn't using more philanthropy currently to extend his reach deeper into the bottom of the pyramid. He shakes his head.

"Look," he said, "I've seen the priorities of the donor community come and go. In the 1980s, aid and philanthropy focused

it? You can't just have a one-size fits all model like giving out bednets. Other things have to fall in place like income levels of people, and building the right marketing and distributing mechanisms. No, we need to build more sustainable systems and I think the real insights will come from local entrepreneurs who are driven to make change, especially for the poor."

I ask about the cost of delivering a baby and am given a price range that from Ksh 3,000 – or \$43 – to nearly twice that amount. When we present the LifeSpring model, Dr. Ndiba seemed almost in shock. "Here in Kenya, things cost so much more than do in India. Food alone costs much more here than there. And people have support systems so that they can save little bits of money from family and friends to pay for services needed. But we have to figure out how and what will keep the low-income sector engaged and eager to use Meridian's services." My sense of the team is that they will do what it takes to figure out this piece,

and we will hopefully have another model of ways to bring health services to those too often left out of the system.

Wednesday, October 1, 2008

NAIROBI, KENYA

Jet lag and a bad dream wake me with a start at 3 a.m., and I never manage to fall back asleep. My room looks onto the road, and I have a choice between hot airlessness and noisy, but fresher air. I choose the latter and pay the price of what the French call a “white night.” That, plus the economic crash in the U.S., frustration at the lack of leadership there, and thoughts about Acumen keep me up for the rest of the night.

When the sun finally wakes and spreads its arms across Nairobi, I venture out for a short run. Clouds hang low and dark in a sky pregnant with an impending rainstorm, and below the glorious jacaranda trees shake an amethyst hello as a counter-offer to what the heavens are promising today. A thin man in a baseball cap carefully piles milk in cardboard boxes shaped like triangles on a street cart. Two men laugh and point at something of mutual interest in *The Nation* as their stacks of newspapers stand beside them, waiting for passersby. Today is Eid, a national holiday, and the day Muslims celebrate the end of their long fast. Later there will be goats slaughtered as families gather and share stories and laughter, and the country moves at a slower pace.

We spend the good part of the day with a potential investee, which is also focused on bringing higher-quality healthcare to low-income populations through a hub-and-spoke model. The same themes emerge from the beginning of our discussions: that it is expensive to be poor, that people expect to pay something for healthcare, even from government, and that extended families are the real insurance systems when push comes to shove. There seem to be very low expectations around

government’s ability to provide anything that comes near to quality and consistent healthcare delivery.

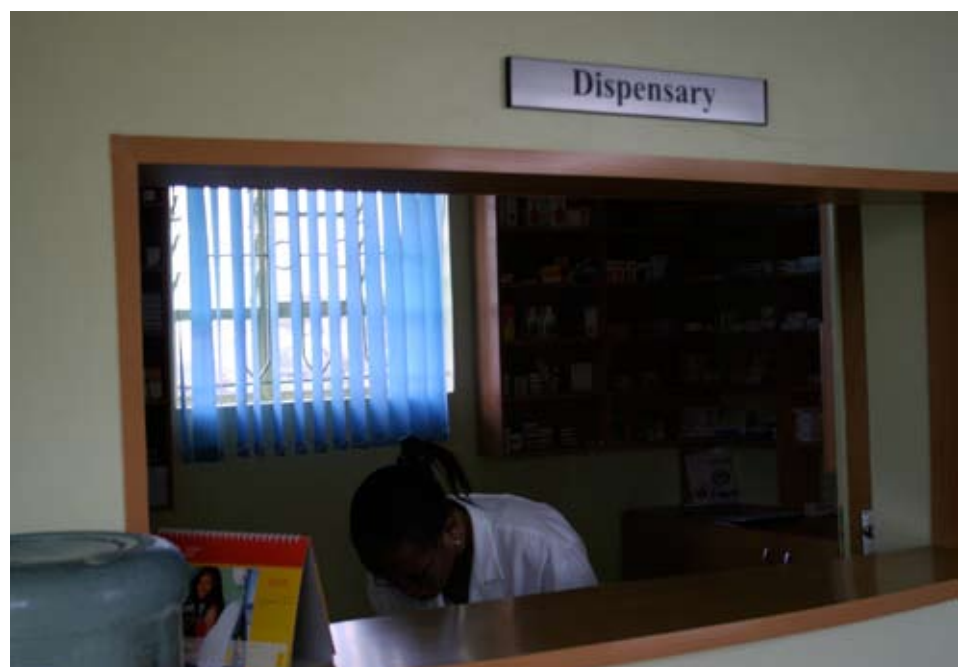
I push hard on this notion of using markets to reach even the poorest. Indeed, we believe at Acumen Fund that we need more creative systems altogether to ensure universal health insurance so that all people can ultimately access the care they need – while feeling certain that the care meets at least a minimum standard. Markets play a role in this, but they cannot -- they absolutely cannot -- play the only role. But having this conversation isn’t always easy, especially among people who feel burned by a system they feel has let them down for too long.

My question continues to be how we can use market-driven approaches to delivering high-quality services along the lines of LifeSpring or Aravind while measuring what it costs – and quantifying who is still left out. In the case of Aravind Eye Hospital in Madurai, India, no one is left out. At the same time, government pays a fee for the very poor who are served, philanthropists continue to contribute, and the organization uses several cross-subsidy

models to ensure access for all. Not only do richer people pay more, but Aravind also earns revenues as an educational training ground for residents from some of the world’s top medical schools. What is essential is that the system is sustainable – and scalable. Over 1.5 million patients use the services of Aravind each year. Granted, the problem of unnecessary blindness is far greater than this, but now it is to the world to grow Aravind itself while also replicating the model, integrating lessons learned and tweaking where cultural uniqueness demands it.

Easier said than done. With the prevalence of aid, it is hard to know exactly where the market is working and where it is failing. One thing is for sure: the market definitely sees opportunity in providing healthcare to mixed-income communities, and most urban areas, including some of Kenya’s toughest slums, are home to families with incomes that cover the spectrum.

We drive through Athi River, the industrial town where both ABE and Insta, the nutrition-fortified food products company, are located. Down an unpaved road we drive past little boys herding goats, women



Meridian hopes to create a nationwide network of clinics that provide affordable care to low-income people.

selling charcoal on the side of the road, and men pushing empty plastic jerricans en route to water pumps so they can sell it at fairly high margins later. The place is a bustle of activity with people working and earning whatever they can to survive. A young, sturdy woman with a red bandana wrapped round her head saunters along in a gold sweater and blue flipflops, carrying one of those yellow jerricans on her head. Though you would probably look at the area and think “poor,” it was hard to know who was making what, especially as so many people have multiple ways of earning income, often a combination of small-scale farming, trading and even making crafts. Our host insists that there are very low-income families among these people, and it is obvious that this is the case. But will the business exclude the poorest, I ask? He doesn't think so: we have a commitment to serving everyone, he says. But it isn't made explicit in the business model.

On to an area called Pipeline and it is even easier to see how mixed some of the newer areas are becoming, especially the extended Nairobi megalopolis. A beautiful office building anchors a street of shops that includes cell phone air time sales, a few cafes and hair salons, and about a half dozen shoe-shine men, all sitting in a row. A bit further down, you can see income levels fall: women are selling tomatoes and slices of watermelon. Young men stand by laundry lines holding dozens of shoes. No one has a proper shop. And after we turn a corner, we find we are driving down muddy roads sided by open sewers. A lake of garbage so rancid it looked like it was heaving back and forth slowly sits alongside the slum's main road. Churches are ubiquitous with names like Glory church, Restoration mission, Lifespring and Overcomers Missionary. Our host says the churches are a great way for good communicators to make money, and the communities are seeing more and more arise.

”Here,” he says, “people are used to paying Ksh 30 (\$.43) for 20 litres of water, \$43 to rent a one room shack each month and all they get is iron sheeting for walls, and they pay a mint to the doctors when they fall ill. Their healthcare especially is dangerous and they know it. They would be willing to pay for something affordable of higher quality. It just hasn't come to these parts yet.”

Being poor is expensive, not just to the pocketbook, but in ways that threaten the soul. And our host is right in that we need to find systems that provide high-quality, affordable services to all people. In my own thinking, I am clarifying what that means, especially in places like urban Kenya where there is a proliferation of aid and charity-driven approaches, true businesses and government service providers. Our job must be to identify the best partners, invest in them, learn with them, measure what we can, and be honest about what it will really take to extend services in a way that makes most sense for a society focused on providing opportunity to all of its people.

And what do we mean by best partners? Those entrepreneurs with the will to experiment and determine what it takes to give all people the chance to make their own decisions, while at the same time, having the skill to make it happen. They must be individuals who will not veer from their dream, but will share with us the ups and downs of learning. They must not be overly ideological, for the real answers inevitably will lie between markets and charity in the area of healthcare for the lowest income groups. They must be willing to accept – and give – constructive feedback. And they must be among those who never cease to question. Increasingly, I am realizing what a tall order this is. And at the same time, I know there is a huge influx of talent in the world that is eager to apply the skills needed to solve tough problems. Bringing that talent to bear on the problems must inevitably be a fundamental and growing cornerstone of this work.

ECOTACT

After a long and productive meeting with the team of ABE co-investors from IPS, we meet with Mr. Kamithi Ng'ang'a, the co-founder of Ecotact, a company bringing public toilets to urban and peri-urban areas in Kenya through a private-public partnership. Nthenya and Ann had met earlier with David Kuria, who couldn't have been more patient and welcoming in showing them what had been accomplished, but I'd unfortunately missed him.

Wendy, Acumen Fund's East Africa portfolio associate, and I walk across Uhuru Park, one of Nairobi's main parks, under a bright blue sky watching the purple jacaranda flowers falling gently to the ground. On this public holiday, families walk hand-in-hand across the cleaned up park, laughing and talking, enjoying a safe, beautiful place that was once a place I wouldn't enter alone for fear of the boys hanging around.



Ecotact provides safe, clean public toilets, like this one near Uhuru Park.

There are actually four public toilets in the park, though one that had been constructed by government was shut down. The longest line is the one outside Ecotact's burnt orange and white structure that stands on the side of the park closest to the main road running across the city. As we get closer, I can understand why: the unit is clean and welcoming. A young woman sits behind a window selling candies and sodas while the accepting the Ksh. 5. Payment for usage (all of the toilets charged the same amount). "Go in! Go in!" Kamithi yells cheerfully, standing in his white Ecotact shirt, khaki pants and bright new sneakers.

I do as I am told and can't help but smile at how clean the women's side is: a young man stands with a mop, constantly cleaning the floor and stalls as women fix their make-up in the mirrors and a mother changes her small son's diapers on a changing table. I'd never seen anything like this in Kenya – nor in New York City for that matter.

Being poor is expensive, not just to the pocketbook, but in ways that threaten the soul.

I walk out and tell Mr. Kamithi how excited I am and he beams, "But you haven't seen the men's side yet. Go on!" Despite my protestations, he grabs my hand and before I know it I am standing in the mostly empty men's room, though at least one man is surprised when he emerges from a stall to see me standing there holding the hand of the elder Mr. Kamithi, proud papa to this new venture.

Ecotact is a private-public venture. Municipal governments provide Ecotact free land for the sites on which the toilets are constructed for five years. Ecotact constructs and runs the units – which may have only toilets or a combination of toilets and showers. Each unit needs to serve a minimum of 600 people a day to break even, but Mr. Kamithi assures me that they

are already seeing numbers beyond that in the high traffic areas.

It isn't enough to see just the one completed toilet. Mr. Kimathi bounds across the park in his sneakers, and the rest of us, all wearing heels, try to keep up. He takes us in a large circuit around Nairobi proper and we see seven different units at various levels of completion. Two contain showers, and all are centrally located, spacious, clean and extremely well designed. There is space for small businesses at most of them, as well: individuals are given the chance to open small shoe-shine shops or sell snacks from built-in kiosks. You can't help but feel excited, especially given how many low-income people travel for hours each day, often doing work for low wages with little access to toilet facilities.

The vision for Ecotact is to build 100 public toilets in the next year. Kamithi assures me that we will see 17 completed by the time

we visit again in January. It is thrilling to see this vision started and, hopefully, we'll have a real model of a private-public partnership that can take the best of business and fuse it with the right kind of subsidy to provide a sustaining public service for all people.

Thursday, October 2, 2008

KIBERA SLUMS, NAIROBI

We drive to Jamii Bora to pay our respects to its founder, Ingrid Munro, and the team. There is less traffic in the Industrial Area than usual, perhaps because we left in the early morning, so we arrive deliciously on time. Olga, one of Ingrid's key team members, walks us from reception to the boardroom where we sit at a long table decked in red and green table cloths that reminds us of Christmas. A roof



Jamii Bora's Ingrid Munro is developing a town for former Nairobi slum dwellers.

deck outside the windows is decorated with scores of terra cotta pots filled with bougainvillea and other colorful flowers.

Ingrid walks in dressed in a white, collared shirt and a navy skirt. Her white hair hangs straight to her shoulders, and her eyes shine as blue as ever. Around her neck is a white cross and she wears, as always, sensible shoes, as my grandmother would have said.

I always appreciate how Ingrid hugs me – long and hard, as if to say I see you, I feel you, I'm glad to be with you. We need more people in the world who know how to hug.

Accompanying Ingrid are several team members, including Philip, who looks after programs, and Eliud, who is in charge of water and making sure the amenities at the Kaputei housing program are in order. Andrew, the extraordinary doctor who took me through Kibera, arrives looking dapper in a grey and black vest with a white shirt beneath.

"This last year has felt like ten," Ingrid starts. "Just think. The year began with the riots all over Kenya. Eighty thousand of our members were affected in some way by the horrors of that time. Can you imagine? But I learned something very important in this time. I learned that you can loot someone's home. But you cannot

loot somebody's knowledge. We have given people knowledge and that has put them on a different step. It means they are moving ahead even if they have temporary setbacks.”

When I was in Kibera last January, I was most struck by how few organizations actually stayed on the ground while the slums burned around them. Most decided to stay outside, but only a few days after the worst of the riots, Jamii Bora was open for business. Its Kibera branch had been violently looted, and the office was without a stick of furniture or even paper and pens. Still, when I arrived on the scene with Andrew and Kadidi, scores of women were waiting with the hope of renewing old loans or taking out new ones. I don't think anyone will forget that Jamii Bora was there when it counted most.

Jamii Bora was also instrumental in rebuilding Toi Market, the second-hand clothing market. I visited it with Andrew and Kadidi right after it had been razed to the ground by a bunch of marauding boys. Ingrid and her team moved quickly, ensuring that all the ethnic groups were represented, raised money and helped

rebuild the market. The endeavor was so successful that Jamii is now looking at possibly building more market infrastructure as a viable enterprise that also serves the poor in a significant way.

It is extraordinary to drive into Kibera again, nine months after I was here during the riots of early January. The boys are still at the gate: the same boys. They don't charge us to get in, but they are brash and imposing. “What are you doing here? Why aren't you just parking?” said one who approached Wendy, who is driving the car. A group of boys are sweeping the streets in a group – more public works.

On the other hand, the area is thriving. Women sell roasted maize along the roads, others sit behind enormous bags of grain or sell second-hand clothing. Whereas in January the area was empty and bleak, this time the area is a buzz of color, activity and noise.

Andrew, the impressive doctor who was my guide in January, leads us past the kiosks and into Jamii Bora's offices. Like last time, people are waiting outside either to repay or to get a new loan. This time, however,

there is furniture again, and staff people are bustling about helping the customers in need of assistance.

Andrew takes us into his office and sits behind a clean desk with his hands folded in front of him. Since January this year, Andrew has been the Kibera branch manager, and his office has recruited 50,000 new members. People lost everything in the area and saw that Jamii opened their doors right after the riots occurred. Andrew and Jamii's communications manager, Kadidi, would walk through the area, a Luo and a Kikuyu, and offer food relief and healthcare to neighbors, always making it clear that all tribes were welcome there.

The challenges are still great. Many of the members who came forth for the disaster-relief loans just disappeared, though Andrew said that now the people are starting to reappear. Andrew guesses that the organization will recover 75 percent of the loans made. Ten to 20 new groups -- or up to 100 people, mostly women -- are arriving each day. And the office is small: Jamii has only three trained staff and eight outreach workers who are visiting businesses and new recruits.

Jamii also is known as the group that helped rebuild Toi Market. The organization revamped the size of each stall to ensure that enough new ones would be constructed to accommodate old and new. The market was originally torched by a group of Nubian boys who felt the land was their birthright (the land originally was given to the Nubians by the British government for settlement following WWII, and some of their descendants then sold parts of it to the traders many years ago). During the rebuilding, the boys came back to harass and intimidate returning traders. Andrew and Kadidi went directly to the boys, convincing them that they actually needed the traders and would find a way to integrate them into the solution.



Toi Market in January.

A group of 200 young men showed up at Jamii Bora on the set morning. I ask Andrew if he felt nervous, and he said, “No, I have no fear of them. To be a leader here, you have to be one of them and I have known them and grown up with them.” Andrew asked that they choose five representatives to enter the office and they discussed their commitment to integrating some of the boys into the reconstructed marketplace. After getting the boys to agree to leave the market alone, Andrew and Kadidi went to the Association of Traders who deeply mistrusted the Nubian boys. Finally, the Association also agreed to send five representatives to a meeting. Andrew and Kadidi formed a Task Force of the ten individuals and then called Ingrid to have a more formal meeting. Ingrid wanted to know the numbers of who was working in the market already as well as the numbers of boys. At the time, there were 1774 traders and over 200 boys. She also insisted that there were Kikuyus and Luos, Kisiis, Kamanas and other ethnic groups represented.

Then Ingrid set two conditions: all existing pre-riots traders would have to be accommodated, as would the 200 Nubian boys. She also insisted that the Kikuyu traders who were displaced at the refugee camps be invited back into the market. The following day, she came to the market with a surveyor and realized the land wasn't sufficient for so many people, especially as many of the traders had accumulated multiple stalls. Consequently, Jamii Bora revised the standard size to 3x3 meters so to have more than 2,500 stalls and accommodate everyone.

Tensions continued to run high, as did the gossip, propaganda and politics. Neighbors felt that Jamii Bora had bought the land and were going to hold the community hostage as it profited. The boys were also putting pressure on Jamii Bora, telling them they needed money and not food alone. And so Jamii hired the boys to provide



Toi Market today.

security and help to distribute food while the construction was going on, paying them anywhere from \$7 to \$10 a day. Three weeks later, Jamii Bora had succeeded in rebuilding the market.

Only ten of the Nubian boys are still working as traders in Toi Market. The rest tried selling their stalls, and about 60 were successful in doing so. The other 130 are renting their stalls to traders who know how to run a business – typically at a rent of Ksh. 1,000-2,000 per month. Additionally, they are working as security for Jamii Bora and doing other petty jobs. They also are organizing themselves around collecting garbage as a private service for the City Council of Nairobi.

The Toi Market traders are beginning to do well again. It took months for the Toi traders to recoup their losses and regain business, but now people from even the most posh areas of Nairobi are coming. There are a few reasons for this. The Market is much better planned now and feels much safer. And indeed, it is safer. The boys provide sound security, and there are hardly any pickpockets now. And most people want to get on with getting on.

KAPUTIEI

In January, Jamii Bora had only begun building houses for its development in Kaputiei, which is located about an hour and a half from Kibera. Kaputiei will house up to 2,500 families who are members of Jamii Bora, and, therefore likely live in Kibera or Mathare Valley or other slum areas around Nairobi. I thought the riots and overall unrest would significantly slow down construction of the houses, and that the prospective buyers might think twice about making such a large investment so far away from the communities in which they currently live.

I was wrong on all counts.

Today, nearly 700 houses are in various stages of construction. More than 250 will be ready to be occupied in October, and there is already a waiting list of people. We drive an hour down through the Industrial Area, past an entrance to Nairobi National Park, into wide open lands traditionally inhabited by the Maasai. We are still not too far from another growing city which, as I said before, is clearly going to become part of Nairobi as it extends its reach as a megalopolis, holding far-flung suburbs and

cities and millions and millions of people looking to make better lives.

As we near Kaputei, Eliud points out, "Look, over there! Can you see the rooftops glistening in the sun!" Indeed, we can – hundreds of red tiled roofs stand as a proud and beautiful call to all of us. I remember visiting two years ago and seeing nothing but wide open spaces and hundreds of thousands of concrete blocks and red tiles lying in well organized piles on the ground, symbols of dreams and self-help. Today, you can already see how much had been accomplished by the people, for the people.

Wendy takes a right from the main road to the middle of nowhere, and we move slowly along dust roads. It feels like we are driving almost in the desert until we slowly pass earth-moving trucks and enormous yellow tractors. Further along, we finally come across what will become a beautiful suburb in less than a month. Workers are gathered, apparently on a break, and all are proud to tell us about their work. Everyone we asked had signed up to buy a house for themselves.

Along the organized roads, we can see the sewers being built and the processes whereby the sewers will carry waste to a common area where it will be filtered

and recycled. The water will be used for irrigation; the effluents, for fertilizing the land. Jamii Bora is focused on maximizing resources, and on respecting the environment. An experiment with solar lighting is being done on a few of the houses, as well.

Just seeing so many houses in a place that used to be empty filled me with emotion and pride to have some small connection to Jamii Bora. What I wasn't prepared for was the emotion I felt when I met Mary and Simon.

The couple must have been in their forties. They drive up in a dilapidated, white truck, which Simon "rents for my mechanic business." Mary, with hair to her shoulders, wide hips and a gigantic smile, carries a big purse and struts enthusiastically to her new house – but only after taking her Jamii Bora ID card and waving it proudly in front of our faces. "Come," she says, "come and see where we will live!"

We happily follow and there, in the empty house, where not a fixture has yet been installed, Mary and Simon proceed to ask us to imagine their dream home with them. "You see," she says, "this is where the sofa will go. And that back there is the kitchen, and can you see where the toilet will be?"

And there will be a real shower! It is all so beautiful." Simon interrupts to point to the master bedroom, equally as gleeful.

Mary puts her hand on his arm. "No," she says, "that is the room for our three children. This one in front is our master bedroom. I want to see the people walking on the street in front!"

The more I learn about housing, the more I think a multi-pronged strategy for low-income people makes the most sense.

Somehow, I said, I think Mary is going to win this battle. Simon shakes his head and smiles. "I know how this will go..." he laughs.

Technically, Mary and Simon make more than \$4 a day through his mechanics business and her grain-trading business. Seven years ago, they started borrowing from Jamii Bora when they were running very small-scale businesses and earning much, much less. Jamii Bora's approach is to provide its members with a ladder to help them learn to generate income and, maybe more important, learn to save and to become a true part of community. One question for Acumen Fund is how to think about our "sweet spot" when it comes to low-income housing. The more I learn about housing, the more I think that a multi-pronged strategy for low-income people makes the most sense.

Perhaps actual ownership isn't the right platform for the lowest-income group, but instead, we should focus on the provision of safe, accessible and affordable rental units. As a family begins to generate money – and savings – they might be eligible for low-interest loans structured in ways they can understand and access. In the case of Jamii Bora, buyers are required to



Building Kaputei is a team effort by Jamii Bora's members.

keep a savings account worth at least 10 percent of the property's value. This isn't considered a down payment, though it functions in much the same way. The mortgage is structured over 20 years with monthly payments set at \$43, which is what most people in the slums pay to rent their houses. If trouble hits the family, the enforced savings protects nearly two years of monthly payments, and it is made clear to home purchasers that their savings will be the first to be drawn down in the case of non-payment.

One question for us is what our own role is in experimenting with different products that will further help poor people accumulate wealth, stability and confidence. At one point, people tip from the very poor to being able to accumulate enough assets to purchase a modest home. It is important to gain clarity on this in housing, for it will likely have corollaries in other areas where we work.

Mary and Simon continue to jump around with excitement as they show us their two-bedroom house with a sitting room and an actual shower! "This means so much," Mary gushes. "And I have been waiting all my life for a house like this. It feels my life is really changed now."

I think of movie clips of 1950s-America, when couples struggling financially could nonetheless get access to veterans' loans and put a down payment on their first house. Their emotions would run high then with all the dreams that those houses represented. And you have to feel the same thing at Kaputei. I can't help but cry just a little bit at the sight of so much hope, pride and abiding gratitude, and I promise to come back sometime for tea or maybe even a little bit of wine to celebrate.

One question is our role in experimenting with different products that will further help poor people accumulate wealth, stability and confidence.

DORAH NYANJA

Dressed in a smart, white pantsuit with a grey and black blouse and a gold chain around her neck, Dorah meets us at the end of a long day. We'd hoped to see her at the clinic, but she was at a training for the day. Still, she meets us with a huge smile and a great, but grounded enthusiasm for what she does and how she does it.

The training she attended was provided to clinical officers who wanted to upgrade their skills around administering drugs and services to HIV-positive women who are pregnant. "It really weighed me down when I would send a baby away knowing the mother needs to provide real care to her, and then the care wouldn't happen and the baby dies."



SHF clinics offer routine and emergency care to low-income communities.

From Dorah's experience, out of every eight people she sees, five are HIV-positive, mostly women. She does testing, especially for antenatal women, but her challenge is what to do when she discovers that the women are HIV-positive. This week, she spent days upgrading her own training to understand the most recent treatment procedures for reducing mother-to-child transmission. A donor promised Dorah that once she is trained, he (or she) will provide the drugs for free. Dorah would then pass the drugs on for free but charge Ksh50 per visit (about \$.75), and the pregnant women would see her every two weeks for 12 weeks. Once the baby is born, Dorah has to start the baby on drugs within 72 hours. But first, she has to convince the mother not to have the baby at home, but instead at a nearby hospital or even her clinic. Dorah's charge is Ksh 2,000 – just a few dollars more than what LifeSpring charges – but she "thanks God if the woman can pay me 50%". In the month of September, Dorah delivered 16 babies: nine in the clinic, and seven as assisted-deliveries at home. Of the 16, four of the women were HIV-positive.

"I'm there in the community. The people trust me. They know I will hold their situations confidentially and will get the right medicines to them. But not everyone can afford what they need." Her official hours are from 7 a.m. to 10 p.m., seven days a week. She also attends to people in cases of emergencies and has two assistants who live in the community and work with her. She's currently looking for a good nurse who can provide services when she's not in the clinic.

Dorah currently sees about 65 patients a day, including consultations, antenatal visits, immunizations and family planning. Since the riots people have not been able to pay her the full price as often as they had before. Dorah also has had to reach out into the community to let them know she is still here and has no plans to

leave. Currently, she extends credit of about Ksh 200,000, or nearly \$3,000 monthly. Some repay, and others bring in other people who can pay so that Dorah can cover her costs and remain in the community.

I ask her about the January riots. "On the first day, I was there and I was so scared. There were fires everywhere and they were destroying the buildings of people from the wrong tribe. And apparently, I was one of those people from the wrong tribe. The gangs kept coming and asking why my building wasn't yet burned down. But the people around would say that I was good and gave a good service. Still, I understood that I had to repay those boys too. I was feeling so insecure, but could I really leave those people and go away?"

"You know, it was so stressful for those women there at the time that they were all delivering premature babies. And then they were in such poor health and traumatized too. And then there were the wounds from machetes or bullet wounds. We would take care of what we could, but we also had to transport people to hospital. We ran out of supplies because most of the agencies stopped working then, so I had to go into town to buy supplies and I couldn't be as careful about quality. Because who else was working on behalf of the community?"

"I just gave the service then for free and I thought God would pay and make things work somehow. The boys were coming with such terrible wounds and I would treat them but I so feared bankruptcy."

Since the riots, while much has improved, there is still significant tension among different ethnic groups and people are feeling the pressure of reduced socio-economic status.

Dorah would like to expand her clinic in Kibera to include a small facility where she could keep patients overnight and start a second SHF clinic in Kaputei. She's already laid the foundation and built most of the clinic, but is short about \$5,000.

"I'm looking for a loan for that amount at a good rate of interest, like 5 percent. I know I could repay within a year, but the problem is that this is too much for the microfinance organizations; and you can't own land in Kibera and the banks won't lend to me without collateral. So I'm just stuck."

She's also looking to borrow and purchase an ambulance for Kibera and thinks it will not only improve her services and business, but will make her safer as well. "When I leave my clinic at 11 p.m., I would turn on the siren of the ambulance so that people would know I was leaving. Have you ever heard of someone hijacking an ambulance?"

An ambulance costs Ksh700,000, or \$10,000 USD. She's been trying to find a loan from a number of local banks. The bankers have assessed the clinic as well as her home as they will insist on collateral, and Dorah thinks it is unlikely that she will get the loan. In five years she hopes to have an expanded clinic in Kibera that offers integrated services to the wider community.

Dorah is also fighting to get a house at Jamii Bora's housing development in Kaputei. She's been a borrower with Jamii Bora since 1999 and has the required savings with them. Once she has a house there, she could start a second clinic in Kaputei. "I am a good manager," she says, "and my dreams are big."

Jacqueline Novogratz
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