

## **Can Microfinance Institutions and Other Financial Service Providers for the Poor Help Victims of Trauma Find Hope and Dignity through Self Employment in the Informal Sector?**

***Keynote by Joshua Goldstein, Vice President, Economic Citizenship & Disability Inclusion, Center for Financial Inclusion at Accion, for the 8<sup>th</sup> PAN-African PCAF Psychotrauma Conference in Nairobi, Kenya, July 13-16, 2015***

Thank you Steve, David, the Africa Mental Health Foundation, and distinguished guests.

I am delighted to be joining you today to discuss how we might be able to help post-traumatic stress disorder (PTSD) survivors connect to livelihood opportunities, which I understand from Dorothy Kiza, Uganda Country Director for the Peter C. Alderman Foundation (PCAF), can be a key to keeping trauma center patients from relapsing into despair.

Today I want to explore with you whether it might be possible for Alderman Trauma Center patients who have gone through a successful course of treatment, including two sessions on livelihood, to become clients of microfinance institutions (MFIs) and build small enterprises.

I am Vice President for Disability Inclusion and Economic Citizenship at the Center for Financial Inclusion at Accion. Accion is the global microfinance pioneer founded in the 1960s that has helped to build 63 microfinance institutions in 32 countries on four continents. In 2013, Accion reached 6.6 million borrowers impacting the lives of upwards of 33 million family members. These borrowers had a 97 percent repayment rate. Over more than 40 years, microfinance has had particular success economically empowering women, which is important and germane, since most trauma center patients are women. It is a proven poverty reduction tool.

An important caveat: For the most poor patients and/or those with incapacitating PTSD, who have no skills, no micro-enterprise and really no economic activity at all, joining a savings group through a version of the graduation model, pioneered by BRAC in Bangladesh, in which an asset such as a cow, goat, or about \$100 to start a business is provided along with skills training and life-coaching, is likely to be a better alternative. (The NGO “Basic Needs” approach is, writes Crick Lund, another interesting possibility for those with severe mental illness.) It can put a person on the road to solvency and can enable an eventual transition to sustainable self-employment. Of course grant money is needed for such interventions. (Parenthetically, at Fonkonze, a wonderful institution in Haiti that uses the graduation model, the case managers have not yet been prepared to include persons with disabilities in their program—which points to the extent of the stigma attached to persons with disabilities. I will address this more later.)

On a personal note, I am a PTSD survivor—the diagnosis my psychoanalyst made more than 30 years ago. I lost a twin to cancer when I was two and a half. I mention this because my parents had the financial resources to get me the help I needed—when I was a child, an adolescent, and again as a young adult. Not once or twice or three times. I believe a mental health problem becomes a mental health disability when it affects one’s ability to function over time, and by this criterion, I had a mental health disability that was ameliorated by a succession of treatments.

So I am passionate about the work you do at PCAF and share your outrage at the paucity of funding for community mental health from governments and foundations. Only the luck of birth fortune allowed me to afford the help I needed. So from my place of extraordinary privilege, I believe with all my heart that in a just society poor people with mental health challenges like mine should get the help they need so they can flourish as human beings. Unfortunately in the international development world I come from this great cause is barely on the radar—in spite of the fact that reaching the most destitute is at the urgent core of all international development work.

All of you are working to change this mindset and trying to increase outreach to the poor who are suffering from PTSD and other so called psychosocial disabilities. I hope by the end of my talk today, we will find some concrete ways to work together.

But why self-employment? Why not go find a job and work for a business that provides a regular paycheck? Isn't that easier and more secure? Of course it is. Most clients of MFIs are what we call necessity entrepreneurs and would rather have such jobs than start their own businesses. But the sobering reality of limited formal sector employment opportunities across Africa makes finding such jobs for persons with physical disabilities, let alone psychosocial disabilities even more challenging than it would be otherwise. Even in my country, the United States, unemployment of persons with disabilities in the formal workplace remains unconscionably high.

A quick definition of informal economy: this term is a bit vague, but basically it refers to that part of the economy made up of tiny businesses run out of the home, that are usually not taxed, that provide no benefits, and are poorly or not at all reflected in statistics about the gross national product and other measures of an economy's health.

Microenterprises, most *often* run out of the home, are classic examples of informal sector businesses. (Most involve trade.) And can be an opportunity lifeline that improves life quality and reduces poverty. A baker can buy a second oven; a vegetable vendor has the capital to buy enough produce to visit her supplier once a week, not once a day, and by buying in bulk increase her margins dramatically. She does not become rich, but she can pay for her children's school fees and school uniforms.

But are such financial products like credit or savings a good idea for someone with PTSD? Would the effort to save or borrow money increase anxiety, for example? There is no easy answer based on my cursory review of the very limited research studies to date – the results are ambiguous and prove nothing conclusive one way or the other.

What we do know from PCAF Uganda Program Director Dorothy Kiza is that relapsing back into mental illness is often caused by a lack of employment—so, on balance, the stress of not working may be equally/ or more stressful than paying back a working capital loan which at least holds out the promise of a more hopeful future. My own hunch is that the answer will only be decided on a case-to-case basis and so no generalization is really possible.

What seems beyond doubt as Crick Lund has written, "Is {the} growing international evidence that mental ill health and poverty interact in a negative cycle. This cycle increases the risk of mental illness among people who live in poverty and increases the likelihood that those living with mental illness will drift into or remain in poverty." And "The Mental Health Action Plan 2013-2020" weighs in citing a big

picture study that estimated that the cumulative global impact of mental disorders in terms of lost economic output will amount to 16.3 trillion between 2011 and 2030.

In 2008, Accion launched the Center for Financial Inclusion with a mission to understand the obstacles in the way of reaching the goal of full financial inclusion for the legions of the poor unbanked, and then seek ways to overcome them. In short, identifying who is being left out and how to bring them into the fold so that economic citizenship will become a reality for all, including persons with disabilities, refugees, indigenous groups, and gays and lesbians. And today I want to formally add persons with PTSD and other chronic mental health challenges to this list. It's about time we address this moral legal and business failure, don't you think?

Over the last three years we have developed a new program devoted to providing financial services to persons with disabilities, who make up, according to the WHO, 15 percent of global population but represent only 0.5 percent of clients of MFIs.

I am happy to report that the Center (and its allied partners working on this issue) has begun to demonstrate significant success in including persons with physical disabilities in Paraguay, India, Bangladesh, and in Uganda, and I hope you can provide us guidance to expand this initiative to include persons with mental health problems.

The CFI has developed and tested and refined a comprehensive "Framework for Disability Inclusion" in Paraguay and India, with the support of organizations like Handicap International and v-shesh, that is helping MFIs around the world to become disability-friendly. The Framework is a how-to guide for how to develop partnerships with local disability organizations, how to make reasonable accommodation and universal design workable and affordable, how to do sensitivity trainings of loan officers and other staff so that they will learn to be comfortable working with persons with disabilities (PWD). The Framework underscores the importance of staff trainings to fight stigma and end discrimination by:

- Determining baseline of current clients with disabilities;
- Determining baseline of staff attitudes toward PWD before customized awareness training commences;
- Developing policy language to be inserted in the institution's existing code of ethics to meet the non-discrimination standard set forth by the Smart Campaign - this code of ethics must be designed to be replicable at other MFIs around the world;
- Developing new human resources orientation material that includes nondiscrimination language in the current policy for all new hires; and
- Creating a simplified "train the trainer" tool, based on Handicap International's comprehensive guide, to make awareness training something any MFI can undertake.

And persons with disabilities have proven to be excellent clients. That is the good news.

But as you all know persons with psychosocial disabilities in Africa and in many other places in the world are, in the words of Nigerian healthcare advocate Ifesinanchi Sam-Emurwa, "doubly stigmatized." And to paraphrase remarks by Columbia University psychiatrist, Dr. Evaristo Akerele, who spoke this past June 11 at the only mental health session on psychosocial disabilities at the [U.N. Conference of State Parties annual disability conference](#): The person with mental health issues is blamed for bringing what

psychiatrists call depression or anxiety on themselves. Beliefs such as that God is upset with them, that drug use is to blame, that witchcraft is at work, are all common. The term “depression” is not culturally acceptable or even understood. There is not an accepted and shared nomenclature for describing mental suffering.

The panelists for this session were well-informed and persuasive but it was no surprise that they were not warmly received by the very small audience. More on that later.

An interesting example of how this “double stigma” plays out also comes from Nigeria in the financial services arena also. The Central Bank of Nigeria (CBN) recently earmarked US\$ 20 million to financial service providers to make loans to persons with disabilities—a great step forward. But it explicitly excluded persons with mental health disabilities as recipients of these loans.

So what can be done to improve the situation? I want to suggest five of the biggest challenges we face, and interventions that I believe we can undertake together to answer these challenges to improve the livelihood possibilities for persons with psychosocial disabilities. I hope this will form the beginning of an action plan.

**Challenge 1:** How can the staff of an MFI with no training in psychology even begin to identify clients with mental health issues if there are no common, agreed-on terms of reference for describing distressed states of mind? And how do we sensitize staff to work with this client segment?

It is relatively easy to determine a baseline of the number of persons with physical disabilities who are clients by asking medically noninvasive questions (or just through observation) about their state of wellness - “Do you have trouble hearing? Do you have trouble seeing? Do you have mobility issues?” Unless a person with mental health issues self-discloses, it is impossible to know if they are suffering from a depressive, anxiety or other disorder (with the exception of persons who are “floridly” psychotic). As we discussed above, these clients most likely do not even have the words for what ails them.

**Intervention:** A) Volunteers from this conference can help financial service providers design survey questions which will allow MFI staff to get a better count of current clients with mental health issues. B) These volunteers along with PTSD survivors themselves can help sensitize MFI staff on how to best reach out to persons with mental health disabilities. They can connect MFIs with community mental health leaders and in particular patient advocates. C) These learnings can then be incorporated into the Framework for Disability Inclusion so that a set of best practices can be developed and then shared with MFIs from around the world.

**Challenge 2 :** Access to basic capital and business training based on the PCAF livelihood experience in Uganda as described by Dorothy Kiza is largely lacking, and, as she explained to me, prevents those with psychosocial disabilities from expanding their projects/activities, and from doing record management, book keeping and other management tasks. There is inadequate community support towards these initiatives, which holds them back. There is also irregularity of some members in attending meetings.

Dorothy decided, after trying to manage business training and financial services internally, to hand it off to organizations that specialized in this area and stick to what they did best as a disability organization. This has worked out.

**Intervention:** A) Connect PCAF graduates to microfinance providers, credit unions, self-help groups, savings groups, and others to professionalize the business training and operations of the PCAF patients. The natural intermediary to make first contact with the MFI or other provider might be the PCAF social worker, during their weekly/monthly follow-up outreach to former PCAF patients in their villages, homes, and workplaces. The Center and I can help with this since it's central to our mission to reach out to vulnerable minorities who remained unbanked.

B) Just as the Center identified two or three institutions in India that were eager to do a pilot to include PWD in their program, we can work to identify two or three MFIs in the PCAF countries of Kenya, Uganda, Liberia, and Cambodia who want to be leaders in including persons with psychosocial disabilities in credit and/or savings groups. I think there is a good chance of success here since PCAF livelihood training in the seventh and eighth sessions is done in groups, which suggests to me that the transition to the group lending methodology of microfinance and saving groups could prove to be quite natural and comfortable. And I am pleased to announce that George Mukassa of the Norwegian Association of the Disabled (NAD) in Uganda who heads up the "We Can Manage" program that helps persons with disabilities form sustainable saving/credits groups, wants to help us start similar groups for persons with PTSD, depression, and other psychosocial problems. To date, "We Can Manage" has overseen the creation of 922 active groups, with thousands of members, more than 60 percent of whom are disabled.

**Challenge 3:** The U.N. does not do nearly enough to recognize the importance of mental health disabilities, when it comes to collecting good statistics, when it comes to prioritizing it in the Sustainable Development Goals (SDGs) to reduce extreme poverty, and when it comes to seeing therapeutic intervention as a significant part of the Convention on the Rights of Persons with Disabilities (CRPD) treaty obligation.

**Interventions:** A) You and your colleagues should lobby the Washington Group on Disability Statistics, the U.N. body charged with this task to include a specific question on mental health in its so-called "short set" of questions that it provides to governments that do censuses and disability surveys. The WG team understands that there is a need to do better on data collection and welcome expert advice on this and I can connect people here to the principals.

B) In the current draft of the SDGs in paragraph 3.4 it reads: "Ensure healthy lives and promote well-being for all at all ages." This is certainly better than nothing, but is pretty weak tea. Professional health care providers like you should lobby the U.N. to add language on mental health while this document is still being shaped.

C) The Convention on the Rights of Persons with Disabilities (2006) in Article 3 says that: "States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law." Which is true and the denial of

legal capacity to persons with psychosocial problems or disabilities is an important rights issue. But unfortunately this completely overshadows the equally important Article 25 on health which mandates that ratifiers “Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons.” And of course this includes PTSD. And Article 27 puts emphasis on work and employment.

Year after year at the U.N. annual Conference of States Parties meetings, my strong impression is that therapeutic interventions for those with mental health struggles are not only given short shrift but are treated with veiled or even open hostility to the extent that the topic is rarely aired at all. I am not exactly sure why this is but I do know that there is an outspoken anti-psychiatry group in attendance which seems to view most psychiatry not as a healing art but as a tool used to deny legal capacity of PWD. To my mind, this is a travesty when, as the PCAF website states: “Over a sixth of the world’s population has directly experienced armed conflict, torture, terrorism, sexual and gender-based violence, ethnic cleansing or genocide.” And that the effects can be devastating: more than 50 percent of survivors cannot lead functional lives because of incapacitating traumatic depression or PTSD. They can’t work or care for their families. Children can’t attend school. Untreated, this can extend into the next generation and beyond. As Steve told me, in sub-Saharan Africa, the treatment gap exceeds 90 percent: less than 10 percent of people who need mental health services to reclaim their lives receive them. So there must be a concerted lobbying by PCAF, and others, to ensure that the right to receive treatment for mental health ills gets equal billing with assuring the right to vote and enjoy equal protection before the law. If this does not happen, it will be much harder to obtain funding from governments and foundations. They must be educated to understand that the SDGs cannot be achieved if the psychological needs of the poor go unmet.

**Challenge 4:** To create a new set of global standards and indicators for microfinance institutions and other financial services providers to follow that will establish the importance of serving PTSD survivors and other persons with psychosocial disabilities.

**Intervention:** The Center for Financial Inclusion will take the lead, with the support of PCAF, to push industry-wide standard-setters like the [Poverty Stoplight](#), [Freedom From Hunger and the Microcredit Summit](#), the [Social Performance Task Force](#), the [Smart Campaign](#), the [Progress out of Poverty index](#), and the [Maya Declaration](#) of the Alliance for Financial Inclusion to add mental health indicators. I only have time to discuss a few of these possible initiatives.

A) I am delighted to announce today that the Poverty Stoplight has offered to take the lead in creating a mental health indicator. The Poverty Stoplight set of indicators, pioneered by Fundacion Paraguaya and now used around the world sees poverty as multidimensional and have developed a tool that allows the poor to measure their own poverty, broken down into different categories. They use 50 indicators grouped into income and employment, health and environment, education and culture, etc. So under the health and environment category is water and the often illiterate clients are shown pictures of a faucet—meaning they get a green if they identify with having a faucet and regular water access – or a picture of a well down the road—meaning those in this category get a red as they have water but it is far away. Some are poor in some categories and not in others. Adding a mental health indicator could be a source of data that could be used not only by MFIs but by local community mental health leaders and

other public health providers. And I was delighted to learn from Crick's talk today about Mark Jordan's new "Community Informant Detection" tool that has a mental health indicator that with a little customization could work perfectly for the Poverty Spotlight.

B) Freedom from Hunger in conjunction with the Microcredit Summit Campaign has just published a new guide called "Healthy, Wealthy and Wise: How Microfinance Institutions Can Track the Health of Clients," in which they asked questions around six indicators, including food security and nutrition, preventive health care, curative health care, water, etc. "The results from these four [studied] MFIs highlighted the added value of health indicators when combined with poverty measurement in helping MFIs understand client well-being," the report states. Their "theory of change" is that with greater financial resources the clients will be able to meet their essential needs as outlined above—like having clean water or improved nutrition.

I have consulted with the author, Bobbi Gray and she is very willing to work with us to see if we can help her develop a seventh indicator around mental health - which is great news.

I can imagine a future where MFIs would refer clients with mental health issues revealed through the new survey question we help design to PCAF and other community mental health providers. Perhaps the client surveys might serve to "identify hot spots" of misery that would guide mental health practitioners and local governments on where to allocate scarce resources. One last thought: Could ACE questions be added to surveys to better understand the overall wellness of the family not just the client? There are so many possibilities to explore.

C) The mission of the highly influential Center for Financial Inclusion's Smart Campaign is to make sure that clients are put first and treated fairly. It has been endorsed by 4,300 microfinance institutions/professionals around the world. Among its "client protection principles" is one called, "Responsible Treatment of Clients." Included in this principal is language enshrining nondiscrimination against persons with disabilities. I am going to push the Smart steering committee to explicitly mention psychosocial disabilities.

With the help of these important industry standard-setting groups, I believe that we can help to break down the attitudinal barriers that keep persons with psychosocial disabilities in extreme poverty unbanked and stigmatized.

My conclusion is that self-employment can offer dignity and hope to persons recovering from mental illness. I think it is worth exploring how we can do more to connect with MFIs and other financial service providers to open their doors to PCAF clients. At the very least this initiative will help fight stigma and bring down attitudinal barriers. Let us see what works and what sticks. It is certainly worth a try.

Thank you for your time today. Looking forward to working with all of you.

Joshua Goldstein