Transforming Cash Transfers:

Beneficiary and community perspectives on the Cash Transfer for Orphans and Vulnerable Children Programme in Kenya

W. Onyango-Ouma (University of Nairobi) and
Fiona Samuels (ODI)

December 2012

Acknowledgements

We would like to acknowledge the many individuals who have contributed to undertaking the study and producing this report. We are grateful to the staff of the Department for Children's Services in the Ministry of Gender, Children and Social Development (particularly Mr Ahmed Hussein – Director, Children's Services, Mrs Mary Mbuga – Head, OVC Secretariat, Lillian Karinga and Samuel Ochieng) for their support in facilitating the study. During the fieldwork phase, the data collection team of Beryl Oyier, Julie Mutuura, Shadrack Orinda and George Khamati provided valuable input that made the study possible.

We are also grateful to Rasto Omolo (District Children's Officer, Makueni) and Jane Nkatha (District Children's Officer, Busia) for facilitating our entry into the field and linking us with the beneficiaries. We also thank the chief of Kwakavisi location, Makueni, the chief of Marachi Central location, Busia, and the voluntary children officers in the two locations for providing us with useful contacts of key informants and mobilising the beneficiaries and non-beneficiaries for the exercise.

We would like to thank Maxine Molyneux, Heather Kindness, Matthew Greenslade, Joanna McGowan, Florence Kinyua, Liz Drake, Vitor Novele and Leigh Stubblefield for providing valuable comments during the report writing.

Above all, we would like the individuals (adults and children) who agreed to participate in this research and generously gave their time for the research process.

This document is an output of a project funded by UK Aid from the UK Department for International Development (DFID). However, the views expressed and information contained within are not necessarily those of or endorsed by DFID, which accepts no responsibility for such views or information or for any reliance placed on them.

Overseas Development Institute
203 Blackfriars Road, London, SE1 8NJ

Tel: +44 (0)20 7922 0300
Fax: +44 (0)20 7922 0399
www.odi.org.uk

Contents

Tables, figures & boxes

Tables

Figures

Boxes

Abbreviations

AAC	Area Advisory Council
AIDS	Acquired Immune Deficiency Syndrome
APHIA II+	AIDS, Population and Health Integrated Assistance Program
ART	Antiretroviral Therapy
BWC	Beneficiary Welfare Committee
CBS	Central Bureau of Statistics
CHW	Community Health Worker
CPRC	Chronic Poverty Research Centre
CPU	Central Programme Unit
CSO	Civil Society Organisation
CT	Cash Transfer
CT-OVC	Cash Transfer for OVC
DCO	District Children's Officer
DCS	Department of Children Services
DFID	UK Department for International Development
DGC	Demand Generation Consultation
DHS	Demographic and Health Survey
DOSC	District OVC Sub-committee
ECD	Early Childhood Development
FGM/C	Female Genital Mutilation/Cutting
FGD	Focus Group Discussion
GDP	Gross Domestic Product
GDI	Gender-related Development Index
GEM	Gender Empowerment Measure
GoK	Government of Kenya
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
IDI	In-depth Interview
ILO	International Labour Organization
KII	Key Informant Interview
LOC	Location OVC Committee
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MGCSD	Ministry of Gender, Children and Social Development
MIS	Management and Information System
MoH	Ministry of Health
MPI	Multidimensional Poverty Index
NBS	National Bureau of Statistics
NGO	Non-governmental Organisation
NSPP	National Social Protection Policy
OECD	Organisation for Economic Co-operation and Development
OPCT	Older Persons Cash Transfer
OPT	Occupied Palestinian Territories
OVC	Orphans and Vulnerable Children
PLWHA	People living with HIV and AIDS
PM&E	Participatory Monitoring and Evaluation
PWD	People with Disabilities
SP	Social Protection
TWG	Technical Working Group
UK	United Kingdom
UN	United Nations
UNAIDS	Joint UN Programme on HIV/AIDS
UNDP	UN Development Programme
UNICEFUN	Children's Fund
UNRISD	UN Research Institute for Social Development
US	United States
USAID	US Agency for International Development
VCO	Voluntary Children's Officer
WFP	World Food Programme

1 Introduction

There is an international consensus that social protection (SP) is a powerful way to fight poverty and promote inclusive growth among vulnerable populations throughout the world. In Africa, there is growing interest in SP, and within this in providing predictable social assistance to poor and vulnerable populations. This has been articulated in the African Union Social Policy Framework, thus making SP a key strategy in poverty reduction across Africa (Ministry of State for Planning and National Development and Vision 2030, 2012). So far, the most popular SP interventions are social cash transfers and public works, although other interventions, including reforms to pension schemes, are also being explored.

Cash transfers (CTs), a form of social assistance, are regular, non-contributory payments of money, provided by the state or non-governmental organisations (NGOs) to individuals or households, with the objective of decreasing chronic (long-term) or acute (shock-induced) poverty, addressing social risk and reducing economic vulnerability (Samson et al., 2011). CTs are predictable transfers provided as part of a social contract with citizens and may include child support grants, orphan care grants, disability grants, social pensions and transfers to poor households, among others. CTs can be unconditional or conditional, with the latter aimed at promoting particular behaviours, such as school attendance, improved nutrition or regular health check-ups.

CT schemes are increasingly being seen as a right of citizenship, and evidence is growing that they can help tackle hunger, increase living standards and improve the education and health of the poorest families (Adato and Basset, 2008). Significant progress has been recorded in a number of developing countries with large CT schemes, including Brazil, Colombia, Honduras, Mexico, Nicaragua and South Africa (Bryant, 2009). New research in Kenya further suggests that CT programmes not only improve nutrition, education and health benefits for orphans and vulnerable children (OVC), but that they also can significantly reduce risky sexual behaviour and HIV infection (IRIN and Plus News, 2012).

This study was a pilot for a multi-country study exploring the experiences and perceptions of unconditional cash transfer programmes in five countries: Kenya, Uganda, Mozambique, Yemen and the Occupied Palestinian Territories (OPT). In Kenya, the focus of the research, given the focus of the programme, was on unconditional cash transfers to OVC; in other countries, the focus on vulnerable groups included older people and people with disabilities. The study explored beneficiary perspectives and the perceptions and opinions of non-beneficiaries and programme implementers in order to create a comprehensive picture of individual, household, community and national views, experiences and perceptions of the CT programmes, ranging from design and implementation to effects and impacts.

The research design was informed by an extensive and comprehensive review of secondary materials[1] and by an analysis of existing quantitative data, where the latter was possible. Primary data were collected using qualitative and participatory methodologies, thus allowing the complexities of reality to emerge and the voices of participants to be heard, while at the same time ensuring critical exploration of gender, poverty, age, socioeconomic status, dis/ability and other vulnerabilities in the project design, the formulation of aims and objectives and in the data collection processes. We sought opportunities to involve different policymakers, practitioners and, where appropriate, OVC in this study, thus enhancing the reliability of our analysis by bringing in diverse perspectives but also supporting different stakeholders' appreciation of the research processes and findings. Capacity building and policy engagement at different levels (from community through to national) and with different target audiences were carried out on an on-going basis.

In addition to carrying out more formal research, the study also used participatory techniques as a means of communicating findings in an engaging and accessible format, but also to engage research participants as collaborators in the narrative construction/storytelling process in ways that promote authorship and ownership. Thus, in Kenya and Mozambique, participatory photography was carried out – in Kenya with children, in Mozambique with people with disabilities. See

[1] An extensive review of secondary materials was carried out for this study and outputs on this can be found on http://www.odi.org.uk/projects/2622-holding-cash-transfers-account-community-perspectives-social-protection-programming and also in the forthcoming synthesis products.

(http://www.odi.org.uk/projects/2622-holding-cash-transfers-account-community-perspectives-social-protection-programming) for details of the participatory photography workshops and outputs.

The report is structured as follows. Section 2 presents the conceptual framework. Section 3 gives an overview of the country context and background, including key vulnerabilities and an overview of the CT-OVC programme. Section 4 outlines the methodology, comprising methods and techniques applied in the data collection, sample sizes, respondent types, ethical considerations and challenges/limitations. This is followed in Section 5 by a description of the study sites and respondents. Section 6 presents community understandings and experiences of vulnerability, and related coping strategies. Section 7 looks at the mechanics and governance of the CT-OVC programme, while Section 8 reviews the use of cash and perceptions around the value and effects of the CT. Section 9 covers programme accountability. Finally, Section 10 contains policy and programme recommendations relating to the programme and next steps.

2 Conceptual framework overview

In the context of the on-going global financial crisis, and in light of current discussions about international development goals beyond 2015, SP is increasingly seen as essential – not just to tackle rising levels of risk and vulnerability but also to promote social justice, of which social inclusion is an integral part (Economic Commission for Africa et al., 2012). The available evidence on the impact of SP largely draws on quantitative assessments, driven by government and development partners' emphasis on results (DFID, 2011). However, our literature review revealed a dearth of evidence around SP programming impacts based on participatory research, especially with regard to intra-household and community dynamics and differential effects on the diversity of marginalised social groups. In order to situate our study on citizens' perceptions of CT programmes in Sub-Saharan Africa and the Middle East, in this section of the report we present a conceptual framework for assessing the extent to which social protection, especially social transfers, can address the marginalisation of diverse social groups to achieve social justice. We focus on the different elements of a 'social protection – social justice pathways framework', including an in-depth understanding of:

- The multidimensional nature of risk and vulnerability;
- The importance of structural and political economy parameters at the national level; and
- The drivers of programme impacts at the local level.

2.1 The multidimensional nature of risk and vulnerability

The nature of poverty and vulnerability is complex, multidimensional and highly contextual (see Figure 1). Poor households face a range of highly interconnected risks at the macro, meso and micro levels, including economic, socio-political, environmental and health-related shocks and stresses (see Table 1). A nuanced understanding of how different social groups experience poverty and vulnerability is therefore vital in order to design and implement effective SP programmes that support pathways out of poverty and contribute to social justice outcomes.

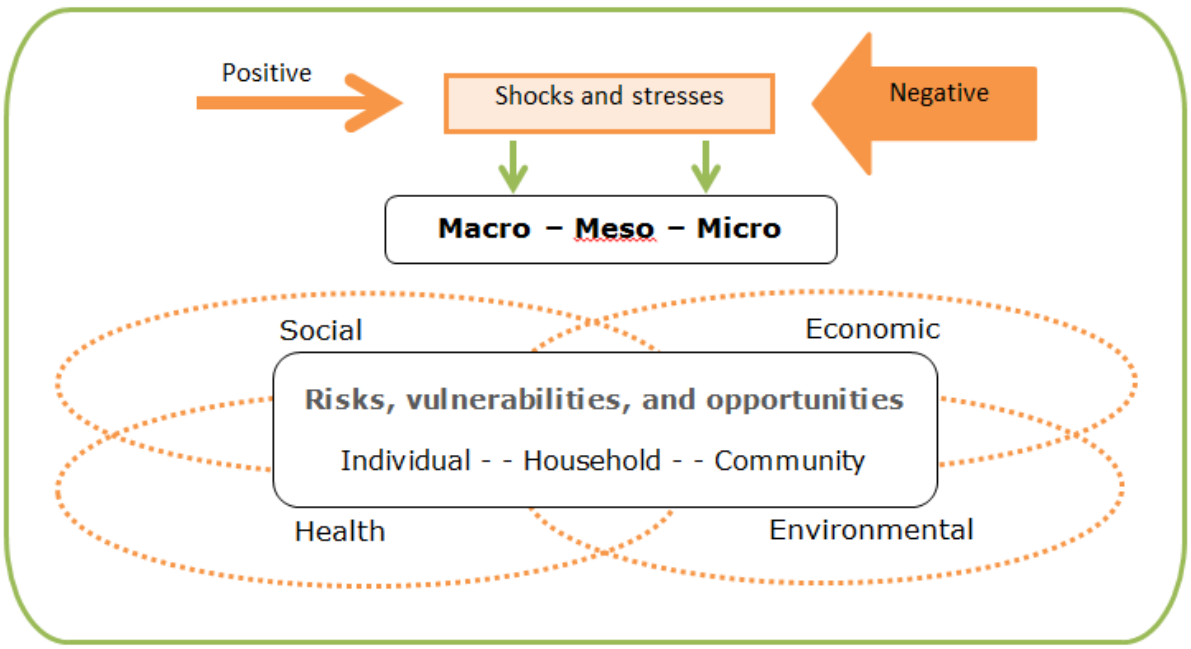
Table 1: Examples of sources of risk and levels of vulnerability

	Macro	Meso	Micro
Economic	Global financial crisis	Social malaise as a result of high levels of unemployment Inter-household inequality in access to productive assets such as land, rights and duties	Job insecurity for low-skilled workers (Razavi et al., 2012). Intra-household tensions owing to economic scarcity and engagement in risky coping strategies (Harper and Jones, 2011)
Socio-political	Demographic change	Erosion of community	Family composition

	and migration Violent conflict	social capital and informal forms of social protection, with especially high toll on older people, who are highly reliant on social ties for wellbeing (ILO, 2011)	(high dependency, intra-household inequality, household break-up, family violence, family break-up), with particularly acute impacts on people with disabilities, who often rely more on family care and support (Marriott and Gooding, 2007)
Environmental	Climate change Environmental degradation	Climate-related migration can put economic, social and infrastructure-related pressure on host communities (Sabates-Wheeler and Waite, 2003)	Exacerbating household economic fragility as a result of falling agricultural yields and exposure to natural disasters (Farrington et al., 2007)
Health	• Ageing population is increasing the prevalence of chronic disease and disabilities linked to older age	• Status-related hierarchies within communities can limit access to health care and public health information for marginalised groups	• Breadwinner loss of productive capacity; on-going costs of care in terms of resources, time

To date, SP programming has largely put greater emphasis on economic shocks and chronic poverty. Attention is also increasingly being paid to socio-political risks and vulnerabilities rooted in inequalities based on gender, ethnic minority or refugee status (Baulch et al., 2010; Holmes and Jones, 2009; Molyneux, 2007; Sabates-Wheeler and Waite, 2003). Devereux and Sabates-Wheeler (2004)'s emphasis on 'transformative' SP and programming that addresses equity, empowerment and social justice as well as material needs marked a pivotal conceptual shift in the way we think about SP. Such transformations can be promoted directly through programme design and implementation or can be linked to complementary interventions, including rights awareness campaigns and behavioural change communication efforts and/or social equity measures such as the passage and enforcement of non-discrimination legislation (Jones et al., 2011).

Figure 1: Multidimensional risk and vulnerability context



Note: The box around the social levels – individual/household/community – shows how they span all of the risk and vulnerability domains (social/economic/health/environmental), and how dynamics at all of these levels are

critical for understanding the risk and vulnerability context that will influence the potential impact of social protection

2.2 Structural parameters

The potential of SP to achieve social justice outcomes (resilience, agency, multidimensional wellbeing – see discussion below) for the most marginalised groups in any society is influenced by an array of structural factors at the national and international levels (see Figure 2), which provide the parameters for what types of policies and programmes may be feasible in a given country context.

First, a productive economy shapes SP opportunities on a number of levels, principally through the available fiscal space. The composition of the labour market is also an important variable, particularly in relation to linkages to complementary income-generating opportunities and exit strategies. Second, a care economy (the country-specific mix of family, state and private sector providers of paid and unpaid care work) plays an important role in shaping the demand for, as well as feasibility and desirability of, particular forms of SP (Molyneux, 2009). Third, social institutions (the collection of formal and informal laws, norms and practices that shape social behaviour) also have considerable influence on development outcomes (Jones et al., 2010). They can be empowering, enabling individual and collective action or they can reinforce inequality, discrimination and exclusion (Rao and Walton, 2004, in UNRISD, 2010). Finally, various international legal frameworks and norms provide clear commitments to social assistance and SP so as to ensure a basic minimum standard of wellbeing for the most marginalised groups in society.

2.3 Political economy influences

National political economy dynamics are also key, as poverty and vulnerability are inherently political in nature. For the chronically poor and most vulnerable groups, who are least likely to benefit from economic growth, politics and political change may be the route to better development outcomes (Hickey and Bracking, 2005). However, until quite recently, decision making around SP focused on economic considerations rather than politically driven approaches that are more context-appropriate and sustainable (Hickey, 2007). Political economists view development policy and programme outcomes as involving a process of bargaining between state and society actors and interactions between formal and informal institutions (Helmke and Levitsky, 2004); accordingly, the framework of this research includes the political institutions, interests and ideas that shape social protection decision making and programming.

Institutions

First, a vital consideration in introducing or scaling up social assistance is the capacity of the state to mobilise funds and other resources (Barrientos and Niño-Zarazúa, 2011). In its assessment of the affordability of CTs, the UK Department for International Development (DFID, 2011) notes that, where a government decides to invest in CTs, spending is typically within an overall budget for a wide range of sectors, and reflects judgements regarding the comparative advantages (e.g. value for money or political gains such as greater state legitimacy) for achieving broader economic and social goals.

Second, limited institutional capacity represents a major challenge to the rollout of SP programmes in most low-income countries, at all stages – from undertaking poverty and vulnerability assessments, to designing and implementing tailored policies, as well as monitoring and evaluating impact (Barrientos and Hulme, 2008).

In many contexts, decentralisation has complicated the picture. While poverty reduction strategies have favoured decentralisation as a way of closing the gap between citizens, local and central government, and strengthening accountability, in practice functions have often been delegated to weak institutions with limited knowledge of anti-discrimination legislation and related programme provisions (CPRC, 2008). This can undermine progressive programme design and opportunities for a strengthened social contract (Holmes and Jones, 2013).

Finally, robust monitoring and evaluation (M&E) is integral to assessing the impact of SP programmes, but there is wide variation in the quality of M&E in different countries and regions. There are also considerable challenges as a result of the limited availability of disaggregated data, especially with regard to intra-household and intra-community dynamics (Holmes and Jones, 2011; Molyneux, 2007).

Interests

Multiple actors are involved in SP policy and programming; in our framework we highlight three key players in particular:

National governments: Evidence from numerous countries suggests competing interests among government agencies ('departmentalism') is a common characteristic of SP programmes (Hagen-Zanker and Holmes, 2012). Programmes are often housed within the ministry responsible for social development, with limited buy-in from key ministries such as finance and planning.

Development partners: Similar 'departmentalist tensions' are frequently mirrored in development partners' approaches to SP. UN agencies and international NGOs endorse a rights-based approach, whereas development partners are increasingly emphasising results-based aid and value for money.

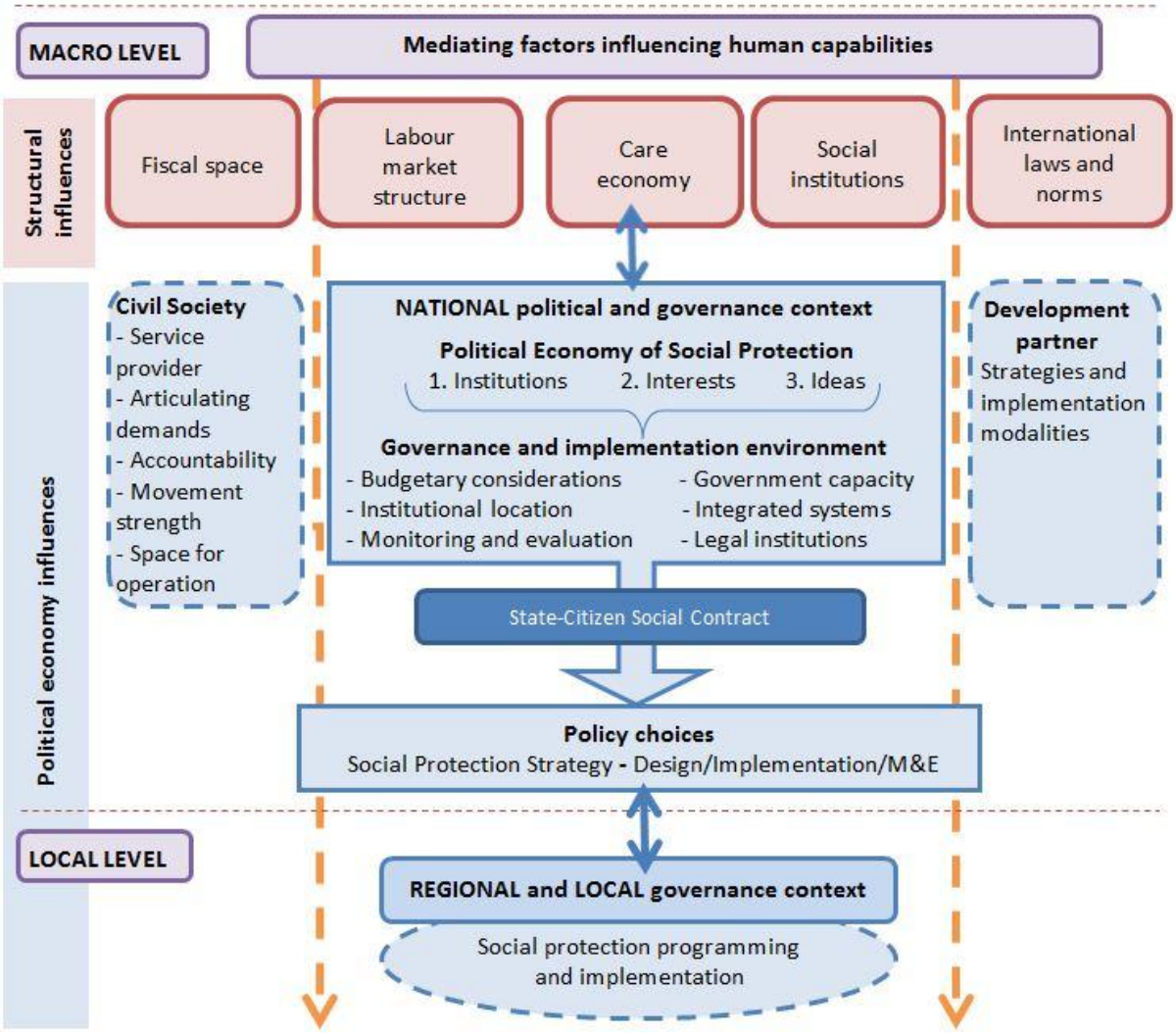
Civil society: The interests of civil society in advancing SP, and how these interests are articulated, are also critical. Given the isolation experienced by socially excluded groups, their mobilisation around self-identified interests, often supported by NGO intermediaries, is a precondition for their participation in the construction of the social contract (Kabeer, 2010). However, most governments and development partners continue to treat civil society organisations (CSOs) as junior partners or subcontracted service providers, and there are few success stories of effective mobilisation around social protection at the national level (Devereux, 2010).

Ideas

Political economy influences are not limited to institutional capacity and interests; they also encompass the ideas that drive decision making. This is certainly the case with SP, where divergent national systems reflect a wide range of ideas about poverty and vulnerability and their underlying causes, as well as the purpose of SP and the role of the state vis-à-vis its citizens. Hickey (2009) argues that the concept of a state–citizen contract helps in uncovering the philosophical underpinnings of state support towards its citizens, especially the most vulnerable, as well as citizens' rights and responsibilities towards the state. However, although there is a robust case to be made in international law for SP as a human right, to date it is recognised as a justiciable right in only very few countries (including India, South Africa and Uruguay). There is clearly some way to go in the shift from 'development as a welfare activity […] to a policy that recognises basic development needs as rights of the citizens' (UNDP, 2010: 6, cited Holmes and Jones, 2013).

The conceptual underpinnings of social policy frameworks advanced by global development partners are also critical, as they often result in shifts of emphasis and action. The International Labour Organization (ILO), the UN Children's Fund (UNICEF) and UN Women all view SP through a *rights perspective,* whereas the World Bank conceptualises it in terms of 'social risk management', with resilience seen as a key tool for growth promotion. The Organisation for Economic Co-operation and Development (OECD) focuses more on the role SP can play in promoting social cohesion, especially in conflict-affected contexts (OECD, 2011).

Figure 2: Structural and political economy influences mediating the achievement of human capabilities



2.4 Local-level impact and outcomes

For SP programming to be both accountable and transformative, national structural and political influences must be increasingly directly linked to local-level impacts and outcomes: for the individual, household and broader community. Given the cumulative and intergenerational impact of vulnerability and risk, it is also key to consider outcomes within the context of individual and household lifecycles (Moore, 2005).

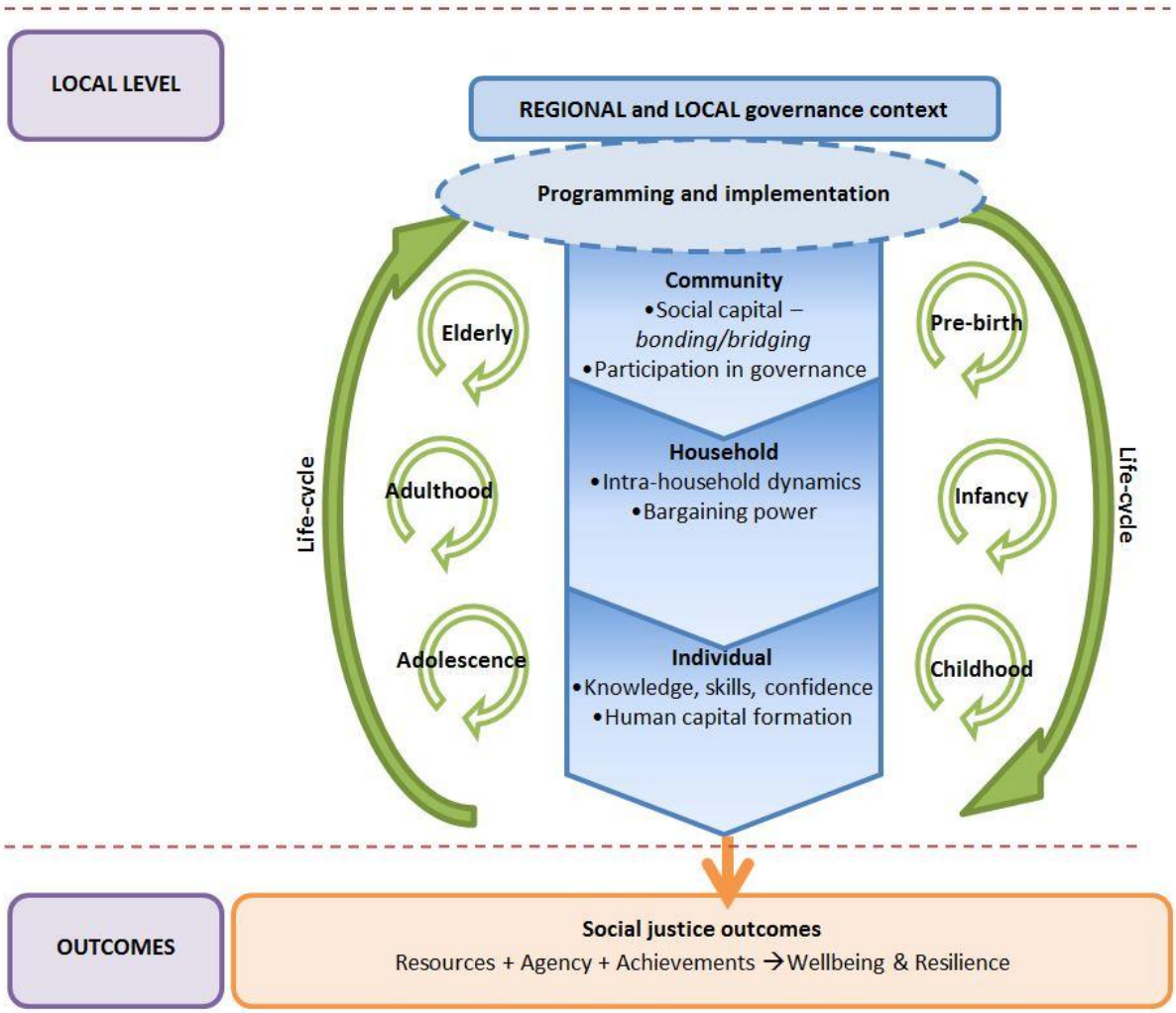
Kabeer (2001)'s conceptualisation of empowerment, as both a process for and an outcome of achieving social justice, is useful in helping frame the pathways through which SP programming affects people's lives. Empowered individuals are able to make strategic life choices (those that represent valued ways of 'being and doing') in three interrelated dimensions:

- **Resources:** Economic, human and social resources (including relationships) that serve to enhance the ability to exercise choice;
- **Agency:** The ability to define one's goals and act on them. Agency encompasses both 'power within' and 'power with', emphasising the value of individual and collective decision making.

- Resources and agency together constitute capabilities: the potential people have for realising **achievements** in valued ways of 'being and doing'. These achievements are framed within the context of relational wellbeing (the extent to which people can engage with others to achieve their goals) and subjective wellbeing (the meanings people attach to the goals they achieve) (Jones and Sumner, 2011).

To achieve social justice, social protection programmes must go beyond a safety net approach and seek to empower individuals and groups to tackle inequalities. Programmes can be designed to promote empowerment, helping to reduce inequalities between different household members and also among different social groups at the community level. Programme design, including targeting, and implementation systems should therefore be informed by the specificities of intra-household dynamics as well as consider the nuances of community relationships and pre-existing tensions between and within social groups, with multiple vulnerability criteria where necessary to ensure inclusion (Chronic Poverty Research Centre, 2008: 48).

Figure 3: Local-level influences, sites of impact and social justice outcomes



While in describing the process of the development of the conceptual framework we have split it into different sections, the various components of the framework come together as can be seen in Annex 1.

The various aspects of this conceptual framework come out in the different sections of this study. Thus, for instance, the country context addresses the structural dimensions and broader political economy, and as such sets the scene for discussing the programme (i.e., programmes are not operating in a vacuum). Discussions of governance and accountability address the governance and implementation environment. And discussions of individual, household and community dynamics

address local-level influences, with the final concern being social justice outcomes, both individual and collective, for the marginalised group the study focuses on, in this case OVC.

3 Country context and background

Kenya borders Somalia to the east, Ethiopia to the north, Tanzania to the south, Uganda to the west and South Sudan to the northwest. Its population is increasing at a rate of an estimated 1 million people per year. The government census put the population at 39.6 million in 2009, but current estimates put the population at 41.61 million.[2] Although most people (70%) live in rural areas, demographic trends show that more people are moving to urban areas. UNICEF estimates that about 50% of the population is below 15 years of age, making Kenya a country with a high dependency burden, with pressing demands on social services, including education and health care.[3]

According to World Bank estimates, Kenya recorded gross domestic product (GDP) of about $33.63 billion in 2011, reflecting a 4.5 % annual growth rate, while the inflation rate stood at 12%. Kenya is mainly an agricultural economy, relying on cash crops such as coffee, tea, wheat, a variety of subsistence crops, livestock and fishing. Major industries include small-scale consumer goods, agricultural products, processing and tourism. The climate ranges from tropical to temperate, depending largely on altitude. While vulnerability to poverty and climate change are the most critical development challenges,[4] other vulnerabilities are related to chronic diseases (HIV and AIDS) and socio-cultural factors (gender discrimination).

Poverty remains widespread in Kenya, despite the government's efforts over the past four decades. Between 2003 and 2009, Kenya's Multidimensional Poverty Index (MPI) value fell from 0.302 to 0.229. Although the incidence of poverty is in steady decline, in 2009 a quarter of the population was still vulnerable to poverty and almost one-fifth lived in severe poverty. Poverty was greater in rural than urban areas; Turkana and Mandera counties had the country's highest poverty rates, at 92.9% and 85.7%, respectively, and Nairobi (22%) and Kajiado (12.1%) the lowest.[5] Kenya's Human Development Index (HDI) ranking has stayed much the same since 2005, and it continues to be classified as a 'low human development' country. Life expectancy at birth increased from 46.4 years in 2001 to 57.1 in 2010 (UNDP, 2003-2011). In terms of progress towards achieving MDG 1, the country is unlikely in the current climate to achieve the target of halving poverty by 2015 (GoK and UNDP, 2010).

Chronic diseases, in this case HIV, clearly have widespread implications in terms of vulnerabilities at multiple levels: individual, household, community and nationwide. In absolute terms, the number of people living with HIV and AIDS (PLWHA) remained at 1.5 million in 2009, following a period of decline between 2001 and 2007. However, prevalence among adults dropped from 8.4% in 2001 to 6.3% in 2009. The majority of PLWHA are adults (1.3 million) and, in 2009, over half (760,000) were women. The prevalence rate of young women living with HIV rose from 1.8% in 2001 to 4.9% in 2009. HIV newly affected about 110,000 adults and children in 2009, and there were an estimated 80,000 AIDS-related deaths, as compared with 120,000 in 2001. In 2009, under half of the people needing antiretroviral therapy (ART) were receiving it, with 32% coverage of children (UNDP, 2003-2009).

Socio-cultural factors, including gender-related norms and behaviours and attitudes towards women and girls, are often indicative of, and lead to, gendered discrimination and vulnerability. According to macro-level indicators, Kenya's level of gender-related development improved between 2003 and 2009, with its Gender-related Development Index (GDI) ranking rising from 0.488 to 0.538. Similarly, the Gender Empowerment Measure (GEM) showed an increase in the percentage of seats held by women in Parliament between 1998 and 2008 (although in 2009 this remained fairly low, at 10%). The ratio of female to male earned income was lower in 2009, at 0.65, than it had been previously (as high as 0.93 in 2005).[6] According to these data, Kenya displayed little or no 'son preference' and good levels of civil liberties for women, but a poor record on ownership rights (CBS et al., 2004; NBS and

[2] http://www.worldbank.org/en/country/kenya
[3] http://www.unicef.org/kenya/overview_4616.html
[4] The World Bank *op. cit.*
[5] https://opendata.go.ke/Counties/Poverty-Rates-by-County/z6za-e7yb
[6] www.genderindex.org

ICF Macro, 2010). In the 2008-2009 Demographic and Health Survey (DHS), 18.66% of the women surveyed had 'sometimes' experience physical violence in the past 12 months and, although the figures are not directly comparable, this shows a decline from the 25% of women who, in 2003, had experienced violence in the 12 months preceding the survey. Moreover, between 1998 and 2003, prevalence of female genital mutilation/cutting (FGM/C) showed a decline from 38% to 31% of women.[7] Gender equality in terms of the women's disadvantages in reproductive health, empowerment and the labour market showed a gradual and consistent improvement between 1995 and 2011.

Vulnerability to climate change remains a key challenge in Kenya, and climate change will continue to have a severe impact on the country. The country's economic and livelihood systems are highly dependent on natural resources, which are very sensitive to any slight change in climatic conditions. For instance, Kenya's key economic sectors include agriculture, tourism, livestock, fisheries and forest products, which are all highly vulnerable to climate change and variability. With regard to effects on the population, vulnerable groups, including women and children, are likely to suffer greater impacts in the case of climate-related disasters or emergencies, given their social roles, inequalities in access to and control over resources and low participation in decision making (Heinrich Boll Stiftung, 2010). Vulnerability to climate change as experienced in natural disasters (drought and flooding) remains high in northern and eastern parts (e.g. Makueni county, one of the study sites) of the country, which are also some of the poorest regions.

3.1 Particular vulnerabilities of OVC

OVC in Kenya are defined as single/double orphans; children who are chronically ill or who have a caregiver who is chronically ill; and children who live in a child-headed household as a result of orphanhood (MGCSD, 2011).

With 46% (2005 estimates) of Kenya's population living under the poverty line, estimates suggest that some 9 million children are in urgent need of support, although the number may be higher as the actual number of children living below the poverty line is unknown (Bryant, 2009). Other estimates indicate that, of the estimated 17.5 million people living below the poverty line, more than half are children, young people and women (UNICEF and GoK, 2010).Between 1990 and 2010, Kenya's under-five and under-one mortality rates dropped from 99 and 64 per 1,000 live births to 85 and 55, respectively. Between 2006 and 2010, a considerable number of under-fives (16%) suffered from moderate and severe underweight, and 35% from moderate and severe stunting.[8] Orphans (0-17 years old) as a result of AIDS had risen in number, from 120,000 in 2001 to 1,200,000 in 2009 (UNAIDS, 2004-2010). The estimated total number of orphans was as high as 1,852,139 in 2008, having increased steadily since 1990 (Pearson and Alviar, 2009).

Net primary school enrolment reached almost gender parity in the period 2005-2009, with the ratio of boys to girls enrolled in primary school at 82:81 over those four years. By 2009, the total primary school enrolment rate had reached 92.9% (about 8.6 million students), up from 67.8% in 2000 (UNICEF, 2011). Between 2000 and 2010, a quarter of all children were involved in employment-related activities, and 6% of children were married by the age of 15 years and 26% by the age of 18. Birth registration shows significant urban–rural variation and, although the urban figure (76%) looks promising, in rural areas just 57% of under-fives were registered at the time of survey in 2011.[9] OVC are more likely to engage in child labour, not to attend school and lack birth registration than other children in the community, as a result of poverty and neglect.

The impacts and consequences of poverty are more severe for children than for any other social group, given children's weaker power relations in the family and society. This compromises their rights to survival, protection, development, participation and dignity. OVC often lack basic necessities, such as shelter, food, clean water, health care and education. Many face additional vulnerabilities, such as poor nutrition, abuse/neglect, lack of legal protection, discrimination and inadequate educational opportunities. Children and OVC living in arid and semi-arid parts of the country are confronted with many challenges, including food and water scarcity, as compared with those living in

[7] http://hdr.undp.org/en/statistics/gii/
[8] http://www.unicef.org/infobycountry/kenya_statistics.html
[9] http://www.unicef.org/infobycountry/kenya_statistics.html

other parts of the country. In addition, children in cultural contexts where early marriage and child labour are permitted, as in the case of pastoralists in northern Kenya, face additional vulnerabilities. Girls are more affected by early marriage, whereas boys engage more often than girls in some form of child labour.

3.2 The policy context of SP and cash transfers in Kenya

In Kenya's National Social Protection Strategy (NSPP) 2009-2014, SP is defined as 'policies and actions aimed at enhancing the capacity of and opportunities for the poor and vulnerable to improve their livelihoods and welfare' (MGCSD, 2009). The strategy recognises several means by which SP can be implemented: unconditional/conditional CTs, public works programmes and social insurance. The focus ('core intervention') is CTs, and the short-term aim is to meet the needs of the poorest and most vulnerable members of society. The three-year target groups (2009-2012) are those OVC, people with disabilities (PWD) and older persons categorised as extremely poor. In the long term, the government aims to establish an integrated SP system, where all interventions and safety nets are linked and managed together. The social CTs currently being implemented in Kenya are: 1) the cash transfer for OVC (CT-OVC) – the focus of the current study; 2) the Hunger Safety Net Programme for the chronically food insecure and extremely poor and vulnerable people; 3) the Older Persons Cash Transfer (OPCT); 4) disability grants for those with severe disabilities; and 5) an urban food subsidy for poor households in urban areas.

The lead government agency mandated with the implementation of the SP framework is the Ministry of Gender, Children and Social Development (MGCSD), which houses the SP Management Board and works in collaboration with national, provincial, district and locational committees to implement the framework. Ultimately, the Kenyan Parliament is responsible for the overall performance of the strategy. Supporting donors and NGOs include the World Bank, Concern Worldwide, DFID, UNICEF, HelpAge International and HelpAge Kenya, Oxfam, CARE International and the World Food Programme (WFP). Other government ministries, such as the Ministry of Planning, the Ministry of Labour, the Ministry of Finance, the Ministry of Agriculture, the Ministry of Medical Services, the Ministry of Public Health and the Ministry of Northern Kenya and Other Arid Lands are also involved and support different aspects of SP. The SP framework also highlights the role the private sector has to play in financing and managing SP. It is envisaged, for instance, that the private sector will put aside a certain percentage of profits as corporate social responsibility to finance SP.

A National Steering Committee for SP was established in 2007 under the leadership of the MGCSD and acts as a platform for inter-ministerial debates in the short-term and joint ownership of SP among state actors, development partners and non-state actors (including the private sector) in the long-term. Arguably, this can be seen as evidence of increasing government commitment to improving the quality of life of the poor through SP. It has also enhanced public debate and awareness on the needs of the poor and vulnerable. The 2010 Constitution provides for basic rights to health, education and decent livelihoods and is the legislative cornerstone for SP in Kenya. The Constitution recognises that every person has a right to social security and commits the state to providing appropriate social security to vulnerable persons and their dependants. The NSPP proposes, among other things, 'to extend social assistance to the various target populations, with the ultimate goal of providing universal access to the vulnerable throughout their lifecycle'.

The formulation of the NSSP guarantees the continuity of social assistance programmes/safety nets for the vulnerable in the future in Kenya. It shows government commitment to SP and overall buy-in to SP as a way of addressing the challenges of vulnerable groups. The policy identifies four principle areas of reform, including the need to define the appropriate programme mix within safety nets, improve coordination among safety net programmes to reduce fragmentation and duplication and increase financing to safety nets in a tight fiscal environment.

This policy context and apparent overall buy-in to SP policy, not only by the government but also by other stakeholders (CSOs and development partners), potentially insulates the various social CT programmes, including the CT-OVC programme, from a change of government in the future. The CT-OVC programme is also a flagship project under Vision 2030 – a key government policy document. However, despite the existence of a conducive political and policy environment, Kenya still faces a number of challenges in the realisation of its SP vision. These include, as outlined above, a declining

trend in GDP growth; a rise in poverty incidence and slow-paced development, which has had a negative impact on social indicators; the HIV and AIDS crisis, which has taken a toll on the population; and climate change-related natural disasters, including severe drought and floods. These challenges have increased the number of vulnerable people, with OVC a key group within this. Although many families and communities continue to care for OVC, severe economic constraints limit their ability to meet children's needs (Bryant, 2009). Overall, children living in communities affected by poverty, natural disasters and HIV and AIDS face serious threats to their wellbeing and healthy development.

4 Methodology

4.1 Research objectives, themes and questions

Key primary field research objectives included:

- Exploring the views, experiences and perceptions of CT programme beneficiaries and other community members (non-beneficiaries) in order to ensure they are better reflected in policy and programming;
- Gathering perceptions and experience from programme implementers;
- Providing examples of best practice on how to involve beneficiaries and communities in participatory M&E of CT programmes;
- Building the capacity of national researchers in qualitative and participatory data collection and analysis.

The conceptual framework provided a tool to guide this inquiry into beneficiary perceptions of CT programming within the context of social justice outcomes. SP programming does not operate in a vacuum, and by addressing the structural dimensions and broader political economy issues this operating space was contextualised. This provided an important starting point to understand both the multidimensional nature of risk and vulnerability and the drivers of programme impacts at the local level, as uncovered in the fieldwork. How individual, household and community dynamics interact with these influencing factors to achieve social justice outcomes for OVCs both individually and collectively is central to our theory of change for transformative SP.

The study also explored a number of crosscutting themes, which it adapted and tailored to particular programme realities and contexts (see Annex 2 for the fieldwork matrix). These relate to 1) individual material, socio-emotional and political outcomes and experiences; 2) intra-household dynamics and change; 3) community dynamics (including social cohesion, exclusion, stigma); and 4) service provision (supply-side issues).

Research questions included sets of questions around views on programming to date and on the potential for future programming. Box 1 presents more detailed questions.

Box 1: Research questions

Views on programming to date

What are the positive and negative effects of CT programmes according to beneficiaries/community members?

- What are the social costs and benefits to taking part in CT programmes?
- What are the intended/unintended effects of CT programmes?
  - Service access
  - Human capital outcomes
  - Voice, empowerment and agency
  - Time use
  - Access to and income from income-generating opportunities

- Intra-household, social status, distributional and multiplier effects of CTs in the larger community

What are beneficiaries' and programme implementers' perceptions of process and design issues/implementation modalities (cash, payment via phone card, etc.)?

- Do they feel:
- The programme was correctly targeted?
- The mechanisms for identification of beneficiaries were appropriate?
- The processes, mechanisms, timing and frequency of the distribution of benefits were appropriate?
- The amount of the transfer was appropriate?
- The transfers reached the intended beneficiaries?
- Any complementary activities accompanying the CT were useful in reducing economic and social risks and vulnerabilities and promoting resilience and wellbeing?

- What do they feel about accountability processes?
- Was the programme fairly executed?
- Were there opportunities to voice complaints?

How do gender, age, ethnicity or caste, (dis)ability and illness, etc. affect the outcomes of CT programmes?

- Are men, women, girls, boys affected/impacted differentially by CT programmes? If so, how, why?
- Is delivery of services affected by prejudicial attitudes of staff towards beneficiaries on the grounds of ethnicity/race/class?
- What are the effects (if any) of patronage systems on attitudes and delivery of services?
- What effect do CTs have on social cohesion at community level?
- Have CTs had either positive or negative effects on social cohesion at community level?
- Have CTs strengthened or weakened traditional SP mechanisms within the community?
- What effects do CTs have on social capital formation – both horizontal (among other community members) and vertically (especially with authorities and service providers)?
- What effects do CTs have on state–citizen relations in terms of conceptualisations of a social contract, understandings of rights and entitlements, etc.?

Views on potential for future programming

- How can the perceptions/experiences of beneficiaries be incorporated into the design, implementation and M&E of CT programmes?
- How can beneficiaries/communities members be empowered to take part in the design and M&E of CT programmes?
- What incentive structures could be put in place to improve the efficiency of CT delivery and services and alter potentially negative behaviours?

4.2 Methods and techniques of data collection

The study employed a number of standard data collection methods, along with innovative tools (see Annex 2 for examples of some study tools) tailored to the objectives and context of the research. Among these were the following key elements:[10]

- **Demand generation consultation:** In order to ensure beneficiaries and other stakeholders' concerns were included in the research tools, this initial process involved consulting members of the community about which kinds of themes and questions should be asked during the study. This entailed carrying out a number of key informant interviews (KIIs) and focus group discussions (FGDs) in a site additional to the two sites selected for the main study. The DGC was conducted in Gatundu district while the main

[10] In addition to the methods listed below, in-depth ethnographic work was carried out after the main study, which at the time of writing was not yet completed. Finding from this ethnographic study will be woven into the synthesis outputs.

study was conducted in Makueni county (eastern Kenya) and Busia county (western Kenyan).

- **In-depth and key informant interviews:** Using semi-structured guides, these were conducted with programme beneficiaries and non-beneficiaries, programme implementers, community leaders, government representatives and other analysts/academics working on SP. In-depth interviews (IDIs) and KIIs sought to elicit diverse perspectives on programme implementation at the national, district and community levels. Programme effects at the individual, household and community levels were also explored.
- **Focus group discussions:** Using semi-structured guides, and also making use of visual tools where appropriate (e.g. mapping exercises, historical timelines), FGDs were conducted with programme beneficiaries and non-beneficiaries, disaggregated by gender, location and age. Questions were structured around key vulnerabilities, programme implementation, use of CTs and effects, accountability, complementary programmes and community participation.

- **Case studies:** Guided by the IDIs and KIIs, case studies were carried out with beneficiaries of programmes identified by their particular characteristics – male/female, age, particular vulnerability – and to explore intra-household dynamics. Using a key theme and issue guide, members of the research team visited individuals and their household on various occasions at different times of the day and over different periods of time, holding discussions and triangulating findings with different members of the family/household, peers and friends.

- **Structured observation:** Guided by KIIs and IDIs, the study identified situations and events that provided interesting perspectives about interactions between programme implementers/service providers and beneficiaries during capacity-building or awareness-raising activities, or when accessing services. The research team prepared a tool identifying key themes or issues to track, and spent time observing and noting interactions, behaviours, non-verbal communication, levels of awareness and confidence, among other things.

- **Life histories**: Using a life history approach in some case studies or IDIs, whereby an individual relates their life story, either focusing on a specific theme or period or taking their life as a whole, this method provided detailed information of change over time and on how the CT programme may have affected change, in particular in relation to issues of empowerment, vulnerability and, more broadly, pathways out of poverty. From life histories, we learnt about the challenges and vulnerabilities beneficiaries face, coping strategies, how the CT has influenced lives and future short- and long-term plans (see Annex 4 for examples of life history reports).

4.3 Site selection

A number of processes informed site selection. First, given overall resources, it was decided to carry out the study in two programme sites in each country, and in each site to explore perceptions of beneficiaries and non-beneficiaries. It was also decided, after discussion among the international and local teams, as well as seeking advice from in-country and London-based DFID advisors, that, in order to keep variability to a minimum, the study would take place in either two rural, two urban or two peri-urban sites. In Kenya, given the nature of the programme and its focus, two rural sites were selected. The two most important criteria used to arrive at a shortlist of sites included: 1) depth of poverty (i.e., the sites had to have high levels of poverty) and 2) longevity of the programme (the sites had to have been in the programme for as long as possible in order to be able to explore change over time). Other selection criteria included population size and coverage of programme, geographical location and livelihoods. Once the shortlist was prepared, the principal investigator discussed it with members of the OVC Secretariat, and, based on interest, logistics and other evaluations being carried out, the sites were narrowed down to two: Makueni and Busia (see Annex 4 for process of site selection).

Within Makueni and Busia, similar criteria were used to select the location for the study, that is, depth of poverty and length of time in the programme, although coverage was also critical, so as to ensure a large enough pool of beneficiaries from which to sample. Location selection was carried out through consultation and review of district-level beneficiaries with district children's officers (DCOs). See Section 5.1 for further details of the sites and Annex 6 for number of beneficiaries in the selected sites).

4.4 Research team, data processing and analysis

The team structure reflected a clear balance of skills, knowledge and experience in qualitative and participatory methodologies. The team comprised the principal investigator and four qualitative researchers. The former had wide knowledge and experience in qualitative and participatory approaches as well as working with children; the qualitative researchers were anthropology graduates with experience in qualitative approaches. Team composition reflected a gender balance (two men and two women) among the qualitative researchers.

All members of the team were conversant in the national language – Kiswahili –which was used to conduct the interviews. In each site, voluntary children's officers (VCOs) were recruited to help in cases where respondents did not have a clear grasp of the national language. The VCOs also facilitated entry into the sites. A communications assistant worked with the team working on the participatory photography.

A member of the international team supported the Kenya pilot, through: 1) various verbal briefings and support over the phone for the DGC; 2) facilitating the training of the country team after the DGC and prior to implementation of the main pilot study; 3) support to the team during the initial days of data collection; and 4) support to the team during analysis of the findings through an analysis/debriefing workshop, and in the report writing.

All interviews, with appropriate consent, were recorded, transcribed and translated. Researchers were also tasked to take notes during the group discussions and also took note of other non-verbal communication during interviews and other meetings (see Annex 6 for daily reporting formats). Following the data collection, a detailed de-brief and analysis meeting was held, in which an analysis plan was developed to identify key themes and sub-themes to first track and then analyse in depth. These themes and sub-themes formed the basis of the coding structure, whereby all transcripts were coded and entered into Excel spread sheets.

4.5 Sample sizes and types of respondents

Table 2 shows the sample sizes and different types of respondents for the various data collection methods used in the study, by study site.

Table 2: Sample type and size by site

	Respondents by site	
Tools	**Makueni**	**Busia**
Social/community mapping and institutional mapping	At beginning: Total 13, 5 women, 3 men beneficiaries 3 women, 2 men 2 non-beneficiaries	At beginning: Total 10, 5 men and 5 women of older ages (5 beneficiaries and 5 non-beneficiaries)
Poverty and coping strategy mapping, done together	At beginning: Total 14,5 men and 9 women, mostly elderly in the community, both beneficiaries and non-beneficiaries	At beginning: Total 10, 7 women and 3 men, middle-aged to elderly, both beneficiaries and non-beneficiaries
Historical timeline/trend	Done as part of non-beneficiary FGD with men: Total 7	Done as part of poverty and coping strategies meeting, after it: Total 10, 7 women and 3 men, middle-aged to elderly, both beneficiaries and non-beneficiaries
Observation	Two at DCO office, 3 hours	Primary school, 2.75 hours

	Respondents by site	
Tools	**Makueni**	**Busia**
	Shopping centre, 3.5 hours Primary school, 2.5 hours Total 4	Clinic dispensary, 3 hours Chief's camp (office), 3 hours Shopping centre, 5 hours Chief's camp, education day, 6 hours Total 5
KIIs National level UNICEF World Bank MGCSD, Management and Information System (MIS) MGCSD, SP Academic NGO/CSO Total 6	DCO VCO (2) Teacher/head teacher Women's group leader Elder/community leader with youth leader (2) Member of Beneficiary Welfare Committee (BWC) Religious leader Social development officer Total 10	DCO VCO (3) Teacher/head teacher Women's group leader (2) Elders/community leader (2) Member of BWC (2) Youth leader Religious leader Total 13
Case studies	Male HIV-positive beneficiary Grandmother beneficiary Total 2	Grandmother beneficiary Female HIV-positive beneficiary Total 2
Life histories	Grandmother beneficiary (3) Mother beneficiary Male beneficiary Grandfather beneficiary Total 6	HIV-positive mother/caregiver/ beneficiary Grandmother beneficiary Grandfather beneficiary Male beneficiary Mother beneficiary Total 5
IDIs	Grandmother beneficiary (2) HIV-positive beneficiary Female child-headed household Child beneficiary Female-headed household beneficiary Male-headed household beneficiary Male non-beneficiary adult Female non-beneficiary household (2) Grandmother non-beneficiary household Total 11	HIV-positive beneficiary Grandmother beneficiary (2) (included as part of the case study) Child-headed household beneficiary Female-headed household beneficiary Male-headed household beneficiary Male child beneficiary Female-headed household non-beneficiary Grandfather non-beneficiary Total 9
FGDs	Adult female beneficiaries Adult male beneficiaries Children beneficiaries boys Children beneficiaries girls Adult non-beneficiaries female Adult non-beneficiaries male Total 6	Adult female beneficiaries Adult male beneficiaries Children beneficiaries boys Children beneficiaries girls Adult non-beneficiaries female Adult non-beneficiaries male Total 6

In total, there were 23 respondents for the social/community mapping and institutional mapping, 24 respondents for the poverty and coping strategy mapping, 17 respondents for the historical timeline/trend, nine observations, 29 KIIs, four case studies, 11 life histories, 20 IDIs and 12 FGDs (comprising 6-10 participants). Recruitment of respondents was facilitated through programme implementers and other key informants.

KII respondents at the community, district and national levels included programme implementers at different levels, community leaders/elders, NGO/association/women's group leaders, academics, policymakers and SP analysts. Observations were conducted based on information provided through

the KIIs and FGDs and dealt with key events involving beneficiaries at markets, schools, health facilities and chief's offices (see Annex 8 for list of key informants).

The above number and range of respondents interviewed, using a variety of different techniques and approaches, including participatory, was sufficient to obtain in-depth and triangulated information on both beneficiaries' and the wider community's perceptions of the CT. The number and range of respondents was also deemed sufficient since, unlike quantitative data which seeks to illicit as many responses as possible to be able to make conclusions which are statistically significant, with qualitative data once the research starts uncovering similar kinds of responses or once variation appears to have been captured to its fullest, the research has in a sense fulfilled its purpose. Thus the numbers above were sufficient to capture the ranges of experiences and perceptions of the CT in these sites.

4.6 Capacity building

Capacity building was conceptualised in a broad sense and covered: 1) research methodologies, for example qualitative and participatory methods, including using various media and communications approaches to collecting data; 2) organisational capacity, for example developing skills in organising training, data collection and analysis processes; and 3) institutional capacity, for example skills to develop risk assessment and mitigation strategies, carry out policy engagement and dissemination events and prepare policy briefings. The principal investigator attended a regional training workshop on the methodologies and approaches to be used, including qualitative and participatory data collection, analysis and write-up. Skills in preparing outputs for different kinds of audiences, including policymakers, donors and members of the community, were also developed, as well as skills around communication strategies and processes. There was also an opportunity to share and exchange with principal investigators from other countries as well as members of the international team.

The capacity of the country team was also built to enable researchers to carry out qualitative and participatory data collection and analysis. The country team attended a five-day training session followed by piloting of the research instruments before embarking on data collection. One member of the country team was also selected to undertake an in-depth ethnographic study on CTs and HIV and AIDS in a fishing village to further build her capacity in data collection, analysis and write-up. This work will contribute towards her requirements in gaining a Master's degree in Anthropology at the University of Nairobi. At the time of preparing this report, the ethnographic study was not yet completed; findings from this will be woven into the synthesis outputs, including the overview report and the Kenya country briefing.

4.7 Ethical considerations

Given the sensitive nature of the enquiry, and the focus on particularly vulnerable and marginalised groups, efforts were made to ensure respondents were fully aware of the risks and benefits involved in participating in the review and that confidentiality and anonymity would be maintained. Informed oral consent was taken and all study participants were informed about the reasons for the review and the issues and questions to be covered during the interview/discussion. The respondents had the right to refuse to participate and could withdraw at any time during the interview; none of them did. A safe space and an appropriate time were identified for interview to ensure confidentiality and minimal disruption to the lives of respondents. In the report writing, quotes and opinions have been made anonymous.

4.8 Challenges/limitations

The participatory nature of the methodology generated considerable interest and expectations among participants, including the need to address all their concerns regarding the CT programme immediately or in the near future. We promised to bring issues raised to the fore; however, this did not seem to convince some participants, who felt some of the issues needed to be addressed urgently.

A key limitation was that participants were contacted through the DCOs and local chiefs, and this could have influenced the kind of respondents who turned up for interviews and discussions. Given time constraints, we could not reach other members of the community (beneficiaries and others) apart from those who turned up at the request of the DCOs and the local chiefs.

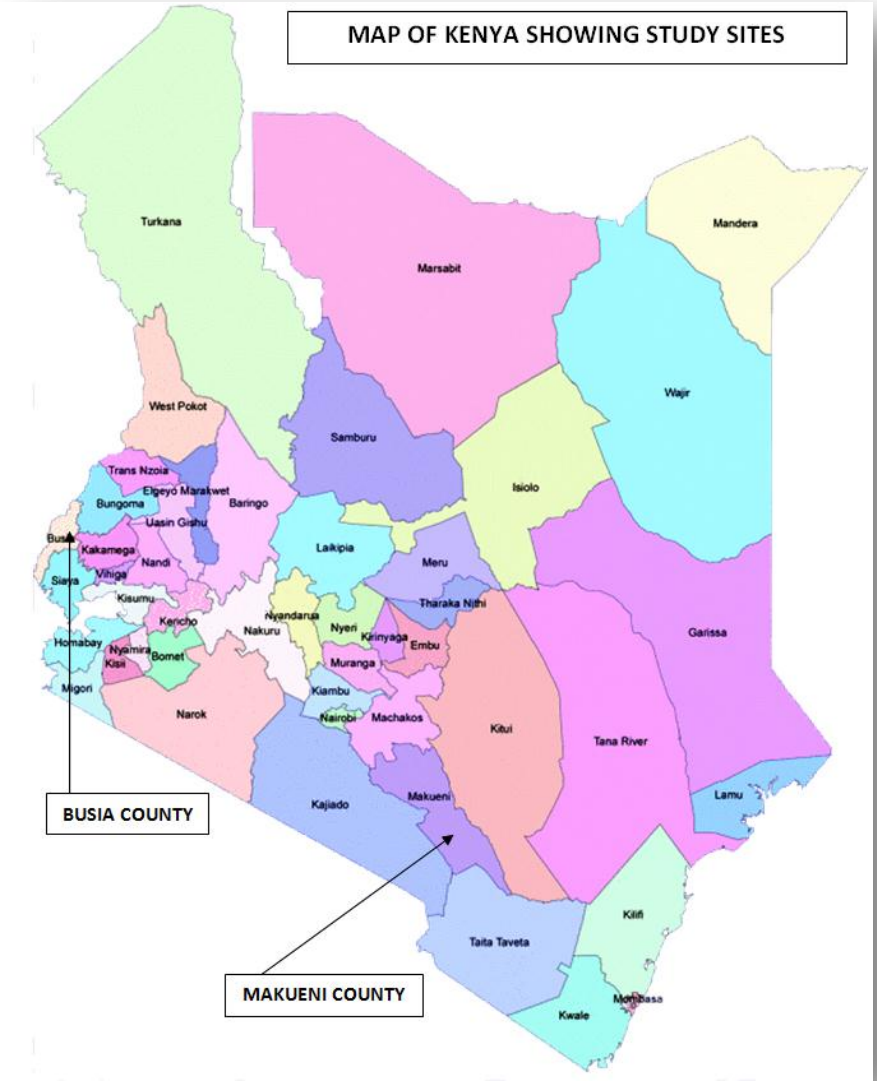
Working with children also proved to be challenging; encouraging them to speak during FGDs was difficult as they were shy and reserved. This was particularly the case in Makueni, because some members of the

research team had no prior experience working with children. In Busia it was easier, partly because the research team already had experience from Makueni; the children were also more outgoing than those in Makueni.

Another limitation was that the study was conducted in only two sites; in each county, it was carried out in only one location that had the highest concentration of beneficiaries. The findings can therefore not be generalised beyond the counties. Nonetheless, because of its participatory and qualitative design, the in-depth and nuanced findings generated will be useful for the programme in Kenya. The study sites were also typical rural sites with high incidence of poverty, as in other rural areas in Kenya, hence the findings are likely to be relevant beyond the study sites.
A key challenge was how to deal with the large quantity of data generated through the array of qualitative tools. The data analysis and report writing turned out to be time consuming and went beyond the envisaged timeframe.

5 Description of study sites and respondents

Figure 4: Map of Kenya showing study sites



5.1 Description of the study sites

The study was conducted in Makueni and Busia counties in Kenya. The administrative functions of the government at the county level are run through the provincial administration, comprising district commissioners, district officers, chiefs and sub-chiefs. Chiefs are in charge of locations whereas sub-chiefs are in charge of sub-locations, making them the government officers who deal directly with the people at the grassroots level. During the study, we interacted mostly with chiefs and sub-chiefs, given their administrative role at the location and sub-location levels. It was through their offices that we accessed the study respondents in the two study sites. Chiefs and sub-chiefs play a critical role in all government and NGO programmes, including CTs, in their areas.

Makueni county

Makueni county lies in the eastern part of Kenya. In this county, the study was conducted in Kathonzweni district, Kwakavisi location. The county is mainly inhabited by the Kamba ethnic group, and the language spoken is Kikamba. Residents also speak Kiswahili, which is the national language; people with formal education speak English as well. Grass-thatched roofs and mud-walled houses are the dominant structures in the area, indicating a high level of poverty. Christianity is the main religion, as confirmed by the presence of Catholic and Salvation Army churches.

Although the county headquarters at Wote can be accessed through a tarmac road, the infrastructure in the rest of the county is not well developed. The study site, Kwakavisi, is 38km from Wote, and has dusty earthen roads that are impassable during the rainy season, making access to essential services such as health facilities a problem for residents. Motorbike taxis (*bodaboda*) are the main means of transport in the area. Residents rely on boreholes and ponds for their water needs, making water a scarce resource in the area during the dry season. There is no electricity in homes, schools, the dispensary or the chief's office. The dispensary depends on gas for its energy needs. The community uses pit latrines for its sanitary facilities.

There is a primary and a secondary school in Kwakavisi. Although the latter is still undergoing construction and lacking in facilities, students have started learning in it. The schools are adjacent to one other and most of the students enrolled in the secondary school come from the primary school. The primary school was set up in 1963 and currently has approximately 415 children from ECD to Standard 8,with class sizes ranging from 37 to 52 children, the average size being around 45 (KII with head teacher). There are seven government-appointed teachers, two teachers employed by the community and two early childhood development (ECD) teachers. According to the head teacher, the number of teachers is insufficient. The buildings in the local primary school are dilapidated and the sanitary facilities are inadequate. In contrast with the school, the dispensary (Level 2) in the area is in good condition and offers a range of services, including reproductive health services and voluntary counselling and testing for HIV (see Box 2).

According to the 2009 census the rural population of Makueni county is an estimated 887,000 people. Poverty incidence was estimated at 64.1% in 2005/06.The main livelihood strategy is mixed farming, with over 60% of residents deriving most of their income from agriculture (livestock keeping and crop production). Other livelihood strategies mentioned by community members include selling produce, exchange of produce for other goods such as sugar, taking goods on credit, paid casual labour and sharing labour. The residents of Makueni often experience crop failure owing to unreliable rainfall, making most households vulnerable to food shortages and/or food insecurity. Data from the poverty ranking and FGDs confirmed that households headed by the elderly, widows and OVC were the most vulnerable to food shortages and/or food insecurity. During the study, we observed that crops in the study area had dried up, and we learnt from residents that rainfall had not been sufficient in the past five years. The dried crops were fed to animals.

Additionally, during the historical timeline exercise, what stood out in most people's minds as affecting their area was drought. This was mentioned as a key factor affecting the community in almost every year mentioned in the timeline. Interestingly, the other main factors highlighted were disease and illness outbreaks. The 1992 outbreak of malaria seemed to have particularly affected the community; it is equally interesting to note that people reported increased deaths owing to HIV in 1998 (see Annex 8 for historical timelines).

Box 2: Kwakavisi Dispensary and HIV and AIDS

The catchment population for Kwakavisi Dispensary is 8,739. There are two nurses, one laboratory technician and one clerk. One of the nurses is in charge and has been there for two years; the other has been there one year and ten months. In addition, there are 57 community health workers (CHWs) covering the area. The most common illnesses are skin infections, respiratory diseases, injuries and malaria. In terms of payment, children under five are free and all other patients pay a registration fee and then receive the medicines and consultation free. Children over five years old have to pay for certain tests. For rape cases, there is no payment for tests.

The nurses carry out provider-initiated HIV testing, and also do the pre- and post-test counselling. According to the registers, between January and June 2012, the nurses tested 331 people of which 10 adults and 2 children were HIV-positive (3.62 prevalence). In June, for instance, the nurses tested 27 people, and one child (a girl, 12 years old) tested positive. According to the health staff, at the time of the test she was not part of the OVC programme; she had come relatively recently to Kwakavisi, having been staying elsewhere with her parents.

Once the nurses identify an HIV-positive case, they refer them to the Comprehensive Care Unit in Kathonzweni (a Level 3 health centre). All those who have tested positive through the dispensary are on ART. Kwakavisi Dispensary gives HIV-positive adults septrin and multivitamins; children under five are given niverapine syrup. Opportunistic infections are treated free.

The nurses thought HIV-related stigma was still present in the community (although others, e.g. VCOs, thought this had gone away). They saw evidence of this in the fact the people still did not want to disclose their status, even to their relatives; they said some people 'even stop taking ART so that household members won't see them'. They pointed out that it was mostly widowed women, aged 28-39, who were HIV positive: 'they are mostly widows, their husbands were mostly working in other places and died. Now they stay with their children, some do farming, others get support from the late husband's brothers.'

According to the nurses, there is an HIV-positive support group in Kwakavisi that meets on a monthly basis. Some of the members are also enrolled in the OVC programme.

The CT-OVC programme was introduced in the county in 2009 with funding from the World Bank and is currently reaching OVC in 27 locations. By June 2012, the total number of OVC on CT stood at 4,762 (MGCSD, 2012) (see Annex 6 for: a) a list of the government's current and future scale-up plan and b) numbers of beneficiaries by county and sub-location according to the DCOs in Makueni and Busia). Kwakavisi location has the highest concentration of beneficiaries in the county. Respondents mentioned that, after the first enrolment into the programme in 2009, there was a second enrolment in 2010, where additional households on the waiting list were selected. There is currently a waiting list, and it is unclear when other households will be able to be included. Other complementary programmes for the vulnerable in the location include general relief food distribution by the government, NGOs and churches during the dry season, and the KaziKwaVijana (work for youth) programme.[11] Other CT programmes (e.g. for older persons) have been taken to other locations; according to the county administrators, the aim is to spread the effects of CTs such that every location has at least one CT programme. Despite this, it was observed that the location had a number of vulnerable older people who equally needed SP. This was clearly evident during the community mapping and poverty ranking exercises. One older woman came up after the exercise to ask to be linked to any programme for the elderly.

Busia county

Busia lies in the western part of Kenya. The study was conducted in Butula district, Marachi Central location (about 40km from Busia). Unlike in Makueni county, the population is diverse and there are three main ethnic groups – Luyia, Luo and Teso. The study site is inhabited mainly by the Luyia and the Luo, who speak both Luyia and Luo languages. Family and kin ties are strongly upheld and people live in groups of extended families sharing ancestral land. Christianity is the main religion. Residents rely on boreholes, springs and piped water for their water needs. Nearly all households

[11] This programme was launched in 2009 by the government with support from the World Bank. It aimed to employ both urban and rural youth in labour-intensive public works projects like road maintenance, water harvesting, afforestation and waste collection. However, given lack of proper structures, it was riddled with mismanagement and funding was stopped in 2010.

have pit latrines, courtesy of campaigns by the African Medical and Research Foundation. There is electricity in the schools, dispensary, chief's office, shop area and some households in the study area. The county has one tarmac road and a number of well-maintained earth roads, making its road infrastructure superior to that in Makueni county.

The estimated population of Busia county was about 442,700 people in 2009, and poverty incidence was 69.8% in 2005/06. Livelihood strategies include subsistence and cash crop agriculture as well as fishing. Agricultural production is the lifeline of the economy, with subsistence crops contributing nearly 36% of average household income and employing over 81% of the workforce.[12] Crops grown include maize, sorghum, finger millet, beans and cassava. Yields are comparatively better than in Makueni: the area receives near adequate rainfall spread over two seasons of the year. Other key livelihood strategies mentioned during community mapping include borrowing goods from neighbours and shops, selling produce, membership in merry-go-round support groups,[13] paid casual labour, CT programmes and donor assistance.

Classrooms and sanitary facilities in schools in Marachi Central are in good condition. We visited one primary school – Bukhalalire – where we held meetings with OVC and the school deputy head teacher. The school has 16 classrooms, all in good condition (cemented floors, stone walls and iron roofs) and a student population of about 600 pupils from Standard 1-8. The school is relatively large, and is built on approximately 3 acres of land. The compound is properly fenced and at the gate there is a watchman who guards it at night. Similar to Makueni, a shortage of teachers has forced the community to hire two teachers to supplement the eight hired by the government. Bukhalalire Secondary School is adjacent to the primary school and is in equally good condition. We were informed during the institutional ranking exercise that most children from poor families graduating from the primary school join the local secondary school (which shares a fence with the primary school) for further education.

Bukhalalire Dispensary provides a range of outpatient services, including reproductive health services and voluntary counselling and testing for HIV. The dispensary has six rooms: a consultation room, an immunisation room, an antenatal clinic and family planning room, a dressing/injection room, a pharmacy and a laboratory. Observation revealed that the dispensary charges consultation fees of KSh100 (US$1.20), which is prohibitive to poor and vulnerable members of the community, such as widows, children and the elderly. A consultation fee is not levied on immunisation services for children. HIV-positive clients are linked to the US Agency for International Development (USAID), and the AIDS, Population and Health Integrated Assistance Program (APHIA II+), which gives them food rations and treatment for opportunistic infections. The impact of HIV and AIDS on the local population emerged during the historical timeline exercise: events related to HIV and AIDS dominated, including times many children became orphans (1990) and when voluntary counselling and testing and ART services were introduced (2004).

The CT programme was introduced in the county in 2009 with funding from UNICEF and DFID and covers eight locations. By June 2012, the total number of OVC receiving CTs was 4,895 (MGCSD, 2012). Marachi Central location has the highest concentration of beneficiaries (see Annex 5). Just as in Makueni, there are a number of households on the waiting list for inclusion in the CT programme during the next round of recruitment. Marachi Central also benefits from other complementary programmes for the vulnerable, including CTs for older persons and those with severe disabilities and food distribution for those living with HIV and AIDS under APHIA II+. In Busia, these programmes exist alongside the CT-OVC in one location; this is not the case in Makueni county.

5.2 Description of respondents in study sites

In order to explore community perceptions, views and experiences of CT in the study sites, we identified and interviewed a wide range of respondents, both beneficiaries and non-beneficiaries. Respondents in the social/community and institutional mapping and the poverty and coping strategy mapping were men and women who were older in age (32-70 years). IDIs and FGDs mainly involved school-going children as beneficiaries of CTs, and in some cases as heads of households. Most adults who participated in IDIs were aged 20-60 years with the exception of a few men and women

[12] https://opendata.go.ke/facet/counties/Busia

[13] Merry-go-round groups are informal groups that meet routinely and alternately in members' houses to discuss their welfare. Ordinarily, members contribute money during each meeting, which is later invested in members' personal projects. CT beneficiaries in the two study areas belonged to at least one such group.

who were recruited in their capacity as grandparent caregivers. Although we strove to maintain a gender balance, this was not possible because of the high numbers of women enlisted as caregivers as compared with men.

The effects of the HIV epidemic on the population in Busia were very noticeable, with many study participants (widows) appearing to be in the final stages of the infection, with clearly visible symptoms. Busia town borders Uganda, and truck drivers along the main highway target young girls for transactional sex. There is also a great deal of cross-border trade, which exposes girls/women to risky behaviour. Although HIV and AIDS was identified as a cause of death in Makueni also, more visible here were the effects of poverty and desperation, mostly as a result of lack of food. Sex work was seen as an important coping mechanism to deal with this desperation.

6 Community understandings and experiences of vulnerability, and related coping strategies

6.1 Understandings of vulnerability

The research findings in the two study sites show that poor and vulnerable people are considered to be those who lack basic necessities such as food, clothing and shelter. The poor and vulnerable are often subjected to vagaries of nature, including droughts, floods and food insecurity, and are often sick as a result of poor nutrition and healthcare. The poverty ranking and coping strategy mapping using participatory tools (see Annex 10) showed that the characterisation of the poor and vulnerable was similar in the two study sites. They live in grass-thatched mud houses, possess inadequate land (i.e. 0.25 acres), lack sufficient clothing (wear torn clothes), have large family sizes with many children (on average four or above), experience food shortages, cannot afford healthcare, lack livestock, work as casual labourers, cannot afford school fees for their children and rely on food donations.

In sharp contrast, people considered average in terms of poverty ranking did well on the above indicators and were considered resilient and/or less vulnerable compared with the poorest. They were characterised by having: good housing (permanent stone structures), access to health care, adequate food/nutrition (have food in a balanced diet form all the time) and adequate land (large tracts of about 5 acres and above), making them the least vulnerable in the community. Most respondents who participated in the poverty ranking exercise considered themselves among the poorest and most vulnerable in the community. Respondents in Busia identified 17/147 members of their community as ‘well off’, 58 as ‘average’ and 72 as ‘poorest’. In Makueni, 14/185 were identified as well off, 46 as average and 125 as poorest (see Annex 9 for poverty and coping strategy identification and ranking). OVCs, widows, persons with disabilities, children, older persons, the landless and women in general were identified as the most vulnerable groups in the two study sites. The ranking shows more poor people in Makueni than in Busia. We also observed more HIV-positive widows in Busia than in Makueni; lack of food for the poorest was a more pronounced issue in Makueni than in Busia.

The findings also show, however, that the above definitions were not always so straightforward. For instance, it was reported in Busia that a person could be living in a brick house with a corrugated iron sheet roof but still be considered poor. It was argued that such a person could be a widow whose husband had died, leaving the household without a breadwinner. In the two study sites, widows were generally considered poor and were more likely to be HIV positive. In addition, widows were found to suffer stigma and neglect from family members; this could be because many widows are associated with HIV as husbands may have died from HIV, and because widows are generally viewed with suspicion on the grounds that they are likely to remarry and are traditionally not accorded inheritance rights within their matrimonial families. In Busia, for instance, one widow was denied use of family land by her brothers-in-law because, according to them, after her husband died, she did not have rights over the land.

Widows also had many orphans in their care; while not necessarily a cause of their poverty, this may make them poorer as they are unable to provide for their basic necessities (food, clothing and shelter). One widow in Busia confirmed this:

> *'I have eight children I have to take care of and they have to go to school, they have to eat and they have to wear clothes. The little I have is not enough for all these children.'*

6.2 Key vulnerabilities in the two study sites

Table 3 shows the different types of vulnerabilities in the two study sites: health-related, environmental, economic, social, psychosocial and infrastructural. Information from this table is drawn from FGDs with community members; as such, it presents community-level perceptions of vulnerabilities at different levels: individual, household and community. There were some small differences in the two sites: environment-related vulnerabilities such as drought, water scarcity, food insecurity and poor crop yields are experienced mainly in Makueni county, whereas individual-level vulnerabilities, including stress – mostly brought on as a result of shortages of food, lack of employment opportunities, HIV and AIDS-related stigma and the need to support the family and other dependants - and drug and alcohol abuse (primarily among men) appear to be more prevalent in Busia. The latter could perhaps be explained by the fact that Busia appears to be suffering more from the impacts of HIV and AIDS, which potentially causes more psychosocial-related stresses (see also below), with men also turning to alcohol and drug abuse. Additionally, the Busia economy is wealthier, owing to, among other things, its better climate, cross-border trade and increased livelihood opportunities, which means more cash in the economy, allowing for increased consumption of alcohol and drugs.

The effects of the vulnerabilities identified were felt in very much the same way at the household and community levels. For instance, vulnerability to HIV and AIDS and food insecurity came out very strongly, and was felt at both household and community levels, as reported both by individuals during IDIs and by participants of FGDs. A female participant in a poverty ranking and coping strategy mapping in Busia stated:

> *'I am positive and I have seven children, three of whom are positive. People have really died here of HIV and AIDS.'*

Respondents felt that water scarcity, poor health care, unemployment, poverty and poor infrastructure were beyond their control and should be the responsibility of the state, hence in a sense reflecting the relationship between the state and its citizens, whereby citizens expect the state to shield them from these forms of vulnerabilities. The state, according to this conceptualisation, is supposed to provide mechanisms that enable its citizens to live a decent life devoid of these vulnerabilities. Study participants felt the state had ignored their plight by not addressing these specific vulnerabilities.

There were differences in vulnerability according to different categories of people. Children were more likely to be vulnerable to orphanhood and lack of basic necessities (food and clothing) than adults. Young men were said to be vulnerable to drug and alcohol abuse, and unemployment, whereas young women were vulnerable to early marriage, sexually transmitted infections and pregnancy. Vulnerabilities specific to PLWHA were stress and opportunistic infections. Stress for PLWHA includes both those specific to HIV-positive people, that is, having to deal with psychosocial issues and the knowledge that they have an incurable disease and the stigma and discrimination they often face, but also the stresses of everyday life: ensuring food and shelter for themselves and their families and meeting their own health needs and the education needs of their children, among other things.

While all poor households were reported to face vulnerabilities at one time or another, household size and composition determine the severity of the effects on particular households. For instance, the effects of poverty, food and water scarcity and poor health care are more severe in larger households comprising about eight children and one adult than in smaller households comprising two children and one adult. Similarly, households comprising children, HIV-positive widows and elderly grandparents generally lack productive capacity as compared with those where there are productive adults, and are therefore more vulnerable than other households. Households with no productive labour cannot engage in wage labour or sharing of labour, which are the most common coping strategies and a typical means of livelihood and income generation in the study sites.

Table 3: Key challenges and vulnerabilities in the two sites

Key challenges and vulnerabilities	Busia	Makueni
Food insecurity/famine		✓
Drought		✓
Poverty (lack of basic necessities)	✓	✓
Water scarcity		✓
Poor health care	✓	✓
High number of OVC	✓	✓
Unemployment	✓	✓
School dropout	✓	✓
HIV/AIDS	✓	✓
Drug and alcohol abuse	✓	
Early marriage/pregnancy	✓	✓
Stress	✓	
Poor infrastructure (roads)	✓	✓
Poor crop yield		✓
Other diseases (malaria, diabetes, cancer, tuberculosis)	✓	✓
Tsetse fly and mosquito vectors	✓	✓

6.3 Coping strategies

The coping strategies vulnerable and poor people use to deal with the challenges they face in everyday life were explored through coping strategy and institutional mapping. Table 4 shows the coping strategies and institutions/persons vulnerable people turn to in case of difficulties (see also Annex 11 for a summary of institutions and individuals).

It is clear that there are no major differences between the two sites in terms of coping strategies and institutions. Coping strategies across the two sites therefore include borrowing from friends and family, engaging in petty business, sharing labour, engaging in wage labour and taking on loans. A few differences stand out, however; these include an informal banking system known as table banking and fund raising, that is, going from person to person to raise money, which is applicable only in Busia, and taking goods on credit, which is applicable in Makueni. Nearly all the coping strategies used are informal and apply to the individual and household rather than the community level. Hand-outs from government or NGOs and the CT programme were the only formal coping strategies mentioned. It seems that, while vulnerability may affect the whole community, ways of coping with the different types of vulnerability are individual and household based.

The findings further show that individual coping strategies are different for children and adults. Children's responses to poverty include staying away from school or dropping out completely, and their coping strategies involve seeking educational bursaries, running away from home, child labour, early marriage for girls, petty crime and food theft/pilferage. Apart from educational bursaries, most of the coping strategies children use are likely to have negative effects on their personal development and may worsen their level of vulnerability. The four child-headed households interviewed had access to very few coping strategies as compared with adult-headed households. For instance, children in these households did not belong to informal support groups, which, for adult members, were able to cushion them from a range of vulnerabilities such as food scarcity, lack of basic necessities and poor health care.

Women were also found to have, or were willing to talk about/mention, more coping mechanisms than men. They belong to informal groups where they engaged in table banking (Busia), borrow from each other and in general shield each other from vulnerabilities that affect their communities. Because of their health condition and stigma, PLWHA also have limited coping strategies and very often rely on formal coping strategies such as CTs and hand-outs in the form of food rations, seeds and farm inputs.

Table 4: Coping strategies for the vulnerable in the two sites

Coping strategy	Busia	Rank*	Makueni	Rank
Small-scale farming	Yes	3	Yes	1
Informal support groups	Yes	1	Yes	1
Table banking	Yes	1	No	
CTs	Yes	1	No	
Fundraising	Yes	1	No	
Borrowing from family and friends	Yes	1	Yes	3
Engaging in petty business	Yes	1	Yes	1
Reliance on hand-outs from donors, government	Yes	3	Yes	3
Engaging in wage labour	Yes	1	Yes	1
Selling produce	Yes	2	Yes	1
Taking goods on credit from shops	No		Yes	1
Sharing labour	Yes	1	Yes	1
Exchanging produce with other goods	No		Yes	1
Taking loans from shylocks	Yes	1	Yes	1

*Note: *Respondents were asked to rank the relative importance of the coping strategies in their everyday life in terms of most important/first option (1), not very important/second option (2) and least important (3).*

Key institutions and persons for support in case of difficulties (Table 5) cut across the two study sites and clearly indicate that the poor consider the government, represented by administrators (chiefs and sub-chiefs), as strategic figures to turn to in cases of problems. Administrators were considered close to the community members and to understand their problems well, making them the first point of call in any attempt to air a problem and search for solutions. Typically, chiefs provide a link between the village/community and the outside world. But it is also important to note that such administrators may have hidden agendas: they may also act in favour of certain people to the detriment of others, they may penalise community members who oppose their views and they have also been accused of extorting bribes from the public. While this was not outwardly apparent to the study team at either of the two study sites, it was mentioned as a possibility by key informants, not necessarily in relation to the CT programme (they referred to cases in other sites and other situations where it had occurred). There is, in fact, a proposal in the 2010 Kenya Constitution to restructure the entire provincial administration system to make it more responsive to the needs of the public. As already mentioned, the research team did not find any evidence of corruption on the part of the administrators, but it is possible that respondents may not have wanted to raise such issues with the team fearing they may be removed from the CT programme or penalised in other ways if they did.

Other equally useful institutions/persons include school/head teachers, church/religious leaders and hospitals/doctors. In Makueni, the BWC (for further details see Section 7.2) was mentioned as being of middle importance; this indicates how a structure created by the CT-OVC programme has become useful to recipients. The BWC was not mentioned in Busia, perhaps because respondents considered only institutions external to themselves. While Members of Parliament are important, they were considered inaccessible and therefore not very useful to the poor in times of need (see also Annex 10). The differences between Busia and Makueni with regard to the relative importance of hospitals/doctors could be explained by the fact that a good number of respondents in Busia were PLWHAs and therefore had regular contact with the health facilities, which made them consider health providers/facilities important during difficulties. Respondents also ranked relatives as very important in Busia, whereas in Makueni neighbours/friends were ranked as very important. We did not find any particular reason for this, but we suspect it could also be explained by the presence of PLWHAs in Busia who had received tremendous support from their relatives.

Table 5: Support institutions/individuals for the vulnerable in the two sites

Institutions/people for support	Busia	Importance*	Makueni	Importance
Administrators (chiefs)	Yes	Very	Yes	Very
School/head teachers	Yes	Middle	Yes	Middle
Church/religious leaders	Yes	Middle	Yes	Middle
Hospitals/doctors	Yes	Very	Yes	Middle
Relatives	Yes	Very	Yes	Middle
Neighbours/friends	Yes	Middle	Yes	Very
BWCs	No		Yes	Middle
Informal support groups	Yes	Very	Yes	Very
Businessmen	No		Yes	Middle
Member of Parliament	Yes	Little	Yes	Little

*Note: *Respondents were asked to rank the relative importance of the institutions/individuals to them when they need support in terms of very important, middle/average importance and less important.*

7 Programme mechanics and governance

7.1 Programme mechanics

The CT-OVC in Kenya is a grant programme that started in 2004 with the aim of setting up an SP system of regular and predictable unconditional CTs to households living with OVC. According to the background documentation, it aims to encourage fostering and retention of OVC within their families and communities and to develop the human capital of both OVC and their families. Specifically, the programme objectives centre around four points:

1 **Education:** Increase school enrolment, attendance and retention of OVC;
2 **Health:** Reduce mortality and morbidity rates among 0-5-year-old children, through immunisations and growth monitoring;
3 **Food security:** Promote nutrition and food security by providing regular and predictable income support to poor families with OVC;
4 **Civil registration:** Encourage caregivers to obtain their national identity cards, death certificates for deceased parents and birth certificates for children.[14]

Administered by the Department of Children Services (DCS) of the MGCSD, the CT-OVC has counted since its inception on the administrative and funding support of UNICEF, DFID, the World Bank and various government committees and bodies, which variously coordinate policy formulation, resource mobilisation, coordination, programme operations and technical advice. Donors offer both technical and financial support to the government; in particular, DFID has offered training to government staff, support to developing the M&E framework, assistance in developing the capacity-building strategy and inputs into the development of programme documents (including, along with UNICEF, hiring a consultant to work with the OVC Secretariat to produce the programme design and operational manual) (DFID and GoK, n.d.; Musembi, 2010).

Beneficiary and community members knowledge of the programme

Community members spoken to in the two study sites were fully aware of the existence of the CT-OVC programme in their respective counties. In Makueni, the programme was well received at inception and people referred to it as 'money for orphans'. Interviews with adults indicated that the local culture dictates that members of society should not interfere with anything for orphans. This cultural understanding structures the interaction of the community with orphans and their understanding of the CT-OVC programme. In contrast, in Busia, the programme was initially opposed when it sought to know the number of children per household. The local culture there generally

[14] http://www.gender.go.ke/index.php/SP-Programmes/cash-transfer-programme-for-orphans-and-vulnerable-children.html

prohibits counting of even chickens: it is believed that counting exposes children, calves and chicks to evil spirits who might end up killing them when they know their number. It was only after concerted publicity efforts by local administrators that community members embraced the programme. The programme is referred to as 'Obama' because its arrival coincided with Barrack Obama being elected as President of the US, as confirmed by life histories. This was despite the fact that there is no US funding for the programme.

Children who participated in the FGDs, while aware their caregivers received money on their behalf, did not know the specific details of the programme in terms of frequency, amount and whether the money could be used for things other than their needs. KIIs confirmed that this was to be expected, because, although the programme was meant to benefit children, it does not target them directly, so no information regarding the programme is given to children directly. However, child household heads (two) and beneficiaries (two) clearly demonstrated that they knew how the programme worked, even though relatives received the CT on their behalf. Similarly in Makueni, three girls in an FGD were aware that the CT should be used for their food, clothing and education needs. It appears that children's knowledge of the programme in the two study sites depends on their level of involvement in household responsibilities, either as household heads or as performers of key tasks in the household. For instance, in Makueni, it might well be that girls' knowledge of the programme has been informed by their closeness to caregivers in their role as helpers in domestic chores.

Targeting process

The programme consists of a three-stage targeting process. In Stage 1, districts are chosen for inclusion based on overall poverty levels, numbers of OVC and presence and quality of other interventions for OVC and HIV prevalence. As revealed by KIIs at national level, the community has no control over the choice of geographic areas; this is done solely by the OVC Secretariat based on the aforementioned indicators.

In Stage 2, community-based targeting is employed through location OVC committees (LOCs) and then combined with a proxy means test.[15] During this stage, sensitisation of the community on the nature and benefits of the programme and its operational procedures takes place. As such, this stage also enables the community to play a critical role in identifying the most vulnerable households. It is also during this stage, according to district-level KIIs, that a standardized form (Form1) is first filled out that identifies households that may be eligible; these data are then entered into the programme's MIS. Enumerators are then sent to visit families and collect more extensive information on eligible households using a comprehensive questionnaire – Form 2 (see Annex 12). This second-round data is entered into the MIS, which then applies a proxy means test to rank extremely vulnerable households (see Annex 13 for proxy means test weights). For a household to be selected to participate in the programme, it must be identified as extremely poor, be supporting at least one OVC under 18 years and not be receiving benefits under another programme in cash or in kind. The age of the caregiver and the number of OVC are also taken into consideration. The ranking system is also designed to give priority to child-headed households, households headed by older people, households with a larger number of OVC and all other households with OVC, in that order (see also Bryant, 2009; MGCSD, 2011).

Stage 3 involves a community meeting to generate the final list of programme beneficiaries. Prioritised eligible household lists generated at district level are then sent back to the community for validation. The community validation process is done through a public meeting (*baraza*), at which the list is presented and approved. If there is consensus in the *baraza* that some cases should be reviewed, the LOCs, supported by the district OVC sub-committee (DOSC), look at these before approving the final list. The final approved list of selected households and the reviewed cases are then sent to the OVC Secretariat of the MGCSD to be entered into the MIS for enrolment in the programme.

Perspectives on targeting

Data from FGDs and IDIs in both study sites showed that community members (both beneficiary and non-beneficiary) perceived the targeting process to be both elaborate and fair. All adult respondents who participated in the study were well versed in the targeting procedures and were satisfied with the main selection criteria – presence of an orphan in the household.

[15] The MIS uses this to rank households using weighted scores, and all households below the cut-off point are considered eligible.

Although respondents perceived most targeting to be fair and transparent, some concerns were recorded in Busia. One of these had to do with some beneficiaries who were considered to have been enrolled in the programme but did not deserve to receive the CT. Two cases were cited of this, one a teacher. However, when we followed up on the case of the teacher, we learnt that he was taking care of about 11 orphans and that was why his household was targeted. Other concerns were raised by non-beneficiary HIV-positive widows who, despite having orphans and being HIV positive, were left out because they were young and energetic, whereas older widows/women with OVC were targeted. This made them feel that the targeting process was unfair because they were equally vulnerable and struggling to care for their orphans. Overall, and both according to respondents and from observation, there appeared to be many vulnerable people in both Makueni and Busia who deserve to be in the programme, with some of them on the waiting list for the next recruitment. In our interactions with both beneficiaries and non-beneficiaries during data collection, we observed that people did not understand why the number of beneficiaries targeted was limited. The issue here is that, since people are aware that the CT-OVC is a government programme, they expect all deserving cases to be automatically enrolled. This reflects citizens' relationship with the state, since provision of SP is often regarded as a duty of the State to its citizens.

Cash Transfer amount and payment system

Beneficiary households are provided with a cash payment of KSh4,000 ($48) every two months.[16] This amount reflects a progressive increase from an initial KSh500 ($6) per month during the experimental phase (2004-2006) to KSh3,000 ($36) every two months during the second phase (2006-2007) and eventually the current amount in the third phase. The total cost of the CT-OVC programme in 2006 was $2.2 million, and from 2006 to 2009 some $9.96 million was spent in the seven pilot districts, with around 15,000 recipient households. The full-scale programme allocated roughly $31.6 million, targeted to cover 100,000 households (reaching 300,000 OVC) in the programme (Ward et al., 2010; World Bank, 2011). According to the most recent government update and KIIs, the programme is implemented in 60 districts in Kenya. Starting from a 500-household pilot in 2004, by May 2012 coverage was at 144,627 households (over 525,000 recipients); it is expected to grow to 160,145 households by 2013 (see Annex 6 for CT-OVC status report). Programme financing increased ten-fold between 2004 and 2010 (ibid.; Ha et al., 2010).

Beneficiaries obtain the cash from a post office. In the study sites, beneficiaries have to travel over 15 km to the nearest post office, incurring travel costs. For example, in Busia, the transport cost was estimated at about $2 for a return trip. While the programme targets OVCs, it is the caregivers who receive the money and go and collect it, often accompanied by someone ('a grandson', according to VCOs from Makueni); if they are unable to go, an alternate caregiver who is known and trusted can also go to collect for them on production of valid identification documents. IDIs with DCOs indicated that, under the current payment system, there are no possibilities of saving the money at the post office: beneficiaries are required to collect all the money.

The amount received per household is fixed, irrespective of numbers of OVC, so a household could have one child or twenty-one and receive the same amount. The number of OVC per household is generally high in both Busia and Makueni: on average there five per household, with the smallest reported number per household two and the largest nine.

Interviews with DCOs indicated that beneficiaries are informed through the LOCs and BWCs, and sometimes through a text messaging service, when to collect the money at the post office. In order to receive the money, beneficiaries are expected to provide identification documents for verification. Funds not collected within two weeks are returned for accounting purposes but are available for collection in the next payment cycle.

Perspectives on the cash transfer amount and payment system

Programme beneficiaries and key informants suggested that, given the high number of OVC per household, there is a need to adjust payment amounts to numbers of OVC in a household, although this would have financial and implementation implications. During the research, the study team learnt of the existence of a committee monitoring the changing socioeconomic status and structure of households in Busia; this committee is also likely to address the issue of payment amounts given the number of OVC in any one household. However, we were unable to follow-up on this at the national level.

[16] This is slightly above a quarter of the minimum monthly wage in Kenya, set at KSh 7,000 ($83).

Although beneficiaries appeared satisfied with the current arrangement, whereby they collect the money from the post office, they also complained of long distances and crowding on payment day. Distance means they incur costs collecting the money, and crowding means they often have to wait for long periods at the post office before they can collect their funds. They are also exposed to the risk of being robbed on their way back home by other members of the public who have seen them waiting for the CT. We learnt from the DCOs that, while the payment window is 10 working days, most beneficiaries go to the post office in the first two days and in groups, hence the crowding. In Busia, one beneficiary complained he had been given fake money. Other challenges related to the payments process include delays in payment on the part of the programme and absence of an authorised signatory when the funds should be collected. A caregiver in Makueni expressed her concern with delays in payment:

'Initially we used to get it, for example, in August and then we skip September and then we are given in October and again we skip November and then we are given in December. But now things have started to change. It is being delayed.'

'Unconditional' nature of the CT

The CT is unconditional but, according to KIIs with programme implementers and the programme operations manual, there are programme objectives (see above) that require caregivers and guardians to fulfil certain roles and responsibilities to ensure effective programme delivery at the household level. These roles include ensuring OVC aged 0-5 years are taken for immunisation and growth monitoring; OVC aged 6-17 years regularly attend basic education; OVC acquire birth certificates; and caregivers attend awareness sessions. While the programme does not consider these conditions for receiving CT, it is envisaged that the fulfilment of these roles and responsibilities will ensure children enjoy the full benefits of the programme. According to KIIs, the CT is not intended to cover all of a child's expenses, but to ensure households are able to foster their children and cover part of their basic food, health and education costs. It is assumed that, in this way, households will meet children's immediate needs as well as investing in their development so they can break the poverty cycle (see also Bryant, 2009). Data collected from beneficiaries on use confirmed that they spend the CT mostly on food, health and education needs of the OVC.

While there were no conditions originally attached to the programme when it began in 2004, Phase 2 of the programme, which began in 2006, aimed to pilot test conditions in selected districts. IDIs at the national level indicated that collaboration with other complementary programmes have been established in these districts to ensure households are able to access and benefit from essential services including education, health care and birth registration. According to key informants, it is only in these districts that conditions are being tested, and guidelines have been established with the Ministries of Education and Health to monitor and promote compliance with conditions and clearly outline responsibilities of participating schools and health facilities. The current research did not look at how far these conditions have been developed, and whether or not they have had any significant impact.

Exit and graduation from the CT programme

Criteria for exit and graduation from the CT-OVC programme are clearly stated in the programme documents, and programme implementers at the district level are aware of these. The programme is structured to ensure maximum impact by providing beneficiaries with the CTs for as long as possible, provided they have a need and they continue to meet the programme criteria. According to programme documents and KIIs, beneficiaries will exit the programme only after being in the programme for five years, during which there is supposed to be a re-targeting of households to determine which should exit or enter into the programme. However, according to the programme operations manual, and confirmed by KIIs, beneficiaries can also exit the programme before the maximum period for the following reasons: 1) failure to collect payment for three consecutive periods as confirmed by the DCO; 2) households no longer having OVC below 18 years; 3) failure to comply with responsibilities for three consecutive periods; 4) own will, whereby household members voluntarily resign; 5) giving false information related to eligibility and/or committing fraud against the programme; 6) households moving to another location where the programme is not operating; and 7) households deemed no longer extremely poor by the Central Programme Unit (CPU) and/or community.

Despite these clear-cut criteria, exiting or graduating from the programme still remains a challenge, according to KIIs with DCOs in Makueni and Busia and at the national level. Beneficiaries who

participated in the study did not report any household that had exited the programme on the basis of any of the above criteria in either of the two study sites. However, interviews at the national level reported one case in Nairobi where a household had exited the programme voluntarily because its members felt they no longer needed the CT. Similarly, interviews with VCOs in Makueni highlighted that there were households still receiving the CT even though they had become better off and/or their OVC were older than 18 years. The VCOs commented that they had tried to raise this issue with the DCO and had given the names of those over 18 years as well as of the families whose incomes/circumstances had improved, suggesting they could be replaced with younger OVC. But they lamented the fact that, as of now, nothing had been done and there was no system in place to graduate these households.

These same respondents also pointed out that, while some households had become used to receiving the cash, awareness-raising activities meant they would accept the fact that they had to exit the programme, given that: 1) they were not considered so vulnerable anymore; 2) there were households and caregivers much more vulnerable than them; and/or 3) their OVC had grown up, were older than 18 years and in some cases were working and earning a livelihood. Key informants at the national level reported that the only criterion it was easy for the MIS to detect was failure to collect by a beneficiary three consecutive times. The MIS may need to be updated regularly and programmed to detect periodically potential exit/graduation cases based on other criteria.

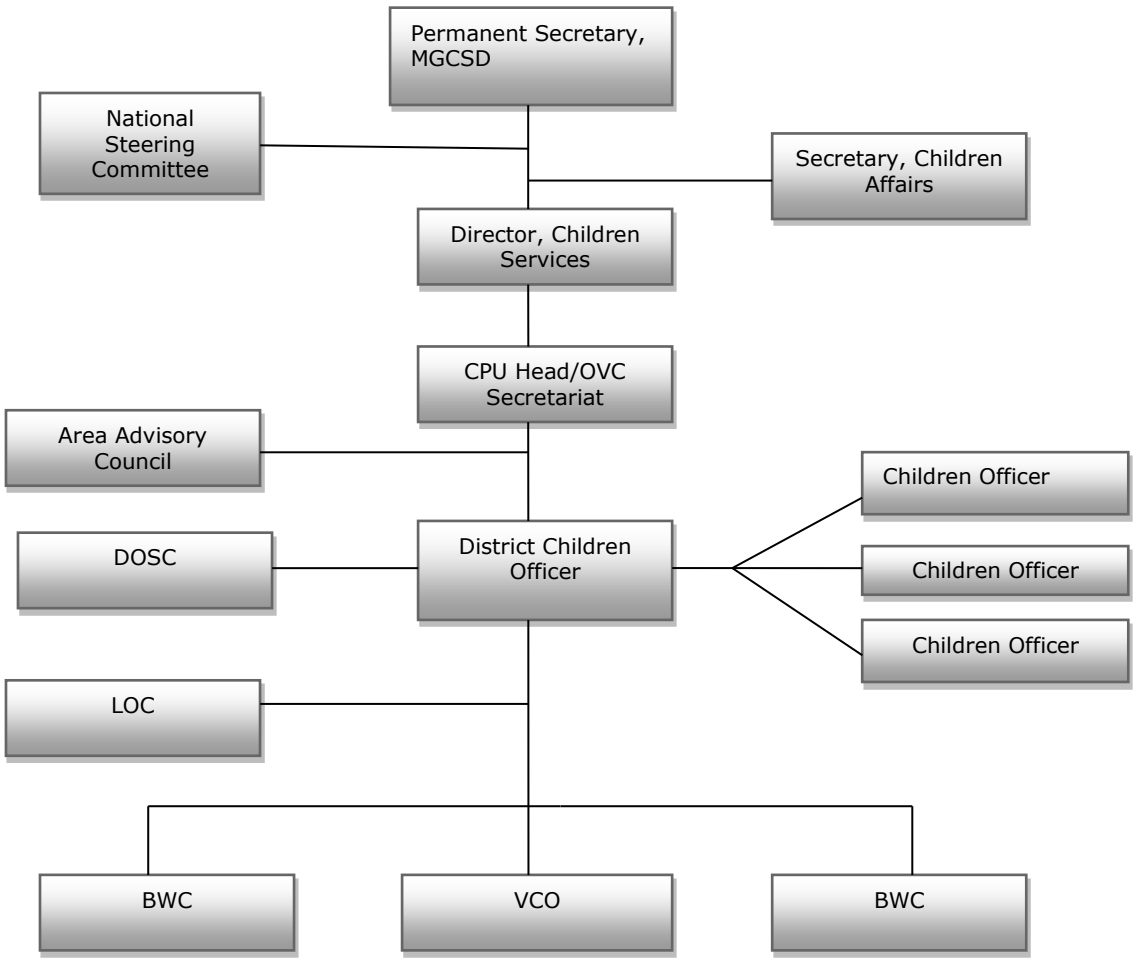
7.2 Programme governance at national, district and community levels

Governance structures

The CT-OVC programme is managed through a series of committees at the national, district and community levels (Figure 5),whose roles are clearly defined in the operations manual that serves as the programme reference document (MGCSD, 2011). At the national level, there is a National Steering Committee for OVC based at the DCS that provides policy guidelines on issues affecting OVC. This comprises policymakers drawn from other relevant line ministries and development partners (UNICEF, World Bank, DFID). The committee provides the link to the broader SP agenda of the government and overall buy-in to SP policy in Kenya.

The MGCSD is the executing agency, coming under the responsibility of the permanent secretary, who provides guidance and makes policy decisions on a day-to-day basis. The DCS coordinates daily implementation and operations. The OVC Secretariat, which constitutes the CPU, is the technical arm of the DCS that coordinates and supervises implementation. The CPU is divided into the following areas: Support, Operations, Planning, M&E, MIS and Administration and Financial Management. The main duties of the CPU include coordinating the identification and selection of beneficiaries, producing lists of eligible households, coordinating logistics for enrolment, supervising compliance with conditionalities/responsibilities, requesting CTs for payment agencies and approving payments to beneficiary households, among others.

Figure 5: Structure of the OVC-CT programme



The CPU coordinator/OVC Secretariat head manages and supervises day-to-day activities related to the programme and provides operational guidelines of the programme to the operations coordinator. The CPU coordinator reports directly to the director of the DCS. Coordinators in the CPU are responsible for the sub-units, including two other staff members working on communication and training. The Technical Working Group (TWG), comprising the OVC Secretariat, UNICEF, the World Bank and DFID, offers technical support to the programme. The role of the TWG is purely to ensure the smooth operation of the programme by reviewing implementation plans and operations through regular meetings.

At district level, the DCO manages the programme, being in charge of administrative aspects (including liaising with the post office and beneficiaries when the CT is ready for collection), and coordinates significant logistical processes. It also serves as a link between the CPU/OVC Secretariat, entities providing health, education and civil registration services and beneficiaries. The DCO is also in charge of monitoring compliance with programme objectives and reporting information and filing in financial reports to send back to the CPU/OVC Secretariat. The DCO works in collaboration with the LOCs, DOSCs and members of the community to support activities related to selection of beneficiaries, enrolment, conditionalities/responsibilities compliance, payments, monitoring, case management and complaints.

LOC members are selected from among individuals in the community who have interest in children's issues. They are chosen and trained by the DOSC. They interact directly with beneficiary households at the community level and their roles include sensitising communities on the plight of OVC, identifying OVC households within their locations, validating selection of beneficiaries through community meetings, assisting in identifying enumerators for household surveys, helping with

enrolment, coordinating home visits and awareness sessions and monitoring the progress of OVC continuously.

The Area Advisory Council (AAC) coordinates and supervises activities and services for children at the district level and is composed of key government department representatives and other stakeholders. The AAC selects and approves programme locations and lists of beneficiary households based on the programme guidelines given by the CPU/OVC Secretariat. The AAC establishes the DOSC, which is in charge of supporting the implementation of the CT-OVC programme as well as creating, training and supervising LOCs. The DOSC also assists in programme cycle activities, including beneficiary selection, monitoring and direct assistance to beneficiaries with respect to compliance, payments, updating records, appeals, case management and complaints.

At community level, the VCOs and the BWC play a critical role. As Box 3 shows, VCOs have to apply for the job and go through an interview process with the DCO. Their role is essentially to monitor and advise CT beneficiaries. The BWC is a committee of beneficiaries selected among themselves. Selection criteria include ability to read and write and willingness to do volunteer work. The BWCs were introduced in 2011 following complaints that the LOCs were not representing the interests of the beneficiaries. Their main role is mobilisation to create ownership among beneficiaries and to enable beneficiaries to support each other in the care of OVC. They also monitor use of CTs and challenges faced by beneficiaries, which they report to the VCOs and DCOs.

There were no differences with regard to programme governance between the two study sites. Programme structures are essentially similar and replicated in all CT programme districts throughout the country.

Perspectives on governance

According to KIIs, human resources at the national level are at near-adequate levels, since all the key positions are filled. However, this is not the case at the district level. Most districts are managed by one DCO and an assistant, who have to deal with all the activities of the DCS (including children protection issues, adoption and correctional services) and not only the CT-OVC programme. At the community level, the programme relies on VCOs and BWC members, who are volunteers; this presents certain problems. According to a KII with an academic working on CT-OVC issues, volunteers, since they work without pay, cannot be relied on to effectively address programme concerns, such as those in relation to case management, in which they would be expected to visit households routinely and report on the care given to the OVC. In any case, they also volunteer their services to many other programmes in the community. We particularly noted that staff at the district level relied on national staff to visit the district periodically to collect data for M&E purposes.

In both Makueni and Busia, according to respondents, the implementation process of the CT-OVC programme is quite smooth and works efficiently. Beneficiaries reported that the various government officials and committees that support the process, including DCOs, chiefs, LOCs and BWCs, are functional and always engaged with them whenever there were issues to be discussed, including delays in payment, care for OVC and use of CTs. The establishment of BWCs, which are composed of beneficiaries, has also increased the participation of beneficiaries in programme governance at the community level. This was corroborated by the DCOs, who reported that BWCs had become an important governance structure at the community level. The OVC Secretariat was aware of previous complaints against LOCs by beneficiaries: according to DCOs, LOCs had been accused of taking bribes from beneficiaries in order to, for instance, have them targeted during the first phase of the programme. BWCs are now seen as the best alternative, since they comprise beneficiaries themselves. Key informants reported that the programme was in a process of transition from LOCs to BWCs. The Busia DCO explained the role of BWCs:

> *'That is why we have the BWCs and these committees are meant to involve the community more in decision making and in monitoring. Because a LOC member is someone who is not a beneficiary so may not really understand the programme all through, so the issue of the BWC is supposed to enable the community to input more into the programme. It is at the initial stages but I am sure we are going to go miles once it picks up.'*

Box 3: VCOs from Makueni

Two VCOs were interviewed in Makueni–one covering Kwakavisi and the other Kavingoni, the adjoining area. There are a total of seven VCOs in the Kathonzweni area. In order to become a VCO, they both went through a selection and interview process undertaken by the DCO. In addition to being VCOs, which is a voluntary position, they also look out for child abuse cases – if they find these they inform the AAC, which channels the information to the DCO. Both VCOs spoken to were also CHWs, also a voluntary/unpaid position.

Both, despite having working on child-related issues for over six years, had just started working as VCOs, although previously they had been working with the AAC. Their role as VCOs in the CT programme is to identify who are the needy; they helped carry out the targeting and were given forms to fill out. According to them, the 'hard core poor families' are those characterised by the following:

- Lack basic necessities;
- Poor shelter (thatched/grass roof, sagging, holes, no cement);
- Limited bedding (share a bed, sleep on the floor);
- No food, one meal/day at night;
- Children not going to school;
- If sick are not taken to hospital;
- In terms of clothing (tatters, rags, not washed properly);
- No toilets.

Once the money is given, they monitor and advise caregivers on its use. They do this by creating awareness of the need to use the money positively. They work as VCOs two days a week, going around houses, visiting beneficiaries for monitoring purposes. They take notes in a notebook (there are no monitoring forms) and take these to the sub-chief, who then discusses issues with the chief; if issues are serious they take it to the DCO.

8 Use of cash and perceptions of its value and effects

8.1 Use of cash by beneficiaries

According to the accounts of beneficiaries and others, the uses made of the CTs by individuals and households are similar across the two sites. This could be attributed to the CT-OVC programme objectives, which are well articulated by programme implementers when recruiting beneficiaries, who also attend a briefing session on the use of the CT before receiving the first one. Key areas in which CT are used include purchase of basic household necessities (food, bedding, clothing, etc.), buying housing materials (shelter), meeting school requirements (levies, uniforms, extra tuition) and paying health bills. Fund use appears to be related directly to the strategic objectives of meeting the needs of OVC, including food security, shelter, education and health, as indicated in the programme objectives. A school-going child from one beneficiary household in Busia stated:

'This money has helped me a lot because I wouldn't have reached Standard 7 and my mother makes sure school fees are paid in full and also at home it cares for all our needs of food, clothing, wellbeing at home and building a house.'

Other uses of the CTs, on which beneficiaries are also advised, relate to securing the future. These include using savings to initiate petty business (e.g. food kiosks, tailoring, motorbike taxis, etc.), purchase of domestic animals (goats, cows, chickens), investing in small-scale farming and contributing to merry-go-round groups, with money later invested in other activities/capital. Roughly speaking, approximately 75% of funds go on consumption, with the remainder invested.

It was evident that instructions given to beneficiaries, mainly by chiefs and VCOs, have contributed significantly to the similarity in the use of CT between the two study sites. Beneficiaries appear to rely on instructions rather than following their own initiative, and sometimes act out of fear that they will be taken out of the programme if they do not follow the instructions. Although beneficiaries reported that they had the freedom to spend the money, they acknowledged that programme implementers always impressed on them that they should spend the money on programme objectives.

Box 4: Excerpts from a life history of a grandfather beneficiary in Makueni relating to advice given on how to use the CT

Researcher: For how long have you been receiving this money?

Informant: This is the fifth year; I was among the first beneficiaries.

Researcher: How were you chosen as a recipient of this money?

Informant: The VCO came with some lady to my home and we greeted each other and asked some questions. They asked me how many children I had and I told them I had eight children and they were in school. One was in secondary school and the rest in primary school. The first has since finished secondary school and is in Nairobi with his elder brother and I was left with the rest, with whom I live.

Researcher: After this, what happened?

Informant: Then we were called by the sub-chief and told there was some money at the DCO and we would be told how to collect it. We told him that we didn't know the place and he should take us there. He offered to take us. We were given the money and they told us to buy a cow and use the remainder to educate the children and buy them clothes, and I did just that, I'm talking on my own behalf and not for anyone else. The second time we were instructed to buy a goat and I did that. Now I have four goats and the cow is seven months pregnant. The third time we were told to buy anything that seemed helpful to us, such as poultry or any other thing. I went and bought chickens, and now I have six chickens. Afterwards, I built a three-roomed house; I am now building the fourth room. That's where I am.

Researcher: What else are you told to spend the money on?

Informant: Food; if a child falls sick I should take them to the hospital. Whenever I get the money I take it to the bank, and when faced with any problem I simply get some money and solve it.

Researcher: How has this money helped you?

Informant: This money has really helped me because my home used to be pathetic but now you can see I have spent it in a good way. I used to feed badly, sleep badly, but now things are good.

Both beneficiaries and key informants in both of the two sites reported cases of misuse, mainly among male recipients, who were said to use some of the cash to buy alcohol. Interviews with VCOs indicated that such cases, once confirmed, would be replaced by an alternative caregiver. There were two such cases in Makueni and one in Busia (interviews with VCOs/women's group leader); during the DGC (carried out in Gatundu South in Kiambu county), four cases were reported. Apart from use of the CT to buy alcohol by men, there were no reported gender differences in CT use, since most caregivers were women. The high number of women caregivers could be explained by the fact that, traditionally, caring and reproduction is in the hands of women; furthermore, in areas heavily affected by the HIV epidemic, in this case Busia, there are large numbers of widows, implying their menfolk have already died. Additionally, women are more likely to take in OVC from their departed relatives than men, again in keeping with the traditional female role of caregiving.

8.2 Value of the CT

There was a general consensus among all the study participants (beneficiaries, non-beneficiaries, children and key informants) that the CT had had an effect on the lives of the beneficiaries. Life with the CT was generally better than life without (see Box 5).

Box 5: Life history of a male beneficiary in Makueni

Researcher: Now let us look at your life. I told you that we would talk about your general life. What can you say of your life in the past five years?

Informant: I have been farming as I cannot do any work or read any more.

Researcher: Only farming?

Informant: The money I get has really helped me and I am so grateful for being a recipient.

Researcher: What can you say has been the best thing in your life for the past five years?

Informant: I have been able to build what I want, and I have made my farm with that money and I have raised the children well.

Researcher: When did you build?

Informant: It started long ago but I have been able to complete it. I built one house and I expanded it with a room and am now expanding it again.

Researcher: Can you remember the year you started your construction?
Informant: It was in 2010.

Researcher: When did you finish your construction?

Informant: It is not over yet.

Researcher: So you built a house, what else?

Informant: Yes, I have always wanted a house and a cow.

Researcher: When did you buy the cow?

Informant: It was the first thing I bought with the initial funds that I got.

Researcher: What else did you buy?

Informant: I bought goats.

Researcher: When did you buy the goats?

Informant: I bought them with the second batch of the money.

Researcher: Which year was this?

Informant: The same year.

Researcher: What else? Which year was it?

Informant: I got chickens in the third year.

Researcher: What other thing do you consider important that have happened to you in the past five years?
Informant: The other thing am grateful about is for the money: whenever I am not able to do some work, I simply get someone to do the work and pay them.

Researcher: When did you start paying people to work for you?

Informant: The third year.

Researcher: What else?

Informant: The other thing is the money they are giving us.

Researcher: What other good thing has happened in your life?

Informant: The food, when I get the money, I buy food, store one sack and the rest we share with the children.
Researcher: In these five years, whom do you think has helped you a lot?

Informant: It's this company giving us the money.

For most of the beneficiaries interviewed, the CT has become a major source of household income, surpassing all other sources; critical to the importance of this income is its regularity. Commenting on anything good that has happened in his life in the past five years, a 73-year-old grandfather in Busia stated:

> *'The good thing is that I am helping my grandchildren and I don't have many needs like in the past, when in case I needed anything I'd just be hopeless. But now if I don't have anything I can run and borrow from someone and promise that when the CT money comes, I repay. That is the good thing that I've seen.'*

Apart from the effect on individual lives and households of beneficiaries, the effects of the CT can also be felt at the level of community, for example in the number of OVC attending school and the development of the local economy. The citizen–state relationship also appears to have improved, as communities feel the state is doing something to address the plight of orphans. At the same time, however, communities did not view the CT as something that fell within their contractual relations with the state and that the state was obligated to provide; this was not the way communities in the two study sites perceived their relationship with the state. Social assistance programmes like food relief and the CT were perceived as things the state provides as and when it has funds and communities are not entitled to receive them. Being rural and with only a modest education, communities were not aware that the Constitution guaranteed them a decent life from the state.

Funds obtained through the CT programme were generally valued more than food/in-kind transfers and other forms of social assistance (e.g. public works, i.e. KaziKwaVijana). Study participants argued that the CT gave them the freedom to spend money on the things they needed as opposed to other forms of social assistance. For instance, the VCOs in Makueni argued that 'people have needs other than just food'. Study participants in Makueni had experience with food aid and indicated that they would prefer cash to food aid because receiving the food made them look like 'dependants'. They stated that, even when they had surplus food aid, they could not sell it because everyone had it, making it difficult for them to get other products. Experience with public works under KaziKwaVijana in the two study sites showed that study participants did not like this type of social assistance because of the work conditions that go with it. Youth had to engage in labour-intensive public works (such as road construction and afforestation) before being paid and they expressed their dissatisfaction because, according to them, the amount of money offered was not commensurate with the work done. They also felt recruitment into the programme was not transparent like in the CT-OVC programme. In fact, overall, the CT was the most favoured form of social assistance; apart from the relative freedom to use the cash as they wished, it also allowed beneficiaries to access many other services essential to their daily livelihoods. One respondent in Makueni summed this up in the following way:

> *'If you give someone something like food, you see the children will still be chased from school. You cannot even buy clothes or shoes and yet you have been given food. And you cannot sell the food. You see [...] money is what is important. You know money is the most important. There is nothing else because if you don't have food you will buy it with money and if you want to educate a child you must take money to school. And what if you are given food only, can you educate a child? You can't.'*

8.3 Positive effects of the CT

Improvements in quality of life

Participants in both Busia and Makueni indicated that the CT programme had led to an improvement in the lives of OVC as well as other members of their household, through the provision of basic life necessities – food, clothing, bedding and shelter. Thus, for instance, according to the VCOs in Makueni, people were now able to construct permanent shelters and have three meals a day since, among other things, with the cash they were able to buy maize. Their health needs had also been partially met through payment of medical bills and purchase of drugs. Respondents emphasised that the CT had gone a long way in terms of meeting the basic needs of OVC and that this benefit had also been extended to other children in the household who were not OVC. The net effect of improvements in quality of life were reported in households as a reduction in the number of children going without food, walking in tattered clothes and without appropriate housing/shelter. For instance, case study observations in four homes of beneficiaries (two in each study site) confirmed that houses were in good condition, OVC were adequately dressed and food was available for the family (see Box

6). Commenting on the effect of the CT on the everyday life of disadvantaged groups in the community, a women group leader in Busia observed:

> *'There is this man in our area who was paralysed on one side and is now disabled, he has five children who are all epileptic and he lived a pathetic life with his children and he was the first person to be called as a recipient and when he got that money their life changed. He has now got a chance to take these children to a special school in Butula where they get treatment. He could not afford their treatment before and the children used to beg all over the place but now that is over.'*

Box 6: Case study in the home of a grandmother beneficiary in Busia

This case study was conducted at the homestead of a 77-year-old grandmother beneficiary. It involved a three-day observation, with two hours of observation each day. The grandmother is a widow taking care of six orphans who are her grandchildren; two are total orphans and four are partial orphans. Three of them are in secondary school, two are in primary school and one is in nursery school. She is the sole provider for these orphans and, other than selling vegetables in the market, depends on the CT to pay school fees for her grandchildren.

Day 1
This was mainly a day of introduction into the home of this grandmother. We walked into her home at around 4:00pm. We found the grandmother waiting for us, as she had been alerted by the VCO that we were going to visit her. The homestead was small, on 0.5 acres of land. There were five houses in the homestead, three mud walled and iron roofed and two with grass-thatched roofs. Behind every house was a small kitchen garden with maize plantations and soya beans.

The grandmother ushered us into her two-roomed house, with a small section of the sitting room partitioned with an old piece of cloth. I later learned that this small section was used as a sleeping area for three of her grandchildren and the other room was her sleeping area. She asked that we pray first before the introductions. After this, she smiled and told us that the CT had really helped her in so many ways. She then pointed outside and showed us a grass-thatched house and next to it an iron-roofed house and told us that the grass-thatched house was the original house but she built the iron-roofed one with the CT. She told us that she built the house for her grandchildren. I later learnt that this house was used mainly by three of her older grandchildren (those in secondary school); she lives with the younger ones in her house.

Day 2
We arrived at the homestead at 11:00am. We found the grandmother seated in her hut waiting for us. We went into the house and prepared to start the interview. We conducted the interview for 1 hour and 15 minutes. The interview was very lively and the grandmother was very knowledgeable on many things about the CT. After the interview, I told her I would stay at her homestead for another 2 hours just so I could get to know her better. She then took me behind her house and showed me the goat she bought with the CT. She told me she was so proud of this goat because it had reproduced three times and this had really helped her because when she sells the kid goats she can pay school fees for her grandchildren. At one point, a woman visited the grandmother and they held prayers in the house. I sat outside and after the prayers the grandmother told me this was the pastor's wife, who comes to pray for her frequently so that God can bless her home.

The grandmother then proceeded to her kitchen, which was a grass-thatched hut located on the left side of her main house. She stayed there for a while and later came out with a bowl of rice and boiled beans and asked me to come in and eat. It was a privilege. After eating, I went back to sit outside. The grandchildren then came back from school for lunch and were served the same food. After they had eaten, they went and took a bath and changed into home clothes.

Day 3
I visited the home at 11:00am and found the three grandchildren in the home. I asked them where their grandmother was and they told me she had gone to a funeral. The children were smartly dressed so I asked them what they were planning to do. The older one told me they were going to fetch water then attend the education day that was being held at the chief's camp. I sat outside the compound as the children went about their chores. One girl was sweeping the compound as the others went out to fetch water. I sat around for another hour and told the children I had to go and asked them to tell their grandmother I had passed by.

Increase in access to basic education

Individual interviews and FGDs with children and adults suggested that the CT had increased access to basic education in the two sites. Children who previously could not attend school owing to a lack of uniforms, books and school levies were now able to do so. Although basic education is free in Kenya, schools still charge some levies, and parents are required to provide uniform and books. These requirements make education inaccessible for many OVC. CT beneficiaries are now able to pay these fees, which has increased school attendance by OVC, as confirmed in interviews with head teachers of the primary schools in the study sites. Additionally, even if the cash is not available, the child is still allowed to stay in school, since the teacher knows they will have it later and can settle the bill then. Teachers also reported that cases of absenteeism and truancy had gone down among OVC, leading to higher school retention and completion rates. Previously, most OVC were sent home as they had not met school requirements, and some eventually dropped out of school. The CT has led to the number of children completing basic education in the study sites increasing, as confirmed by interviews with local leaders and the DCOs. The DCO in Busia reported:

> *'Yes, yes, yes, I can say that the community has really benefited so much and we are seeing a big change in the community. Caregivers have been able to foster more orphans in their families [...] and I can say that enrolment in schools has been high, retention of OVC in schools has been high.'*

Social acceptance of OVC owing to reduced stigma

The CT has contributed to the social acceptance of OVC in communities. We learnt that, previously, orphans were discriminated against and stigmatised because they were perceived to be a burden to the fostering households and relatives. KIIs (with DCOs, VCOs and local leaders) revealed that people, in particular close relatives, in the two study sites were previously reluctant to foster orphans, but the situation had changed with the introduction of the CT programme and people were now more than willing to foster OVC. This has resulted in improved status for OVC, who are now considered valuable additions to households, since the benefits almost invariably extend from the child to the wider household, especially in cases where there is a small number of OVC. Cases were mentioned of relatives competing over who should live with the orphaned children. This reduction in stigma and overall acceptance of OVCs were felt at both the household and the community levels. Individual children also spoke about having more friends now than before, which appeared to coincide with when they started receiving the CT. Thus, a possible conclusion drawn from the findings is that OVC are becoming increasingly accepted by other children into a community of peers, and as such their own social capital and networks have been enhanced.

Empowerment of vulnerable and stigmatised groups

Findings indicate that the CT has contributed to the empowerment of vulnerable groups in the study sites by, among other things, giving them a voice in the community. According to local chiefs and VCOs, for instance, vulnerable groups (older widows, the elderly and the poor) are beginning to participate actively in community meetings at *barazas*, schools and market places. These groups, who are the main beneficiaries of the CT, can now meet their basic needs just like other members of the community. In this way, they have regained social acceptance in the community. For example, beneficiary widows reported that they were now being treated just like other members of the community during village meetings. Beneficiary children also reported increased social acceptance in schools and among their peers (see also Box 7).

Additionally, the fact that respondents were involved in qualitative and participatory data collection in the current study is also likely to have empowered them. For instance, during the research process, a great deal of discussion arose around identification of the most vulnerable, and respondents were keen to voice their opinions and also for their experiences and perceptions to be heard.

Box 7: Effects of the CT on HIV-positive people

According to VCOs, in Kwakavisi there are 13 OVC and 6 caregivers who are HIV positive; in Kavingoni, there are 6 OVCs and 5 caregivers who are HIV positive. An HIV-positive caregiver is also on the BWC. According to the VCOs, the lives of HIV-positive people have improved; members do not discriminate and there is no longer any stigma. VCOs also pointed out that classmates of children who know they are HIV positive do not discriminate. This comes as a slight contrast with what the nurses from the dispensary said (see Box 2).

Social capital formation

Social groups have been formed around CT social networks. We were informed of merry-go-round groups made up of CT beneficiaries where members contribute money and support each other in times of need. The CT has fostered a sort of identity, with people coming together to deal with the uncertainties of life, as confirmed in IDIs and FGDs with CT beneficiaries. Women (who are the main beneficiaries of the CT) dominate these social groups. According to respondents, these groups also offer informal psychosocial support to HIV-positive widows and advise elderly grandmothers on how to handle OVC. The BWCs, championed by the OVC Secretariat, also enhance identity and social capital formation through regular meetings that deal with beneficiary affairs, such as how to derive the maximum benefit from the CT, how to provide appropriate care to OVC and misuse of the CT. Although social capital formation and the activities of social groups were more pronounced in Busia, possibly because the economy there is generally stronger than in Makueni, some similar fledging activities were also reported in Makueni (see Box 8).

Box 8: CT and formation of social groups in Makueni

According to the DCO in Makueni, there is a location in Sultan (not the study site) where caregivers have come together to form a self-help group. During the bi-monthly payment meetings, the group chats about the way forward and contributes about KSh 200 ($2.38). There are about 40 members, which amounts to KSh 8,000 per time. They use the cash to buy goats for the members, with different members having access to the goats on different occasions. According to the DCO, other groups have emulated such kinds of activities.

'When we meet with them, we emphasise to them that this money is time bound and they are not going to be given this money forever. Every project has a timeline and we tell them to do some kind of income-generating activities to sustain the household, which they take very positively. These households have been economically empowered in a way, and you will find in the community there is some kind of identity they have gained as beneficiaries of that programme.'

Building economic capital and investing in children's future

One of the activities of the social groups formed by CT beneficiaries is to save and pool money, with members using the money generated individually and in groups to invest in petty business and the purchase of domestic animals (cows, goats, and chicken) (see Box 8). In Busia, when beneficiaries receive the money, they pool it then give it to one person in turn on a monthly basis. This has enabled them not only to invest in petty business and buy livestock but also to build houses for those in need of shelter. Table banking, also reported in Busia, operates under the same principle: money is lent out with minimal interest (1-2%) depending on the person's immediate need for cash. On an individual basis, the CT has also allowed beneficiaries to invest in animals, to 'become good farmers since they can afford good seeds now' (VCOs, Makueni) and to open bank/savings accounts – according to VCOs, three-quarters of beneficiaries now have savings accounts. The building of economic capital in the study areas appears to have recorded some success since the advent of the CT, and the CT is considered a means of securing the future should households exit the CT-OVC programme. It is also seen as a means to invest in the future of children. This success can be attributed partly to the instructions given to beneficiaries by programme implementers and local administrators.

Stimulating the local economy

Both beneficiaries and non-beneficiaries as well as key informants concurred that the effect of the CT on the local economy could not be underestimated. A trickle-out effect has been noted, whereby nearly everyone/institution, from 'shopkeepers, schools, *bodaboda* taxi drivers, bar owners, thieves and health facilities', has benefited either directly or indirectly. Most of these institutions and persons have an understanding with beneficiaries, whereby they render services or give goods on credit and are paid once beneficiaries receive the CT. The net effect is that the CT can arguably be seen as promoting local economic growth. The effect is thought to be greater where there is more than one type of CT in one location, such as in Busia, where older persons and those with severe disabilities also receive the OPCT and disability grants, respectively.

Feeling of self-worth among OVC

There is evidence that the CT has contributed to a feeling of self-worth and increased the self-esteem of OVC (see Box 9). The children we talked to and whose homes we visited are now going to school and are better clothed and fed and, according to their own words as well as observation, this has led

to an increase in their self-confidence, which may in turn have made them become more outgoing. In interviews and FGDs, they talked about their future confidently and pointed out how they wanted to succeed in school and lead a better life. Their immediate kin as well as the surrounding community have also come to accept them as not only a valuable resource for households but also an important investment for the future community. Deprived children were also reported to have reduced their engagement in bad habits. A women's group leader in Busia said:

'Since the CT came, stealing and taking other people's chicken by the children is over.'

Box 9: The CT and feelings of self-worth among OVC

In the following conversation, a beneficiary girl in Makueni explains her feeling of self-worth created by the reduction in suffering since she was enrolled in the CT-OVC programme:

Interviewer: And how has the money changed your life?

Participant: I am not suffering the way I used to suffer.

Interviewer: What kind of suffering?

Participant: Like not getting anything to eat, lack of food and clothes.

Interviewer: Ok, how has this money changed your life in school?

Participant: I have paid for school fees and I'm not chased out of school anymore. I used to go back home and so while others were studying I was sitting at home. I am not suffering any more.

Interviewer: Ok. And how do you feel physically and emotionally?

Participant: I am stronger.

8.4 Negative effects of the CT

The negative effects of the CT programme came out mostly in the form of tensions at household and community level. Tensions at household level were reported by around 15% of beneficiaries spoken to, with only a few incidents reported. All beneficiaries reported tensions at community level. DCOs, VCOs and key stakeholders at community level (youth, religious leaders, elders, women's group leader) reported such tensions.

Tensions among caregivers at the household level

Tensions among caregivers were mainly experienced between spouses, with women accusing men of spending the CT on alcohol. Such tensions were said to be isolated and usually occurred in households where men were the listed recipients of the CT. According to respondents, the BWCs and VCOs in the two study sites handle such cases when they come to their attention and, depending on the perceived 'misuse', usually recommend the substitution of the man with his wife as recipient. Men apparently do not take this lightly and often assert their authority as heads of households by subjecting women to physical violence. During the DGC, a woman group leader reported a case of a couple separating after the woman was chosen as the alternative recipient, the man having been accused of using the CT to buy alcohol. This separation also affected the child, who had to relocate to be with her grandmother. The Makueni DCO reported a similar case:

> *'We've also had cases of couples (separating).I had a case where the caregiver was selected to be the man, the grandmother of this child used to complain that, whenever this man is paid, the money never got to the children. We decided to change to the alternative caregiver so that the grandmother could receive the money, not knowing that we were actually causing "fire". This old man told the grandmother not to step into the homestead because she was now receiving the money.'*

Tensions between biological children of caregivers and OVC

Sometimes, tensions arise between the children of the caregiver and the OVC, with the caregiver spending the money on their own children rather than the OVC. According to the VCOs from Makueni, the child then comes to them to complain since 'they know that the cash should be there for them'.

However, according to the VCOs, this happened mostly in the early days of the programme; caregivers have now changed their behaviour, having been advised to by the VCOs.

Tensions between caregivers and OVC

Tensions between caregivers and OVC arise when some OVC are seen to have become 'arrogant' and 'disrespectful' to caregivers, according to caregivers and KIIs at community level. These OVC are said to be aware that caregivers receive the CT on their behalf and put demands on the caregivers (e.g. to be bought expensive clothes and shoes) and challenge their authority. A case was cited in Busia of a child deciding to change residence to live with another caregiver because their demands were not met. This created tension between the previous caregiver and the new one, who were siblings. Tensions between caregivers and OVC were also reported in schools, according to a head teacher in Busia:

> *'There are some […] I call them conflicts, whereby the caregiver cannot provide the required care as far as this money is concerned and the children are aware, they even know when he or she has gone to collect but when the money comes they are not given their share correctly. It has even caused conflict at school, with the caregiver not ready even to come to discuss matters affecting the child. At home they are at loggerheads because of the money.'*

The above quote shows that children's demands for their rightful share of the CT may have been perceived or misconstrued by adults as arrogance on the part of the children. In most cultures, children are rarely involved in decision making on matters that concern them, and it is not surprising that adults consider such demands arrogant.

Tensions between beneficiaries and non-beneficiaries in the community

Such tensions arise because many in both sites consider themselves deserving cases yet have not been recruited into the programme. Some of these cases are on the waiting list and have been informed that they will be included when funds become available. There are also cases of children who have become orphans since the targeting and recruitment phase. There is therefore a perception of unfairness at having been left out while being just as needy as those included in the programme. This fuels a latent tension between beneficiaries and non-beneficiaries. These tensions were mainly reported by non-beneficiaries, VCOs and local administrators, with beneficiaries most likely not wanting to raise this issue, for fear of jeopardising their position in the programme.

Arrogant and disrespectful beneficiary caregivers

According to VCOs, some caregivers have become arrogant and disrespectful and no longer attend meetings. VCOs then 'need to spell out the regulations to them […] otherwise there is a tendency to abuse the system'.

CT insufficient for household needs

Beneficiaries felt that the value of the CT was insufficient to meet their needs, given the high cost of living. This is exacerbated by the fact that the CT amount does not take into account family size. According to KIIs, IDIs and FGDs, extremely vulnerable beneficiaries who have no alternative sources of income, such as elderly grandmothers, have a difficult time convincing young OVC that the money given is not adequate for all their needs. This, as indicated above, becomes a source of tension within the household.

Erosion of informal SP

To a certain extent, we observed that the CT was contributing to the erosion of informal SP systems. Previously, despite the economic constraints many households faced, taking in vulnerable children, whether orphaned or not, was an accepted part of daily life and a responsibility that adults, mostly those related by kinship, had to take on. As such, existing household resources just had to be stretched further. Such forms of fostering now have a monetary value placed on them and orphans are seen as crucial assets as they bring in an income. Some people who are willing to take in orphans are doing so not necessarily because they want to foster them, or because they feel it is their 'traditional' duty, but because they look forward to receiving the CT. This came out during an interview with the DCO in Makueni:

> *'We have had a lot of case management in our office, even at the location level. With time, this project is becoming known, and we've had cases where OVC are being relocated, a child who was staying with the aunt moves to stay with his paternal uncles, so the moment the*

child has been relocated you have people coming to demand the money be shifted to somebody else. Unless we make some kind of enquiry, we may end up making wrong decisions and at the end of the day it's about this money. Before the money came, these people were staying in a peaceful manner, so you might find an issue of children being incited to relocate to another relative.'

Local support systems could therefore be said to be slowly giving way to formalised systems, where caregivers receive the CT in return for fostering OVC. In traditional African society, such local or indigenous support systems are strong and children are considered to belong to both the extended family and the wider community, and would therefore not suffer in the event that their parents died. Traditional mechanisms are also eroding because of other shocks and stresses and reduced household resilience owing to, among other things, HIV and AIDS-related deaths and diminishing means of livelihoods.

9 Programme accountability

Overall, study participants at the sites reported satisfaction with the way the programme had been implemented. Data collected from both beneficiaries and non-beneficiaries indicate that the programme reaches the poorest and most vulnerable households in the community, namely, those with OVC and that are also predominantly headed by the elderly, PWD, HIV-positive persons, widows and women. The principal concern voiced was that there are many poor and vulnerable households at the two sites and the programme is yet to cover all of them. Isolated cases of cash going to the wrong people were reported, but further investigation revealed that these were linked to poor targeting by LOC members or the receiving of false information from beneficiaries in the initial enrolment, when robust systems had not yet been developed. There were no concerns regarding handling of beneficiaries by programme staff, although the VCOs in Makueni reported that some beneficiaries were difficult and did not want to adhere to the guidelines of the programme. Generally, beneficiaries reported being treated with respect by the payment service provider and other programme implementers in the two sites. No discrimination of any form was recorded during fieldwork.

Other aspects of accountability explored in the study include beneficiary views towards conditionalities, participation in programme assessments or evaluation and views on any forms of complaints and/or grievance channels, which include appeals.

9.1 Views on 'conditionalities'

It appears that the programme objectives of ensuring OVC receive regular food, clothing and shelter, attend school regularly, access health care and acquire birth registration are almost invariably construed as conditions by both beneficiaries and non-beneficiaries. Beneficiaries reported that programme implementers and other stakeholders monitor compliance with these objectives, or 'conditions'; community-level stakeholders report those who do not comply to the programme implementers. VCOs, BWCs, LOCs, teachers, chiefs and village elders were mentioned as gatekeepers who kept an eye on the beneficiaries and how they used the CT. Beneficiaries who do not comply risk being replaced by alternative caregivers. An HIV-positive beneficiary mother from Busia confirmed this:

'Oh yes there is a case where one beneficiary missed the money for two months and then she came with the teacher [to confirm the child was attending school] and after that she was given it but before she brought the teacher she was totally denied.'

Hence, it is evident that, while there are no conditions as far as the spending of the CT is concerned, beneficiaries are expected to use the money on activities that relate to the programme objectives. Community views on conditions, elicited through IDIs and FGDs, revealed that community members do not view the 'conditions' as bad, and would like them to be enforced even further to ensure OVC get the maximum benefit from the CT. A male non-beneficiary adult in Makueni supported this when he said:

'People should be given conditions and, if they fail to observe them, relatives who can take good care of those children [OVC] should take them.'

KIIs with programme implementers at the district and national levels also supported the introduction of conditions to ensure the desired programme objectives were met: conditions would make it easier to monitor the impacts of the CT by generating clearly measurable indicators. More importantly, conditions would enhance accountability on the part of beneficiaries since they would be given clear targets. The programme is currently piloting certain conditions in selected districts in the country. Similar in many respects to what are currently called programme objectives, these include ensuring all eligible children attend primary school, young children are taken to health facilities for immunisations and other health interventions. The results are not yet available, but will inform programming as to whether full conditions should be introduced at national level.

9.2 Participation in programme assessments or evaluations

Although beneficiaries in the two study sites acknowledged having participated in past programme evaluations, this entailed only being asked a few questions by evaluators. A beneficiary women's FGD in Busia claimed evaluators 'came, looked around, asked questions and went'. The results of the evaluation were not communicated to the beneficiaries, although they were told they were using the money well and the value of CT increased from KSh 3,000 ($36) to Ksh 4,000 ($48) every two months.

It appears the evaluations were not really participatory and mainly involved asking questions. Involving beneficiaries and members of the community more broadly in M&E and other aspects of the programme is critical to ensure their concerns, priorities, perceptions and experiences are taken into account, as well as to foster ownership of the programme. This has already been done during the vulnerable household selection process and to a certain extent in the follow-ups by VCOs. However, their involvement in more formal programme evaluations and assessments has not occurred to any great extent. As such, beneficiaries seemed unaware of the potential benefits of being involved in such evaluations. During this study, not only were beneficiaries' views sought initially on how to frame the study, i.e. during the DGC, but also they were given the space to express their opinions and perceptions of the CT programme, ranging from the mechanics of it to their views on its future, through the use of participatory processes. They were also asked for their views on how they could be more involved in the future in its functioning, a question they found somewhat difficult to respond to, although they welcomed the research team's efforts to hear their thoughts.

KIIs with programme implementers at the district and national levels underscored the importance of community involvement in the programme. Box 10 demonstrates a lack of community involvement in the decision regarding the change of the payment service provider from the post office to Equity Bank. While the intentions here were good – to pilot a more efficient payment process –the lack of community involvement led to an initial boycott of the exercise. Consultations with community members about potential changes that could affect their lives, and obtaining their opinions, buy-in and support for such changes, would enhance both community and beneficiary participation in programme implementation, leading to increased ownership.

Box 10: The need for community involvement in the CT-OVC programme

The DCO for Makueni expressed the need to involve the community in the programme by giving an example of how beneficiaries reacted to the piloting of a new payment service provider in Machakos county. The MGCSD was piloting a second payment agent (Equity Bank) and beneficiaries were supposed to undergo enrolment. Beneficiaries were told they were going to receive the money from the bank as opposed to the post office. Some caregivers looked at the bank and compared it with the post office and concluded that they would be disadvantaged. Thus, they did not want the bank and there was a kind of revolt. When these people went to register in Machakos, people boycotted the registration then went to the media and the local radio station (Musyi FM), where the news was broadcast that people were being forced to move to Equity Bank even if they did not want to. The MGCSD has now put this exercise on hold in Machakos.

'If the people had been involved from the initial stages and sensitised to the change, there would not have been such a scenario. We need to involve the people in the case of any changes in the terms of payments; when we want to introduce a new agent, we need to seek the opinions of caregivers rather

than just rolling out any changes the MGSD has decided on. You might find that they will revolt in this way because they also have rights. As much as they are being assisted, they also need to be listened to and they have a right to be listened to and to give opinions of how they would like things to be done. There is need to involve caregivers in anything involving the programme and their opinions need to be sought before any changes are made by headquarters.'

9.3 Views on complaints/grievance channels

A complaints and grievance channel is available for raising any complaint or grievance as well as appeals related to the programme. Interviews at all levels (community, district and national) pointed to a procedure for raising complaints and grievances right from the community level up to the OVC Secretariat level. Complainants can channel their complaints through the lower levels (VCOs, DCOs, chiefs) but also access the higher levels (OVC Secretariat) directly.

The system works through a toll-free telephone number issued to all beneficiaries for the purposes of reporting. Apart from this, they can report problems and grievances directly to VCOs, chiefs and DCOs. KIIs at the national level revealed that the complaints and grievance system is run by an independent firm called Kimetrica, which is charged with receiving and processing complaints on behalf of the programme. Kimetrica was contracted by DFID in 2009 on behalf of the TWG to develop a comprehensive external process monitoring system for the programme, including development of the beneficiary complaints and grievance reporting system. Programme staff claimed that, through this system, complaints and grievances are reported directly to the OVC Secretariat, where they are addressed expeditiously.[17]

Community-level data from IDIs and FGDs indicated that most beneficiaries were aware of the existence of the telephone complaints and grievance system. However, none of the study participants reported having used the channel to report a complaint or grievance. Most of them preferred to use local channels, mainly chiefs, VCOs and LOCs. The chiefs were considered the most useful channel for forwarding complaints and grievances. This was expressed in an FGD with female beneficiaries in Busia:

> *Participant 2: 'I really thank our chief because they usually call us here at the centre and they ask us if we are not served well while receiving this money. Anyone who has a problem while receiving this money should tell him and we don't see anyone saying they are having any problem with this money. But they call us for a meeting here and everyone comes here and we are asked to say if we have any problem.'*
>
> *Participant3:'The chief tells us that we should be open. Even if it is the LOC member who is giving you problems, if it is the village elder who is giving you problems because of this money, we should say it freely.'*

Despite the existence of these channels at the community level, very few grievances were reported regarding the programme's implementation mechanics. In Busia, two complaints were mentioned regarding the disbursement of the money at the local post office. One beneficiary claimed she was given fake money, and another was paid less money than she should have received. According to VCOs in Busia, who investigated these claims, it was difficult to ascertain at which point these events occurred since they went shopping after receiving the transfer and only discovered the problems thereafter. Delays in payment and distance to payment points were the main concerns reported in Makueni. We observed during the research that Makueni beneficiaries travel a longer distance to the payment point than their counterparts in Busia. Most of the complaints reported to the chiefs have to do with tensions regarding the use of the CT at the household and family levels. Non-beneficiaries also complained to the chiefs regarding targeting, especially when they felt some needy cases had been left out of the programme. Such complaints were also reported to the district- and national-level programme implementers during follow-up visits. However, nothing changed following these complaints; households were informed only that they had been put on the waiting list as a limited number of households could be enrolled at a given time.

[17] Despite various attempts, the team was unable to get any further information on Kimeterica, for example on how it is set up, how it is staffed, where it receives their complaints from, etc.

The insignificant number of complaints and grievances at the two sites, despite the existence of an open and discreet complaints system, could be attributed to the feeling among beneficiaries that they do not need to complain since the CT is free. This came out very strongly in FGDs, where respondents said that as poor people, when they are not served well, they just 'leave it to God'. It also points to lack of awareness among the poor and vulnerable in the two study sites of their rights. A female non-beneficiary from Makueni stated:

> *'I think if you have been given something for free you cannot [...] complain.'*

10 Policy and programme recommendations and next steps

We explored respondents' views on programme-related future directions and policy recommendations. We looked at the different perspectives, including those of beneficiaries, implementers, national decision makers, civil society stakeholders and development partners. The recommendations relate to programme targeting, programme management, amount of the cash transfer, strengthening of programme systems, programme staffing needs, community participation, programme scale-up, conditionalities, integration of the programme with other SP programmes and programme sustainability. A next steps section outlines the sequence of feedback events as well as the products that will be forthcoming linked to this study. It is important to point out that the findings from this study are one part of the picture; other programme M&E information and other factors (e.g. financial resources, capacity, etc.) also need to be taken into consideration when assessing affordability, sustainability, feasibility and acceptability of different design and implementation options.

10.1 Targeting

Targeting was a key issue for study participants at the community level, who were concerned about the large number of needy non-orphan children who were not targeted. The current system of targeting mainly orphaned children was said to leave out children living in destitute households, defined as households lacking basic necessities despite the presence of adults. Beneficiaries, non-beneficiaries and community leaders recommended considering destitution and not only orphanhood in targeting because children in such households are equally vulnerable even though they have parents.

To address the problem of how to define children as vulnerable or not during targeting, civil society stakeholders recommended transforming the CT-OVC programme into a child rights programme. One national-level CSO representative pointed out the challenges of the current system of determining needy children as follows:

> *'I think it [the CT-OVC programme] should be transformed into a child rights programme. The definition of vulnerability can sometimes be very tricky; it's hard to define who is vulnerable and who is not. But I think the way the programme is designed, it's targeting orphans because mostly orphans are enrolled, it leaves out many children who may not necessarily be orphans but they need as much help as the others do, and at times even much more.'*

According to key informants, the current programme takes care of OVC but leaves out many other vulnerable children. A child rights programme would aim to provide SP to all needy children; under such a programme, caregivers of needy children would receive a child support grant. However, it should be noted that, although a child rights grant would achieve greater coverage, the costs and benefits involved, including the amount of money required to fund a nation-wide programme, would have to be considered against other available options.

10.2 Programme management

Recommendations on programme management included the need to increase the frequency and improve the efficiency of the CT, decentralization of activities and systems, monitoring of programme effects on OVC and joint programming for CT-OVC programme.

Frequency and efficiency

Beneficiaries would prefer more frequent and efficient disbursement of the CT than is the case currently. Although some beneficiaries prefer to receive the money bimonthly because they receive a bigger amount, others would like to receive monthly payments to avoid incurring debts in local shops. Beneficiaries also reported that the CT was sometimes delayed, not coming every two months as expected. Other delays are experienced at the payment point, because of long queues, for example. Beneficiaries are often paid on specific days, and lack of staffing to process the numbers arriving can cause overcrowding and delays.

Decentralisation of activities and systems

Beneficiaries recommended decentralising the payment points and bringing them closer to the village, because they incur costs and risks collecting the CT from the post office, which is quite a distance away. They asked that programme implementers explore other payment modalities that would eradicate the need for them to travel long distances, such as banking agents or a mobile money transfer system. However, VCOs in Makueni felt local payments would entail security concerns and the post office was still the ideal.

National-level programme implementers and donors suggested some programme activities, such as M&E, be decentralised to the county and district levels in order to reduce the workload at national level. Equally, systems such as the complaints and grievance system, which can be managed at lower levels, should be decentralised to reduce overdependence on the OVC Secretariat.

Monitoring

There is a need to monitor programme effects on OVC. Although OVC are the target, they do not receive funds directly, hence it is necessary first to identify key indicators and then periodically monitor whether funds have been used to support OVC by assessing how they perform against these key indicators (food, clothing, education and health). According to programme implementers at the district level, this would reduce fiduciary risks, such as of caregivers spending the CT on their own priorities, as seen in a few isolated cases of the CT reportedly being used to buy alcohol.

Joint programming

Joint programming is required at the national level. Currently, donors (UNICEF, DFID and the World Bank) and the government support the programme in different districts. This translates into four projects with different sources of funding that are run and accounted for separately. According to key informants at the national level, there are plans to put all the funds into one basket for use on any component of the programme. This will address the current problem whereby some districts are well funded in terms of operational costs while others are not, depending on who is supporting the programme.

10.3 Cash transfer amount

Increasing the amount of the CT

Beneficiaries acknowledged the significant role played by the CT in their lives but at the same time requested that in the future the amount of money be increased to cushion them from inflation (which was at 4.14%in October 2012). They reported that, owing to the high cost of living, the current CT, last reviewed in 2008, was insufficient to meet the basic household needs of OVC and at the same time address their education and health needs. Special consideration should be given to OVC attending secondary schools, whose school fee requirements are higher than for those attending primary schools. There is also a need to take into account the costs incurred collecting the CT from the payment service provider (e.g. transport, food), which the beneficiary has to cover, thus lessening the overall value of the transfer. It will be necessary to assess these challenges alongside an analysis of the savings and investments beneficiaries make in order to arrive at an appropriate increased rate.

Taking into account the number of OVC per household

Beneficiaries, programme implementers at the district level and key informants in the academic and NGO sectors considered irrational the current practice of giving one amount of money to all households irrespective of the number of OVC. Households with fewer OVC benefit more than those with a higher number of OVC. Donors/development partners also felt it was important to rationalise the CT according to household size in order to provide a true measure of its impact on households. Future programming should take this into consideration to ensure all households derive equal benefit.

10.4 Programme delivery systems

Donors and national-level programme implementers recommended building more robust systems for programme delivery. This will require strengthening systems for complaints and grievances, M&E and payment service provision, as well as the MIS. It was reported that plans are underway to introduce a more efficient and secure payment system.

A new payment service provider (Equity Bank) has been identified and is piloting a biometric system for identification and payment, using a smart card linked to a point of sale device that identifies beneficiaries using finger and thumbprints. The money is loaded onto the smart card and the beneficiary can withdraw the amount they want and also retain some on the card. Another benefit is that beneficiaries will be able to withdraw money through agents in their localities. When this is scaled up, it is expected to be a more efficient and secure system for transferring money to beneficiaries than the current system.

10.5 Programme staffing

Increasing the number of qualified staff working for the programme

Key informants at district level felt that staffing at the DCO was inadequate to provide effective support to all programme activities at the district and community levels, particularly M&E, case management and reporting, among other things. During an observation at the DCO in Makueni, for instance, members of the study team saw people waiting for half a day to discuss various child-related issues. The DCO head has only one assistant and sees people only three days a week, with the other two days spent in the field and in court. This shows he has many issues beyond the CT-OVC programme to deal with. There is therefore a need to hire more qualified staff to address these shortages at the district level.

Incentives to community-level staff and volunteers/hiring personnel to work at community level

The programme currently relies on volunteers (VCOs and LOCs) to run activities at the community level. These two groups offer voluntary services and are not able to devote enough time to ensure effective implementation. If they were given some form of incentive, this could make their inputs more effective, systematic and sustainable.

Meanwhile, according to the DCOs, being part of the community means these actors also tend to have conflicts of interest in dealing with beneficiaries. As such, DCOs also suggested hiring non-community personnel to work at the community level.

Increasing staffing at national level and building capacity

Donor representatives pointed to the need to address staff shortages within the programme more broadly and also to build the capacity of existing staff. They observed that, as that the programme is scaling up rapidly, it will be necessary to match this through staff recruitment to ensure proper implementation. There is also a need to build the capacity of existing staff to effectively manage a scaled-up and devolved programme.

10.6 Community participation

According to stakeholders in CSOs and academia, mechanisms should be put in place to increase community involvement and participation in the CT programme. Such mechanisms could include, for example, publicity campaigns to create awareness and working with existing community-level structures such as church, youth, women and clan groups. Increased involvement and participation

are likely to lead to community ownership and, subsequently, demands for, among other things, accountability in the way funds are used from the national to the local level.

10.7 Programme scale-up

According to donor representatives, there is a need to scale up the programme in order to make an impact at the national level. As long as many OVC remain outside the programme, it will be difficult to feel its impacts on a national scale. Scale-up would require enrolling more vulnerable households, as recommended by beneficiaries and local leaders in the two study sites. Some respondents spoke about a waiting list, but it was unclear how long people have to wait before being enrolled in the programme. There was a general consensus among respondents that future programming should seek additional funding to enrol more households.

10.8 Conditionalities

Implementers at the district and community levels, echoed to some extent by programme beneficiaries, advocated for the introduction of tougher conditions to ensure accountability on the part of beneficiaries. Programme objectives were in fact viewed as conditions, but these respondents felt enforcement was not strict enough to ensure compliance. Both beneficiaries and other respondents felt that penalties other than being removed from the programme, for instance being made to account for how the money is spent, should be introduced for those who fail to comply. Implementers felt that conditions would ensure caregivers spent money on things that benefit OVC.

10.9 Integration of the programme with other SP programmes

Key informants at national level felt that implementing the currently standalone programmes could lead to duplication of efforts; there was an urgent need for coordination and some level of integration of all SP programmes as envisaged under the NSPP to enhance coordination and reduce fragmentation. Harmonisation of all CT programmes would not only create a national social protection programme, wherein all CT programmes are managed, but will also facilitate the exploration of modalities for a common payment system and targeting and a single registry. This would promote the sharing of experiences and create synergies for CT programmes in the country.

Programme implementers and donors felt that integration of the CT-OVC with other programmes for the vulnerable would enable beneficiaries to derive a great many benefits from social assistance programmes, including those related to education, health and food security. For instance, integration would make it possible to allow OVC to transit into other programmes for the vulnerable, such as bursaries covering their education up to university level. The current fragmentation in social assistance programming (e.g. in targeting) means vulnerable groups are denied the chance to benefit from access to a range of programmes, hence defeating the purpose of the overall SP policy.

The proposed establishment of a single registry for all SP programmes, which all social transfer programmes can use to avoid duplication of efforts, is a step towards integration. The register is meant to capture the details of everyone who is receiving any kind of SP in the country. Once a single registry is in place, all systems for CT will be linked. So far, only the Hunger and Safety Net Programme and the CT-OVC programme have robust systems; other CTs are operating on manual systems.

10.10 Sustainability

Interviews with programme implementers and decision makers at the national and district levels pointed to a need to look into the sustainability issue, given that donor funding is usually time bound. Political commitment will be necessary to increase the proportion of the government budget allocated to SP programmes. In 2010, government expenditure on SP was equivalent to 2.28% of GDP, whereas spending on safety nets alone was only about 0.80% of GDP. Key informants at the national level also recommended that, instead of spreading out SP programmes across different ministries, as is the current practice, it might be more sustainable to harmonise and integrate them all into one basket, to which a percentage of government funding is allocated every year.

10.11 Next steps

Findings from this study will be fed back in different formats at different levels, including community and district, national, regional (at a forum to be held in Nairobi, bringing together findings from the African countries) and international (in London). Visual materials, including photographs, videos and digital stories, will also be presented at these different levels, where appropriate.

After discussions with key stakeholders, both from the OVC-CT programme and within DFID Kenya and DFID London, four-page country briefings will be produced, drawing on the full reports and highlighting key findings and programme and policy recommendations tailored to country and programme contexts. These country briefings will be ready for the national, regional and international events.

A synthesis report and synthesis briefing will then be produced, providing an overview of findings and programme and policy recommendations, drawing also on the background literature review and the ethnographic work in Kenya, Mozambique and Uganda. This will be ready in time for international dissemination.

Finally, drawing on findings from all the above products, existing guidance and toolkits on participatory M&E and other relevant documents and debates (e.g. on value for money), guidance for beneficiary participation in monitoring and evaluation of cash transfer programmes will be developed.

References

Adato, M. and Bassett, L. (2008) 'What is the Potential of Cash Transfers to Strengthen Families Affected by HIV and AIDS? A Review of the Evidence on Impacts and Key Policy Debates'. Technical Report, Joint Learning Initiative on Children and HIV/AIDS, Learning Group 1: Strengthening Families.

Barrientos, A. and Hulme, D. (2008) *Social Protection for the Poor and the Poorest: Concepts, Policies and Politics.* Basingstoke: Palgrave Macmillan.

Barrientos, A. and Niño-Zarazúa, M. (2011) 'Financing social protection for children in crisis contexts', *Development Policy Review* 29(5): 603-620.

Baulch, B., Minh Nguyen, H. T., Thi Phuong, P. T. and Pham, H. T. (2010) *Ethnic Minority Poverty in Vietnam.* Working Paper No. 169. Manchester: Chronic Poverty Research Centre.

Bryant, J.H. (2009) 'Kenya Cash Transfer Programme: Protecting the Health and Human Rights of Orphans and Vulnerable Children'. *Health and Human Rights* 11(2): 65-76.

CBS (Central Bureau of Statistics), MoH (Ministry of Health) and ORC Macro (2004) 'Kenya Demographic and Health Survey 2003'. Calverton, MD: ORC Macro.

CPRC (Chronic Poverty Research Centre) (2008) *The Chronic Poverty Report 2008-09: Escaping Poverty Traps.* Manchester: Chronic Poverty Research Centre.

Devereux, S. (2010) 'Social Protection in Africa: Where Next?' Discussion Paper. Brighton: CSP, IDS.

Devereux, S. and Sabates-Wheeler, R. (2004) 'Transformative Social Protection'. Working Paper 232. Brighton: Institute of Development Studies.

DFID (Department for International Development) (2011) *Systematic Reviews in International Development: An Initiative to Strengthen Evidence-Informed Policy Making*. London: DFID.

DFID (Department of International Development) and GoK (Government of Kenya) (n.d.) 'Orphaned and Vulnerable Children Programme (OCV)'. Programme Outline. Nairobi: DFID and GoK.

Economic Commission for Africa, ILO, UN Conference on Trade and Development, UN Department for Economic and Social Affairs and UNICEF (2012) *Social Protection: A Development Priority in the post-2015 UN Development Agenda.*Thematic Think Piece. UN System Task Team on the Post-2015 UN Development Agenda.

Farrington, J., Slater, R. and Holmes, R. (2007) 'Linking Social Protection and the Productive Sectors'. Briefing Paper 28. London: ODI.

GoK (Government of Kenya) and UNDP (UN Development Programme) (2010) 'Progress in Attainment of MDGs and Way Forward Towards Achieving MDGs by 2015 in Kenya'. Draft, September.

Ha, W., Chai, J. and Alviar, C. (2010) 'Targeting in Kenya's Cash Transfer Programme for OVC'. Tunis: AfDB.

Hagen-Zanker, J. and Holmes, R. (2012) *Social Protection in Nigeria: Synthesis Report.* London: Overseas Development Institute and UNICEF Nigeria.

Handa, S., Pettifor, A. Thirumurthy, H. and Halpern, C. (2012). 'Effect of a national social cash transfer program on HIV risk behavior in Kenya'. Abstract for IXI International AIDS Conference 22-27 July 2012, Washington DC.

Harper, C. and Jones, N. (2011) 'Impacts of Economic Crises on Child Well-being'. Development Policy Review 29(5): 511-526.

Heinrich Boll Stiftung (2010) 'Climate Change Vulnerability and Adaptation Preparedness in Kenya'. Nairobi; Heinrich Boll Stiftung.

Helmke, G. and Levitsky, S. (2004) 'Informal Institutions and Comparative Politics: A Research Agenda'. *Perspectives on Politics* 2(4): 725-740.

Hickey, S. (2007) 'Conceptualising the Politics of Social Protection in Africa'. Working Paper 4. Manchester: BWPI.

Hickey, S. (2009) 'The Politics of Protecting the Poorest: Moving beyond the "Anti-politics Machine"?' *Political Geography* 28(8): 473-483.

Hickey, S. and Bracking, S. (2005) 'Exploring the Politics of Chronic Poverty: From Representation to a Politics of Justice?' *World Development* 33(6): 851-865.

Holmes, R. and Jones, N. (forthcoming 2013) *Gender and social protection in the developing world: beyond mothers and safety nets*. London: Zed Books.

Holmes, R. and Jones, N. (2009) *Putting the 'Social' Back into Social Protection: A Framework for Understanding the Linkages between Economic and Social Risks for Poverty Reduction.* London: ODI.

Holmes, R. and Jones, N. (2011) 'Why is Social Protection Genderblind? The Politics of Gender and Social Protection'.*IDS Bulletin* 42(6).

ILO (International Labour Organization) (2011) *International Labour Conference, 100th Session, 2011, Report VI: Social Security for Social Justice and a Fair Globalisation. Sixth Item on the Agenda.* Geneva: ILO.

Jones, N., Harper, C. and Watson, C. (2010) *Stemming Girls' Chronic Poverty: Catalysing Development Change by Building Just Social Institutions.* Manchester: CPRC.

Jones, N., Samuels, F., Gisby, L. and Presler-Marshall, E. (2011) *Rethinking Cash Transfers to Promote Maternal Health: Good Practice from Developing Countries.* London: ODI.

Kabeer, N. (2010) *Can the MDGs Provide a Pathway to Social Justice? The Challenge of Intersecting Inequalities*. Brighton: IDS and the MDG Achievement Fund.

Marriott, A. and Gooding, K. (2007) *Social Assistance and Disability in Developing Countries.* Brighton: Sightsavers International.

MGCSD (Ministry of Gender, Children and Social Development) (2009) 'National Social Protection Strategy'. Nairobi: MGCSD.

MGCSD (Ministry of Gender, Children and Social Development) (2011) 'CT-OVC: Operations Manual'. Nairobi: MGCSD.

MGCSD (Ministry of Gender, Children and Social Development) (2012) 'CT-OVC Status Report FY 2011-2012'. Nairobi: MGCSD.

Ministry of State for Planning and National Development and Vision 2030 (2012) *Kenya Social Protection Sector Review*. Nairobi: Government of Kenya.

Molyneux, M. (2009) *Conditional Cash Transfers: A 'Pathway To Women's Empowerment?* Pathways Working Paper 5. IDS, Susses. ISBN: 978 1 85864 562 X (http://www.pathwaysofempowerment.org/PathwaysWP5-website.pdf

Molyneux, M. (2007) *Change and Continuity in Social Protection in Latin America: Mothers at the Service of the State*? Geneva: UNRISD.

Musembi, D.N. (2010) 'Results on Operational Impact Evaluation of the Cash Transfer for Orphans and Vulnerable children (CT-OVC) Program in Kenya'. Nairobi: World Bank.

NBS (National Bureau of Statistics) and ICF Macro (2010) 'Kenya Demographic and Health Survey 2008-09'. Calverton, MD: ICF Macro.

OECD (Organisation for Economic Co-operation and Development) (2011) *Perspectives on Global Development 2012: Social Cohesion in a Shifting World.* Paris: OECD.

Pearson, R. and Alviar, C. (2009) 'Cash Transfer for Vulnerable Children in Kenya: From Political Choice to Scale up'. Policy and Practice. New York: UNICEF.

Razavi, S., Arza, C., Braunstein, E., Cook, S. and Goulding, K. (2012)*Gendered Impacts of Globalization: Employment and Social Protection.* Geneva: UNRISD.

Sabates-Wheeler, R. and Waite, M. (2003)'Migration and Social Protection: A Concept Paper'. Working Paper T2. Brighton: IDS.

Samson, M, van Niekerk, I. and MacQuene, K. (2011) *Designing and Implementing Social Transfer Programmes.* Second edition. Cape Town: EPRI.

UNAIDS (Joint UN Programme on HIV/AIDS) (2004-2010) *Global Reports.* Geneva: UNAIDS.

UNDP (UN Development Programme) (2003-2011) *Human Development Reports.*New York: UNDP.

UNICEF (UN Children's Fund) (2011)*The State of the World's Children in 2011*. New York: UNICEF.

UNICEF (UN Children's Fund) and GoK (Government of Kenya) (2010) '2009 Situation Analysis of Children, Young People and Women in Kenya'. Nairobi: UNICEF and GoK.

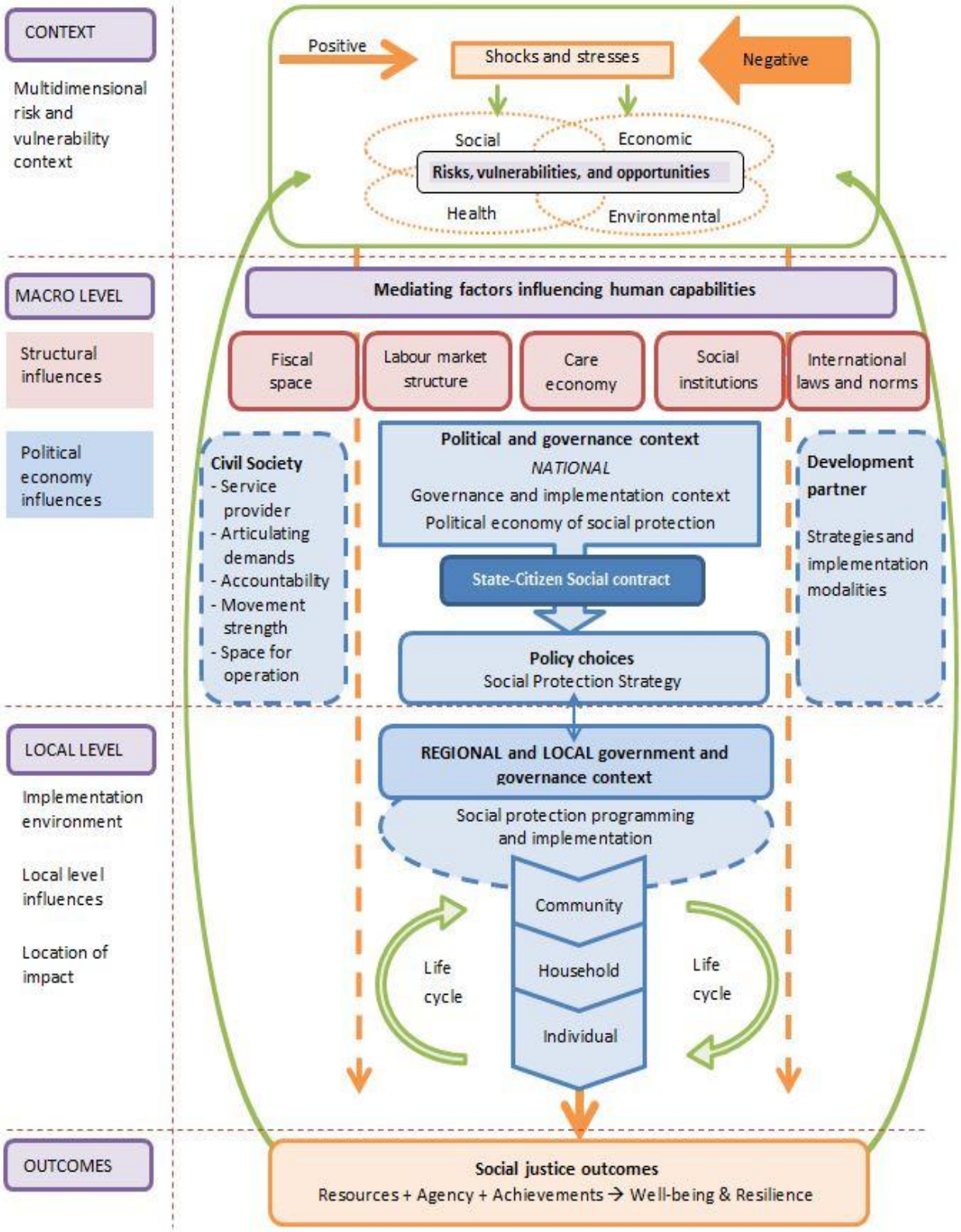
UNRISD (UN Research Institute for Social Development) (2010) 'Why Care Matters for Social Development'.Research and Policy Brief 9. Geneva: UNRISD.

Ward, P., Hurrell, A. Visram, A., Riemenschneider, N., Pellerano, L., O'Brien, C., MacAuslan, I. and Willis, J. (2010) 'Cash Transfer Programme for Orphans and Vulnerable Children (CT-OVC), Kenya: Operational and Impact Evaluation, 2007-2009 Final Report'. Oxford: OPM.

World Bank (2011) 'Kenya Cash Transfer Programme for Orphans and Vulnerable Children'. Aide Memoire, Joint Review and Implementation Support Mission. Washington, DC: World Bank.

Annexes

Annex 1: Complete Conceptual Framework Diagram



.....

Annex 2: OVC fieldwork matrix

Tools	When	With whom
Social / community mapping When identifying homesteads, including themselves, make sure they say who is beneficiary and who is not, who was/ex beneficiary. Institutional mapping If enough time after the social mapping, do the institutional mapping with the same group.	At very beginning	Large group -10-15 people, CT beneficiaries and non-beneficiaries
Poverty and coping strategy mapping Done together	At the beginning, first day of possible, perhaps in the afternoon, after the social/community mapping	Between 8-10 people, different group from those doing the social and institutional mapping.CT beneficiaries and non-beneficiaries
Historical time-line / trend (see also notes)	Whenever is possible. Could also link to the above tools if people have the time, are willing to speak, etc.	Small group of older people, include some who know about the CT programme
Observation (3 observations per site)	Whenever the situation arises, according to what you find in the area...	
Key Informant interviews (6-8)	As and when you find them. Perhaps do KIIs with DCO and VCO early on so can also help with entry into the area.	District children's officer Volunteer children's officer Teacher / head teacher Women's group leader Elders /com. leader A member of BWC Youth leader Religious leader
Case studies (2 per site) Aim is to understand the person in their broader household context Use the IDI guide as starting point Involves informal conversations, observations at different times of the day, hanging out, drawings, etc. Speak to different members of the household asking similar questions but tailored to them You may have to go back a few times to the household	Identify quite early on with help from VCO so that can build rapport with this person, their household, family, etc.	Grandmother/care giver (looking after many OVC)- current beneficiary HIV+ caregiver or OVC if consent given If you find someone who has graduated from the programme can do case study with them
Life histories (4-8 per site) Follow tool; draw lines of flip chart; record interviews; translate and transcribe; draw /reproduce charts in word	Throughout, not at very beginning, after the participatory tools. VCO can help with selection, also can identify interesting cases through the group meetings.	All beneficiary households, have been in programme for as long as possible: Grandmothers (2) Grandfather (1) Mothers (1) Men (1) Youth (1) Include former beneficiary to see if

Tools	When	With whom
		transfer made any difference
IDIs (10 per site) IDI beneficiary adult IDI beneficiary child IDI non-beneficiary adult IDIs should be selected from the poorest households according to their own poverty ranking, see above. So use poverty ranking criteria given by the community together with support from the VCO in selection the IDI respondents.	After the community mapping. From then onwards.	Grandmothers/caregiver/beneficiary /female headed household(2) MHH / beneficiary (1) FHH (not a grandmother) beneficiary (1) HIV+ beneficiary household (1) Children beneficiary CHH (13-17age)(female or male as appropriate) (1) Child beneficiary (8-12age)(female or male depending on above, i.e. no the same)(1) Grandmother non-beneficiary caregiver (1) FHH non-beneficiary (1) Male (father or grandfather) non-beneficiary caregiver (1)
FGDs (6 per site) FGD beneficiary adult FGD beneficiary child FGD non-beneficiary adult (Ensure that the FGD is in area where poorer people reside/ density of programme participants)	After the community mapping. From then onwards.	Adult female beneficiaries (1) Adult male beneficiaries (1) Children beneficiaries (9-13;14-17) (2) –one with boys one with girls, as appropriate Adult non-beneficiaries female (1) Adult non-beneficiaries male (1)

Annex 3: Study tools and guides

FGD – Beneficiaries main study – adults

Undertake a detailed household level vulnerability mapping and explore the following:

Selection of FGDs should help to illuminate differences between socio-economic groups

Theme 1: key vulnerabilities and coping strategies [*spend no more than 15 mins discussing the vulnerability context*]

- What are the key challenges people face in this community? As individuals? Within the household? Within the community?(Probe: food insecurity, disability, health (HIV), drought, social exclusion, discrimination (on basis of age, gender, ethnicity), violence/ conflict, etc.)
  - Are there particular challenges faced by children, young people in this community?
  - Are there any noticeable changes in challenges faced in this community (over time; according to the season; according to the type of difficulty)
- What are the key coping mechanisms used in this community? What do people do when in difficulty? (probe: reduce consumption, take on more work, ask non-working family members to take on more work, selling assets (whose assets? women's vs men's), engage in labour-sharing strategies, labour pledging (lack of control when labour returns are demanded = sign of deep distress), borrow/ go into debt, ask for support from extended family or friends, migrate domestically or internationally, rely on remittances)
  - Are there particular coping mechanisms that affect children (probe for boys and girls)? (probe: withdrawal from school; child work; fostering; reduced frequency/varietyof meals; other)
- If you had more money, what would you spend it on (e.g. health, education, buying land, setting up a small business, etc.)?

Theme 2: CT programme

History and membership:

- What do you know about the programme goals? How did you find out about this?
- How are people selected to receive the cash?
  - Describe the process/your experiences of the process
  - Who selected them?
  - What do you think about the selection process? Has it changed over time? (e.g. rotation of households as programme beneficiaries?)
  - What has been the effect of this selection process on community relations, dynamics? (e.g. positive, negative)
  - Do some people receive the cash transfer who shouldn't receive/are there some people who deserve it and who don't receive it? Why do you think this is?
- Have you had any training/education about the programme? Have you received any information about the programme? If so, who provided this? In what format?
- What do you expect you will get from programme participation? Why?

Access and distribution:

- How much cash is given? How often? By whom? To whom?
- How or where distributed? Is the frequency of receiving it sufficient?
- How far away is the collection point? Are there safety issues in accessing the cash? (esp. for girls/ women)
- Is the amount of cash adequate?
- Are the payments regular and predictable?

- Are there conditions (formal and informal) attached to receiving it (e.g. attend an awareness-raising session, send children to school, send children to hospital, etc.).? If so, what and how are these enforced? If no, do you think there should be conditions? Which?
- In addition to the cash is anything else given (information, links to other services, preferential access to other services, etc.)? What do you think of this?

- Do you think cash is the best/most appropriate item to give to vulnerable households and groups? If no, what else could be given?

Use *(fill out a matrix to fill..)*

- What do people use the cash for?
- Who within the household decides how the cash should be used?
- Do you think the cash is used in the best way possible? If not, how could it be improved?
- Are there particular uses of the cash that most concern children (school fees, books, uniforms, shoes, nutritious food); if so, what and how are these decided upon?

HH description	**Use of money? (e.g. small business, consumption, service access for kids, transport); proportion of money spent on x item (including e.g. bribes)**	**Who decides on the use?**	**Has decision-making on money in your household changed since the introduction of the CT programme?**	**If you had more money, what would you do? What would you use the money for?**
e.g. type of household (widow, grandmother care giver, male headed households, female headed household				

Effects

- What are **positive** effects of the cash transfer?
  - On **individuals** (probe re age, ability, gender differences), **households** (probe re male vs female headed households, extended family hhs, polygamous households, etc.), on the **community** as a whole? (both in terms of bonding social capital – i.e. links to peers – and bridging social capital – i.e. links to authorities)?
- What have been the specific effects of the cash transfer on the children in your household (can be both positive and negative)? (e.g. stigma, exclusion at school, less pressure to engage in sexual favours)
- In thinking of the most significant ways this programme has changed your lives, what comes to mind?
- What are the **negative** effects of the CT programme? Has it created tensions/problems/issues/ conflict within the household, between households, communities, including between those who have received the cash and those who have not? If so, how have these tensions been manifested?
- What do you think could be done to ease these tensions?
- Are there other people like you but who are not on the programme? How have things changed for your household compared to them over time? (e.g. building assets)

Accountability

- Overall, are you satisfied with the programme and the way it is working in your community?
  - This programme is supposed to reach the poorest/OVC households, do you think this is happening in reality?
  - Some people say the cash is going to the wrong people? What do you think? Is this a problem in this community?

    - Some people say they are not being treated respectfully by programme staff? Is this a concern in your community?
- Supposing you were not selected onto the programme, is there anything you could do to address this? Complain? Etc.
- Supposing you were treated unfairly, what would you do?
- Do you know of processes in place to ensure that everyone receives the same amount?
- Is there occasion / a process for you to voice your concerns? If yes, to whom, when, how often?
    - Is there an official process/system in place for complaining?
    - If there is a complaint system, do you think it could be improved? What type of mechanism would you prefer (talking to an elected representative? Speaking to village head? Speaking to clinic staff? Speaking to a programme implementer? Voicing concerns on local radio? Via text or mobile phone (an anonymous method), prefer not to have a complaint system
    - Have you ever voiced a concern/made a complaint? To whom, about what? Why/ why not?
        - What happened after you voiced your concern?
        - Were you concerned about being victimized/punished as a result of voicing your complaint?
- Are you aware of any evaluation processes? If so have evaluation findings been shared with you?

Theme 3: complementary services / programmes

- Are there other types of services/ programmes you would like to be linked to/ benefit from? (e.g. education bursary, child sponsorship, violence prevention, legal aid, agricultural training, livelihoods programming, micro-finance groups, vocational training).
    - How could programme implementers help you access these other services or programmes?
- In some countries, people have an ID card which helps people access different types of programmes to which vulnerable people are entitled.
    - Which types of programmes do you think they should be entitled to?
    - Do you think this type of system, i.e. with the ID card, would be helpful? (e.g. In Ghana, CT programme beneficiaries, are supported to get access to subsidised health insurance).
    - Could there be difficulties in getting this to work? (e.g. doing paper work and negotiating redtape to establish documentation, paying for brokers if illiterate, issue of fake ID cards, sharing of ID cards, need for birth registration, travelling to govt offices to register, etc.).
    - If there you think there could be difficulties, what could be done?

Theme 4: Future directions

- If the programme were discontinued, what effects would it have on your life (e.g. no longer able to invest inx , y etc.?
- How would you see the programme continuing in the future?
    - What changes would you make, if any?
    - What could be improved? (probe: targeting, frequency, amount, complementary programmes, links to information, evaluations/ lesson learning etc.)
- How members in the community could become more involved in the programme, be given a say in it?(e.g. suggestion/complaint line via text/ mobile phones)

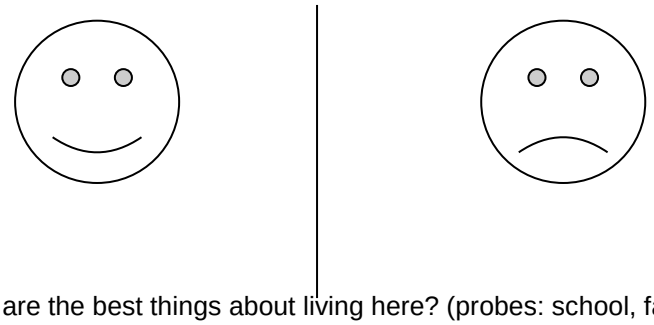
FGD – Beneficiaries main study – Children

Background questions

- Do most children attend school here? If not, why not? (e.g. not enough money to pay for fees, books, etc.)?
  - Are there any particular groups of children who do not attend school? (make follow up)
  - Who usually goes to school in the family (brothersvs sisters, younger vs older siblings?)
- If you go to school, what is your experience like? How is it like being at school (positive, negative, mixed…)? (differences by boys vs girls, younger vs older children).
- Do you eat before you go to school? If so, what...
  - Do you get enough food?
  - Do you get school meals? Does everyone get school meals...
- [for 13-17 yrs group) What typically happens to children once they leave primary school? (e.g. leave school, go to secondary school, find a job, get married, get pregnant, migrate to towns/cities to find work, stay with relatives).
  - Are there any opportunities for vocational training in your area? Do most young people who want to participate in such training? If not, why not?
- What activities do children do in the household? According to different age groups (8-12, 13-17), boys or girls...
- Do children here do any paid work? If so, which type of children? Which age? What do they do, when, how often....
- Do you know about children's rights? What are these? Who can help you access them?

Part one: Happy and sad face exercise

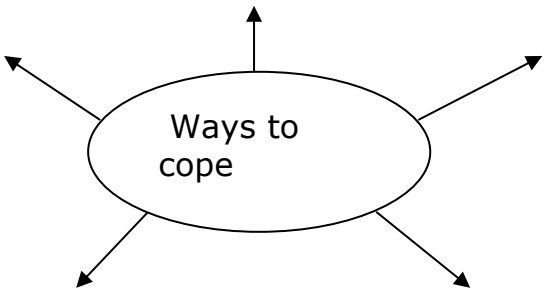
The facilitator would start the session by drawing on the flip chart a smiley face on one side of the paper and a sad face on the other, with a line drawn straight down the middle. They would then ask the group about what they thought were the best things about living in their community followed by the not so good things. Responses would then be written below the corresponding face. The purpose of the exercise is to elicit information on what children think are the key issues in their communities. The facilitator should try to encourage responses that think about both the wider community members and about their own individual situations.



- What are the best things about living here? (probes: school, family, friends, play)
  - Encourage participants to think about other people in the community (girls/boys, men/women, disabilities, older people etc) as well as about children, young people and their own situation.
- What are the not so good things about living here? (probes: poverty, illness, fear, danger) (Encourage participants to think about challenges and obstacles that different people face as well as what they personally think)
  - What are some of the main difficulties that you face, and that your family/household faces? (e.g. threats, violence towards children, abuse, neglect)[probe for differences between boys and girls]
  - When your family experiences such difficulties, how does this affect you as children? (probe do you take on any additional tasks in the household? Do you try to work to earn money? Do you continue to go to school? Do you have enough time to do the things you want to do, e.g. homework? Can you get support from others? If so, whom?)} [*Daily activity analysis*]

Spider diagram

To move the discussion forward to thinking about how what children do to cope with the 'not so good things' in their community, a spider diagram should be used to facilitate a discussion. The title 'Ways to cope' would be written in a bubble in the centre of the flipchart and lines drawn out from the bubble would point to responses given by participants which are written as and when they are given.



- How do children and young people cope with these difficulties? How are their coping strategies different to those of adults? Do different types of children have different ways of coping? (e.g. girls vs boys; able bodied vs not; etc.)?

Part 2: Perceptions of the CT programme

The facilitator would start this part of the FGD with a brainstorm of what the children already know about the cash transfer programme. A spider diagram could be used or alternatively a list could just be written on the board.

- What do you know about the cash transfer programme[18]? (probe: purpose, targeting, amount, history) (Spider diagram). Are any of you currently members?
- Do you know how and why families/households are selected to participate in the programme?
- Do you know why some families/households are not selected to participate in the programme?
- Do you know how much cash participating families/households receive, who within the household receives this, and what it is intended for?
- Do you know how households/families use the money they receive?Is any of the money used on things or activities that are of special or direct benefit to children?)

Effects

- Has this programme changed your life in any way? (e.g. access to school, better food, access to medicine, less time doing chores, less time doing paid work)
- What have been the positive effects for children? How does the money help them? (probes:reduce poverty, help families pay for basics e.g. food/school/transport, reduce discrimination/social exclusion)
- In thinking of the most significant ways this programme has changed your lives, what comes to mind? (brainstorm and rank/score – 1 to 5...)
- Have there been any negative effects? ((brainstorm and rank/score – 1 to 5...)
- Are children in households who receive cash transfers treated differently to those who don't? How? (probes: by peers, teachers, adults)

Theme 4: Future directions

- What changes do you think should be made to make the programme better?

[18] Note that it may not be called a cash transfer programme and will therefore need to be substituted with the local name and a short explanation of what the programme aims to do so even if people aren't familiar with the name they may be aware of such government support.

- How do you think the programme could be improved to better respond to the needs of children?
- What types of help do vulnerable children receive here? How helpful are the cash transfers compared to these other types? (List, and rank could use a scale of 1-5)
- Is it important to listen to children's views? If so, why?

IDI – programme beneficiaries main study - Adults

Probes:why, what, where, how, when, who, how often...

Probing sentences:

- ***Tell me more about it...***
- ***What do you mean by that ...***
- ***Can you explain better / more....***
- ***Give me examples...***
- ***How is that / how /what do you mean....***

1. Family status and living arrangements

- Adults: Are you married, since when, who do you live with, the number of children you have, number of other dependents (e.g. older family members, members living with a disability or illness), who is the primary care-giver in your household?

2. Household and individual livelihood and coping strategies

- What do you do to survive/ what are your main activities? What about other family members?
- How do you make money?
- What is division of labour and economic assets in the household/ who does what activities? And why? Who owns what?
- What difficulties/challenges, etc do you face? When in difficulty what do you do? What are your coping strategies? How effective are these/each coping strategy (after each coping strategy ask how effective is it...)?

3. Social networks (highlight differences between men/women, older/younger, etc.)

- If you are in trouble, need financial support, feeling sad, etc. what do you do? Who do you turn to (state, family, church, ..spider diagram)?/ where do you go? What support do you receive (emotional, economic, in-kind).
  - Do you give support to others? Who, for what? Has this changed over time...
  - Have your social relationships/networks changed over time (also because of the CT programme)? Have they become stronger / weaker? How, why, since when...
- Are you a member of a group? (formal and informal, e.g.kin or clan groups, merry go round, church groups, etc.) Since when? What do you do/ what are the objectives of the group? How many members are there? How do you become a member? How often do you meet? What benefits do you get from belonging to the group?

4. Intra-household dynamics / tensions

- Who makes the decisions and controls resources (cash, land, animals, buildings, family members' labour, family members' time, etc.) in your household? Why is this the case? Has it always been like this? / Who makes decisions in the household over what types of issues? Care of children, elderly, sick? Use of other people's labour? Consumption? Sale of assets?
- Do you have disagreements within the household/family? If so, over what? When you face disagreements with other family members how do you resolve them? What happens? Has this changed? If so why, since when, etc.?

- If the household faces a problem, what do you do? What processes are involved for resolving the problem?
- Are you aware of the rights you have as a adult/woman/man? What are these? Who can help you access them?

5. The CT programme; membership/targeting

- Since when have you been a member of the programme/receiving a cash transfer? / how long have youbeen a member of the CT programme?(duration)
- What do you know about the programme goals? How did you find out about this?
  - Have you had any training/ information or education about the programme? If so, who provided this? In what format?
- What do you / did you expect you will get from programme participation? Why?
- How were you selected? Who selected you?
  - What process was involved? What did they do to select people?
  - What did you think of that process, was it fair/unfair? Why?
- Are you the only one in your household currently receiving the cash transfer? If no, who else, since when? If yes, has anyone ever received? If yes, who, when stopped receiving, why?
- Do you think the right people receive the cash transfer? If no, why?
  - Do you think there are some people who should have received but didn't? If so, which people and why?

Access/distribution

- Where do you go to get the cash? Who gives it to you?
  - Is it the same person/place every time?
  - Do you go alone or does someone accompany you? If yes, who, every time, etc.
- How much do you receive?
  - Has it always been the same amount? If it changed, when, why?
  - Is the amount of cash adequate? (if no, why not..)
  - Do you think cash is the best/most appropriate item to give? If no, what else could be given?
- How often do you receive the cash?
  - Are the payments regular and predictable?
  - Is the frequency of receiving it sufficient, should it be more/less frequent?
  - When was the last time you received the cash?
- In addition to the cash is anything else given (probe: information, links to other services, preferential access to other services, etc.)?
  - What do you think of this? Is there anything else you would want them to provide?
  - Since when have they been providing these other things?
- Are there conditions attached to you receiving the cash? (do you have to do certain things to receive the cash, e.g. attend an awareness raising session, send your children to school, etc.).If so, what? If no, do you think there should be?
- What challenges have you faced in accessing/getting the cash? (probe: time to travel to receive it, other costs involved in travelling, loss of labour time, stigma associated with receiving it, etc.)

Use

- Who collects the cash in your household? Who keeps the cash? Has it always been like this? If it has changed, when, why, etc...
- What do you think the cash should be used for? / are you given instructions on how the cash should be used? If yes, who gives you this information?

- What do you use the cash for?
  - Who decides what to use the cash for?
  - Last time you received it what did you do with it?
  - Is any of the cash used for things that are of particular benefit to your children? If so, what? / Are there particular uses of the cash that most concern children (school fees, books, uniforms, shoes, nutritious food); if so, what and how are these decided upon?
  - Do you think the money is used in the best way possible? If not, how could it be improved?
  - What types of changes would facilitate improvements/allow you to better use the money?
- What are your sources of household income (including the CT)? Rank them in terms if importance (1 most important, to 5 etc. least important).(How important is the CT to you /your household expenditure? How does it compare to other transfers / income coming into the household? If small, big, why , etc.?)
  - What would happen / what would you do without if you did not have it?
- {What proportion of your total expenditure does the CT support? ***(Pie chart - go through different expenditures and where income comes from for each expenditure)}***

Effects

- How was your life before you received the cash transfer? (probe: economic, social, inclusion/exclusion aspects).
- What are **positive** effects of the cash transfer?
  - On you as an individual (probe re age, ability, gender differences),
  - On your family/household - certain members of your household, which, why (probe re male vs female headed households, extended family hhs, polygamous households, etc.),
  - On the community as a whole (both in terms of bonding social capital – i.e. links to peers – and bridging social capital – i.e. links to authorities)?
  - What effects has the cash transfer had on your life?
    - Has it changed your relationship with your spouse? If yes, how, for the better/worse?
    - Has it changed your relationship with other members of the household? If yes, how, for the better/worse?
    - Has it changed your status in the community? If yes, how, for the better/worse?
- What have been the specific effects of the transfer on your children? (e.g. stigma, exclusion at school, less pressure to engage in sexual favours)
- What are the **negative** effects of the CT programme?
  - Has this programme created tensions/problems/issues between people, including between those who have received the cash and those who have not? If so, how have these tensions been manifested/how can you see these tensions?
  - What d'you think could be done to ease these tensions?
- If the programme were discontinued, what effects would it have on your life (e.g. no longer able to invest in x or y)?
- Are there other people like you but who aren't on the programme? How have things changed for your household compared to them over time? (e.g. building assets)

Accountability

- Overall, are you satisfied with the programme and the way it is working in your community?
  - This programme is supposed to reach the poorest (OVC households/ the most vulnerable, women/ female-headed households, disabled people, etc. **– tailor to country context**) ? Do you think this is happening in reality?

    - Some people say the cash is going to the wrong people? What do you think? Is this a problem in this community?
    - Some people say they are not being treated respectfully by programme staff? Is this a concern in your community?
- Supposing you were not selected onto the programme, is there anything you could do to address this? Complain?
- Supposing you were treated unfairly, what would you do?
- Do you think / know of processes in place to ensure that everyone receives the same amount?
- Is there space/occasion for you to voice your concerns?
    - Is there an official process/system in place for complaining?
    - If there is a complaint system, do you think it could be improved? What type of mechanism would you prefer (talking to an elected representative? Speaking to village head? Speaking to clinic staff? Speaking to a programme implementer? Voicing concerns on local radio? Via text or mobile phone (an anonymous method), prefer not to have a complaint system?)
- Have you ever voiced a concern/made a complaint? If yes, to whom, about what? If not, why not?
    - What happened after you voiced your concern/made a complaint?
        - Were you concerned about being victimized / punished as a result of voicing your concern? Were you victimized / punished? How? Etc...
- Are you aware of any evaluation processes? If so have evaluation findings been shared with you?

Future directions

- How would you see the programme continuing in the future?
    - What changes would you make, if any?
    - What could be improved? (probe: targeting, frequency, amount, complementary programmes, links to information, evaluations/ lesson learning etc.)
- How could members in the community become more involved in the programme, be given a say in it?(e.g. suggestion/complaint line via text/ mobile phones, etc.)

IDI – programme beneficiaries main study – children (10+)

Family status and living arrangements

- Children: How old are you? Who do you live with? How many siblings do you have? Who is your main/primary care-giver? Are you responsible for taking care of any one?

Household and individual livelihood and coping strategies

- What are your main activities? Inside the household (household chores; looking after other children, etc.) Outside the household (agricultural-related activities; other).
    - Do these differ for boys and girls?
- Do you go to school? If yes, which grade? If no, when left (if went), why, etc.
- Do you engage in any activity which brings you money? If yes, who asks you to do this? What happens to the money you get? What do you do with the money you make? Who do you give the money to?
- When your family is in difficulty (e.g. lack food, someone is unwell, lack money, etc), how does this affect you? (probe Do you take on any additional tasks? Do you continue to go to school? Etc.)

Social networks (highlight difference between girls/boys):

- Do you have friends here? How often do you meet with them? What do you do? Where do you go, etc.

- If you are in trouble, e.g. need support at school, financial support, feeling sad, etc., what do you do? (Where do you go? Who do you turn to? What kind of help do you receive (emotional, financial, material (food), etc.)?
  - Have you changed friends over time? Have you more friends now than before? Or less friends now than before? How, why, since when...
- Are you a member of any group or club (at school, in your neighbourhood)?If so, since when, where/which? What do you do in the group? How many members are there? How do you become a member? How often do you meet? What benefits do you get from belonging to the group? If you're not a member of a group or club, why?

Intra-household dynamics / tensions

- Are you consulted by your parents or family on issues that concern you? / Do you parents ask for your opinion in matters that concern you? If so, on what issues? If not, who makes the decisions that concern you?

The CT programme

Specific questions for children:

- Do you know anything about the CT programme? What do you know?
- Since when has your family been a member of the programme/receiving a cash transfer?
- Do you know how your family was selected?(Who selected you? What process was involved? What did they do to select people? What do you think of that process, was it fair/unfair? Why?
- Who in your household is currently receiving the cash transfer?
- Do you think the right people receive the cash transfer? If no, why?
  - Do you think there are some people who should have received but didn't? If so, which people and why?

Access/distribution

- Who in your household receives the cash? Do you know where they go to do so and how often? Do they have any difficulties in receiving the cash?
- Do you know how much cash is received? Is anything else received in addition?
- Do you know if the cash is supposed to be used in a particular way or for a particular purpose? If so, what?

Use

- What does your family/household use the cash for?
  - Who decides in your family what to use the cash for?
  - Last time, what did your family use it for?
  - Was some of the cash used specifically for things that are of benefit to you or your brothers and sisters?

Effects

Has this programme changed your life in any way?

- What are some of the positive effects of the cash transfer?
  - On you
  - On your brothers and sisters?
  - On your family?
- Can you describe any ways in which your life has changed since receiving the transfer?
  - In terms of your activities (at home, school, in the community
  - In terms of your relationships(at home, school, in the community)
  - In terms of how you feel (physically, emotionally)

- In thinking of the most significant ways this programme has changed your lives, what comes to mind? ((e.g. access to school, better food, access to medicine, less time doing chores, less time doing paid work)
- Have there been any negative effects?

Future directions

- How could the programme be made better to improve the situation of children?
- If the programme stopped, how would this affect you?
- What other types of help do you receive? How important is this programme compared to these other types of help (list and rank)
- How could you as a child become more involved in the programme in the future?

Life Histories – with adult and youths, male and female

The aims of the LHs are:

- To explore in-depth individuals' experiences of risk and vulnerability, and the individual, household, community and policy-level factors which shape available coping/resilience strategies
- To gain an understanding of the relative importance of the cash transfer programme over time and in diverse individuals' lives

Scope:

- In each site 8 life histories will be carried out amongst beneficiaries of the CT programmes. They will be identified during the FGDs and KIIs, but will likely include 1 male and 1 female youth and 3 female and 3 male adults.
- The interview will last approximately 60 minutes
- The respondent will be given a drink in recompense for their time

Preparation:

- As the other interviews, once oral consent is taken, the LH will be recorded and then translated and transcribed verbatim
- Additional notes, observations, will be noted by the researcher
- A sheet of paper and pens need to be brought to the interview

Please be prepared that in some cases a LH will not work so if after around 10 minutes the researcher feels that it is not working either they should bring the interview to an end politely, or convert the conversationinto an IDI. This may be especially the case with youth who have shorter histories to be reflected on and probably less experience at articulating their life story.

Please also be prepared that people who have suffered various tragedies may not want to speak in any detail about these and researchers need to be sensitive as to whether they should continue the discussion, give the person the option for a short break, or whether being a sympathetic ear is in fact of value.

Guiding questions (youth/adult; male/female)

Introductions

- Basic background information (name, age, place of birth, living arrangements etc)
- Explain the objectives of this study and the format of the interview

About the CT programme

- Since when have you been a member of the programme/receiving a cash transfer?
- How were you selected? Who selected you?
- Where do you go to get the cash? Who gives it to you?

- How much do you receive?
- How often do you receive the cash?
- In addition to the cash is anything else given (probe: information, links to other services, preferential access to other services, etc.)?
- Are there conditions attached to receiving it? If so, what? If no, do you think there should be?
- What do you use the cash for?
- How would you rate the relative importance of the programme compared to other forms of formal or informal social support (e.g. from friends, relatives, neighbours, NGOs, etc.)?

Individual recent past (2/3 years for youth, 5 years for adults)(give examples whenever)

- Can you tell us about your life over the last two or three / five years?
- Has anything gone particularly well during this period? What have been the positive changes? Who and what was responsible?
- What particular challenges have you faced over the last two or three/five years (longer period for older people)?
- Can you explain why you think you faced these challenges?
- Have you / your family tried to overcome these challenges? What strategies have you used? How well have these strategies worked? How important have your family resources / networks been in assisting you overcome challenges? Have they changed, deteriorated, improved, etc. over time, then, now?
- Have other families in the village also used these strategies to overcome similar challenges?
- How do you think your options / strategies have been similar or different from girls/boys, women/men (opposite sex to interviewee) of the same age?
- Has the CT programme provided support to overcoming these challenges? If no – why not? If yes - in what way?
- When the programme begun, how was it working? How is the programme working now?
- How has being a member of the CT programme influenced your choices and decisions?
- How might access to a CT programme earlier in your life have shaped your options had it been available?
- Have you taken steps to secure your future, i.e. investing in assets, etc. with the idea that you might leave the programme?

Interviewer draws key events on a timeline over the past two/three or 5 years in order to summarise content (STEP 1 in diagram below).

Longer past

Interviewer uses a longer visual timeline to prompt the discussion around the longer past (e.g. interviewer draws a longer timeline underneath the one above (shorter timeline) and draw arrows between the two to show connections) (STEP 2 in diagram above).

- Thinking back to when you were younger, can you map out **key events** in your life up until now (positive and negative) Why have these been important?
  - At individual level (e.g. schooling, health)
  - Household level (e.g. livelihood opportunities; available household resources; decisions in the household to spend on schooling, health, income generating; changes in the family (birth, death, marriage, divorce etc));
  - Community level (e.g. discrimination/exclusion from community activities or resources; exclusion from participating in community decision making, violence)
- How has the way you and/or your family lived life until now influenced the way you deal withthe challenges you identified before?
- Do you ever think that if you had made a different choice before, your life would be different now? What would you have done differently?

- How might access to a CT programme earlier in your life have shaped your options had it been available?

Future plans (please note that in some instances (e.g. if the person is elderly, very ill) questions about the future may be sensitive so these may not be appropriate to ask at all, or they should be asked quickly)

- Given your present circumstances what are you planning to do in the short term? What are your longer term plans?
- How do you think your options are similar or different from someone from the opposite sex of the same age?
- To what extent can the CT programme help you achieve your short term and longer term plans?
- How would you change the CT programme to better meet your needs?
- Is your view the same as others in the household or do different members have different opinions?

Key informant interviews – community leaders, programme implementers, government policy makers, social protection analysts - main study

From national level stakeholders get organogram of key policy and programme staff at different levels involved in the CT programme

Community leaders

Themes to cover:

- What is your role in the CT programme/What's your relationship to the CT programme?
  - Are you involved in identifying beneficiaries? If, so how?
    - What are the main issues, problems, challenges in identifying beneficiaries (probe validity of identify, what happens for newly vulnerable)
    - How do specific groups get identified, registered?
    - Are the numbers of potential beneficiaries restricted? How do you then select among the eligible?
  - Are you involved in programme implementation, monitoring
    - What are the main issues, problems, challenges in programme implementation, monitoring
  - Do you work with programme implementers? If so, how
- How do beneficiaries access the cash? Are there issues/concerns? (risks of cash being stolen, do they need brokers, etc.)
- How do community members perceive the CT?
  - What do you think their expectations are? How they will benefit from it?
- Are there awareness raising activities linked to this CT? (e.g. when transfer occurs is there a community meeting? If so, what does it entail?
- Effects of the cash transfer:
  - how has the programme affected the community as a whole (positive, negative), how has it changed over time (lasting change or more transient change only?);
  - have excluded groups become more empowered/vocal/involved;
    - have women, disabled, etc. become more empowered; if so, how can this be seen?
    - Are people/excluded groups more able to speak to people in authority, to demand their entitlements, rights, etc.?
  - has the programme had any unintended spin-offs/benefits; (healing divided communities/reinforcing social divisions, social division /fragmentation)

- compared to other programmes/sources of support (church, remittances, NGOs, etc) how do you see this programme? How important is it compared to these others? (amount, type of support (psycho-social support), consistency, regularity, etc.)

- Eligibility
  - Is it fairly targeted, do you think some people have benefited more than others? If yes, which, why?
  - Does it reach the most vulnerable groups? (insert probes around particular vulnerable groups, OVCs, elderly, disabled, etc.)
  - Are there some people who are not receiving it but deserve it? Are there some people who receive it but don't deserve/need it?
    - Have you actively intervened to influence the selection process? If so, how? Why?
    - Have you ever had to intervene to actively remove people from the programme? How? Why?
    - How could the programme guidelines be adapted to your community needs/dynamics?
- Challenges
  - What are the main obstacles to the programme working well? (unavailability of cash, not regular, capacity and attitudes of staff, etc.)
  - Has it created any tensions – for example between beneficiaries and non-beneficiaries, or within the household between men and women, siblings, older and younger people, etc.?
  - Has the programme led to tensions in the wider community? if so, between whom and who, why, what can be done to address these?
  - Do they think recipients would prefer to receive something else? If so, what?
  - Do they think conditions should be placed on receiving the cash? if so why and which?
  - What do you think might be some of the challenges from the perspective of programme implementers (including capacity constraints –both in terms of substance e.g. limited gender or child-sensitive awareness – time, budget)
  - Do you think these challenges are specific to this location or is your view that these are cross-cutting concerns, affect other areas of the country?
- Future directions:
  - If the programme were discontinued, what effects would this have on ex-beneficiaries lives/livelihoods?
  - How would you see the programme continuing in the future?
    - What changes would you make, if any?
    - What could be improved? (probe: targeting, frequency, amount, complementary programmes, links to information, evaluations/ lesson learning etc.)
    - How could the programme become more child and gender sensitive?
  - Could members of the community become more involved in the programme, be given a say in it?(e.g. suggestion/complaint line via text/ mobile phones). If so, how? Would this be helpful in your view? Why/why not?
  - In some countries, people have an ID card which helps people access different types of programmes to which vulnerable people are entitled.
    - Which types of programmes do you think they should be entitled to?
    - Do you think this type of system, i.e. with the ID card, would be helpful? (e.g. In Ghana, CT programme beneficiaries, are supported to get access to subsidised health insurance).
    - Could there be difficulties in getting this to work? (e.g. doing paper work and negotiating redtape to establish documentation, paying for brokers if illiterate,

issue of fake ID cards, sharing of ID cards, need for birth registration, travelling to govt offices to register, etc.).
        - If there you think there could be difficulties, what could be done?
    - What would you advice the head of the district/implementers, policy makers, MPs, donors, etc. (people in authority but linked to the CT programme) on how this programme could be improved?

Programme implementers (volunteer/community based, district level people, questions/emphasis will vary)

Themes to cover:

- Details of the programme:
    - Institutional arrangements for programme implementation (which ministry/department? Collaboration with other departments)
    - since when, who is targeted, how was targeting done;
    - how much is given, how often;
    - who gives/how is it distributed;
    - how does the distribution work at community/village level;
    - what else is given (information, link to services, etc.);
    - are there conditions linked to the cash, if so which, if not why not? (note if talking to DCO don't ask if conditions are attached)
- Accountability mechanisms:
    - Are there processes in place to ensure that everyone receives the same amount; if so, what, are they effective?
    - Is their space/occasion for community members to make a complaint? If yes, to whom, when, how often? If not, do you think this could be useful? How could it work?
- Benefits of the programme:
    - have excluded groups become more empowered/vocal/involved;
    - has the programme had any unintended effects/benefits;
    - how if at all has it benefitted the professional development/capacity building of programme implementers?
- Challenges of the programme:
    - What challenges do they think recipients face: is the cash sufficient; do they receive it frequently enough; do they think recipients would rather receive something else, what? do they think conditions (**both formal and informal**) should be placed on receiving the cash, if so why and which;
    - Do they think the programme has led to tensions within households or between households in the wider community; if so, between whom and who, why? What can be done to address these?
    - Do you think some people have benefited more than others? If yes, which, why?
    - Do you think the distribution in this area has been fair?
    - What challenges do you face as implementers:
        - Lack of qualified staff
        - Lack of transport to reach remote hhs
        - lack of capacity strengthening opportunities
        - lack of support from other service providers
        - lack of clarity on goals of the programmes
        - are they pressurized into giving to people who perhaps don't deserve it;
    - Do you carry out any form of M&E? If so, what challenges do you face in relation to that? (e.g. indicators?)
    - What specific logistical challenges do you face? E.g. communication with beneficiaries and with their superiors, in getting cash out to post office/banks, in

reporting back, in updating files/records, etc**. In inter-ministerial coordination? (only ask DCO)**

- How do you share lessons from this programme? What are the challenges in terms of lesson learning?
- How do you share the knowledge from this programme? What are the challenges in terms knowledge sharing?

- Future programming:
  - How would you see the programme continuing in the future?
  - What changes would you make, if any?
  - What could be improved? (probe: targeting, frequency, amount, complementary programmes, etc.)
  - How could the programme become more child and gender sensitive?
  - If a beneficiary changes residence, could they continue in the programme in their new location? If no, what could be done to keep them in the programme?
  - Are some people asked to leave the programme?
    - Are there incentives to encourage people to leave the programme?
    - What happens if household situations change? i.e. they are no longer eligible
    - Do people have to re-register?
  - Do you think members of the community should become more involved in the programme, be given a say in it?If yes, how, why; if no, why not.

Programme/policy designers in govt or NGOs

Themes to cover:

- What other social protection programmes exist that address the particular vulnerabilities of people in this country/district/community?
  - What other CT programmes exist
- Their knowledge of this CT programme – details (*keep it very brief here*…)
  - How this programme links with other CT programmes/broader SP in-country programming
  - How did the design of this programme come about, what was the origins, who designed it, the extent of government ownership in the process
- What they think of it: the benefits/successes and challenges (and what evidence do they base this on):
  - What are the main benefits
    - how have people's lives changed
    - unintended change/benefits
  - What are the main challenges
    - Whether conditions should be placed,
    - whether targeting should occur in a different form;
    - whether the cash is sufficient;
    - whether they think something else should be given;
    - sufficient coordination among government agencies involved in programme roll-out and M and E?
    - whether there is sufficient linkages to complementary services ;
    - whether it has created tensions amongst community members;
    - whether it has suffered from elite capture, and/or whether certain people have received when they shouldn't and vice versa
    - challenges regarding m and e systems and indicators
    - administrative challenges in implementation, distribution, etc
    - financial sustainability

- Future programming:
  - How would you see the programme continuing in the future?
  - What changes would you make, if any?
  - What could be improved? (probe: targeting, frequency, amount, complementary programmes, building on informal social protection approaches, etc.)
  - How could the programme become more child and gender-sensitive?
  - How could the programmes positive effects be strengthened?
  - How do you view graduation and exit issues? How do you take people off the programmes? When, what criteria, etc.
- In some countries, people have an ID card which helps people access different types of programmes to which vulnerable people are entitled.
  - Which types of programmes do you think they should be entitled to?
  - Do you think this type of system, i.e. with the ID card, would be helpful? (e.g. In Ghana, CT programme beneficiaries, are supported to get access to subsidised health insurance).
  - Could there be difficulties in getting this to work? (e.g. doing paper work and negotiating redtape to establish documentation, paying for brokers if illiterate, issue of fake ID cards, sharing of ID cards, need for birth registration, travelling to govt offices to register, etc.).
  - If there you think there could be difficulties, what could be done?
- Do you think members of the community should become more involved in the programme, be given a say in it?If yes, how, why; if no, why not.
  - Views on social audit approaches and feasibility in this context

Academic analysts of social protection programming in-country;

Themes to cover:

- Is there an adequate safety net in this country? Which vulnerable groups should they be including? Does targeting OVCs in Kenya (*add for specific vulnerable groups in different countries*) make sense in their country context?
- There is an ongoing debate about state versus private social sector provision, what's your opinion and experience on this? Could /does private sector provision work in your context? Can they adequately reach/ /target the most vulnerable? Pros and cons ...
- What social protection programmes exist
  - What other CT programmes exist
- Their knowledge of this CT programme – its relative strengths and weaknesses vis-à-vis other social protection instruments in the country.
  - How this programme links with other CT programmes/broader SP in-country programming
- What are the main benefits
  - how have people's lives changed
  - unintended change/benefits
  - changes in state-citizen relations/ social contract / governance/ accountability
- Have there been gains in legitimacy to government / evidence that it has made the government more popular? Who gets the credit for the outcomes of the programme?
- What are the main challenges
  - Whether conditions should be placed,
  - whether targeting should occur in a different form;
  - whether sufficient synergies are tapped with informal social protection/ safety net approaches (e.g. ROSCAs, remittances, church support, etc.)?
  - whether there is sufficient link to complementary services ;
  - whether it has created tensions amongst community members

    - whether it is sustainable
- A common challenge can be local elite capture, what form might it take? How can it be avoided, dealt with, etc.?
- Are there any mechanisms to ensure accountability in general / in this programme? What are your views of them? Are they effective, if not, why not, etc.
- Future programming:
    - How would you see the programme continuing in the future?
    - What changes would you make, if any?
    - What could be improved? (probe: targeting, frequency, amount, complementary programmes, M and E, lesson learning/ knowledge sharingetc.)
    - How could the programmes positive effects be strengthened?
    - How do you view graduation and exit issues? How do you take people off the programmes? When, what criteria, etc.

Plan for observation

Sites where to observe: please *adapt the below accordingly*

- School - observe children in schools, how dress, the meals, whether possible to link some of the children to OVC status and therefore part of the CT programme...
- Merry go round meetings, formal or informal...
- Other informal gatherings – barazas, women's meetings, etc.
- Cash delivery points – post office or bank?
- Implementer monitoring visit to village – LOC member / children's officer...
- Children's office
- BWC if have a meeting

Topics to capture:

- Interactions, relationships, etc. between people, difference according to age, gender, education level, etc.
- How policy changes may be affecting beneficiaries, service delivery, etc.
- Do service providers/ programme implementers treat everyone in the same way? (based on gender, age, level of education, dress, etc.)
- Is service / programme delivery adequate (e.g. delays, lack of equipment, open hours, attitudes of staff, staffing levels, and why)? Try to rate poor, reasonable, very good, areas for improvement...
- Was social interaction among beneficiaries shaped by the setting?If so, how? (e.g. concerns re stigma? Staffing attitudes)?

How to observe:

- Researcher will be sitting/standing/wandering around observing situation, people in the context
- Observer should blend in as much as possible - clothing, attitudes, etc.
- If appropriate may start chatting with people, e.g. may comment about how hot it is, length of queue, informal chit-chatting, but should not seem like an interview and no taking of notes
- If appropriate can ask questions, to beneficiaries, to others around to find out what is happening or what happened in a certain situation

Length of time to observe

- Halfa day + (min 3 hours)

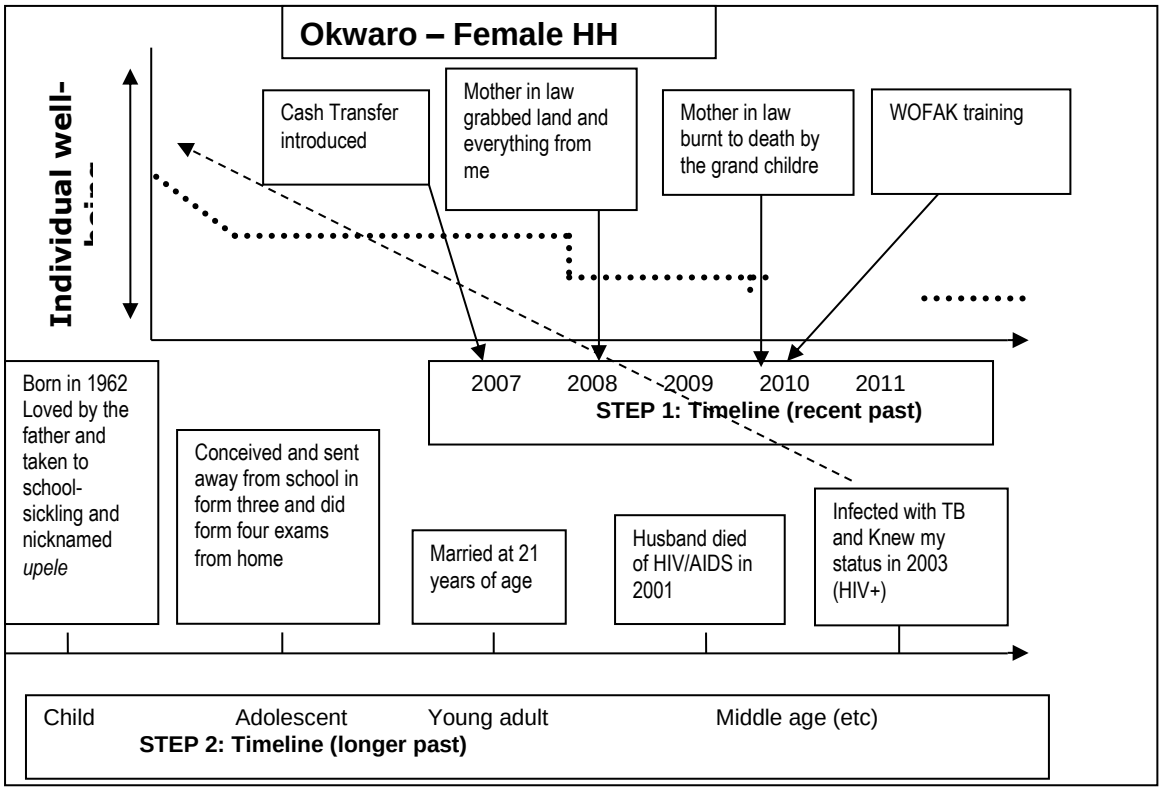
Things to keep in mind/note:

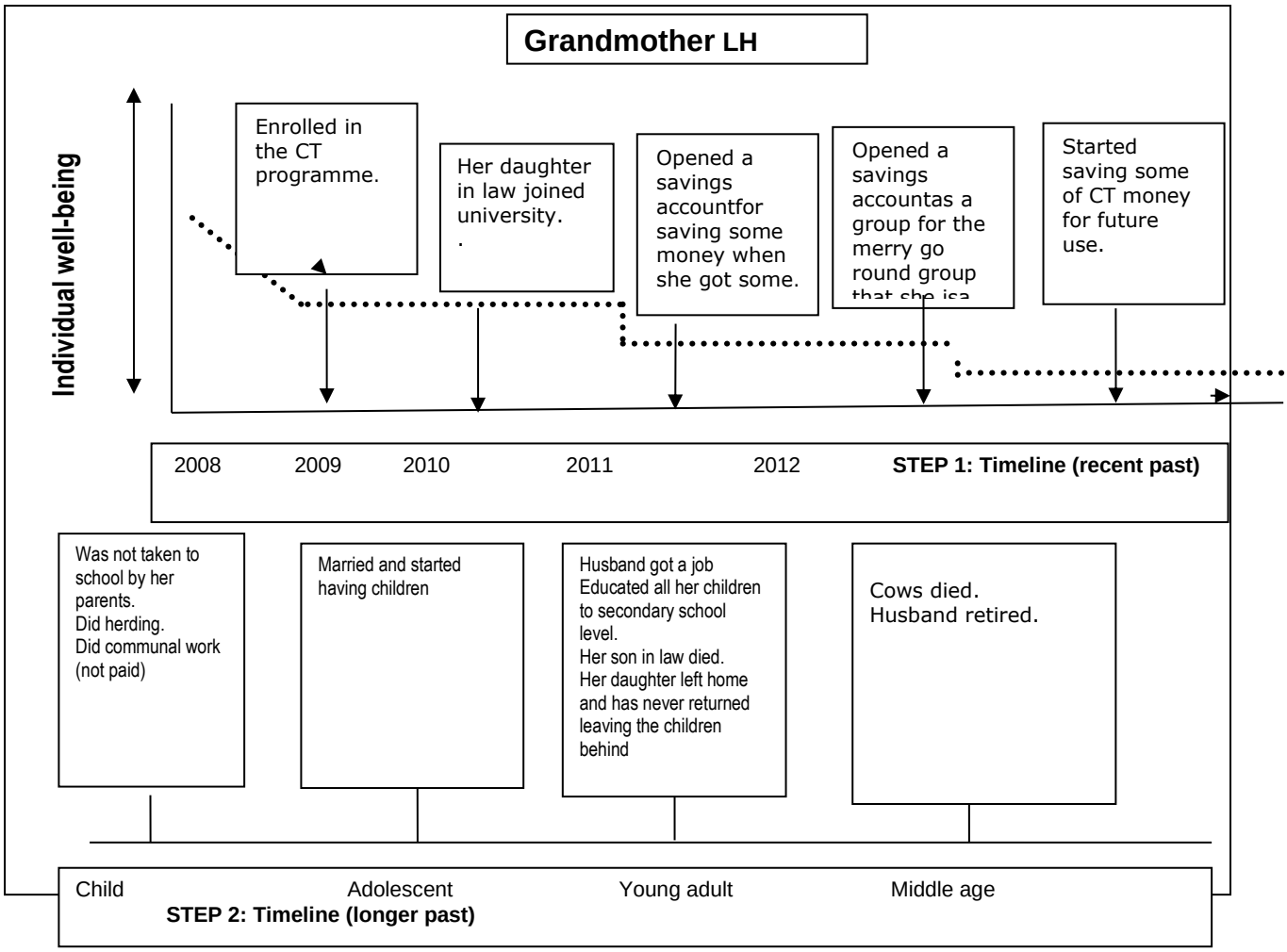
- How many people are in the queue
- Is the queue orderly?
- the surroundings, physical things, state of repair, drinking water, shelter, sanitary facilities
- how people are organized, seating arrangements, etc.
- who is present, what people are wearing, how they present themselves, the way they talk, etc
- whether people come alone or accompanied, if accompanied by whom… (esp. If old, children, pwd)
- what are people doing, what is happening
- any sources of tension between community members? Between community members and implementers?
- Over-heard conversations about dissatisfaction / satisfaction with programme or service delivery
- when does activity occur – time, the sequence of events, etc.
- where is it happening
- how is the activity organized
- an event/situation/a happening which stands out, describe in detail
- people's reactions, feelings, expressions, etc. both verbal and non-verbal
- How important was non-verbal communication in people's interactions
- Did some members of the group seem to stand out more than others? Why did you think this was so & what could it indicate?
- Check what people do, their reactions, etc. after they leave the facility often a lot is captured when they are leaving, feel more at ease as have finished, etc.
- Is it shameful to be in the queue?
- Distance travelled to reach clinic, delivery point

Writing up/guidance notes:

- *don't jump to conclusions straight away*
- *look for more evidence, ask people to confirm things (triangulate)*
- *note the date and length of time of the observation*
- *how you being there affected the situation, how you think it affected the situation if nothing very obvious, how people responded to you*
- *Have notebook in your bag but don't show people, if need to take notes immediately do so discreetly (outside..)*
- *Write up all notes at the end of each period of observation, provide as much detail as possible, describe literally what you saw*
- *As much as possible record expressions, ways of saying things, etc. verbatim, i.e. word for word, noting who said this, gender, age, in what context/situation, etc.*
- *Note difference between what you see, the facts, and your interpretation of events, i.e. what you think was happening, how you explain it, your feelings on seeing it happening, how you explain others reactions, etc.*

Annex 4: Examples of life history reports




Grandmother LH
Individual well-being
Enrolled in the CT programme.
Her daughter in law joined university.
.
Opened a savings accountfor saving some money when she got some.
Opened a savings accountas a group for the merry go round group
Started saving some of CT money for future use.
2008
2009
2010
2011
2012
STEP 1: Timeline (recent past)
Was not taken to school by her parents.
Did herding.
Did communal work (not paid)
Married and started having children
Husband got a job
Educated all her children to secondary school level.
Her son in law died.
Her daughter left home and has never returned leaving the children behind
Cows died.
Husband retired.
Child
Adolescent
Young adult
Middle age
STEP 2: Timeline (longer past)

.....

Annex 5: Site mapping and research site selection

District	Poverty Incidence % (2005/6)	Date Included	Urban-Rural	Province	Main Livelihoods	Comments
Tana River	76.9	2012**	Rural	Coast	**Livestock production:** Agriculture accounts for 85% of the annual household earnings. Livestock production, mainly nomadic pastoralism engages 50% of the population (KFSM 2012).	Too new
Malindi	76	2009	Mixed	Coast	Mixed farming, small-scale commerce and tourism	May be a posibility, but has a medium sized town and is not in the Western Province
Kwale	74.9	2008	Rural	Coast	Mixed farming, livestock rearing, fishing, tourism	Meets all criteria, but is not in the Western Province
Samburu	73	2009	Rural	Rift Valley	Mixed farming: Agriculture (crop and livestock production) employs over 72% of the population and contributes 2.7% of households' incomes (KFSM 2012).	Meets all criteria, but is not in the Western Province
Isiolo	71.6	2012	Mixed	Eastern	Mixed farming, small-scale commerce	May be a posibility, but has a medium sized town and is not in the Western Province
Busia	69.8	2009	Rural	Western	Subsitstance and cash crop agricultue: Agricultural production is the lifeline of Busia district's economy. The sub-sector contributes nearly 36% of household income and employs over 81% of the workforce	Meets all criteria
West Pokot	69.4	2012**	Rural	Rift Valley	**Livestock production:** About 60% of the district's residents derive their livelihood from agriculture. Livestock rearing is the major economic activity (KFSM 2012).	Too new
Kilifi	68.5	2011	Rural	Coast	**Mixed farming** (both crop and livestock) is the main livelihood means for the district's residents, accounting for nearly 81% of total household earnings (KFSM 2012).	Too new
Gucha	67.4	2009	Rural	Nyanza	Subsistence and cash crop agriculture (e.g. sugarcane)	Meets all criteria, but is not in the Western Province
Marakwet	66.5	2012**	Rural	Rift Valley	Livestock production	Too new
Makueni	64.1	2009	Rural	Eastern	Mixed farming: Over 60% of Makueni residents derive their incomes from agriculture (livestock keeping and crop production (KFSM 2012).	Meets all criteria, but is not in the Western Province
Kitui	63.7	2009	Rural	Eastern	Livestock production is the backbone of Kitui's economy and together with crop farming account for nearly three-quarters of household earnings (KFSM 2012).	Meets all criteria, but is not in the Western Province
Mwingi	62.6	2010	Rural	Eastern	Subsistence agriculture (e.g. maize and sorghum) and agro-pastoral activities	Meets all criteria, but is not in the Western Province
Baringo	59.8	2012**	Rural	Rift Valley	**Agro-pastoral** livelihoods	Too new
Teso	59.8	2012	Rural	Western	**Mixed and subsistence farming:** 65% of income comes from agriculture; 18% (GoK 2002)	Too new
Machakos	59.6	2009	Mixed	Eastern	Mixed farming and small-scale commerce	May be a posibility, but has a medium sized town and is not in the Western Province
Kuria	58.9	2012**	Rural	Nyanza	**Mixed farming**, agro-forestry	Too new
Bomet	58.7	2012	Rural	Rift Valley	**Mixed subsistence and cash crop farming:** Tea & pyrethrum, maize, millet, hillside mixed crops & livestock	Too new
Mt. Elgon	58.7	2012**	Rural	Western	**Mixed farming:** Cultivation (cash crops and subsistence production) and livestock keeping	Too new
Taita Taveta	56.9	2010	Rural	Coast	Mixed subsistence and cash crop farming: Maize, wheat, millet, cotton, livestock	*Meets all criteria, but is not in the Western Province
**Please take a look at this: http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/AFR/2011/12/06/F9B77F27FDCDC0F6852578B5003D22E5/1_0/Rendered/INDEX,						
Listed as: **GOK/WB funded YR 4* 2012-2013**. From: **Scale-up Plan for the CT-OVC Program for period ending 30th June 2011 and projected numbers for 2012**						
Note: The numbers for Mt. Elgon, Baringo and West Pokot are identical to those in the excel document, so they must be from the same source.						

.....

Annex 6: Number of Beneficiaries

1.0 CT-OVC status report FY2011/12 and projected scale-up for 2012/13

	No.	Poverty Incidence by District (%), 2005/6	District	Pending	GOK 09/10	UNICEF/DFID	GOK 10/11	World Bank	WB Project Map	DFID supported districts
Initial	1	42.5	Migori			4,453				4450
7 funded	2	74.9	Kwale	581		2,092				2,092
districts	3	43.7	Homa Bay			3,018				3,007
	4	52.0	Suba			1,663				1,663
	5	22.0	Nairobi	654		2,470				2,470
	6	49.6	Kisumu			2,764				2,949
	7	49.2	Garissa	633		1,480				1,480
Total						**17,940**				
	8	59.6	Machakos			4,327				4,327
7 new	9	69.8	Busia	2,886		4,962				4,962
GOK/DPfunded	10	50.7	Bungoma	1,235		4,791				4,791
districts*	11	39.4	Nakuru			3,312				3,312
2009-2010	12	40.1	Siaya	1,493		3,294				2,996
	13	40.5	Rachuonyo	961		3,465				3,000
	14	76.0	Malindi	6,575		2,679				
Total						26,830				
	15	64.1	Makueni		811			4,951	OVC	
GOK/WB	16	63.7	Kitui		811			4,314	OVC	
funded YR 1*	17	67.4	Gucha		811			2,330	OVC	
2009-2010	18	36.1	Thika		811			2,909	OVC	
	19	73.0	Samburu		811			2,022	OVC	
	20	41.1	Vihiga		811			4,067		
	21	54.4	Kakamega		811			2,797	OVC	
Total					5,677			23,390		
	22	56.9	Taita Taveta		1,209			2,322		
GOK/WB	23	47.4	Nandi		1,471			2,200		
funded YR	24	32.7	Nyeri		972			2,734		
2*2010-2011	25	50.2	Trans Nzoia		951			2,000	OVC	
	26	62.6	Mwingi		924			1,941	OVC	
	27	47.0	Lugari		1,695			2,558	OVC	
Total					7,222			13,755		
	28	46.7	Nyando		2,010		2,010	2,000		
GOK/WB	29	46.3	Nyandarua		993	930	2,000		OVC	
funded YR 3*	30	68.5	Kilifi		1,039	1,081	2,000			
2011-2012	31	51.6	Butere		1,353	1,345	2,000			
	32	24.6	Bondo		1,972	1972	2,000		OVC	
	33	28.5	Muranga		1,992	1992	2,000			
Total					9,359	9330	12,000			
	34	49.6	Uasin Gishu		959	961	2,000		OVC	
GOK/WB	35	36.6	Embu		1,117	1117	2,000			
funded YR 4*	36	71.6	Isiolo		1313	1313	2,000		OVC	
2012-2013	37	58.7	Bomet		1120	1120	2,000		OVC	
	38	59.8	Teso		1994	1994	2,000			
	39	54.2	Kisii Central		1828	1828	2,000		OVC	
Total					8331	8333	12,000			
	40	46.6	Nyamira		1,978	1,978				
GoK	41	21.8	Kiambu		1,170	1,098				
	42	30.8	Meru North		1,169	1,350				
	43	48.7	Tharaka		1,290	1,290				
	44	32.8	Buret		930	930				
	45	51.8	Koibatek		1,167	1,167				
	46	37.6	Mombasa		1,134	1,215				
	47	25.2	Kirinyaga		1,315	1,315				
Total					10,153	10,343				
	48	58.9	Kuria	391		1,500				
GoK	49	66.5	Marakwet	27		600				
	50	50.5	Laikipia	293		1,800				
	51	26.7	Narok	219		1,100				
	52	69.4	West Pokot	544		1,100				
	53	59.8	Baringo	234		900				
	54	11.6	Kajiado	266		1,500				
	55	50.9	Trans Mara	84		84				
	56	58.7	Mt .Elgon	62		800				
	57	50.2	Mbeere	142		1,800				
	58	31.2	Meru South	172		1,100				
	59	31.0	Maragua	373		1,200				
	60	76.9	Tana River	481		1,800				
						17,000				
Estimated totals		**47.0**		**6,575**	**40,742**	**44,770**	**45,006**	**61,145**		

2.0 Number of beneficiaries by County and sub-location according to the DCOs

.....

Number of Beneficiaries in Busia County

Location	Number of Beneficiaries
Nasewa	392
Marachi Central	**1428**
Bujumba	455
Township	929
Nambomboto	380
Bwiri	429
Bunyala West	435
Bunyala Central	440
Total	**4,888**

Number of Beneficiaries in Makueni County

Location	Number of Beneficiaries
Wote	183
Kilala	74
Ukia	330
Kithembe	101
Kako	29
Kasikeu	111
Kiteta	118
Mulala	118
Mbooni	156
Kithungo	73
Kiima-Kiu	165
Kalamba	147
Mukaa	261
Kathonzweni (incl. Kwakavisi)	**396**
Kithuki	82
Kisau	70
Kikoko	112
Ilima	153
Nzaui	70
Tulimani	386
Kiou	93
Mavindini	118
Total	**3,346**

.....

Annex 7: Example of daily reports from fieldwork

Template for daily reporting – Friday 6TH July 2012: Makueni

Instructions:

- ***Compile every evening after fieldwork – one person to take charge***
- ***Every person to contribute at least 2 items per category***
- ***Send to PI to then send on to ODI***

Tools / interviews used today:

- *2 Historical Timelines one with FGD Female Beneficiaries and another with FGD Male non-beneficiaries.*
- *FGD with Female Beneficiaries*
- *FGD Male Non-Beneficiaries*
- *FGD Female Non-Beneficiaries*
- *KII Religious Leader*
- *IDI CHH*
- *IDI Child Beneficiary*
- *2 IDI Female Non-Beneficiary(Not FHH)*
- *KII Women Group Leader*
- *IDI Male Beneficiary*
- *IDI Grandmother Non-Beneficiary*

1. Key findings – surprising, interesting – to start also grouping/clustering together

Historical timeline

From the historical timelines the participants indicated that the CT money came one year after the post-election violence and this money really helped them since there was inflation during this time. There were difficulties in getting money and food.They also indicated that this was the time that World Vision came with a program called food for work where they had to dig trenches and were paid in form of food.

Tension within community caused by CT

- *It was interesting when one beneficiary woman pointed out to me that this CT program created tension between the communities members as those who didn't receive the money stopped talking to those who were receiving saying that they were getting free money for nothing. This was a problem in the beginning but as the second group was recruited then people understood that it was an on-going process and eventually it will also reach to them.*

Knowledge of CT programme

- *The male non beneficiaries knew so much about the CT programme yet they were not in it. Didn't expect them to know so much because they are not in the programme. They even knew the use and informal conditions that the money was attached to like the first time they received the money it was lump sum of Ksh 12,000 and they were told to go and buy a cow with the money.*

Coping strategies

- *The non-beneficiaries thought that the neighbours offered much more support to the vulnerable groups than the family and chief. This was interesting because yesterday when doing the mapping, neighbours didn't come out as strongly as today. It was obvious today that without neighbours one is as good as dead. The neighbours will not let the children sleep hungry.*

- *It is interesting when non beneficiaries said that even if the rains will fail they will still do farming expecting to harvest. They share communal labour by working on rotations in different homes. They also burn charcoal although they indicated that they know the effects of burning charcoal like not having firewood since the charcoal is for selling yet they will not be left with any firewood to use for themselves. They also said that it destroys the environment but they still do it because it is a source of livelihood.*
- *I found it interesting when I talked with a widower beneficiary and he indicated that he has 9 children and his mother so 10 dependants and he said that CT has really helped him because he could not work. The responsibilities were overwhelming for him and when I asked him if he does any other economic activity he said that he is too weak to work so he depends on the CT money. When I asked him if this money is withdrawn what he would do and he said that now he would go and look for work.*
- *Another thing that was interesting is that one of beneficiary women told us that she does not know why people are complaining all the time that they do not have money yet they have hands and can work and weave ropes. She even showed us a rope that she had woven and was going to sell it at Ksh20. I liked the way she said people should not just sit ndeeee (onomatopoeia).*

Household use of the CT money

- *Most beneficiaries want to buy land for vulnerable children using the CT money despite the amount. They say that the vulnerable children do not have land and as a care giver it would be important that before they die they buy for the children land.*
- *I also found it interesting that these people are so much into the idea of buying livestock yet they know that the money should be used for school, food and clothing but all the time they said they would want to buy livestock with the money for the vulnerable children.*
- *I found it interesting when I talked to non-beneficiary men and they said that if they had more money they would drill a borehole and start irrigation and sell water to other people. This was interesting to me because this people know that they have a lot of potential in agriculture but they are constrained by the weather conditions.*

Positive effects of CT

- *It was interesting when I talked to the children and for them food was most important and that is what they mentioned that the CT programme has really helped them with alongside school fees and clothing. One child told me that whenever she does not eat supper she will not go to school the following morning because she will be very hungry to go to school.*
- *Another thing that was interesting is that one of beneficiary women told us that she does not know why people are complaining all the time that they do not have money yet they have hands and can work and weave ropes. She even showed us a rope that she had woven and was going to sell it at Ksh20. I liked the way she said people should not just sit ndeeee (onomatopoeia).*

Annex 8: List of key informants

Participants	Organization/Designation
National Level	
MichaelMunavu	World Bank
Marion Ouma	African Platform for Social Protection
Luis Corral	UNICEF
WinnieMwasiaji	Department of Gender, MGCSD
John Njoka	University of Nairobi
Lillian Karinga	Department of Children's Services , MGCSD
Samuel Ochieng'	Department of Children's Services, MGCSD
Districtand Community Levels	
RastoOmolo	District Children's Officer, Makueni
Jane Nkatha	District Children's Officer, Busia
District Social Development Officer, Makueni	MGCSD
Titus Ndiko	Headteacher, Kwakavisi Primary School
Catherine Okumu	Deputy HeadteacherBukhalalire Primary School
Martin Muya	Chief, Kwakavisi Location
Jonathan Wambua	VCO, Makueni
Johnson Musyoka	VCO, Makueni
Bernard Mwale	VCO, Busia
LinetMadara	VCO, Busia
Jacinta Muendo	BWC, Makueni
Henry Osuru	BWC, Busia
Dominic Kisuna	Youth leader, Makueni
Allan Odhiambo	Youth Leader, Busia
MuyaLombo	Community Elder, Makueni
Joel Mulamba	Community Elder, Busia
Regina Chumwa	Women Group Leader, Makueni
Jane Anyango	Women Group Leader, Busia
Milton Kudondo	Religious Leader, Busia
L. Kioko	Religious Leader, Makueni

Annex 9: Historical timelines

MAKUENI

Numbers of participants (at beginning):14(at end): 14

Location: Kwakavisi (Makueni District)

Kind of participants (men, women, etc.): men (7) non-beneficiaries

Age (average): ≈40

Date: 06/07/2012

Time start: 1226hrs Time end:1450hrs

Historical Timeline			
Year	Event in the Country	Year	Event in the community (Kwakavisi)
1992	Introduction of Multi-party system	1992	Drought Survey of the land Malaria outbreak
1994	Famine	1994	Drought
1998	Bomb blast El-nino flood	1998	Drought Outbreak of Yellow Fever, Malaria, Cholera, Typhoid. Increased deaths due to HIV/AIDS
2002	President retired	2002	Drought
2003	Freedom of speech Free primary education Constituency Development Fund introduced Local Authority Transfer Fund introduced	2003	Drought First case of Brucellosis reported in the area Title deeds issued to community members by the area MP (Hon. KivuthaKibwana
		2007	New location (Kwakavisi) created with new Chief, village Drought
2008	Coalition government Second Prime minister Post election violence	2008	New District (Makueni) New secondary school (Kwakavisi Secondary School) Drought
2009	Drought	2009	Selection of household for the CT programme Drought
2010	New Constitution	2010	New staff houses at the hospital built Economic Stimulus Programme introduce Built a new school Issued the first instalment of the CT (KES 12,000) AMREF dug a borehole at Kwakavisi Drought
2011	Kenyan military in Somalia (Operation Linda Nchi)	2011	Drought
2012	Ministers Saitoti and Ojode dead in plane crash	2012	Drought

Notes

The participants were more knowledgeable of the events that had taken place in their community than those that had taken place in the country, especially if those events were more than 10 years ago. In most of such events such as the survey of the land, issue of title deeds and allocation of the new location and village, they had to consult each other as they were not so sure of the specific years that the event occurred.

In 1992, during the outbreak of malaria, every household was affected and lost at least a member.

The outbreak of typhoid, cholera and yellow fever in 1998 was attributed to the unusual rain and shortage of clean drinking water. *"wakati hiyo mvua ilinyesha kidogo baada ya ukame lakini hiyo maji yake ilikuwa rangi tofauti sana, ilifanana na vumbi"* [in this season, there was a short span of rain after the long drought but the rain water had an unusual colour; it was brown].

.....

BUSIA

Historical Timeline

The historical timeline was conducted after the poverty mapping and coping strategy with the community members. The community members could easily identify years and events and this made the process interesting and fast enough. Interestingly the women were more conversant with the events and one man in the meeting exclaimed, “You women you know all these things and you don’t tell us!”

National event		Community key events	
Year	Event	Year	Event
1990	HIV/AIDS scourge, many orphans were left behind		
1992	Multi- party elections conducted Railway corporation collapsed		
1994	Famine /Hunger brought by drought by drought	1994	Famine that was nicknamed *ndirankongo* (hold your back). People had money but there was no food
1996	Good sugarcane prices (factories bought sugarcane at good prices)		
1997	General elections		
1998	Elnino floods Many industrial companies collapsed ie. (Rift Valley Textiles and Kenya Cooperative Creameries) Bomb blast in Nairobi		
2004	Government partnered with NGOs and started giving HIV support ie nutrition, education and treatment ARVs and TB drugs were availed for free	2004	AMKENI – an NGO, trained community on the importance of knowing ones status and getting out of stigma. Constituency Development fund was introduced to the community and schools, dispensaries, boreholes, bursaries, fishponds etc. were built
		2005	Electricity was brought from Bumala to Butula and supplied to schools, hospitals and markets
		2007	CT programme came to assist orphans with school fees, uniforms, food, and guardians also benefited. APHIA II bought uniforms, utensils, blankets, mattress and other bedding for community members. They also helped in paying school fees for the children.
2008	Post-election violence		
		2009	ARVs were availed in the sub-district hospitalsand this reduced the burden of access since thedrugs were only available at the district level (BUSIA)- this was done by AMPATH WOFAK – trained the community on children’s rights and also trained community health workers
2010	Referendum for the new constitution	2010	Campaign on safe drinking water by NGOs ie. LifeStraw-giving water guard and life straws
2011	Kenya fights Alshabab in Somalia	2011	AMREF – started latrine project in the community. Every homestead was required and supported to build a latrine Famine nicknamed- *bamba eighty*- a kilo of maize rose from 30 kshs to 150 kshs

Annex 10: Poverty and coping strategy identification and ranking

Template for Poverty Ranking 5th July 2012_Makueni

Background Information

This poverty ranking was done with community members in Kwakavisii sub- location in Kathonzweni District Makueni County. We started the meeting with 14 members and sustained this number all through the meeting. It was a mixed group of both men and women (5 men and 9 women) mostly elderly in the community.

Facilitator: Oyier Adhiambo Beryl

Note Taker: Shadrack Okumu Orinda

Process

The meeting started at 11:52 hrs with a prayer from one of the members. The group had a mix of people, both beneficiaries and non-beneficiaries of the CT program. At the beginning, a few people tended to dominate the discussion though afterwards everyone participated actively. This could be because some were not familiar with the process at the beginning but eventually they got a hang of it. Generally the mood was relaxed and people gave very interesting examples in the discussion.

Key Vulnerabilities

The outstanding vulnerability that came out clearly was drought which they associated with hunger and lack of water.

Other vulnerabilities were:

- Diseases like TB, malaria, typhoid, breast cancer,
- Lack of school fees
- HIV /AIDS (was brought out in its own category unlike other diseases)
- Poor roads, schools
- Inadequate teachers in schools
- Unemployment
- Lack of basic needs
- School dropouts primary
- Low prices of farm produce
- Low crop yield

Well off	Average	Poorest	Comments/Notes
Vehicles	Can afford a borehole	No good houses	
Big Houses	Irrigates his farm	Grass thatched houses	
Grade cows and goats -Has a minimum of 3 cows and at least 15	7-10 hectares of land	No good clothes	
Stone houses	A teacher, business person and farmer	Get food donations	
Corrugated-Iron roof houses	Has a stone house	Mud houses	
Grow fruits in the home	Iron roof	Children can't go to school because of lack of fees	
Can afford medication for their livestock	4-5 children	Many children 6-10.	The respondents indicated that the poor don't practice family planning thus have many children.
Can afford medical care	Has grade cows	No livestock like cows and goats	
Are employers of the poor	Some have cars	Have 3-6 chicken	
Have 20 hectares of land	Most have bicycles and motor bikes.	Cannot afford veterinary care for their chicken	
Can buy more land	Children attend public/ government schools	Cant afford medical care	
Live in Nairobi		Sells produce at a throw away price	

Well off	Average	Poorest	Comments/Notes
Business persons		Are casual labourers	
Are landlords		3-4 hectares of land	
Have 2-3 children		Lack bedding	The respondents said that the poorest sleep on the bare floor.
Children go to private and mission boarding schools.		Children go to government schools.	
Totals 14/185	46/185	125/185	

Coping strategies

There were various coping strategies but it was evident that the poor have more coping strategies since they lack money at all times. During the poverty mapping it was also evident that the majority of the community members in the meeting categorized themselves as poor and it was therefore easier for them to identify with their coping strategies than those used by the other categories.

Farming came out as a coping strategy for all categories but the poor sold the farm stalk after crop failure to the well-off who own animals at a throw away price. “You know a rich man will always want to take advantage of a poor man. What can you do you just have to sell it even for 500Ksh because you need the money and the crop has failed. The rich man will buy the maize stalk and give it to his animals. ”

Borrowing a plough for digging was ranked first for the poorest because they lack farm implements to use for farming. “A poor man cannot own an ox- plough so he will wait for the rich man to finish ploughing first then he will go an borrow. This makes the poor man to start farming much later because he has to wait.”

Borrowing in general was said to be embarrassing to the poorest because one cannot keep on borrowing. “You know you cannot keep on going to people to ask for things because they will start calling you a beggar.”

For the average it was said that since they have a status in the society then they avoid borrowing. “You know these are teachers and business people and you cannot see them borrowing.”

Sharing labor also came out as one of the best ways of coping for the middle class and the well off because they can offer food to those who help them. “You know a poor man cannot even call someone to help him because he will not even afford food to give this person. These others like the middle class and well off can give food to those who come to help them.”

Stealing came out as a coping strategy for the rich and not the poor. The group agreed that it is the rich who steal large amounts of money. “It is the rich who steal big money from where they work like in the big offices in Nairobi.”

Coping strategy	Well off	Rank	Average	Rank	Poorest	Rank	Comments
Farming	Yes	3	Yes	3	Yes	1	The well off and average farm but not mainly for subsistence use. For the poor they feel that they have to farm to get food.
Borrowing ox-plough					Yes	1	They depend on farming but since they lack farm implements they borrow from the well off.
Selling maize stalk (Failed crop)					Yes	1	This is a coping strategy when the crops fail due to droughts. The poor sell the stalk to the well off who use as animal feed.
Borrowing from neighbours					Yes	3	It is embarrassing to borrow from neighbours all the time so this comes as a last resort. The average also don't borrow because most are teachers and they would not like to lower their status.
Taking goods on credit from shops			Yes	1			They have a monthly earning that guarantees that they will pay back. The poor do not take credit from shops because they can't pay back.
Exchanging produce with other goods i.e eggs for salt, sugar			Yes	1			The average who have some extra produce like eggs can take to the shop and exchange for other goods like salt and sugar.
Taking loans from shylocks			Yes	1	Yes	2	The average can take small loans from shylocks as a first option because they have a monthly salary and can guarantee to pay back. For the poor it comes as a second option once another option has been explored.
Borrowing from relatives			Yes	3	Yes	3	Relatives only assist when one is bereaved.
Engaging in casual wage labour					Yes	1	This is always the first option to go and find any casual work that can pay per day/hour.
Stealing money	Yes	3					The well off will strategize on how to steal large amounts of money from their work places.
Loans from banks	Yes	1	Yes	3			The middle class would rather go to shylocks than banks because banks take a longer process and are not close to the people.
Informal groups i.e merry go rounds			Yes	1	Yes	3	You can only be a member if you have money to contribute to be a member. The poor cannot afford to be members of merry go rounds.
Sharing labour	Yes	1	Yes	1	Yes	3	The poor cannot share labour because they don't have money or food to pay for help.

Key

1= Most Important/ First option

2= Not very important/ second option

3= Least Important/ Last option

The meeting ended at 1420 hours having done poverty ranking and coping strategy.

Annex 11: Summary of institutions and individuals

Template for Institutional analysis (Bubble diagram) - Busia

Background information:

We arrived at about 1645hrs at the chief's camp where a large group of people were waiting for us. We started with the community mapping, which entailed the drawing their entire location, including the institutions (e.g. schools, health centres, and churches), physical topography and homesteads. With this we got to know how people live, challenges they face and the coping strategies to these challenges across age and gender.

All the participants come from poor backgrounds and have therefore limited ways of income. They mainly rely on subsistence agriculture, which in most cases there is very limited harvest and very small scale income generating activities such as keeping poultry and selling off part of their harvest. Most of the participants in the community mapping had more than one OVC under their care, with one of them having four OVC.

Some participants could communicate in English. All the participants had a relatively good mastery of Kiswahili language in which the meeting was conducted.

Numbers of participants (at beginning): 10 (at end): 10

Location: Bukhalalire (Busia), Marachi Central Division

Kind of participants (men, women, etc.): men (5) and women (5) of older ages (between 32 and 70); mixed beneficiary (5) and non beneficiary (5)

Age (average): ≈45

Date: 11/07/2012

Time start: 1700hrs **Time end: 1835hrs**

Facilitator(s): George Khamati

Note taker: Julie Mutuura

How was the process?

Was it participatory; did everyone take part in the discussion; did anyone walk out, why: was it difficult / easy to manage, why; were people comfortable / uncomfortable, why? etc.

All the participants were upbeat by the idea of drawing a map of their area. From the beginning there was full participation. Most of the participants had good artistic impression of their area. Though it was difficult for them to locate some objects on the map, their general knowledge was above board because they seemed to know the areas of their residence and could easily point then on the map. This made the process manageable, coordinated, and interesting and an easy activity. Those who did not actively draw participated in giving directions to various stations and homes.

Summary of findings from sheets:

Key people / institutions turn to in times of difficulty	How support in times of difficulty	How important are they to you (very, middle, little)	How accessible are they to you (very; middle; little)	Comments / notes
Administrators (Chief, Assistant chief, administration police	Solving inter person conflicts Solving land conflicts Addressing gender violence Signing forms for issuing IDs Issuing of birth and death certificates Solving inter/intra family conflicts	Very	Very	The participants feel secure and confident with the services offered by the administrators. They consider them the pillar of the community '*haondiomsingiwetu'* The administrators know them in person and know their homes. They feel that this bring them close to the government
School/Head teacher	Consulted when the children do not perform well in school Give financial support – they act as sponsors for the children's education Accommodate students in times of lack of school fees Solves intra hh conflicts such ac as 'rebellion' of the children	Middle	Middle	The teachers do not assist in any other way e.g. medical fees, food, hh items
Church/ Religious leaders (pastors/ priests	Give prayers when the people are sick Give baptismal cards to facilitate application of the national ID Solve marital/family problems Solve conflict in the church	Middle	Very	The men thought that the church and the pastors' main role was offering prayers
Hospital/Doctor	Give medication when sick Refer the sick to appropriate hospitals when unable to treat Act as intermediaries between food donors (e.g. ARMPATH) Give counselling/advice on nutrition esp. For children; for VCT services	Very	Very	Some doctors attend to them immediately while others do not. Those that do attend to them immediately are considered to be good and have a good heart, the converse is true.
Relatives	Assist in counselling the children Give food support Offer advice Give financial support e.g. through fundraising Assist in school fees	very	Very	The relatives are always ready to help regardless of the type of problem one has. They are so careful to keep the good relations between them and their relatives because they believe that if one is not in good terms with their relatives they will have it hard in life (*mtuakikosananawatuwanyumbani, hapondipoameumamawe*)
Agricultural Extension officers	Check the types of soil and advice on what to plant Advice the kind of fertilizers to use in their farms Give directions on how to make manure for their farms When in problems of weeds e.g. Striga weed, they help them to deal with it.	Little	Little	
Neighbours	Give food in times of	Middle	Middle	The help that one gets from the

Key people / institutions turn to in times of difficulty	How support in times of difficulty	How important are they to you (very, middle, little)	How accessible are they to you (very; middle; little)	Comments / notes
	shortage Can give clothing in for children Can give money e.g. school fees for children Give psychological support e.g. in bereavement			neighbour depends on the level of friendship between them. They always keep a working relationship with their neighbours because they never know when one might need them And also the neighbour might be the only person to help in cases where the friends and relatives are far.
NGOs e.g. LifeStraw, World Bank	Provision of clean water Facilitation the Immunization of children	Very	Little	Not everybody benefits from the help that the NGOs give though they appreciate what the NGOs do.
Friends	Give food in times of shortage Can give clothing in for children Can give money e.g. school fees for children Give psychological support e.g. in bereavement	Very	Middle	Friends are considered very vital in the lives of the people though many of the friends are not always close in times of difficulties, they must be called from far but once they know of their difficulties, they help.
MP/ councillors	Assist during funerals and fund raising	Little	Little	They feel that these leaders are very far from them and cannot be accessed in times of need. Some have only seen them once or twice during the campaigns while some have seen them at a distant in prominent persons' funerals
Groups e.g. merry-go-rounds and funeral groups	Assist in paying of school fees Help in establishing long term income generating activities Assist in times of bereavement	Middle	Little	Each group has different function; therefore the help obtained from each varies. For instance one cannot get economic benefits from groups dealing with funerary issues.

Write-up of notes from note taker

Discussions/disagreements about relative importance of different people / institutions

The administration (which include the chief, sub chief, village elders and police) were rated as the most important and closest to the people in times of need. *"hawa administration wanatusaidia sana kuliko wengine wote, na tena ukiwataka unawapata tu haraka."*

Though the roles/help from the friends and that from neighbours overlap, it came out clear that they have more confidence in their friends even though some of them might be living very far from them compared to their neighbours *"Rafiki ni muhimu sana kulika jirani ingawa ni vizuri kusalimia jirani na kuweka ujirani mwema hata kama sio rafiki yako kwa sababu ukiwa na shida yeye atakusaidia kama rafiki ako mbali."* [In times of need, friends are more helpful compared to neighbours though it's important to keep a good relationship with the neighbour because the friends might not be within reach in critical times.]

"Rafiki anakusaidia na vitu vingi kama chakula, nguo za watoto na pia mtu akiwa na matanga rafiki anampa moyo. Pia ukitaka kuenda mahali kama hospitali, rafiki anakubeba na baiskeli hata kama hauna pesa." [Friends do help in many ways like food, clothes for the children and psychological support during bereavement. They also help when in need of transport to hospital and also carry you on their bicycles when you have no fare.]

The relatives are always ready to help regardless of the type of problem one has. They are so careful to keep the good relations between them and their relatives "*mtu akikosana na watu wa nyumbani, hapo ndipo ameuma mawe."* [If one is not in good terms with their relatives they will have it hard in life]

The participants were disappointed in their political leaders (MP and councillors). These leaders only visit only those who are rich and those who campaign for them during the elections and never bother

with the rest of the masses. One said *"hawa wanasiasa wanawatembelea tu marafiki wao na matajiri, lakini watu kama sisi oh ho...utangoja. Hata kwa hoyo matanga, wanaenda tu kwa wenya wanazo sio maskini kama sisi. Tena wanaweza kuwasaidia wale wanaowasaidia wakati wa uchaguzi."* [These politicians only visit their friends and the rich, but for us, oh no...you'll really have to wait. Even for the funerals, they only attend to the rich not the poor like us. They also help those who help them during the elections (campaigners and financiers).

On the part of the doctors' and hospitals, they are very important (because to them, absence of diseases is of the highest priority) and easily accessible. *"ukiwa na afya nzuri, hiyo ni muhimu sana kuliko kitu kingine chochote."* [The absence of illness in a person is the best thing in life]. However some of the participants felt that there was not much help in times of need from the doctors and hospitals. "*hawa madakitari na hospitali hawawezi kukusaidia kama hauna pesa. Wanatusaidia kupitia Armpath. Kile wanatusaidia bila pesa ni kutuongoza tu na maneno. Pia hawatupatii chakula ama ukiwa na shida ya mtoto."* [These doctors and the hospital cannot attend to you when you don't have money. They only help through a programme called Armpath – an NGO which donate drugs, vaccinations and food through hospitals. The hospital and doctors only help by talking to us and counselling. They do not give us food nor help when a child has problems (i.e. school fees, uniform]

On the teachers, the participants also felt that they cannot be of much help beyond the school. *"unajua, mwalimu mkuu anatusaidia kwa kutuachia watoto wasome wakati hatuna pesa halafu tukipata tunawapelekea. Pia walimu wengine wanaweza kukulipia pesa kwa shule halafu ukipata, unamrudishia. Lakini mambo ya chakula na shida zingine hapo hawawezi kusaidia"* [You know, the head teacher helps us by allowing our children to stay in school when we do not have money to pay until we have. Other teachers pay school levies for the children when we do not have but when we get the money; we have to pay them back.]

Template for Institutional analysis (Bubble diagram) : Makueni

Background information:

When we arrived, the people were already seated.

We started with the community mapping, which entailed the drawing their entire location, including the institutions (e.g. schools, health centres, and churches), physical topography and homesteads. With this we got to know how people live, challenges they face and the coping strategies to these challenges across age and gender.

All the participants come from poor backgrounds and have therefore limited ways of income.

From the community mapping, it emerge that there were so many schools (both primary and secondary)

Numbers of participants (at beginning): 14 **(at end):** 14

Location: Kwakavisi (Makueni)

Kind of participants (men, women, etc.): men (6) and women (8) of older ages (between 35 and 70); mixed beneficiary (7) and non beneficiary (7)

Age (average): ≈45

Date: 05/07/2012

Time start: 1226hrs **Time end:**1450hrs

Facilitator(s): George Khamati

Note taker: Julie Mutuura

How was the process? Was it participatory; did everyone take part in the discussion; did anyone walk out, why: was it difficult / easy to manage, why; were people comfortable / uncomfortable, why?; etc.

At the initial stages of drawing the map, many were reluctant but later picked up and were willing to clarify and contribute by drawing, though one member who seemed illiterate indicated that "*nitachora na mdomo"* meaning that he will draw with his mouth (translated to mean that he can help in giving verbal instruction).

The members seemed to know the areas of their residence and could easily point then on the map. This made the process manageable, coordinated, and interesting and an easy activity. However there were some older women (3) who didn't understand English or Swahili but they contributed through the aid of a volunteer translator within the group.

Summary of findings from sheets:

Key people / institutions turn to in times of difficulty	**How support in times of difficulty**	**How important are they to you (very, middle, little)**	**How accessible are they to you (very; middle; little)**	**Comments / notes**
Administrators (Chief, Assistant chief, headmen	Solving land conflicts Issuing of birth and death certificates Give food rations Help in times of abuse (sexual) Solving inter/intra family conflicts	Very	Very	The administrators know them in person and know their homes. They feel that by them (administrators) understanding them well; they are more close and considerate of them.
School/Head teacher	Accommodate students in times of lack of school fees Assists in acquiring the birth certificates Solves intra hh conflicts such ac as 'rebellion' of the children Gives information in cases where a child is mentally retarded – the Ht can give advice on where to take the child for treatment Gives advice and helps to refer sick children to hospitals	Little	Little	Though they understand their problems, they can only let their children in school at limited durations and therefore not considered very important
Religious leaders (pastors/ priests	Give prayers in times of 'temptations' Solve marital problems (acts as counsellor) 'open houses' with prayers Fundraising for school fees	Middle	Little	The religious leaders are not the immediate resort in times of difficulty. This is because they must be notified well in advance for an appointment to materialize. Some (priests) are only symbolic and unreachable. They do not visit them in their homes and never avail themselves for consultations.
Doctor	When sick they seek medication Go for counselling/advice When abused (esp. sexually abused)	Middle	Middle	Doctors/ clinical officers are considered important since one of the main problems facing these people is diseases. These however only give medicines and offer treatment services, which are paid for, they don't give cash gifts, free medication or loans which are considered high in value.
Businessman	When hungry – gives items on loan Gives money for fees Gives food (cereals) Buy hh items, animals and use money to pay school fee	Little	Little	When unable to sort the needs the businessmen may refer the people to other businessmen and act as guarantors for loans They are not reliable as they mostly postpone meeting the people which is viewed in bad light by the people. The people feel that the businessmen exploit them by buying their stocks and hh items at low prices and later sell to them at higher rates.
BWC/AAC	Speak to the children who drop out of school	Middle	Very	

Key people / institutions turn to in times of difficulty	How support in times of difficulty	How important are they to you (very, middle, little)	How accessible are they to you (very; middle; little)	Comments / notes
	Liaise them with the DCO			
Neighbours	Help in food Give hh goods	Very	Very	They are considered very important, only second to the administrators. Much of these 'helping' is not free, rather a form of securing the future (a kind of insurance) to be reciprocated at a later date.
Midwives (*ngaisicha*)	Help in delivery especially during delivery emergency Consulted when there is a problem with the pregnancy Record and take the sick person to hospital and village heads	Little	Middle	
Herbalists	Give herbs / medicine during illnesses (stomach upsets, malaria and coughing)	Middle	Middle	Contacted when one doesn't have much money. They are more trusted than the doctors and hospitals
CHW	Assistwhen people are sick by directing them to hospitals Give advice concerning health issues Liaise them with hospitals	Middle	Middle	Are considered relevant but since they don't give food and money their importance is not that much.

Write-up of notes from note taker

Discussions/disagreements about relative importance of different people / institutions

The respondents have lived in this area the whole of their lives, some trading and doing menial work throughout this area. The respondents also felt that the researchers had donations to give and therefore sought to impress as much as possible. This was evident at the end of the activity some of them approached some researchers for perceived donations for information given.

The administration (chief, assistant chiefs, village heads) work close to the people and are considered to be the most important of all the institutions and people. They help in solving conflicts related to land, neighbours, family, birth registration, death certificates and help in distributing food (from the NGOs and the government) during famine. The administration also link people to the police especially in cases of sexual abuse. *"Administration inatusaidia sana. Kwa mfano mtu akishika mtoto tunempeleka huyo mtu kwa chief, halafu chief anampeleka kotini."* The administration helps us in times of various difficulties. For instance, when a child is raped, the chief facilitates the arrest and prosecution of the rapist].

The neighbours are considered very important and very accessible. *"jirani anaweza kukusaidia hata usiku"* [a neighbour can give you help even at night].

The head teacher helps in various ways but especially in dealing with children-school affairs. One thing that stuck out is the help of the head teacher when dealing with mentally challenged children. *"walimu wanakusaidia ikiwa na mtoto ana ugonjwa wa akili. Kama ukiwa na mtoto kama huyo mwalimu anakwambia mahali pa kumpeleka, kama ni kwa hospitali ama kwa shule zao."* [The head teachers also help if you have a child with mental issues. If you have such kind of a child, the head teacher advices on whether to take the child to hospital or to a special school for the disabled.

There was a disagreement on the importance of the religious leaders. Some members felt that they were very important (referring to the pastors) and actively participate in daily lives of the people like 'opening homes, marriages' while others thought that the religious leaders as least important (referring to the priests). *"hawa wachungaji wanasaidia na mambo ya kiroho na maombi tu. Pia kama mtu anataka kuingia kwa nyumba mpya na pia ndoa, anaita mchungaji afungue kwa maombi"* [these pastors help with prayers and spiritual nourishment only. Though, if one has built a new house or newly wedded, the pastors offer prayers for blessings.]

On the priests *"hao wako mbali sana, na tena unawaona tu kwa kanisa, hawawezi kukutembelea nyumbani ukiwa na shida"* [those are very far from us, and we only see them in the church, they cannot visit you at home even when you are in difficulties.]

Witchcraft and witchdoctors (*wachawi*) were initially named as some of the important people who help them in times of need. They were dismissed off. *"Wachana na hao, wanatudanganya tu."* [Leave them out, those just deceive people]. They were however replaced by herbalists (*daktari wa mitishamba*). Even after probing and re-assuring them of confidentiality and anonymity, they still could not talk about witchdoctors and the respondent who mentioned it seemed to shift positions and said that there are no witchdoctors.

Others thought that the herbalists were very important and provide treatment for conditions that the modern medicine cannot heal such as stomach upsets (which require rituals). There was a disagreement on the ease of access of the herbalist. Some people thought that they were not easy to access since they perform rituals and demand payment in terms of animals which are very expensive. However, others thought that the herbalists are also preferred in cases one is constrained financially. *"huwa tunaenda kwa daktari wa kienyeji kama hatuna pesa kwa sababu kwa hospitali, hauwezi kuhudumia ikiwa hauna pesa."* [We visit the herbalists when we do not have money to visit the hospitals which requires that one have money to be attended to.]

On the businessmen, the participants felt that these were of very little importance and punitive. They complained that the businessmen exploit them *"hawa ni kama tu wezi, sisi tukivuna shambani, wananunua mazao kwa bei mbaya sana, lakini tukienda kununua kwa duka zao, bei inapandishwa hata mara tatu. Pia ukiwa na shida, wananunua vitu za nyumbani kama viti na meza na wanakuacha bila kitu."* [these are like thieves, during harvest, the businessmen buy our farm produce at very low prices and sell it back to us at very high prices – at times threefold – in times of scarcity. When you have financial problems, the businessmen buy household items such as furniture and leave you with no assets].

The CHW assistance is little compared to the doctors. *"hawa wanatusaidia kupatia watoto chanjo wakitutembelea nyumbani. Pia wanatuambia twende hospitali tukiwa wagonjwa."* [the CHW help in the immunization of our children when they visit us in our homes. They also refer us to visit hospital when we are sick].

On BWC/AAC, the participants felt that their importance is very little though they are easily accessible. *"wakati mwingi wanashindwa kutusaidia na shida zetu na wanatuambia twende kwa chief. Kwa mfano mtoto akikataa kwenda shule na anasumbua wananiambia nimpeleke kwa chief. Hawatusaidii kwa njia nyingine yoyote."* [mostly the BWC/AAC are not able to solve our problems and opt to send us to the chief. For instance, when there are conflicts between the (beneficiary) child who refuses to attend school, they advice me to report him/her to the chief. They do not give any other help (food, clothing, medical fees, school fees etc.].

Annex 12: Comprehensive questionnaire (Form 2)

D. HOUSEHOLD MEMBERS' ROSTER | **E. EDUCATION** | **F. HEALTH** | **G. LABOUR**

No.	FOR ALL PERSONS IN THE HOUSEHOLD				FOR PERSONS AGED BELOW 18		FOR ALL PERSONS	FOR ALL PERSONS		FOR ALL PERSONS	FOR ALL PERSONS
	20 What is the full name of all the members of the household? MAKE A COMPLETE LIST OF ALL INDIVIDUALS WHO NORMALLY LIVE TOGETHER IN THIS HOUSEHOLD, STARTING WITH THE CAREGIVER. (CONFIRM THAT CAREGIVER NAME HERE IS THE SAME AS THE CAREGIVER LISTED ON COVER) FIRST NAME / MIDDLE NAME / SURNAME	21 What is the relationship of THIS PERSON to the caregiver? CAREGIVER 1 SPOUSE 2 SON 3 DAUGHTER 4 FATHER / MOTHER 5 SISTER / BROTHER 6 GRANDCHILD 7 OTHER RELATIVE 8 SERVANT (live-in) 9 FOSTER CHILD 10 OTHER NON-RELATIVE 11	22 GENDER M..... 1 F..... 2	23 Does THIS PERSON have a birth certificate or ID? Yes..... 1 No..... 2	24 What is date of birth of THIS PERSON? If known (DD / MM / YYYY)	25 Is the biological father OF THIS PERSON alive? YES... 1 NO..... 2 DOESNT KNOW 3	26 Is the biological mother of THIS PERSON alive? YES... 1 NO..... 2 DOESNT KNOW 3	27 Has THIS PERSON ever attended school or currently YES.. 1 NO... 2 (skip 25)	28 Highest or current class attended PRE-SCH 0 PRIMARY STD 1 ..... 1 STD 2 ..... 2 STD 3 ..... 3 STD 4 ..... 4 STD 5 ..... 5 STD 6 ..... 6 STD 7 ..... 7 STD 8 ..... 8 Form 1 or above 9	29 Does THIS PERSON suffer from a chronic Yes...1 No....2	30 Does THIS PERSON have any disability Yes..1 No....2	31 Is THIS PERSON currently working? Yes..... 1 No..... 2	32 What was the main occupation during the last month? NONE 1 FARMER 2 LIVESTOCK FARMER 3 FISHERMAN 4 PASTORALIST 5 JUA KALI(self) 6 MANUAL LABORER 7 SMALLSCALE I 8 OTHER 9
1												
2												
3												

H. DWELLING CHARACTERISTICS AND WEALTH

33 What is the major construction material of the WALLS?

MUD/COW DUNG	1
GRASS/ STICKS/ MAKUTI	2
STONE	3
WOOD	4
BRICK/BLOCK/CEMENT	5
IRON SHEETS	6
TIN	7
OTHER (SPECIFY) _____	8

34 What is the major construction material of the FLOOR?

MUD/COW DUNG	1
GRASS/ STICKS/ MAKUTI	2
STONE	3
WOOD	4
CEMENT	5
TILES	6
OTHER (SPECIFY) _____	7

35 What is the major construction material of the ROOF?

MUD/COW DUNG	1
GRASS/ STICKS/ MAKUTI	2
STONE	3
WOOD	4
BRICK/BLOCK/CEMENT	5
IRON SHEETS	6
TIN	7
OTHER (SPECIFY) _____	8

36 What type of TOILET does this household have?

FLUSH TOILET	1
PIT LATRINE	2
NONE/ PAN/ BUCKET	3
OTHER (SPECIFY) _____	4

37 What is the main source of drinking water used by this household?

PIPED WATER INSIDE DWELLING	1
PIPED WATER OUTSIDE DWELLING	2
WATER TRUCK / VENDOR	3
PUBLIC TAP	4
SPRING OR WELL	5
RIVER, LAKE, POND OR SIMILAR	6
OTHER (SPECIFY) _____	7

38 What is the household's main source of LIGHTING fuel?

ELECTRICITY	1
PARAFFIN/KEROSENE	2
GAS	3
FIREWOOD	4
CANDLES OR FLASHLIGHTS	5
OTHER (SPECIFY) _____	6

39 What is the household's main source of COOKING fuel?

ELECTRICITY	1
PARAFFIN/KEROSENE	2
GAS	3
FIREWOOD	4
CHARCOAL	5
RESIDUE/ ANIMAL WASTE/ GRASS	6
OTHER (SPECIFY) _____	7

IF APPLICABLE

40 How many farming acres of land does this household own?

IF APPLICABLE

41 Do you own real state property here or elsewhere?
yes =1 no = 2

IF APPLICABLE

42 How many cattle does this household own?

Traditional Zebu

Hybrid

IF APPLICABLE

43 How many goats does this household own?

IF APPLICABLE

44 How many sheep does this household own?

IF APPLICABLE

45 How many pigs does this household own?

IF APPLICABLE

46 How many camels does this household own?

47 Other poverty characteristics the household may have and are identified by the enumerator

_____

_____

_____

_____

_____

_____

To be filled by data entry officer:

Annex 13: Proxy means test weights

	RURAL	URBAN	NAIROBI
Constant	8.178	7.523	8.339
Caretaker Characteristics			
Age	-0.001	0.003	0.000
square			
Education STD. 7	0.064		
Education STD. 8	0.102		
Education Form 1 or above	0.246	0.256	0.088
Household Characteristics			
Number of boys aged 6-17 working		-0.049	
Number of girls aged 6-17 working	-0.008	-0.040	
Number of adults age 18 or more working		0.042	0.079
Household Size	-0.159	-0.154	-0.343
Household Size Squared	0.008	0.007	0.028
Number of chilren aged 0-5	-0.136	-0.259	-0.343
Number of chilren aged 0-5 Squared		0.037	0.073
Number of OVC-children under 17	-0.025	-0.033	-0.169
Number of OVC-children under 17 Squared			0.023
Main Source of Drinking Water			
Piped Water inside Dwelling	0.172	0.198	0.447
River, Lake, Pond or Similar	-0.074		
Main Source of Lighthing Fuel			
Firewood	-0.520		
Electricity		0.280	0.118
Main Source of Cooking Fuel			
Firewood	-0.308	-0.216	
Gas		0.534	0.561
Type of Toillet			
Flush toilet	0.237	0.520	0.472
Pit Latrine	0.094	0.393	0.331
Major Construction Material of Walls			
Stone	0.166		0.030
Wood	0.149		
Major Construction Material of Roof			
Iron sheets	0.153		
Brick, Block, Cement		0.121	0.191
Major Construction Material of Floor			
Cement		0.140	
Mud, Cow Dung **or** Grass, Sticks, Makuti	-0.234		
How many Traditional Zebu Cattle Owned			
None	-0.466		
How many Hybrid Cattle Owned			
1 or 2	0.194		
more than 2	0.302		
How many Sheep owned			
1 to 5	0.094		
more than 5	0.134		
How many Camels owned			
None	0.035		
How many Goats owned			
None	-0.054		
Provincial Dummy			
3 Coast	0.045	0.152	
4 Eastern	-0.056	0.141	
5 North Eastern	0.098	-0.018	
6 Nyanza	-0.029	0.209	
7 Rift Valey	-0.015	0.049	
8 Western	-0.026	0.133	
Interactions			
No Camel x No Zebu	0.290		
North Eastern x No camel	-0.154		

Annex 14: Communication and policy engagement approach/matrix

Communications Strategy for the Community Perceptions of Cash Transfers Study in Kenya

1. Introduction

This communication strategy outlines the roadmap for communicating the results of the community perceptions of cash transfer study in Kenya. The focus in the Kenya Study was on cash transfer for OVCs. The strategy is formulated around four objectives drawn from the communication objectives of the main project. It identifies the target audiences at the local, national, and international levels. The local and national audiences are mainly drawn from the stakeholders in the country working on issues related to social protection in general and in particular CT for OVCs. The key tools/activities identified include community feedback sessions, participatory photography workshops, technical reports/policy briefs, meetings with target working groups, media briefing for journalists, dissemination of digital stories and photos through social media, and national, regional and international dissemination. These tools/activities are tailored to specific audiences. The communication messages are also outlined.

2. Project objectives

- Explore the views, experiences and perceptions of CT programme beneficiaries and other community members (non-beneficiaries) in order to ensure they are better reflected in policy and programming
- Increase the capacity of national and regional research institutes in participatory monitoring and evaluation in cash transfer programmes;
- Encourage greater use of and more effective approaches towards inclusion of beneficiaries and their communities in cash transfer programme M&E processes; and
- Promote lesson learning across DFID offices and internationally (including to public audiences) in these areas and inform national, UK and global debates.

3. Communications objectives

- To listen to marginal voices and use creative and innovative ways in which to express and amplify them thereby redressing imbalances in representational power.
- To communicate beneficiary/community-informed evidence on cash transfer programmes to national, regional, UK and global cash transfer debates
- To ensure uptake of the findings of our research and facilitate better informed policy making and practice;
- To make research more accessible and engaging to those actors beyond the immediate fields in which research evidence tends to operate as a means of consolidating public support for cash transfer programmes.

4. Audiences

Local level

- Beneficiaries
- Community members
- Chief/local leaders
- District Children's Officer (DCOs)/Voluntary Children's Officers (VCOs)
- Beneficiary Welfare Committees (BWCs)
- Religious leaders

National

Policy makers

- Ministry of Gender, Children and Social Development
- OVC secretariat

- Ministry of Finance
- Ministry of State for Planning, National Development and Vision 2030
- Ministry of Labour
- Ministry of Education
- Ministry of Health

Network and NGO focal points/civil society

- Social Protection Actors Forum (APAF) – Kenya/African Platform for Social Protection
- Action Aid International (AAI)
- Concern Worldwide
- CRADLE
- Deaf Initiative Network
- HelpAge Kenya
- Kenya Alliance for the Advancement of Children (KAACR)
- Kenya Union of the Blind
- OXFAM
- Railway Children
- Save the Children
- United Disabled Persons of Kenya (UDPK)
- World Vision
- Africa Institute of Health and Development

Academics

- WinnieMitula , John Njoka, GerrisomIkiara – University of Nairobi

Media/journalists

- Key Media Houses – Nation Media, Standard Group, Royal Media, Mediamax - K24
- Feature story journalists
- Editors Guild
- Media Owners Association
- Kenya Union of Journalists - KUJ

Public audiences

- General audiences requiring publicity

International

International governments/policy makers - UK Government

Donor agencies – DFID, UNICEF, World Bank, WFP, USAID, JICA

Other groups at international level - Academics, International NGOs/networks/civil society, Public audiences, Media/journalists

5. Possible messages

- CTs have improved the quality of life of OVCs
- CTs have contributed significantly to school enrolment and retention
- CTs have contributed to the formation of social and economic capital
- The amount of CT given is not sufficient for the needs of OVCs
- There is need to integrate all interventions targeting vulnerable populations
- There is need to enrol more OVCs in to the CTP

- There is need to provide more information and publicity regarding the CTP
- Strengthen accountability measures
- Strengthen M&E to provide data on large scale impact

6. Tools and activities

	Audience	**Tools/Activities**
Level		
Local	CT Beneficiaries Community members Chiefs DCO VCOs BWCs Local leaders	Demand generation consultations Participatory photography workshops Community Feedback sessions
National	Ministers &Policy makers	National level dissemination event, Policy briefs
	Media/journalists	Breakfast meeting/media briefing with journalists
	Network & NGO focal points/CSOs	Focused meetings with target working groups/networks/CSOs
	Academics	National dissemination event, technical reports, peer reviewed articles
	Public audiences	National dissemination event, Print and social media (blogs)
International	International Governments/ policy makers	International dissemination event, policy briefs, technical reports
	Donor agencies	
	Academics	
	International NGOs	
	Public audiences	Dissemination of digital storiesand photos through facebook, twitter, blogs
	Media/Journalists	

.....

Communications plan matrix		Objective			
		1. To listen to marginal voices and use creative andinnovative ways in which to express and amplify them	2. To communicate beneficiary/community -informed evidence on cash transfer programmes to national, regional, UK and global cash transfer debates	3. To ensure uptake of the findings of our research and facilitate better informed policy making and practice	4. To make research more accessible and engaging to those actors beyond the immediate fields in which research evidence tends to operate
Level	Audience				
Local	Cash transfer beneficiaries Community members Chiefs/local leaders DCOs/VCOs BWCS	Demand Generation Consultations Participatory Photography Workshops Community feedback sessions			
National	Ministers and policy makers		National level dissemination event, Policy briefs Focused meetings with target working groups/networks/CSOs National dissemination event,technical reports, peer reviewed articles Breakfast meeting/media briefing with journalists National dissemination event,Photography exhibition, Print and social media (blogs)		
	Network and NGO focal points/civil society				
	Academics Media/Journalists Public Audiences				
International	International governments/ policy makers, Donor agencies		International dissemination event Dissemination of digital storiesand photos through facebook, twitter, blogs		
	Academics				
	International NGOs/networks				
	Public audiences Media/journalists				

Kenya policy influence plan

Context

The Government of Kenya (GoK) has outlined its 'National Social Protection Strategy', 2009-2014. It defines Social Protection (SP) as "policies and actions aimed at enhancing the capacity of and opportunities for the poor and vulnerable to improve their livelihoods and welfare. The focus ("*core intervention*") of the SP strategy is cash transfers to various vulnerable groups including orphans and vulnerable children (OVC), Persons with severe disabilities (PWDs), Older persons, the urban poor living in slum areas, and people affected by natural disasters such as droughts and floods. The lead government agency mandated with the implementation of the GoK SP framework is the Ministry of Gender, Children and Social Development (MGCSD). The SP Management Board is housed within this Ministry and works in collaboration with National, Provincial, District and Locational Committees to implement the SP framework. The CT-OVC is implemented by the OVC secretariat in the Department of Children's Services in the Ministry. The government is the lead contributor to the programme with support from development partners that include the World Bank, UNICEF and DfID (IDA).

The Government of Kenya recognizes that poverty and vulnerability pose significant risks to its citizens, thus challenging the country's social and economic foundations. It is estimated that about 40% of the population live below the national poverty line while 19% live in extreme poverty. The government further recognises that SP is multisectoral involving state and non-state actors. The use of evidence by the government in policy making is noted in existing policies such as Poverty reduction strategy paper (PRSP) of 2001 and the economic recovery strategy for Wealth and Employment (ERS) of 2003. The political environment is conducive for SP and a National Steering Committee (NSC) for Social Protection has been established. The platform acts as a platform for inter-ministerial debates in the short-term and joint ownership of Social Protection in the long-term. This is evidence of Government commitment to improving the quality of life of the poor through SP. There is also a greater public debate and awareness on the needs of the poor and vulnerable.

Risks

There are political risks associated with the upcoming general election slated for March 2013.This is likely to interfere with our dissemination plan around the same time. The high political temperatures that characterise electioneering period in Kenya often start three months prior to the election date.There is going to be high political turnover as key policy implementers resign from Government service to join politics as the election date gets close.As at September 2012, the Permanent Secretary in the MGCSD (a key policy implementer) had resigned to join elective politics. It is therefore definite that new policy implementers will be in office after the general election and this might slow the uptake of the evaluation results.

We believe that the risks related to manipulation of the information by the press are limited since the CT programme is well established in Kenya. Any misinformation can easily be verified by getting the right information from the relevant government departments.

In order to mitigate the risks that are associated with the upcoming elections we prose to delay our dissemination until after the election in March. This will find when new top policy implementers have been appointed and assumed office. The results of the evaluation will therefore be taken up by those who shall have been mandated to lead policy implementation for the next five years.

Policy objectives

- To develop the capacity of the MGCSD/OVC secretariat and stakeholders to understand and respond to issues relating to CT-OVC regarding gathering routine data, accountability mechanisms and publicity concerns.
- To contribute to change of strategy by the MGCSD/OVC secretariat by presenting data on the negative effects of CTs to OVCs
- To influence resource allocation to the CT-OVC programme by presenting data on the positive effects of the CTs on the everyday lives of OVCs and the community in general.

Stakeholder analysis

We have identified the following groups to target to influence policy:

1. Ministry of Gender, Children and Social Development

This is the parent ministry responsible for SP programmes in Kenya including all the CTs. The Ministry is the key policy maker and implementer with regard to SP.A number of policy making and implementing organs have been created in the Ministry including the SP Board and the OVC Secretariat. Changes targeting the CT programme will have to be channelled through this Ministry. The Ministry is also responsible for bringing on board other relevant Government Ministries dealing with different aspects of SP as well as Non State Actors.

2. Ministry of State for Planning, National Development , and Vision 2030

Responsible for government planning, this Ministry will be very useful in influencing policy change. The Ministry has human resource for drafting policies and oversees the implementation of Vision 2030 which is a key policy document for the government of Kenya. There is emphasis on SP in the Social and Political pillar of Vision 2030.

3. Ministry of Finance

Responsible for government finances and will have to be involved in any discussions relating to government budget and finances. The Ministry has been key in the establishment of structures for the CT-OVC payment system.

4. Kenya Platform for Social Protection

The platform comprises NGOs and CSOs working on SP issues and is instrumental in lobbying for policy change. Given its intermediary role between government and development partners it will be instrumental in lobbying development partners to increase their funding for SP.

5. Technical Working Group (TWG) for the CT-OVC

This comprises the members of the OVC secretariat and key development partners who are currently funding the CT-OVC including the World Bank, UNICEF and DFID. The group is well versed with the operations of the CT-OVC in Kenya and any policy change will have to be presented to them before reaching out to other stakeholders. It is also a good forum for targeting both government and donor representatives.

6. National Council for Children's Services

The Council is a semi-autonomous government agency mandated to plan, regulate and coordinate children's rights and welfare activities. It has oversight mandate for child protection and welfare in Kenya. It brings together people of diverse background s which relate to child protection and welfare. They will be brought on board to enhance change of strategy in the delivery of CT-OVC.

.....