TRANSFORMING CASH TRANSFERS

COUNTRY BRIEFING

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

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Our research aimed to explore the perceptions of cash transfer programme beneficiaries and implementers and other community members, in order to ensure their views are better reflected in policy and programming.

Introduction

Key points:

- **The cash transfer has large positive effects at individual, household and community levels, including raising children's self-esteem, improving quality of life and stimulating social capital.**
- **Overall programme implementation is seen to be fair and the different-level committees function adequately. However, despite the existence of an independent complaints procedure, uptake is minimal.**
- **Recommendations include adjusting the transfer amount to take into consideration household size and inflation, bringing paypoints closer to the community and including vulnerable children who may not be orphans in the programme.**

Introduced in 2004, the Cash Transfer for Orphans and Vulnerable children (CT-OVC) in Kenya is an unconditional CT programme implemented by the government and supported by a number of donors. It forms a key aspect of the Kenya National Social Protection Policy (2011), which provides for basic rights to health, education and decent livelihoods.

To participate, a household must be identified as poor against a set of criteria (e.g. household size/composition, dwelling characteristics, asset ownership); be supporting at least one OVC under 18 years; and not be receiving benefits under a similar programme. Beneficiary households are identified through an elaborate community-based selection process. All households, irrespective of size, receive $48[1] every two months through the nearest post office, with the caregiver receiving the cash on behalf of the OVC. Caregivers and guardians must fulfil certain responsibilities, including ensuring OVC aged 0-5 years are taken for immunisations and growth monitoring; OVC aged 6-17 years regularly attend basic education; OVC acquire birth certificates; and caregivers attend programme awareness-raising sessions. Otherwise, they risk being replaced by alternative caregivers. The programme is implemented in 60 districts in Kenya; by May 2012, coverage was at 144,627 households and it is expected to grow to 160,145 by 2013.

This country brief draws on qualitative research focusing on beneficiary and community perceptions of the CT-OVC programme in Kenya, as part of a multi-country study in five countries (Kenya, Mozambique, Occupied Palestinian Territory (OPT), Uganda and Yemen) by the Overseas Development Institute (ODI) in partnership with national research teams involving primary and secondary data collection and analysis, and commissioned by the UK Department for International Development (DFID). The study aimed to ensure policy and programming better reflect the views of programme beneficiaries and implementers. The study was conducted in two districts of Kenya: Makueni in the east and Busia in the west.

1. This is slightly above a quarter of the minimum monthly wage in Kenya, set at $83, and represents approximately two-thirds of the international poverty line of $1.25 per day.

Poverty, vulnerability and coping strategies

According to respondents, the poor and most vulnerable live in grass-thatched mud houses, possess inadequate land, wear tattered clothing, have large family sizes, experience food shortages, cannot afford health care or children's school fees, lack livestock, work as casual labourers and rely on food donations. In Busia in particular HIV and AIDS is a key vulnerability, with many widows living with HIV and AIDS not only extremely poor but also suffering stigma and neglect.

The most vulnerable in both sites were said to be OVC, widows, persons with disabilities, children, older persons, the landless and women in general.

'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' (widow, Busia).

Respondents also identified differences in vulnerability for different categories of people: young men to drug and alcohol abuse and unemployment, young women to early marriage, sexually transmitted infections and pregnancy.

Coping strategies include borrowing from friends and family, petty business, sharing labour, taking goods on credit, engaging in wage labour and taking out loans. Children may stay away from or drop out of school, run away from home, engage in child labour, marry early (girls) and get involved in petty crime. Women may belong to informal groups, borrow from each other and (particularly in Busia) set up informal banking systems. The government, represented by local administrators (chiefs and sub-chiefs), is the key institution the vulnerable turn to for support. Other institutions/persons include school/head teachers, church/religious leaders and hospitals/doctors.

> I have eight children to take care of. 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.
>
> (Widow, Busia)

Effects of CTs on the lives of beneficiaries and their communities

On building social capital: *'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'* (grandfather caretaker, Busia).

On declining negative coping strategies: *'Since the CT came, stealing and taking other people's chickens by the children is over'* (women's group leader, Busia).

On increasing self-worth/confidence: *'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 anymore'* (girl, Makueni).

On tensions: *'There are some conflicts, whereby the caregiver cannot provide the required care [...] and the children are aware [...] 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'* (head-teacher, Busia).

Experiences of CTs and perceptions of programme design and implementation

Positive and negative experiences of the SCG

Cash is used to purchase basic household necessities (food, bedding, clothing) and housing materials, meet school requirements (levies, uniform, extra tuition) and pay health bills. These expenditures are related directly to the programme's strategic objectives (education, health, food security and civil registration). The CT is also sometimes used to develop livelihood activities, including starting small businesses, purchasing domestic animals, engaging labour, investing in small-scale farming and contributing to informal savings groups.

Respondents felt that, unlike other forms of social assistance, the CT gave them freedom to spend the money on what they needed. Thus those who had experienced food aid said it had made them feel like dependants; those who had experienced public works felt the wages were not commensurate with the work done. For most beneficiaries interviewed, the CT has become a major source of household income, surpassing all other sources; critical to its importance is its regularity.

- At individual level, the quality of life of OVC has improved: they now have better clothing and more food, live in better housing and have their health needs met. OVC are now going to school, and have the cash to pay for uniforms, books and school levies. The CT has contributed to a feeling of self-worth among OVC; they talked about their future confidently and discussed wanting to succeed in school and lead a better life. OVC also spoke about having more friends now and becoming increasingly accepted by other children into a community of peers, thus also enhancing/building their social capital and networks.

- At household level, the quality of life of other members has improved in the same way as for OVC. Households are also now more able to build economic capital and invest in a future for their children – many beneficiary households have opened bank accounts, others are involved in informal banking schemes and some others have invested in petty business, livestock and farming. The CT has also reduced the stigma households once faced when fostering large numbers of OVC.

- At community level, the CT has contributed to the social acceptance of OVC: previously, orphans were discriminated against because they were perceived to be a burden. People are now more willing to foster OVC, thus improving their status and seeing them as valuable additions to the household. The CT has also contributed to the empowerment of vulnerable groups by giving them a voice in the community, such as in community meetings. Social capital has been generated and social groups have been formed around the CT; these groups also offer informal psychosocial support to widows living with HIV and AIDS and advise elderly grandmothers on how to handle OVC. Finally, the local economy has been stimulated, with a trickle-down effect meaning most people in the community have benefited either directly or indirectly from the CT.

Some negative effects were reported:

- Tensions among caregivers at the household level regarding use of the CT, mostly between spouses, with women accusing men of spending the CT on alcohol;

- Tensions between caregivers and OVC, arising when some OVC are seen to have become 'arrogant' and 'disrespectful' to their caregivers, making demands on them;

- Tensions between beneficiaries and non-beneficiaries in the community, as there remain many who feel they should be included in the programme; and

- Some evidence of erosion of informal and traditional social protection or social support systems, such as around keeping orphans.

Tensions at household level were reported by only around 15% of beneficiaries; all beneficiaries reported tensions at community level.

Perceptions of programme design and implementation

All community members were aware of the existence of the programme, although non-beneficiaries did not know the monetary value of the CT. Similarly, most OVC, while aware their caregivers received money on their behalf, did not know the details in terms of the CT's frequency and its objectives.

Community members (both beneficiaries and non-beneficiaries) felt the targeting process was fair and were satisfied with the main selection criterion – presence of an orphan in the household. Nevertheless, according to respondents and from observation, there were cases of vulnerable people not being included in the programme, some of whom were on the waiting list for the next recruitment round. Beneficiaries were generally satisfied with the current arrangement whereby they collect money from the post office, although they complained of the distance (up to 15 km) and the costs this entails ($2 for a return trip). Crowding on payment day is also a challenge – even though there is a window of 10 working days in which beneficiaries can collect – as are occasional delays in the post office actually receiving the funds. Most respondents felt the amount received could be increased; this was particularly the case with households with many OVC, since all households receive the same amount, irrespective of numbers of OVC.

Programme governance and accountability

The **Ministry of Gender, Children and Social Development (MGCSD)** is the executing agency for the CT-OVC programme; the OVC Secretariat coordinates and supervises implementation; and the Technical Working Group (TWG), comprising the OVC Secretariat and key donors, offers technical support. At district level, the District Children's Office (DCO) takes care of administrative aspects and coordinating logistical processes. While human resources at national level are adequate, at district level staff are stretched and at community level the programme relies mainly on volunteers, including voluntary children's officers (VCOs), locational OVC committees (LOCs), beneficiary welfare committees (BWCs), chiefs and sub-chiefs.

Overall, beneficiaries reported **satisfaction with implementation**. Community-level implementers monitor adherence to programme objectives, and those not complying risk being replaced by others. Most respondents felt, however, that **stricter conditions would not only allow for easier monitoring of the CT's impacts**, since there would be clearer indicators to track, but also **enhance accountability** on the part of beneficiaries: 'If they fail to observe them [conditions], relatives who can take good care of those children [OVC] should take them' (male non-beneficiary).

Beneficiaries can call a toll-free telephone number for the purposes of **reporting complaints**; they can also report complaints directly to VCOs, chiefs and DCOs. This system is managed by an independent firm called Kimetrica. However, very **few grievances had been reported** in general, with most complaints reported to chiefs being about tensions regarding use of the CT at household level. Non-beneficiaries have also complained to chiefs regarding **targeting**. The insignificant number of complaints may be because **beneficiaries feel they are not entitled to complain**: *'I think if you have been given something for free you cannot [...] complain'* (female non-beneficiary).

Conclusions and policy implications

Study participants proposed a number of recommendations:

- **Targeting.** The current system of targeting mainly orphaned children was said to leave out children living in destitute households, defined as those lacking basic necessities despite the presence of adults. It was recommended to widen the programme to include all vulnerable children.
- **Programme management and delivery.** Recommendations included; bringing payments points closer; decentralising some activities, such as monitoring and evaluation (M&E), to the county and district levels; and joint/integrated programming at national level to stop some districts being better funded than others. Donors and national-level implementers also recommended building more robust systems for delivery: strengthening grievance systems, M&E and payment service provision, as well as improving the Management Information System.

> This money has helped me a lot it cares for all our needs of food, clothing, wellbeing at home and building a house.
>
> (School child, Busia)

- **Transfer amount.** Beneficiaries and donors felt there was a need to rationalise the CT according to household size. Beneficiaries acknowledged the significant role the CT played in their lives but at the same time requested that the amount be increased to cushion them from inflation.
- **Programme staffing needs:** numbers, incentives and capacity building. At district level, increased numbers of qualified staff are needed to improve efficiency. The programme currently relies on volunteers to run activities at the community level; providing incentives could improve their effectiveness and commitment. Donor representatives also pointed to the need to address staff shortages and build the capacity of existing staff.
- **Community participation.** According to civil society and academic stakeholders, mechanisms should be put in place to increase community involvement and participation. This might include publicity campaigns to create awareness and working with existing community-level structures like church, youth and women's groups. Increased involvement and participation are likely to lead to greater community ownership as well as demands for increased accountability.
- **Conditionalities.** District- and community-level implementers, as well as beneficiaries, advocated for tougher conditions to ensure accountability on the part of beneficiaries, with penalties for those who fail to comply. Implementers felt conditions would ensure caregivers spent the money to the benefit of OVC.

- **Integration with other social protection programmes.** National-level informants felt the programme's current standalone nature was a challenge, since it might lead to duplication of effort and lack of coordination. Harmonisation would not only mean the creation of a national social protection programme to coordinate all CTs, but also make possible the development of a unified payment and targeting system. The government is currently developing a single registry for all social transfer programmes.
- **Programme scale-up and sustainability.** Donor representatives were in favour of scaling up the programme to make an impact at national level. Implementers and decision makers at national and district levels also highlighted a need to explore issues of sustainability. In this regard, political commitment will be necessary to increase the proportion of the government budget allocated to social protection .

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As part of the research process, a selection of child beneficiaries took part in participatory photography workshops run in collaboration with the charity, PhotoVoice. More information about participatory photography and its use in development research, as well as photographs and digital stories produced by participants, can be found on transformingcashtransfers.org.

Photographs:

Cover photo: Samuel guides a group of participants in using their new camera skills, Kwakavisi, Kenya © Lucy Williams 2012 / ODI / PhotoVoice
Inside cover: Children participating in the pilot, Kangemi, Kenya © Samuel Mbuto 2012 / ODI
Page 2: Girl in yellow dress © Stalla Mueni 2012 / ODI / PhotoVoice
Page 4: Boys aged 10-14 years getting to grips with the cameras, Kwakavisi, Kenya © Lucy Williams 2012 / ODI / PhotoVoice
Page 5: A school friend reads the text under a photo at the community celebration,Kwakavisi, Kenya © Lucy Williams 2012 / ODI / PhotoVoice

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