SOCIAL PROTECTION POLICY IN PROMOTING HUMAN DEVELOPMENT OUTCOMES: THE CASH TRANSFER PROGRAMME FOR ORPHANS AND VULNERABLE CHILDREN IN KIAMBU, KENYA

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ABSTRACT

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Cash transfers, integral in social protection, have increasingly been viewed as a viable measure of promoting human development outcomes in low and middle income countries in the face of persistent poverty exacerbated by the HIV/AIDS pandemic. Sub-Saharan Africa has been the worst hit by the HIV/AIDS pandemic with almost two thirds of the world's HIV/AIDS patients living in the region. By 2005, 12 million children were orphaned by the disease while 2 million more below 15 years of age were estimated to be infected (UNICEF, 2005:2). To address the plight of orphans and vulnerable children in Kenya the government together with various international development agencies launched the Cash Transfer Programme for Orphans and Vulnerable Children (CT-OVC) in 2004 to provide for the basic needs of OVC and promote their human development.

With the capability approach as its theoretical framework, this research seeks to determine the value attached by recipients of the CT-OVC to capabilities in the four broad dimensions of social life, health, education and play. It also seeks to gauge the extent of attainment of functionings in the four dimensions, and the association between participation in the programme and one's functionings in the key dimensions. The research is conducted through a quasi-experimental design which compares recipients of the cash transfer to non-recipients and mixed methods are used to collect and analyse data.

Results show that OVC consider capabilities in the dimensions of social life, education, health and play to be of high value in their lives. Children in the recipient group appear to have attained functionings in the four dimensions to a higher degree than their counterparts in the comparison group. There is also an association between participation in the CT-OVC programme and attainment of functionings in all four dimensions. Perceptions from participants explore further opportunities created or

expanded through the CT-OVC as well as participants' suggestions on the programme.

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DECLARATION

I declare that **Social Protection Policy in Promoting Human Development Outcomes: The Cash Transfer Programme for Orphans and Vulnerable Children in Kiambu, Kenya** is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

JOYCE NJERI MARANGU

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACRONYMS AND ABBREVIATIONS

ART	Antiretroviral Therapy
AIDS	Acquired Immune Deficiency Syndrome
CCT	Conditional Cash Transfer
CSPF	Consolidated Social Protection Fund
CT	Cash Transfer
CT-OVC	Cash Transfer programme for Orphans and Vulnerable Children
DFID	Department for International Development (UK)
DSD	Department of Social Development
DOSC	District Orphans and vulnerable children Committee
GDP	Gross Domestic Product
HDR	Human Development Report
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
KKV	Kazi Kwa Vijana (work for youth) programme
LIC	Low income country
LOC	Location Orphans and Vulnerable Children Committee
MGCSD	Ministry of Gender, Children and Social Development
MIC	Middle income country
OVC	Orphans and Vulnerable Children
PLWA	People Living with AIDS
PPR	Persons-per-room
SASSA	South African Social Security Agency
SD	Standard deviation
SIDA	Swedish International Development Authority
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund

USD	US Dollars
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

1.1 Background

After a long period of development practice which has seen the rise and fall of many different interventions aimed at tackling poverty in the developing world, social protection in these countries is beginning to take root. This is in part due to the increased acknowledgement of the role that it plays in contributing towards attainment of the global development agenda as exemplified by the Millennium Development Goals (MDG) (Devereux and Sabates-Wheeler, 2007:1).

By shielding the ultra-needy from vulnerabilities, addressing risks and fighting chronic poverty (Farrington and Slater, 2006:500) social protection is proving to be useful in enhancing their wellbeing and spurring development. Among the various social protection strategies, cash transfers have emerged strongly as an effective way to promote equitable growth and provide a breakaway from intergenerational poverty for vulnerable households in the developing world. There is a wealth of evidence in Brazil, for instance, that cash transfers have contributed to the reduction in inequality by 28 percentage points of the Gini index from 1995 to 2004, and by 12.5 percent in South Africa (Department for International Development [DFID], 2011:17). Effects have been favourable in both middle income countries (MIC) and low income countries (LIC) but with the greatest impact being experienced in LIC due to their relatively lower baseline levels (DFID, 2011:20). With regards to the spread of the cash transfer schemes particularly in the global south, Barrientos and Hulme (2008:4) view it as being akin to what they term "a quiet revolution." This is in reference to the manner in which cash transfers have moved from the margins of development policy into mainstream policy frameworks of several developing countries in the last two decades.

There is extensive evidence that cash transfers promote human development by helping improve health outcomes (Maluccio and Flores, 2004; Aguero et al., 2007). The impact on health in both of these studies has almost exclusively centred on anthropometric measures of nutrition since food security is considered to be one of the major ways in which cash transfer gains are made. In this case, height-for-weight and height–for-age measures have been

extensively used in evaluations and findings indicate that both of these measures can be improved through cash transfers.

The impact on education as another key human development outcome has also been widely investigated and the findings seem favourable, in the sense that both conditional and unconditional transfers are likely to promote enrolment in school as well as attendance. This is true particularly in programmes targeting households with children (UNICEF, 2009:10; Handa and Stewart, 2008:19). This outcome is perhaps brought about by improved nutrition which impacts positively on child growth and development; the reduced need for children to engage in productive work to supplement their parents' income making it possible to attend school; or through direct means such as payment of school fees. Effects of the transfer on student pass rates have however been mixed with some studies finding no real change (DFID, 2011:27) while others find improved pass rates, especially for girls (Chaudhury, 2008). These differences are perhaps due to the disparities in access to quality education services in the different contexts.

Childhood orphanhood is thought to be a major determinant of adult poverty through different channels including poor investment in the human development of children. The HIV/AIDS pandemic has contributed greatly to the number of orphans globally and more so in sub-Saharan Africa where it was estimated in 2005 that some 12 million children were orphaned by AIDS and another 2 million below 15 years were living with HIV/AIDS. The region is also home to almost two thirds of the world's HIV/AIDS patients. All these factors combine to make it the worst hit region globally (UNICEF, 2005:2).

To address the plight of orphans and vulnerable children in Kenya, the Cash Transfer Programme for Orphans and Vulnerable Children (CT-OVC) was launched in 2004 to provide for the basic needs of poor children orphaned or made vulnerable particularly due to the HIV/AIDS pandemic and currently serves 230 000 orphans and vulnerable children (OVC). This was in recognition that cash transfers have contributed towards the care and support of persons affected by HIV/AIDS including orphans and vulnerable children through for instance, making it possible to access health centres and increased expenditure on nutritious diets needed to complement antiretroviral therapy (ART) (DFID, 2011:20).

Nearly all of the previous studies on social protection programmes for human development of children have focused mainly on their health and education outcomes. Although these are important human development indicators and more importantly, are valued by the children,

there is need for research to go beyond these two indicators and investigate additional outcomes insofar as the expansion of opportunities and freedoms for children are concerned. Very little is known for instance on the impact of cash transfers on capabilities in dimensions such as social life and play which might be equally valued by children. This study aims to discover the valued capabilities among the Orphans and Vulnerable Children (OVC); and the extent to which the CT-OVC social protection policy is succeeding in promoting attainment of functionings for the children. As posited by Sen (1992) in his capability approach[1], the concept of capabilities refers to the real opportunities that exist for one to be or do something: for instance the opportunity to get a proper education. Functionings on the other hand refer to one's achievements or their beings and doings (Sen, 1999b:7), for instance, being well educated. The study shall make use of both quantitative and qualitative methods to determine the outcomes of the programme and findings might then inform policy makers on its usefulness in enabling people, and especially OVC, to lead the kind of life they "value or have reason to value" (Sen, 1999a:75).

1.2 Overview of Study Area: Kenya and Kiambu County

Based on the economic indicators of the country, the World Bank ranks Kenya as a low income country, with a gross domestic product of USD40.7 billion (World Bank, 2014). The country's expenditure on social protection stood at Ksh.37.1 billion (USD463.8 million) in the 2011/12 government budget having undergone a 13.5 percent increase from the 2009/10 budget period (World Bank, 2013:214). This has led to the expansion of social protection programmes in the country. There has however been a substantial drop in government's spending on social protection as a percentage of the national budget from 4.2 to 3.8 percent within the same period (ibid.). For a low-to-middle income country (LMIC) such as Kenya to provide comprehensive social protection to its citizens, it is recommended that up to 5.6 percent of its GDP be allocated towards this sector (European Commission, 2013:6).

In the past few decades, substantial gains have been made in the health, education and income levels in the country ensuring the overall human development in the country remains on an upward trajectory. However, the United Nations Development Programme (UNDP, 2013) classifies Kenya as one of the developing countries with a low human development based on its Human Development Index (HDI) score of 0.519. This is an indication that there is still much to be done in expanding people's choices to enable them achieve the things that

[1] Concepts in the capability approach are discussed in greater detail further on in chapter three.

they value and particularly on key indicators of human development which include health, education and income levels.

The total population in Kenya stands at 38.5 million (Kenya National Bureau of Statistics [KNBS], 2009). Nearly half (49%) of this population is below 18 years of age (UNICEF, 2012b). The population in Kiambu County, where the study was undertaken is over 1.6 million which makes it the fourth most populous county in Kenya. Of the total population in Kiambu, 38.7 percent are within the 0 to 14 age group (KNBS, 2005/6:14 and 26) and only 67.4 percent live with both their parents. For 1.8 percent of these children, both their parents are deceased. Thus, the county has a slightly higher number of orphaned children than the national average which stands at 1.2 percent. It is estimated that there are 2.6 million orphans aged below 17 years in Kenya (UNICEF, 2012b). This is indicative of the possible need for rolling out such social protection programmes as the CT-OVC in this area.

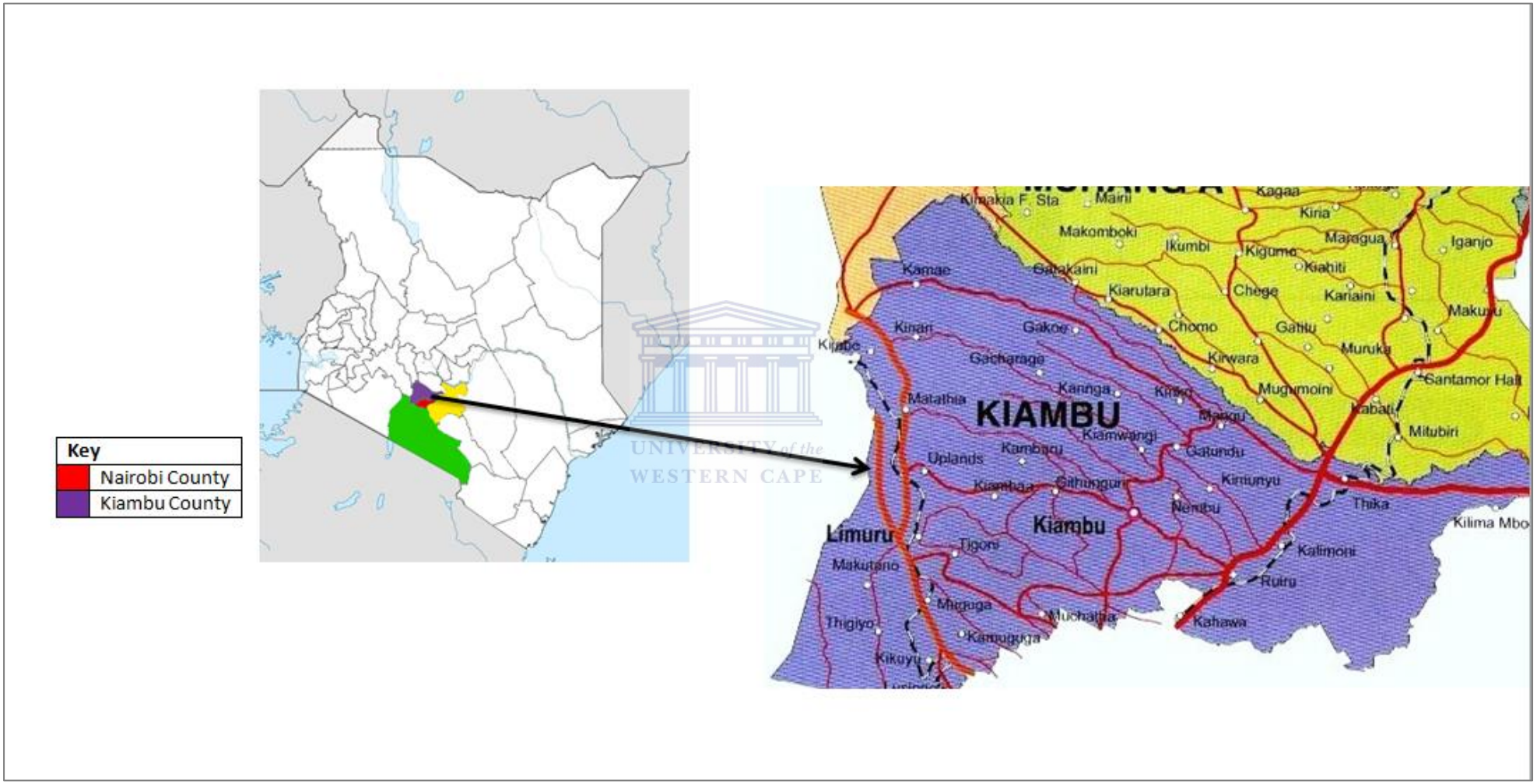
Kiambu County is situated within the Central Province of Kenya and borders the capital city, Nairobi to the north. The illustration in figure 1 below locates Kiambu within the country.

Kenya has a considerably high youth literacy rate at 92 and 94 percent for females and males respectively according to UNICEF (2012b). The mean years of schooling for adults is 7 (UNDP, 2013). This is substantially lower than in countries with a higher human development index such as Norway where the mean is 12.6. In Kiambu County, 99.6 percent of the population aged between 6 and 17 years are reported to have ever attended school in their lifetime (KNBS, 2005/6:34). This is a much higher percentage than the national average which stands at 93.4 percent. Majority of schools in the country, including all government schools, follow the 8-4-4 education system where students are required to spend 8 years in primary school, 4 years in secondary school and another 4 years at the tertiary level. Comparative studies of educational attainment amongst orphans and non-orphans in Kenya indicate that orphans between the ages of 10 and 14 have an equal school attendance rate to those who are not orphans (NACC and NASCOP, 2012:91) showing that orphans in the country might not be as excluded from educational opportunities as one might expect. The high enrolment in this age group is possibly due to free primary education provided by the government.

The HIV pandemic remains one of the greatest health challenges in Kenya presently and has considerably impacted on the health system and social service provision in the country. This has had an overall effect on the human development of the country as health is one of the key

indicators in the HDI. By the end of the year 2011, it was estimated that there were 1.6 million people of between 15 and 49 years living with HIV in the country (NACC and NASCOP, 2012:2). This is despite a drastic reduction in HIV prevalence by 14 percent since 1995 to the present prevalence rate of 6.2 percent. The number of HIV infected persons has remained high due to relative ease in access to antiretroviral therapy which reduces mortality, coupled with the high population growth rates in the country.

Figure 1: Location of Kiambu County within Kenya



Source: Ndeiya Ward Kiambu (2013).

In the Central Province of Kenya where Kiambu County is located, although HIV prevalence has seen a slight decline from 4.9 percent in 2003 (Central Bureau of Statistics, 2004:222) to 4.6 percent in 2011 (NACC and NASCOP, 2012:217), this is still more than four times higher than in the province with the least prevalence rate in the country, which is North Eastern Province, at only 0.9 percent.

Transmission of the virus is mainly within the 15-49 age group with the majority of new transmissions occurring within stable heterosexual relationships. With 58 percent of the infections being among women, there is an inevitable rise in transmissions from mother to child. In 2011 alone, it was estimated that 12,894 newborns acquired HIV through birth (NACC and NASCOP, 2012: x). Although the number of orphaned children is declining from previous years, it is still considerably high. According to NACC and NASCOP (2012:90), for almost half of the 2.6 million orphans in the country one or both parents have died from AIDS related complications. This underscores the huge impact that the AIDS epidemic has had not just on adults but also on children who are left vulnerable, and thus brings to attention the need for interventions to meet their needs.

In response to the high number of children orphaned by AIDS in the country, the government has scaled up assistance for affected households. Currently, more than 21 percent of households with orphans are receiving some form of assistance from the national AIDS budget up from a mere 14 percent in 2007. Moreover, preventive programmes initiated by the National AIDS Control Council have put 48,547 children and 490,437 adults on ART respectively (World Bank, 2013:210-211).

In addition, development partners including civil societies, community and faith based organisations have been actively engaged in trying to mitigate the impact of the epidemic on the affected households. This is for instance in the provision of schools to facilitate the continued enrolment of orphans, training on entrepreneurship to facilitate income generation in these households as well as initiatives to foster retention of children within the community.

1.3 Problem Statement

Social protection policy is increasingly being used to advance the development agenda especially in the attainment of the MDGs which target to reduce extreme poverty and hunger, stop and begin to reverse the spread of HIV/AIDS and attain universal basic education for all children. A growing recognition of new forms of social protection such as cash transfers as an

effective strategy to meet these goals has led to their adoption, first in the MICs and shortly after in the LICs as a major strategy for development.

Development, based on the capability approach, may be understood to be the process of expanding the freedoms or opportunities that people value and have reason to value (Sen, Sen, 1999a). Any attempt to assess these valued freedoms should thus make an attempt to consider what these valued freedoms are within the particular context. If the objective of development is to expand the opportunities of people in all aspects of their lives, policy evaluations should not restrict themselves only to conventional indicators but rather consider their effectiveness in broadening people's opportunities (Spicker, 2008).

However, previous research on social protection has focused mostly on income, education and health spheres made popular by the Human Development Index (HDI) but which are generally considered insufficient domains with which to gauge human development (Alkire, 2007:347). The dimension of social life has recently begun to get noticed, but here too, the concentration is on adult relationships and not so much on children's. Furthermore, while there is strong evidence on the beneficial effects of play to the growth and development of children, very few studies if at all, have attempted to investigate the link between development programmes such as child focused social protection and the expansion of capabilities in social life and play dimensions. This study aims to determine whether capabilities in the dimensions of social life, education, health and play are valued among the Orphans and Vulnerable Children (OVC); and the extent to which the CT-OVC social protection programme is succeeding in promoting the attainment of these capabilities.

1.4 Objectives and Research Questions

1.4.1 Objectives

The aim of the research is to determine the value attached by beneficiaries of the CT-OVC to capabilities in the four broad dimensions of social relations, health, education and play and the extent to which achieved functionings in these dimensions are enhanced by the programme.

The specific objectives of the research are as follows:

i) To investigate the different perspectives presented in the available literature on cash transfer programmes, notably on child cash transfers in various regions; and in particular in the Sub Saharan region.

ii) To provide an in-depth analysis of the Cash Transfer Programme for Orphans and Vulnerable Children in Kenya and particularly in Kiambu County.
iii) To determine the level of importance that the recipients of the OVC cash transfer place on capabilities within the four dimensions of social life, health, education and play.
iv) To find out the extent to which the CT-OVC programme enables the recipients to attain functionings within the four dimensions chosen, through a quasi-experimental study.
v) To investigate the participants' perceptions of the programme and on areas that it could improve on to better promote the capabilities of OVC in the four dimensions of interest.

1.4.2 Research Questions

The central questions in this research are:

- Do the recipients of the CT-OVC value capabilities within the four key dimensions of health, education, social life and play?
- Is there an association between participation in the CT-OVC programme and the attainment of capabilities and functionings of recipients within the four dimensions of social life, education, health and play?
- What are participants' perceptions of the programme and are there areas that the it could improve on to better promote the capabilities of the OVCs particularly in the four dimensions of interest?

1.5 Thesis Outline

Chapter 1: **Introduction**

This chapter has presented a general overview of the research highlighting the problem statement, goals and objectives. It has also contextualised the study within Kiambu County in Kenya and given an overview of social policy in the country, the problem statement and objectives of the study.

Chapter 2: Literature Review and Overview of CT-OVC

This chapter provides a detailed discussion of the existing literature on social protection policy. It begins by reviewing available literature on social protection insofar as it promotes the human development of people then proceeds to present the Cash Transfer Programme for Orphans and Vulnerable Children (CT-OVC) which is of interest in this research.

Chapter 3: **Theoretical Framework**

The third chapter presents the capability approach as the theoretical framework for this research. The chapter also explores the link between the capability approach in measuring human development outcomes. It further explains the selection process of the key dimensions of capabilities of orphans and vulnerable children which are measured in this research. Finally, it outlines the main hypotheses of the study.

Chapter 4: Research Methodology

This fourth chapter begins with a presentation of the quasi-experimental research design used in the study. It then describes the data collection methods and the sampling techniques used in the research. In addition, it gives an overview of the data analysis and presentation methods employed, as well as the ethical considerations made.

Chapter 5: Findings and Discussion

An analysis of the gathered data shall be presented in this chapter with a detailed discussion of the findings. It presents the descriptive statistics, and test results of the first and second hypothesis of this research. The final section of this chapter presents qualitative data from in-depth interviews and participant observation.

Chapter 6: Summary, Conclusion and Recommendations

This final section contains the conclusions drawn from the empirical research. It makes appropriate recommendations to the relevant parties involved in the CT-OVC, in relation to the improvement of human development outcomes of the children. It also points out the limitations of the study and calls attention to the areas that require further research.

CHAPTER TWO

LITERATURE REVIEW AND OVERVIEW OF CT-OVC

2.1 Introduction

This chapter provides a detailed discussion of the existing literature on social protection policy insofar as it promotes the human development of people. It begins by reviewing available literature on social protection globally and narrows down to cash transfers particularly those targeted at improving the wellbeing of children. It then proceeds to present the Cash Transfer Programme for Orphans and Vulnerable Children (CT-OVC) which is of interest in this research.

2.2 Social Protection

Governments in developing countries have addressed poverty and deprivation in a number of different ways, but which are now termed as social protection (Ellis et al. 2009:4). From the food subsidies of the 1960s and 1970s which were abandoned due to among other reasons the huge costs involved in subsidising local supplies to the safety nets characterised by food-for work and public works schemes which emerged in the 1980s, social protection in developing countries is seen to have been in existence for a long time (Ibid.).

The current mode of social protection has morphed from the recognition of the shortfalls of previous models and the need to overcome various challenges associated with earlier social protection strategies. They also promote context specific solutions to poverty, inequality and exclusion. For instance, public works schemes although providing wages to people with no other alternatives are limited in how far they can achieve their objectives due to their exclusion of physically weak persons such as the elderly and sick. Despite their problems however, they still remain relevant in some contexts. For instance the National Rural Employment Guarantee Scheme of India is still a fundamental response to rural poverty in the country (Ellis et al. 2009:4).

Social protection is delivered through different actors such as governments, private institutions and NGOs. It serves a number of interrelated functions. First is the protection function whereby it safeguards consumption of vulnerable people. Secondly, it prevents vulnerable people from further deprivation which may result in harmful coping strategies for children, including school dropout to provide labour. The third function is that of promotion of people's ability to overcome deprivation. From a child-focused approach promotional

measures support child development and create opportunities for them to be educated or to achieve good health (Guhan, 1994:38). Additionally, social protection plays a transformative role where it eliminates injustices that perpetuate vulnerability of certain sections of people in society through empowerment of such people. For children, this would mean engaging them in decision making about issues that affect their wellbeing (Devereux and Sabates-Wheeler, 2004:7).

Thus social protection may be described as all engagements by public, private or voluntary organisations which are meant to prevent, protect and manage risks and vulnerabilities of poor and excluded groups. As suggested by Jones and Holmes (2010:1) child focused social protection requires a broad understanding of the vulnerabilities and risks that face children and their caregivers while taking into account that these vulnerabilities are likely to vary in the course of childhood.

In sub-Saharan Africa, different actors are involved in the delivery of social protection including governments, international development organisations as well as civil societies. In Kenya, the Ministry of Labour, Social Security and Services is responsible for overseeing the provision of social protection in the country (Republic of Kenya, 2014b). Under this ministry is the National Social Protection Council which was enacted through parliament. This council is charged with coordinating the delivery framework and generally harmonising aspects of social protection programmes such as targeting techniques and monitoring systems (World Bank, 2013:194).

Social protection responsibilities in the country are divided amongst four departments through which issues of vulnerability are addressed. They include: 1) Gender, Children and Social Development 2) Special Programmes 3) Youth Affairs and Sports and 4) Development of Northern Kenya and other Arid Lands (World Bank 2013:193). More specifically, these departments are tasked with addressing risks and vulnerabilities of marginalised groups, steering emergency responses, promotion of inclusivity particularly of youth, the disabled, women and inhabitants of semi-arid regions of Northern Kenya.

The Gender, Children and Social Development department is responsible for the cash transfer programme for orphans and vulnerable children which is of particular interest in this research. It is required to: formulate policies on gender, children and social development; provide social welfare for vulnerable groups and provide support for community

development. This department is also engaged in formulating development programmes as well as establishing institutions for children's care and development (World Bank 2013:193).

2.3 Evidence on the Impact of cash transfers on child outcomes

Since the mid-2000s, cash transfers have increasingly been viewed as viable alternatives to conventional social welfare programmes. Like other types of social protection such as food transfer, input provision and asset transfer, they are primarily meant to reduce vulnerability of poor people. Cash transfers may be defined as the "direct, regular and predictable non-contributory cash payments that help poor and vulnerable households to raise and smooth incomes" (DFID, 2011:2). There is a wide range of forms in which the cash payments may be made, for instance: they may be issued as bank notes, credited in bank accounts, or mobile phone money transfers, or even as cash vouchers or stamps (Ellis et al. 2009:10). They take varying forms such as conditional versus unconditional or universal versus targeted social transfers.

Conditional cash transfers (CCT) are a form of welfare provision most common in Latin America. They complement the provision of education and healthcare services that is demand-driven. In conditional cash transfer programmes, money is paid out to vulnerable families on condition that they enrol their children in school or take them to health centres on a regular basis (Rawlings and Rubio, 2005:29). The health and education components of conditional cash transfers are considered to promote human capital and thus support human development in the population.

In Mexico for instance, the PROGRESA cash transfer programme was found to have a significant impact on children's health. It was found that there was an increase in birth weight by 127.3 grams and height by 1.1 centimetres for children in households receiving the grant compared to those who did not. Similarly, health improvements were also recorded in Colombia with children in recipient households achieving a 7 percent reduction in stunted growth (UNICEF, 2009:9). There is also evidence in Latin America to show improvement in education outcomes of children whose households received cash transfers. In Nicaragua, there has been a 6 percentage point increase in pass rates among grade 1 to 4 children; while in Jamaica, children recruited into the PATH cash transfer programme increased their attendance in school from 11.1 percent to 45.5 percent (UNICEF, 2009:10).

The impact of cash transfers on education as another key human development outcome has also been widely researched. Evidence shows that the transfers are likely to increase the

enrolment rate in schools as well as attendance (UNICEF, 2009:10). For example, a study by Handa and Stewart (2008:19) on an orphan scheme in Malawi found a 5 percent increase in enrolment rates among children aged 6 to 17 years. The study compares the impact of the programme on orphans only and on poor children who are not orphans and finds the impact on education to be greater in the latter group. It concludes that educations impacts are more greatly felt when cash transfers are targeted at all vulnerable children rather than just orphans. This is because orphaned children might be fostered in relatively wealthy households.

Effects of the transfer on student pass rates have however been mixed with some studies finding no real change (DFID, 2011:27) while others find improved pass rates, especially for girls (Chaudhury, 2008) these differences are perhaps due to the disparities in access to quality education services in the different countries.

Possible ways through which the cash transfers could be affecting education outcomes is through improved nutrition which impacts positively on child growth and development; the reduced need for children to engage in productive work to supplement their parents' income making it possible to attend school; or through direct means such as payment of school fees and purchase of books, school uniform and other study materials (DFID, 2011:27).

Orphans and vulnerable children along with their caregivers face not just "economic deprivation" in terms of unmet material needs but also "social deprivation" in terms of limited freedoms to engage equitably in social networks (Devereux and Sabates-Wheeler, 2004:26). This may in turn limit their social competence and affect their growth and development as well as their attainment in, among other things, education (Kontos and Wilcox-Herzog, 1997:247). The social life of OVC therefore makes for an important consideration if their wellbeing is to be promoted. There is mixed evidence of the impact of cash transfers on social relations. While Ressler (2008) using the foodways concept of the livelihoods approach finds social relationships to have improved, Macauslan and Riemenschneider (2011:64) finds them to have worsened as a result of the transfers which he concludes have had a negative effect on the well-being of recipients. He finds that the recipients now prefer to be "less rich and less resented". However, both of these qualitative studies focus on adult relationships and fail to indicate impacts of the transfers on children's social lives.

While there seems to be consensus on the effectiveness of cash transfers in poverty alleviation and promotion of human development, the debate on whether they should be

conditional or not rages on. For some thinkers, impact evaluations have done little to verify which of the intervention elements has a stronger impact: whether it is the transfer or the conditionality (Rawlings and Rubio, 2005:49). By way of example, in the PATH programme mentioned, 74 percent of the recipients cited "trying to comply with PATH requirement" as the main reason why their school attendance rose compared to previous years (UNICEF, 2009:10).

Other studies argue that transfers alone do not significantly increase school attendance, for instance, and it is thus necessary to attach education related conditionalities (Kakwani et al., 2006). However, replication of the conditionality appendage may not work out as favourably as it has in Latin America, in countries where healthcare and education services are inadequate and of low standards as is the case in many sub-Saharan countries, Kenya included. Hanlon et al. (2010) for instance argue that conditionalities are unnecessary as they increase costs in addition to infringing on the dignity of the deprived persons. Yet another school of thought is that the debate on conditionalities is overstated since it might be argued that each form of cash transfer programme has some kind of conditionality attached to it (Ellis et al., 2009:18), for instance a certain income threshold for one to be considered as needy, or minimum age for social pensions. However, with regards to this last thinking, one might draw a distinction between criteria for eligibility which recipients might have control over and those in which they do not. For instance, participants may not have control over factors such as age but can decide whether to comply with certain other stipulations set out by the CCT such as school enrolment.

All in all, the majority of the available research has shown that cash transfers do play a fundamental role in poverty alleviation and that they have a direct and almost immediate effect on people's living standards in addition to reducing vulnerability among the poorest households and thus contribute to their human development outcomes (Kakwani et al., 2006:562).

The key role that cash transfers play in the improvement of living conditions in different spheres: economic, political, environmental, gender empowerment and so on, continues to be recognised and integrated into policy frameworks. According to DFID (2011:60) "replication and expansion of cash transfer programmes has promoted the simultaneous development of a wide range of institutional and legal frameworks for these programs." This has consequently

increased the integration of social protection strategies into constitutional legislation in countries such as Namibia, South Africa, Botswana and Kenya.

Cash Transfers for Children

Child cash transfers are just one form of cash transfers with the others being social old age pensions, public works, women enterprise funds and safety net programmes. In the Southern African region cash transfers for children are steadily being favoured as a means to address vulnerabilities of children as seen in a number of countries' adoption of the child-sensitive social protection strategy.

One of the most notable forms of child cash transfers is South Africa's Child Support Grant (CSG) which was introduced in 1998. It is targeted at children from poor families who are aged below 18 years, and had been rolled out to over 10 million children countrywide as of 2012. Evidence from empirical studies indicates that the grant has mostly had a positive impact in promoting health and literacy outcomes of child recipients (Triegaardt, 2005:249). One evaluation of the CSG for instance finds that early enrolment of children in the programme reduces their likelihood of illness by 9 percent, particularly for boys. With regards to education, the CSG has also contributed to reduced absenteeism from school. It was also found to increase the number of grades completed by 0.14 more grades. The study also found CSG recipients who enrolled earlier on to have higher mathematics test scores by 0.77 points, than those with only a few years into the programme. This difference was however not statistically significant (DSD, SASSA and UNICEF, 2012).

Similar to South Africa's Child Support Grant but on a much lower scale is Zambia's Child Grant programme initiated in 2010. The grant is targeted at children aged below 5 years who are from very poor families. Available research shows favourable outcomes for children receiving the grants, for instance in the increment of meals taken, as well as improvement in some health indicators including decrease in malnourishment (American Institutes for Research, 2013:8).

In the East African region, a recently initiated child grant in Tanzania stands out alongside Kenya's own social grant for orphans and vulnerable children. Like Kenya's CT-OVC programme, Tanzania's National Costed Plan of Action for Most Vulnerable Children (NCPA) was introduced to cushion vulnerable children, particularly those orphaned by AIDS, against risks and challenges facing them such as the burden of disease in the family.

However, unlike the Kenyan programme, the NCPA does not offer similar amounts of transfers to vulnerable children of all age groups but targets are rather distinguished by age and area of residence, whether urban or rural (United Republic of Tanzania, 2008:10).

In Kenya, the Cash Transfer Programme for Orphans and Vulnerable Children (CT-OVC) was launched in 2004 to provide for the basic needs of poor children orphaned or made vulnerable particularly due to the HIV/AIDS pandemic. A more detailed description of the programme is offered in the succeeding subsection.

2.4 The Cash Transfer Programme for OVC

The Cash Transfer programme for Orphans and Vulnerable Children (CT-OVC) in Kenya was launched in 2004 and was among the first of its kind in the country in its quest to foster children's rights and attempt to develop their human capital. It is one in a recent wave of cash transfer strategies geared towards poverty alleviation and income redistribution in sub-Saharan Africa and more so in the East African region.

The CT-OVC programme is one of three cash transfers in Kenya that form the Consolidated Social Protection Fund (CSPF) with the other two being the Cash Transfer for Older Persons and Cash Transfer for Persons with Severe Disabilities. The CSPF is among the chief projects of the country's Vision 2030 long term development plan and is primarily meant to reduce the vulnerability of poor and excluded groups. It was established based on the urgent need to tackle the persistent high poverty rates, alongside the deterioration of livelihoods and weakening of family support systems at the household level especially due to HIV/AIDS (Republic of Kenya, 2014a:19-20).

Cash Transfer for Orphans and Vulnerable Children is a social security programme in which non-contributory maintenance is paid out to households living with orphans or/and vulnerable children. Being non-contributory means that recipients are not required to make any contributions before they can access the payments. It is also means-tested, thus only meant for very poor households (Spicker, 2008). All households undergo a proxy mean test and those below the threshold are recruited into the programme. Its aim is to encourage fostering and retention of OVC in their families and communities as well as promote their human development. More specifically, its focus lies in the following areas:

- Health - To reduce mortality and morbidity of children aged between zero and five years.

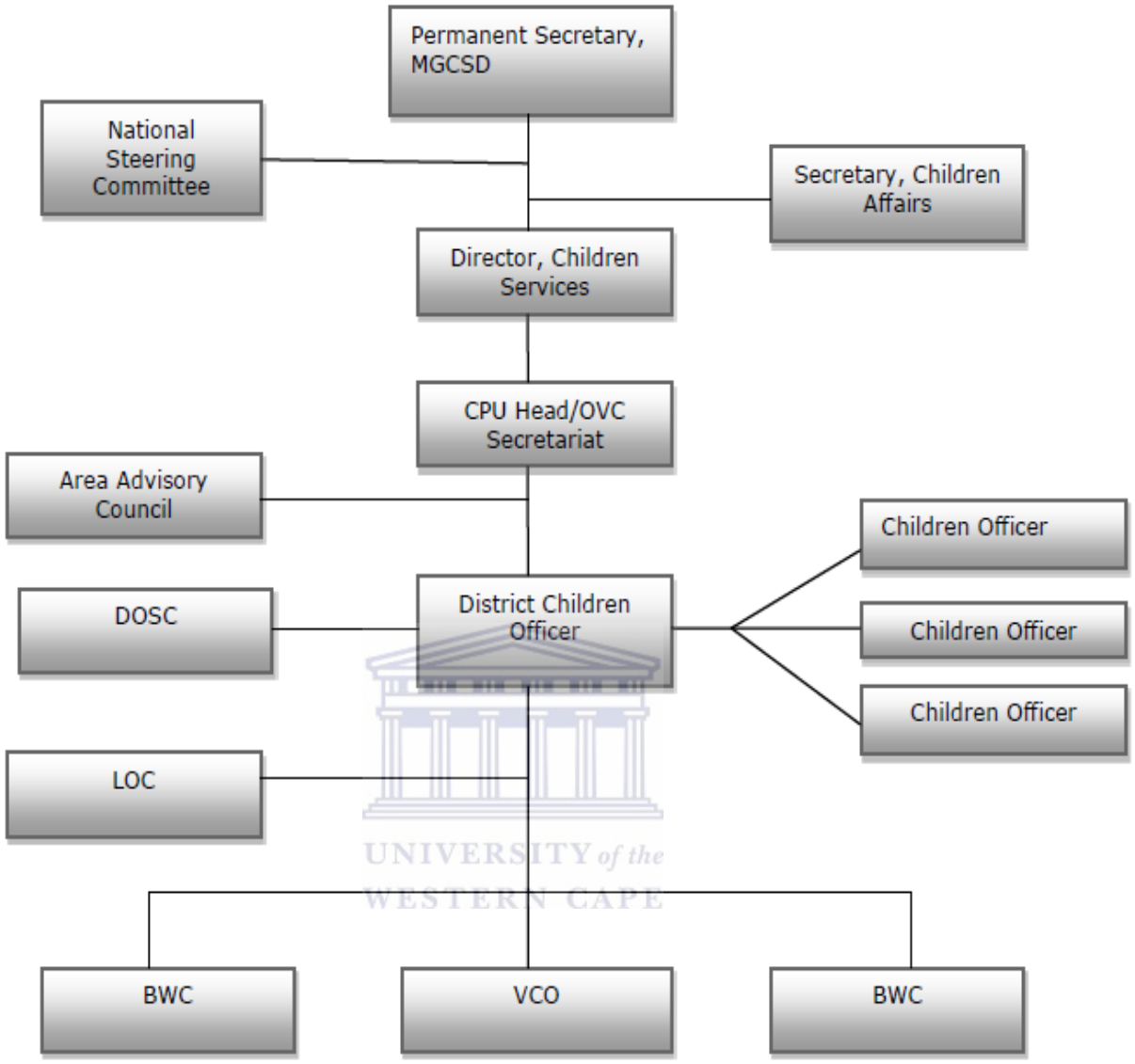
- Education - To increase school enrolment and attendance as well as reduce the rate of school dropout.
- Food security - To promote child nutrition in impoverished households.
- Civil registration - To boost registration through obtainment of birth certificates for OVC, death certificates for deceased parents and identification cards for caregivers (MGCSD, 2010:15).

Structure

At its inception in 2004, this programme fell under the Ministry of Home Affairs and was funded by UNICEF. In its second year of implementation (2005) various stakeholders became involved including the World Bank, DFID and Swedish International Development Authority (SIDA) among others. Presently, the cash transfer is being implemented by means of a partnership between an assortment of donor organisations and the Government of Kenya's Ministry of Gender, Children and Social Development, Department of Children's Services which is now the Ministry of Labour, Social Security and Services.

The administrative structure is as illustrated in figure 2. At the highest level is the National Steering Committee which is responsible for providing guidance on policy making (MGCSD, 2010:8). This committee aligns the CT-OVC programme with the broader social protection policy in the country and comprises representatives from other line ministries as well as partnering organisations (Onyango-Ouma, 2012:35). The Director of Children Services (DCS) is the Secretariat of this committee.

Figure 2: CT-OVC Organisation Structure



Source: Onyango-Ouma, (2012:36)

The Ministry of Labour, Social Security and Services acts as the executing agency under the directorship of the Permanent Secretary (PS). The PS is responsible for providing guidance on policy formulation on an everyday basis. The DCS is in charge of execution of procedures in the operations manual and implementation of the programme (MGCSD, 2010:8).

The Central Programme Unit (CPU) provides technical support to the CT-OVC programme. It is also responsible for the planning, monitoring and evaluation, management information systems, administrative work and financial management units of the programme. For each of these units there is a coordinator responsible for activities within that unit that contribute to

the overall programme development. The CPU is also responsible for recipient selection, approving payments to recipients, and generally handling all logical aspects of the implementation process. The CPU Secretariat plays a supervisory role to the operations coordinator in the day to day procedures. She/he reports directly to the Director of Children's Services in the ministry concerning the CT-OVC programme at the national level (MGCSD, 2010:12).

The DCO at the district level performs administrative duties and serves as a link between the CPU, recipients and other stakeholders such as healthcare education and civil registration agencies. It is responsible for monitoring compliance and reporting back to the CPU Secretariat (MGCSD, 2010:12). The DCO works in conjunction with Location OVC Committees (LOC), District OVC Sub-Committees (DOSC) as well as community members in support of enrolment related activities, compliance, case management, payments and complaints.

The DOSC members are responsible for sensitizing leaders at the district level about the programme. They also select LOC members who are directly in contact with the community members and who then sensitize the community on issues of interest to the programme such as the plight of OVC. The LOC members are responsible for identification of OVC through community meetings, helping with recruitment and identification of enumerators who carry out surveys on the households. They also assist in monitoring of the programme by observing progress of OVC (MGCSD, 2010:14).

Coverage

The programme was at first targeted at the vulnerable households in arid and semi-arid regions of North Eastern Province in Kenya, and soon after, at provinces that had the highest HIV/AIDS prevalence (UNICEF, 2012a). Presently, the CT-OVC has been expanded to attain nationwide coverage.

The first phase of the programme which was rolled out in 2004 delivered cash transfers to 500 very poor families in three districts of Garissa in North Eastern Province, Kwale in Coast Province and Nairobi in Nairobi Province. This pilot programme had no conditionalities attached and cash recipients had freedom on how to spend it. Five months into the programme, recruitment of the needy families spread to an additional 10 districts across the country reaching 5000 more families. The districts include: Mombasa, Kisii Central,

Machakos, Trans-Nzoia, Bungoma, Meru North, Nyandarua, Nyeri, Nakuru and Siaya (Bryant, 2009).

The second phase began in May 2007 pushing up the number of beneficiaries to 10.500. At this stage, expert assistance was sought from Latin America based on their success rate with cash transfer programmes. The numbers increased to more than 100.000 households and 230.000 OVC in the course of phase three and four. The programme which went full-scale as from 2009, aims to reach 300.000 OVC in some 74 districts countrywide by the year 2015.

As can be seen in the table below the progression of its coverage between the years 2008 and 2012 has been rapid with the number of households covered increasing more than threefold in this period from 45.911 to 144.933. The number of districts covered has also risen by 47 percent from 47 to 69.

Table 1: Number of households and districts covered (2008/09 to 2011/12)

	2008/09	**2009/10**	**2010/11**	**2011/12**
No. of households covered	45,911	82,371	124,991	144,933
No. of districts covered	47	47	60	69

Source: World Bank (2013:200)

Targeting

Vulnerabilities of children became a national concern and were given special attention in Kenya's social policy first as a result of an increase in the death toll from HIV/AIDS which is responsible for about 700,000 of the estimated 1.8 million orphaned children in the country **(**UNICEF, 2012a**)**. The idea is thus to promote retention of OVC within the families and community, and enhance their human capital. Secondly, the programme is meant to relieve the burden of social protection from caregivers within the family or community set-up who are themselves ill equipped to provide this care as they are struggling financially (Bryant 2009).

The programme is meant to benefit needy households in the following order: 1) child-headed households, 2) households headed by elderly person(s), 3) households with most OVCs and finally, 4) other households with OVCs (Bryant, 2009). A child in this programme is taken to be any person below the age of 18 years. As a prerequisite for enrolment, the household must have an OVC permanently residing in the home, be extremely poor and not be benefiting from any other cash assistance programme ((MGCSD, 2010:16). Extremely poor households

are taken to be those living below the lower food poverty line of KSh.988 (USD 12.35) in rural areas and KSh.1475 (USD18.43) in urban areas per person per month. The lower food poverty lines relate to the average expenditure required to reach the recommended daily calorie intake of 2250 kilocalories per adult (ibid).

The programme defines OVC as a child who has lost one or both parents as a result of death; is chronically ill or has a chronically ill caregiver; or a child who lives in a child headed household as a consequence of orphanhood (MGCSD, 2010:16). For one to be considered chronically ill, they must have been persistently ill for at least 3 months and unable to attend to normal duties.

Delivery

At its commencement the recipient families received Ksh.500 (USD 6.25) per month but this amount has risen to the present Ksh.4000 (USD 50) disbursed once in 2 months to each household. According to the programme action plan, the amount is only meant to cover part of the household's living costs including education, health and nutrition.

Disbursement was initially through 'secretive' delivery by District Children Officers but is presently being made through the post office. A special identity card issued upon recruitment is required for the caregiver to access the money from the post office. According to UNICEF (2012a) the administrative procedure is extremely cost effective since 90 percent of the funds ultimately reach the beneficiaries. The remaining 10 percent goes towards policy development and institutional strengthening in addition to other administrative costs incurred in the delivery of the CT.

Graduation from the Programme

Recipients of the cash transfer are expected to exit the programme after 5 years (MGCSD, 2010:16). However, other predetermined factors could also result in termination of transfers to particular households. They include: attainment of 18 years of age by all OVC in the household, movement of household into another district or area where the programme is not operational, change of circumstances in the household where they are no longer deemed to be very poor or failure to claim payments for three consecutive months. Exit from the CT-OVC could also be voluntary in which case the caregiver is required to inform the LOC beforehand.

Impact of the CT-OVC

Two major evaluations of the CT-OVC programme have been carried out so far with slightly varying results (Ward et al. 2010; The Kenya CT-OVC Evaluation Team, 2012). The programme was found to have had a largely positive impact in recipients' households. This was particularly so in reducing poverty, promoting food consumption and dietary diversity and in improving health and education outcomes of children.

A household survey conducted on the programme found the CT-OVC to have been associated with a significant increase in food, health and clothing expenditure by Ksh.145 USD 1.81), Ksh.35 (USD 0.44) and Ksh.29 (USD 0.36) per month respectively (The Kenya CT-OVC Evaluation Team, 2012). It also found the productivity of caregivers in households receiving the transfer to be higher than in those that did not receive it.

These findings differ to some extent with those from an earlier impact evaluation carried out by Ward et al. (2010). In their study, Ward et al. found that although there was a significant increase in food expenditure and dietary diversity, the mean expenditure on health had remained at the same level. The CT-OVC was also linked with a reduction in incidences of illness as well as number of poor households seeking professional medical services, although this impact was minimal.

Although they found school attendance not to have increased much as it was already high at the onset of the programme, there was however an increase in secondary school enrolment which normally requires additional funds as it is more expensive than primary school. The CT-OVC thus affords poor households some extra funding with which they can enrol OVC into secondary school (Ward et al. 2010: vii).

Previous impact evaluations also show that the programme has reduced child labour among recipients with a 3 percentage point decline in the number of 6 to 13 year olds doing paid work. Unpaid work by children had also reduced by close to 4 hours a week for both male and female children (Ward et al. 2010: vii).

2.5 Conclusion

This chapter has described social protection, identifying its functions and as well explored the different forms in which it is delivered. It found contemporary social protection to increasingly take the form of cash transfers although these are complemented by other forms of social protection such as food assistance and asset transfers, depending on the specific vulnerabilities being addressed.

Using a child-centred approach to social protection and placing it within the context of sub-Saharan Africa, the next subsections in the chapter introduced cash transfers for children along with evidence of their impact on children's development. They noted that cash transfers for children have a capacity to improve education and health opportunities of children. The final subsection gave a detailed presentation of the CT-OVC programme in Kenya centring on the key elements of coverage, targeting, delivery system and the administrative structure of the programme.

Drawing from the existing literature reviewed in this chapter therefore, studies such as this one are much needed in making a contribution towards reducing knowledge gaps on the impact of child-focused cash transfers in outcomes of children in dimensions such as health and education, but more importantly in the rarely researched dimensions of social life and play.

CHAPTER THREE

THEORETICAL FRAMEWORK

3.1 Introduction

This chapter presents a discussion of the theoretical framework. It begins by introducing the capability approach and its key defining concepts which will be used in this study. These concepts include: capabilities, functionings and adaptive preferences. The subsequent section presents the human development approach which finds its basis in the capability approach and which provides the framework from which to gauge the progress made in the wellbeing of people, particularly the recipients of the CT-OVC. Both the capability approach and the human development approach provide a backdrop from which the four main dimensions measured are drawn. The next section explains the selection process of the key dimensions of social life, education, health and play. The final section shall then propose the hypothesis of the research.

3.2 The Capability Approach

The capability approach is a paradigm which sees development as the freedom to live the life one values or has reason to value (Sen, 1992:5). This approach conceptualises development to be normative or based on value judgement in the sense that it specifies how individuals or groups ought to behave for them to make progress and this ultimately affects policy (Alkire & Deneulin, 2009:4). In the capability approach, poverty is seen to be the deprivation of certain capabilities necessary for wellbeing. Wellbeing, either of an individual or a group, in this approach is viewed from different dimensions and is based on their capabilities and functionings (Robeyns, 2005:94).

The capability approach provides a useful framework for practical evaluations and assessment or research on policies in the different dimensions of wellbeing. Robeyns (2005:94) argues that as a framework, it only facilitates evaluation rather than attempt to explain the different phenomena involved in the determination of wellbeing, for example, poverty and inequality. In this approach, policies are evaluated with regard to the extent to which they are able to expand people's freedoms to achieve the kind of life they value. For instance, it looks at whether people are healthy, have access to education facilities or can participate in social activities.

The approach as posited by Sen (1999a) has some key distinguishing features: capabilities or freedoms, functionings, agency and adaptive preferences. Functionings refer to people's achievements or what one succeeds "to do or to be" (Sen, 1999b:7) for instance being literate, well-nourished or being able to participate in decision making. The concept focuses on the variety of things that people find to be important in their lives (Alkire, 2002:2). The goal of programmes that attempt to alleviate poverty should thus be to expand the choices that matter to the people so that they may enjoy 'valuable beings and doings'.

As suggested by Sen, the functionings should be those identified by the research respondents so as to avoid the danger of the research imposing valued freedoms on the respondents. Sen has refrained from naming a definitive list of capabilities arguing that no one set could suffice for the many different contexts that researchers may find themselves in (Alkire, 2005:119). It therefore remains for the participants to identify their functionings, through discussions, which can then be used for evaluative purposes. This makes the capability approach useful in conducting participatory research.

Sen (1992) defines freedoms as the opportunities one has to achieve the things they value. Capability, which has come to be used as a substitute term for freedoms, refers to a person or group's autonomy to promote or achieve valuable functionings (Alkire, 2005:121). Capabilities are therefore in essence, the real opportunities that exist for one to be or do something: for instance the opportunity to get proper education, opportunity to participate in community decision making and so on.

Another important component of the capability approach is agency. Agency is seen as the individuals "who have diverse valued goals and commitments on behalf both of themselves and of their society, and who contribute to public discussion about social goals" (Alkire, 2005:125). Sen (1999a:18-19) sees agency as "someone who acts and brings about change, and whose achievements can be judged in terms of her own values and objectives, whether or not we assess them in terms of some external criteria as well." He believes that rather than being a passive aid recipient one can change their own and others' destiny given the right opportunities.

In recognition of the useful role played by agency in development, the UNDP (1990:9) writes, "People are the real wealth of a nation." They indeed play an active role in bringing about changes in their societies and are not mere recipients. Human development treats agency in two ways. First is the provision of fundamental necessities for human capital

development including healthcare, education, decent living standards (core in the HDI); and human rights protection. Secondly, agency is seen in terms of its ability to effect changes in social policy either through individual or collective action (Fukuda-Parr, 2003:308).

The concept of adaptation is also of key importance in the capability approach. It is believed that individuals "adapt to poverty and deprivation by suppressing their wants, hopes and aspirations" (Clark, 2007:1). Adaptive preferences are acquired through the socialisation process in the oftentimes mistaken belief that one cannot achieve their aspirations due to the status quo. The problem of adaptive preferences can however be countered through reflection of participants and facilitated processes.

Clark (2007:5) distinguishes between two key ways in which adaptation occurs: first, through social conditioning and secondly through causal mechanisms. Social conditioning is by such means as religious indoctrination while causal mechanisms can be as a result of people adjusting their aspirations either downwards due to difficult circumstances; or upwards as new opportunities continue to emerge. To reduce inaccuracies caused by adaptive preferences in data collection, Comim (2008:171) suggests the use of triangulation methods which promote accuracy particularly of subjective data.

The greatest criticism of this approach is perhaps on the difficulty in measurement. Measurement in the capability approach is carried out through indices as in the Human Development Index (HDI), or through prescribed lists suggested by thinkers in this approach. Amartya Sen whose brainchild the capability approach is, insists that it is beyond the theorists' scope to prescribe a list of capabilities by which all societies are to be gauged. He suggests operationalization of the approach should be according to the context and insights of empiricists as is the case with the dimensions used in the HDI (Alkire & Deneulin, 2009).

The capability approach has been chosen for this research because it has a broad framework on which it focuses, rather than the conventional narrow focus on income and expenditure. Along with its focus on poverty reduction the approach also addresses the question of justice in terms of access to resources. Programmes that are designed to meet the needs of children and particularly OVCs should provide opportunities for them to lead a life which they have a reason to value. Therefore, such programmes should have knowledge concerning the functionings that the children or youth and their families value.

3.3 The Human Development Approach

The Human Development Approach developed mainly by Mahbub ul Haq and widely adapted into UNDP development interventions, may be considered as one of the most notable offshoots of the capability approach. It uses the capability approach as it philosophical and methodological base. Human development is concerned with the process of broadening people's choices (UNDP 1995). It aims to develop "a comprehensive approach to development, including an agenda of policy priorities, tools of analysis and measurement, and a coherent conceptual framework" (Fukuda-Parr, 2003:302).

Human Development Reports (HDR) which give an assessment on progress made in human development outcomes have their basis in the capability approach. The reports which are now annual publications were launched in 1990 and are believed to influence policy formulation in different areas (Fukuda-Parr, 2003:302). The HDR was formulated to underline the importance of concentrating development process on people's issues rather than on purely economic indicators (ul Haq, 1995).

Although the human development approach has extensive expert input from various fields including development economics and quantitative research techniques, the greatest input is undoubtedly from Sen's capability approach. In this approach, human development is defined as "the process of enlarging a person's functionings and capabilities to function, the range of things that a person could do and be in her life" for instance being educated (Fukuda-Parr (2003:303).

Since its inception in 1990 the Human Development Approach has been strengthened through the development of measurement instruments such as the Human Development Index (HDI), the Gender Empowerment Measure (GEM) and the Human Poverty Index (Fukuda-Parr, 2003:302). According to Fukuda-Parr (2003:305) the HDI has met its objective of increasing the focus on basic human capabilities, particularly in the dimensions of health, education and living standards. It is currently being used by development organisations such as the UNDP in designing programmes, and by governments in formulating policy.

The main aspects in human development include the evaluative aspect and agency aspect. The evaluative aspect involves the assessment of progress made in the lives of individuals as a clear and precise development goal and through the use of human achievements as the main indicators. The agency aspect looks into individual's or groups' engagement into fostering improvements for instance through political participation (Sen, 2002a).

A systematic approach has been followed in the identification of suitable capabilities against which the effectiveness of the social protection policy can be gauged as proposed by Robeyns (2005:209). The next section shows the steps taken in the selection of dimensions.

3.4 Selection of Dimensions

The research aims to measure the achieved functionings within the following four main dimensions: education, health, social life and play. In selecting relevant functionings to be measured, the research follows the methodology suggested by Robeyns (2005:209-211). It includes the following steps: 1) Engage with relevant academic and non-academic literature in the context of the research 2) Engage with other lists that have been developed over time 3) Open up the list for discussion. For the purpose of this study, the researcher shall also include an important step identified by Walker (2010) as it appears useful in social policy evaluation, and so 4) Identification of the capabilities or functionings from the policy, in this case, from the cash transfer for Orphans and Vulnerable Children (OVC).

3.4.1 Engaging with relevant literature

Considering the existing literature on the capability approach, it is possible to identify some dimensions upon which a great level of importance has been placed. For instance, education, which is conceptualised as the ability to acquire knowledge and intellectual development, is one of the key dimensions identified by scholars. Sen (1999a and 1999c) argues that education is a key aspect of social equity. According to him, the capabilities that one has as a child have an impact in their adult life and therefore refusal to pursue or denial of an opportunity to pursue education as a child presents a challenge in one's adult life in terms of reducing the opportunities that one has in life. Education is important not just in enabling one to engage in gainful employment but also for its intrinsic value.

Additionally, empirical evidence from Walker (2006) measured qualitatively shows that female students also value learning particularly for the opportunities it affords them in life. A similar finding has been made by Biggeri et al. (2006) in a study in which children from different backgrounds identify their valued beings and doings. Other scholars have also considered education to be an important capability, for instance Robeyns and van der Veen (2007) include education in their proposed capability index for policy formulation.

The second dimension considered in this research is health. Sen (2002b) believes that it is impossible to speak of social justice without health being a major concern. Health may be considered important mainly because it is an enabling factor in the attainment of other

functionings. In the case of children, it is difficult for them to attain other valued states including being literate or even enjoying a fulfilling social life if their physical or mental wellbeing is lacking. Studies also show that children value being healthy, and this is particularly well pronounced in cases where a family member is sick, if they themselves are ill or if they have lost a family member due to illness (Uyan-Semerci, forthcoming).

3.4.2 Capabilities drawn from the OVC policy

In relation to policy, health may be linked to the objective of setting up the cash transfer programme. It is observed that a considerable number of children are orphaned as a result of the HIV/AIDS pandemic which has continued to afflict the country. It may also be argued that some of the OVCs are infected by the virus and therefore may be facing health challenges. Policy makers thus need to make careful consideration of the health aspect with regard to the wellbeing of the OVCs.

The policy also aims to promote retention of OVCs in their families by providing a basic income for their upkeep. In this way, it promotes the care and nurture of such children since the relatives are encouraged to take over the caregiving role for the OVCs. Biggeri et al. (2006) identify love and care as one of the key capabilities that children value. These two attributes may be considered to constitute the social life, or what Nussbaum (2003:41) terms as "affiliation."

The OVC policy also seeks to safeguard the rights of the child. Human rights encompass broader issues such as education and health which are also fundamental in children's rights. Unique to children's rights however is the right to play (United Nations Committee on the Rights of the Child, 2013). This is because play is considered fundamental to the growth and development of children. Psychologists have long since argued in favour of the centrality of play in promoting children's well-being. For instance, Ginsburg et al. (2007) consider play to be important for the development of the child in terms of cognitive abilities, as well as their physical, social and emotional wellbeing.

3.4.3 Engaging with other lists

The researcher uses this step to find out if other authors, based on scientific studies, consider the selected dimensions fundamental for human development. The proposed list of functionings is considered against two separate capability lists (Quizilbash, 1996; Nussbaum, 2003). It is found that the four dimensions:

- Education/literacy/basic intellectual and physical capacities
- Bodily health/ nutrition
- Play/enjoyment/ leisure
- Affiliation/ significant relations with others and some participation in social life;

are identified by both authors as being fundamental capabilities for people's wellbeing. Similarly, among the basic capabilities proposed by Robeyns and van der Veen (2007) in the creation of a capability index for policy formulation, each of these four dimensions features in the list.

3.4.4 Debating the list

The final step in the selection of the dimensions to be used in the research is the opening up of the list for debate and discussion. In this case, the list was opened up for discussion with peers in the Development Studies field and with a mentor who is well versed with the capability approach.

Furthermore, the participants of the study were given an opportunity to rate, in the questionnaire, the extent to which capabilities within the four listed dimensions are important to them.

In concluding the selection criteria for the dimensions to be measured, the research also takes into consideration the conditionality aspect which is impossible not to mention when one is dealing with cash transfer interventions. A consideration of introducing conditionalities into the programme is already being made, and if fully integrated, is likely to involve the health and education dimensions. Research into whether these two aspects are valued among the participants and if the CT facilitates their achievement is therefore necessary. The dimensions of social life and play complement the list due to their intrinsic importance in the development outcomes and in overall welfare of children particularly those who are orphaned and vulnerable.

3.5 Dimensions and Indicators

The dimensions for capabilities identified in this study including some of the indicators are as shown in table 1 below:

Table 2: Key Dimensions and Indicators

Dimension	Indicators
Social life **[The perceived level of support given by family members or friends]**	Having at least 5 of the following indicators • Having someone who will listen to them when they talk • Someone they count on when they need advice • Someone to take them to see the doctor if they need it • Someone who shows them love and affection • Someone to have a good time with • Someone to confide in or talk about themselves or their problems • Someone to get together for relaxation • Someone to do something enjoyable with
Education **[Being able to acquire knowledge through learning and instruction]**	• Enrolment in school: child enrolled in school • School attendance rate: 90 percent school attendance rate • Child's grades: a grade of D and above as grades lower than this are considered to be a fail • Promotion into next class *vis-a-vis* repetition • Child's engagement in extracurricular activities
Health **[Having or being in a state of physical wellbeing]**	• Incidences of illness • Access to adequate food (nourishment): three balanced meals a day • Access to safe water and sanitary conditions: daily access to improved water source • Protection from hostile persons/environment: a house/physical structure to live in
Play **[Engaging in pastimes for fun and relaxation]**	• Adequate time for recreational activities: at least 7 hours per week • Resource allocation for recreation/hobbies: a percentage of the household resources is used for recreation • Access to at least one play space (e.g. playing field or park)

Source: Authors own

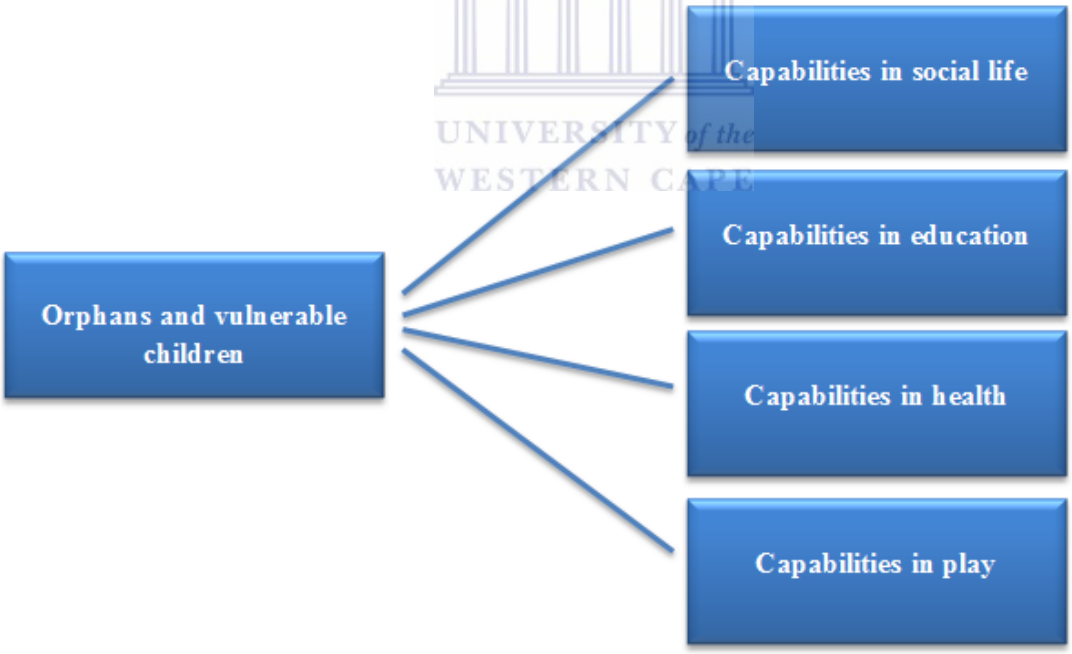
The dimensions measure the value that the participant attaches to the given capability. This shall be done by asking them to rate how important the four dimensions are to them, by use of a likert scale. Subsequent questions will evaluate the extent to which the CT-OVC programme has succeeded in regards to these dimensions through the RCT method which compares the treatment group (CT-OVC recipients) to the control group (CT-OVC non-recipients).

3.6 Hypothesis

3.6.1 Hypothesis 1

Based on the discussion of the theoretical framework on the capability approach and human development approach in this chapter, it is taken that children consider capabilities in the four dimensions of interest to be of great importance in their lives. The hypothesis is therefore that orphans and vulnerable children value capabilities in the social life, education, health and play dimensions.

Figure 3: Representation of capabilities important to OVC



3.6.2 Hypothesis 2

Cash transfers are meant to improve the wellbeing of the recipients by increasing the opportunities that they have to be and do the things that they value. The cash transfer for orphans and vulnerable children is thus expected to improve the achieved functionings of the recipients. Thus the second hypothesis of this study as shown in figure 4 below is that: being

a recipient of the cash transfer for orphans and vulnerable children is associated with increased achievement of functionings.

Figure 4: Representation of association between participation and functionings

3.7 Conclusion

This section has presented the theoretical framework upon which the research was based which is the capability approach. It discussed the capability approach as an important foundation for the human development approach and an alternative method of measuring the wellbeing of people. It also discussed the systematic selection of dimensions to be measured, which are deemed to be valued beings and doings of the research participants. These dimensions include social life, education, health and play. The chapter then ends with a look into the two proposed hypotheses that the study aims to test. The first is that OVC value capabilities in the dimensions of social life, education, health and play. The second hypothesis is that being a recipient of the cash transfer for orphans and vulnerable children is associated with increased achievement of functionings.

CHAPTER FOUR

RESEARCH METHODOLOGY

4.1 Introduction

This chapter provides a description of the research methods used in the study including the research design, sampling method, data sources, method of data collection as well as the method of data analysis. It also details the ethical considerations made by the study given its sensitive nature as it deals with school-aged children.

4.2 Research Design

Research design is considered to be "a plan or blueprint of how you intend conducting the research" (Babbie & Mouton, 2002:74). It focuses on the particular study being planned and the aims of the study. During the research design process, the researcher determines whether to use qualitative or quantitative methods, or mixed methods. This study makes use of the mixed methods research. A mixed methods design is one which focuses on the collection and analysis of both qualitative and quantitative data in one or a series of studies (Johnson and Onweugbuzie, 2004:17). The advantage of combining qualitative and quantitative approaches is that it gives a deeper understanding of the research problem than would a single one of the two.

The research also employed a quasi-experimental research method. This requires that an intervention group (which is affected by an intervention) as well as a control group (which is not affected by the intervention) be used in the study (NONIE, 2009: xiii). The intervention group consisted of 100 OVCs who had been recipients of the CT for at least 18 months. The control group was made up of 100 OVC who had similar characteristics as the intervention group save for being recipients of the funds. In both groups the OVC were between 6 and 18 years old. The control group was selected from the waiting lists of prospective recipients and from suggestions from the LOC committees.

4.3 Data Collection

Secondary data was collected from policy documents of the Ministry of Gender Children and Social Development (MGCSD), as well as research publications, journals and reports from research institutions. Primary data was collected using the mixed methods approach. This

involved the use of questionnaires, in-depth interviews and participant observation techniques as follows:

Questionnaires

The quantitative component of the study involved administering questionnaires to the intervention and control groups. According to Babbie and Mouton (2002:265), questionnaires enable data collection by asking people questions or asking them to agree or disagree with statements. The questionnaire sought to measure the extent to which CT-OVC recipients and OVC in the control group value capabilities in the dimensions of social life, education, health and play. It also measured the achieved functionings of OVC in both groups. It was translated into Swahili language for respondents who preferred to use Swahili (cf. Annex 1).

In-depth Interviews

This technique was used to gather data qualitatively. In-depth interviews are the technique of choice in collecting data on perspectives, personal experiences and life histories (Mack et al. 2005:29). The interviews were used to explore the general perceptions of the community about the cash transfer programme and to seek their opinion on areas that needed improvement. They were conducted using semi-structured interview guides and involved both recipients of the CT as well as non-recipients.

Participant observation

Participant observation is useful in data collection of naturally occurring behaviour of persons in their natural setting (Mack et al. 2005:13). The researcher made use of observation techniques in order to identify the interaction patterns and other observable characteristics of recipients of the CT-OVC and non-recipients, with regards to the key dimensions of interest in the study.

4.4 Sampling

The target population was the orphans and vulnerable children, caregivers and families of the children as well as project implementers. Only one respondent was selected per family receiving the OVC cash transfer. Systematic random sampling was used in the study. It is a type of probability sampling method whereby units from the population are selected using sampling intervals (Lund Research Limited, 2012). This sampling method is advantageous in that it helps reduce the risk of bias and is highly representative of the population being studied.

Respondents in the recipient group were drawn from the database of recipients of the CT-OVC obtained from the District Children's Officer in Kiambu County. The same office provided the database of persons in the waiting list, from which the control group was randomly drawn. A total of 100 respondents were chosen from the recipient group from a total of 216 recipients (every 2.16th person) for the quantitative component of the study. An equal number was selected for the control group from a population of 113 (every 1.13rd person). It was determined beforehand that there were no pre-existing patterns in the lists which might have introduced biasness.

The control group was determined through a pipeline control group design. According to NONIE, 2009:109) this design is appropriate when a project is implemented in phases as was the OVC grant. In this case, prospective beneficiaries in phase two who will only receive the benefits at a later stage are suitable for use as a control group. This is particularly because they already meet the threshold for being enrolled into the programme having undergone the necessary selection process and been found to meet the requirements. They can thus be used as the control group for phase one subjects.

Questionnaires were administered to 200 participants as shown in table 3 below. There was a high response rate of 80.5 percent.

Table 3: Sample size of the study

Group	Population	Sample size and no. of questionnaires issued	No. of questionnaires filled out
CT-OVC recipient	3700	100	74
Comparison	113	100	87
Total		200	161

Source: Field survey, 2013

Purposive sampling was used to select 10 interviewees from the caregivers, implementers as well as committee members. The interviews were conducted in order to give in-depth information on the CHEP programme which could not be captured through questionnaires, for instance the perceptions of the participants towards the programme. The interviewees comprised of persons who are involved in the programme at different levels as shown in the table below.

Table 4: Sample selection of interviewees

Type of involvement	No. of interviewees
Children (OVCs)	4
Caregivers	2
CT-OVC personnel	2
Community members	2
Total	**10**

Source: Field survey, 2013

Site Selection

Both the recipient group and comparison group were situated within Kiambu County in Central Province, Kenya. Selection of this particular location was mainly because of available resources. Proximity to researcher was also a key consideration. Based on consultations with the CT-OVC personnel, a rural area was chosen instead of an urban or peri-urban one in order to avoid respondent fatigue[2] since the urban and peri-urban folk are quite regularly exposed to research. Kiambu County also had some OVC on the waiting list who had already met the programme criteria to get enrolled. The waiting list was crucial for use as a comparison group.

4.5 Data Analysis and Management

Data management was carried out as follows: The original questionnaires were stored safely in keeping with the protection of the confidentiality of the respondents. Data cleaning protocols and a codebook were designed in order to code categorical variables. Once the survey was completed, data was entered into MS Excel spread sheets and later on transferred into STATA version 12 for statistical analysis.

Data analysis enables a researcher to extract information from the data collected. Different statistical methods were used to derive an informed analysis. These include descriptive statistical methods and inferential statistics (Fielding and Nigel, 2000) which were used as follows.

Descriptive analysis

[2] The CT-OVC personnel based on their sound experience in the programme had witnessed most of the researchers from different institutions mainly conducting research in the urban areas for various reasons, for instance ease of access. They observed that participants in these areas appeared to them to be losing interest in participating.

Descriptive statistical methods include measures of central tendency such as mean and mode; and measures of dispersion such as standard deviation. They were used to describe the collected data through numerical and graphical means.

Hypothesis testing

Inferential statistics are concerned with drawing conclusions on a population from a sample and testing hypothesis (Babbie and Mouton, 2002). They were used to test the research hypotheses for significant relationships between the key variables. Inferential analysis was used to investigate the first hypothesis that 'Orphans and vulnerable children value capabilities in the four dimensions of social life, education, health and play.'

The second hypothesis that 'Being a recipient of the cash transfer for orphans and vulnerable children is associated with increased achievement of one's capabilities' was investigated by carrying out t-tests to examine systematic differences in the functionings of recipients of the CT-OVC fund and non-recipients in cases where the data was numerical. In addition, for categorical data, chi square tests were used to determine whether there was any significant relationship between nominal variables, for instance, access to play area and participation in the CT-OVC. Kernel density estimates were also used to ascertain the frequency distribution of the data (Field, 2013). A Kernel density estimate is a non-parametric measure of probability density that is related to the histogram but preferred for its properties such as smoothness and continuity. All the tests conducted were preceded by normality tests in order to make sure that appropriate tests were being undertaken.

Correlation analysis was used to determine whether there was an association between being a recipient of the cash transfer and the four aggregate indices of social life, health, education and play. Correlation analysis is useful in identifying the relationship between two variables (Field, 2013:267). The correlation analysis was valuable in determining the direction and strength of any such associations in the survey. The Kendall's tau non-parametric correlation was the statistic of choice given that it offers more accurate generalisations for small data sets with a large number of tied ranks (Field, 2013:278).

For this study, the pre-selected level of significance applied for all tests of mean comparison and correlations was at 5 percent (α=.05). The level of significance informs one of the likelihood that the observed differences in sample means of variables between the groups (for the former type of test) or observed correlations between variables (for the latter type of test)

are the product of chance. The null hypothesis is not rejected in the event that the results are not statistically significant at the 5 percent level of significance.

Qualitative data analysis

Qualitative data analysis methods were used to gauge the participants' perception of the CT-OVC program. To analyse the collected data, the researcher employed an in-depth exploration of the responses gathered from interviews. This technique was used because it is useful in identifying hidden information and explanations of phenomena which might not have been captured using quantitative methods.

The identification and refining of important concepts resulted in the grouping of data into three main themes. First were the general comments on the CT-OVC as a whole. Secondly, the data was grouped into perceptions on the four key dimensions of interest (social life, health, education and play), and lastly, on the recommendations for the improvement of the programme to better meet the needs of the participants. The results were then presented using quotes and descriptive narratives.

4.6 Ethical Considerations

The researcher was fully aware of the sensitivity of conducting social research with children due to their vulnerability and 'powerlessness,' and was therefore committed to proceeding with utmost caution insofar as ethical issues were concerned. In their suggestions on conducting ethical child research, Morrow and Richards (1996:100) consider respect of children's competencies as a crucial point of departure. All ethical standards upheld for adults should also be extended to children and added.

The researcher thus proceeded to adhere to the following ethical standards during the field study:

- Any respondent under the age of 18[3] could only participate with written, informed consent of the parent or adult caregiver; and the parents were allowed to be present during the data collection if need be.
- It was explained to each participant that the study was intended to contribute towards improvement of the CT-OVC programme for the benefit of the recipients and that no harm whatsoever was intended on them at any stage of the study.

[3] A child is defined as any person under 18 years of age (UN Convention on the Rights of the Child).

- The research sought voluntary participation and any information gathered thereof was to remain strictly confidential. All the gathered data was stored confidentially and was only accessible to the researcher.
- Participants were allowed to withdraw from taking part for any reason and at any point during the research; and were informed of their right to do so beforehand.
- A proposal was submitted to and approved by the University of the Western Cape's professional ethics committee, the Institute for Social Development research committee, the Children's Department in Kenya and the National Council for Science and Technology responsible for granting research permits in the country before the actual data collection was undertaken.
- The researcher undertook responsibility in ensuring all gathered information was treated sensitively and confidentially as well as protecting identities and interests of all participants. For instance, the interviews were also conducted in a private setting where interviewees could give their opinions without unintended parties listening in. In addition, in the reporting of the findings, interviewees remained anonymous.
- Research findings shall eventually be disseminated to all relevant parties. The researcher shall bear responsibility for how the children are represented in the study. As Morrow and Richards (1996:101) note, children might not have much power in influencing how they are represented and therefore it is the obligation of the researcher to maintain ethical conduct throughout the research and especially when disseminating their findings.

Granted that incorporating children into social research raises a number of ethical concerns, excluding them altogether from research does create another debatable ethical stance as it hinders exploration into social problems affecting them, which might have an impact on their wellbeing.

4.7 Conclusion

This chapter has presented the methodology applied in the study. The study employed a quasi-experimental research design wherein an intervention and control group were selected from recipients of the CT-OVC and non-recipients in Kiambu County. Mixed methods were used in both the data collection and data analysis processes. In the data collection phase three main techniques were used, which are: questionnaires, in-depth interviews and participant

observation. The ethical considerations made in the study have also been detailed in this chapter with due consideration of the sensitivity of children's research.

CHAPTER FIVE

FINDINGS AND DISCUSSION

5.1 Introduction

This chapter provides a detailed analysis of both the quantitative and qualitative data collected in the survey. It begins with a description of the study sample and proceeds to investigate the first two research questions which are: 1) Do the recipients of the CT-OVC value capabilities within the four key dimensions of health, education, social life and play? 2) Does the programme promote the achievement of these capabilities?

The main hypotheses shall be tested in order to guide in investigating the research questions. The main hypotheses of this study is that: 1) Orphans and vulnerable children value capabilities in the four dimensions of social life, education, health and play, and 2) Being a recipient of the cash transfer for orphans and vulnerable children is associated with increased achievement of one's capabilities.

The subsequent section shall then draw from the qualitative data to answer the third and final research question: What are the participants' perceptions regarding the programme in the four broad areas of social life, education, health and play; and are there areas that the programme could improve on to better promote the capabilities of the participants? This section shall then be followed by a conclusion of the key findings.

5.2 Demography

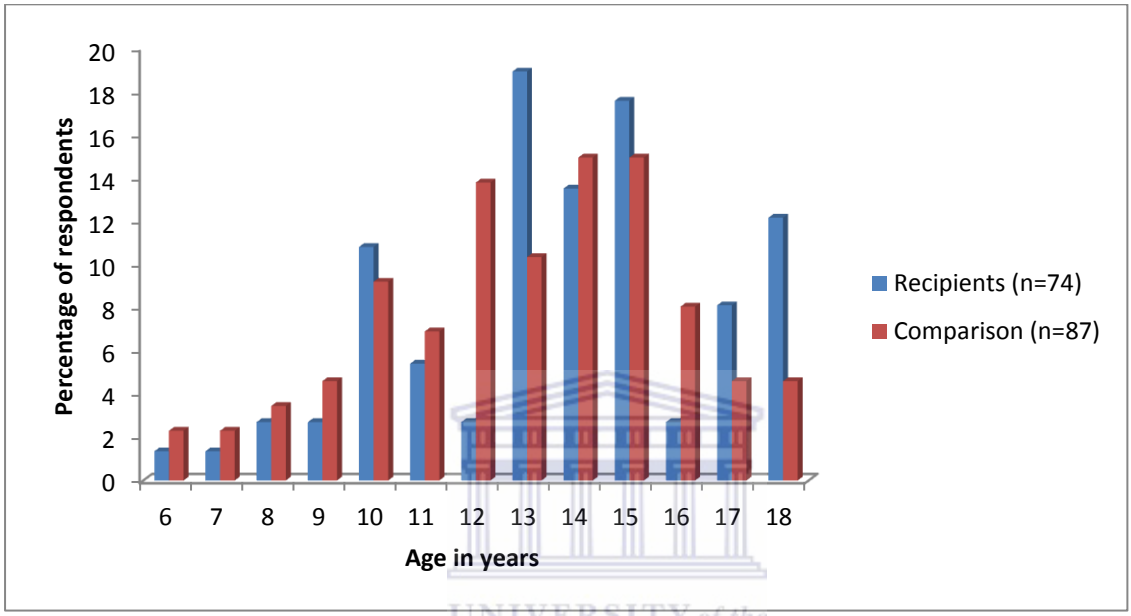
The total number of respondents in the study was 161. Of these, 74 were recipients of the cash transfer for orphans and vulnerable children. From the comparison group, a total of 87 respondents participated. The demographic characteristics including age, gender, type of caregiver and education level of the caregiver were similar for both groups. This was a key consideration in ensuring comparability of the respondents as shall be described in this section.

The distribution of females in the sample was 51.35 percent in the recipient group and 51.72 percent in the comparison group. The number of males was slightly less compared to the females at 48.65 and 48.28 percent of the total number of respondents respectively.

The mean age of the respondents was 13.22 years (SD=2.9138) with the youngest child being 6 years old and the oldest 18 years. The CT-OVC recipients were slightly older than the

comparison group at 13.62 years and 12.89 years respectively. The age of the respondents showed a normal distribution when the test for skewness and kurtosis was conducted[4]. A t-test carried out showed that the age difference was not statistically significant at the 5 percent level of significance. Figure 5 below shows the age distribution among participants in both groups.

Figure 5: Age of respondents



The findings show that the children and adolescents in the CT-OVC programme and the comparison group mostly live with a parent (69%) or with grandparents (28%) as illustrated in figure 6. However, almost double the respondents in the comparison group are in the guardianship of their parents than those in the recipient group at 86 percent and 47 percent respectively. This is indicative of the targeting process whereby children who are single- or double-parent orphans are given priority during the recruitment process over vulnerable children who have both or one of their parents alive (MGCSD, 2012:16).

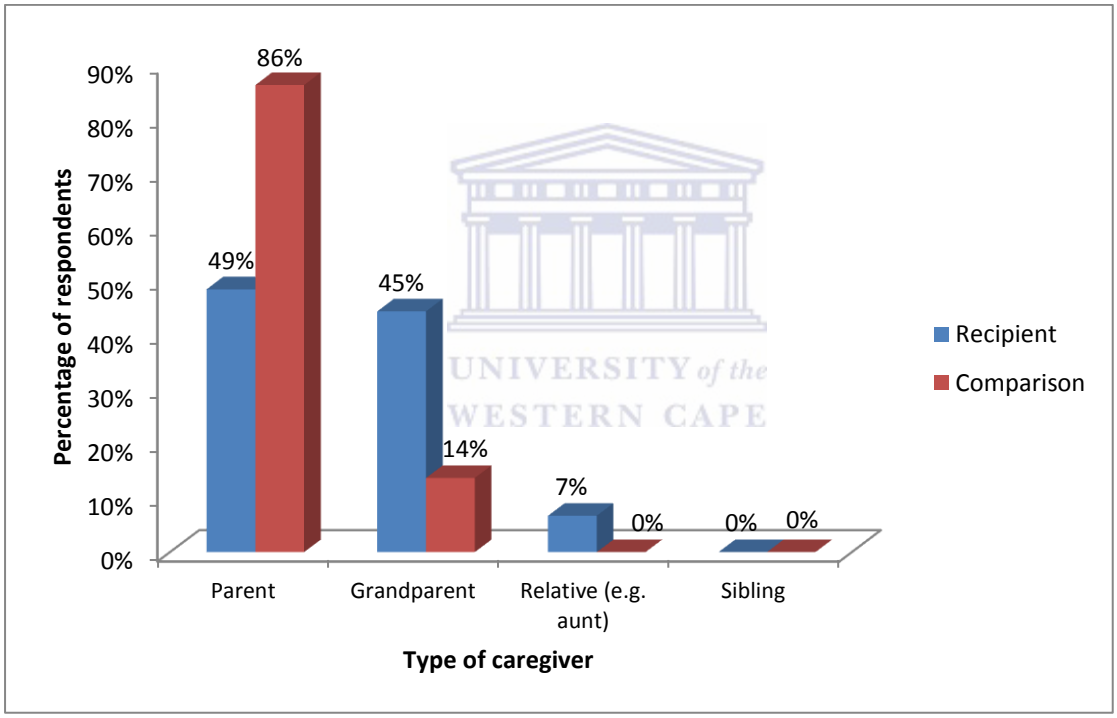
In both groups, none of the respondents is in a child-headed family as shown in figure 7 below. These findings are consistent with those of the baseline survey carried out by Oxford Policy Management (Hurrell et al, 2008: v) which found child headed households to be very rare in the regions where the programme is being undertaken. This could be attributed to the kinship child care system where children are often taken under custody of their relatives, mostly grandmothers, in the event that they are orphaned or that their parents are not able to

[4] Cf. Annex 4 for all tests of normality.

take care of them (EveryChild and HelpAge International, 2012:7). The kinship system of caregiving is more common than institutionalised care such as orphanages in sub-Saharan Africa (ibid).

Emerging research however shows that cash transfer programmes such as the CT-OVC present the risk of eroding local support systems in favour of formal systems in which community members are incentivised to take up the caregiving role in exchange for CTs (Onyango-Ouma, 2012:47). There was however no indication that such a shift was taking place in this particular study although further research might be useful in identifying such trends in future.

Figure 6: Caregivers of the respondents

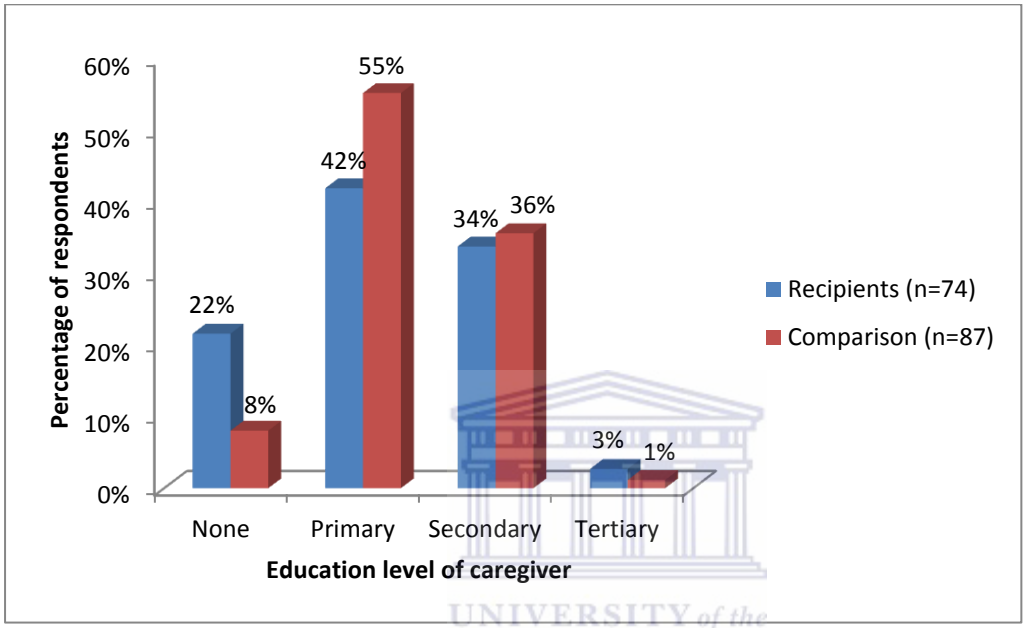


Parental education has been found to have an effect on the educational attainment of the child in previous research. For instance, it may lead to better performance in school and also motivate children into pursuing higher education (Ermisch and Pronzato, 2010:15). The education level of parents or guardians is also an important determinant of the health status of children as has been evidenced by other studies (Cochrane et al. 1982:213; Desai and Alva, 1998:71). It is therefore important for these aspects to be comparable between the intervention and comparison groups in the quasi-experimental study.

The educational level of the caregivers of respondents in the recipient group was found to be similar to that of participants in the comparison group as indicated by results from a chi

square test. The highest level of education attained in both was primary education at 41.89 and 55.17 percent in the recipient and comparison groups respectively as indicated in figure 7 below. A considerably high percentage of respondents' caregivers had no formal education at all. Overall, 21.62 percent of caregivers in the recipient group and 8.05 percent from the comparison group had no basic education whatsoever.

Figure 7: Education level of guardian



In conclusion of the demographic characteristics, it is notable that the CT-OVC recipient group does not systematically differ with their counterparts in the comparison group when important demographic variables such as age, sex, type of caregiver and the education level of the caregiver are compared.

5.3 Capabilities in selected dimensions

In this subsection the study investigates first, the level of importance that participants place on the capabilities in the broad dimensions of social life, health, education and play. Secondly, it determines the observable differences in the two groups based on these key dimensions, and finally identifies the relationship between participation in the programme and the children's outcomes in these four dimensions.

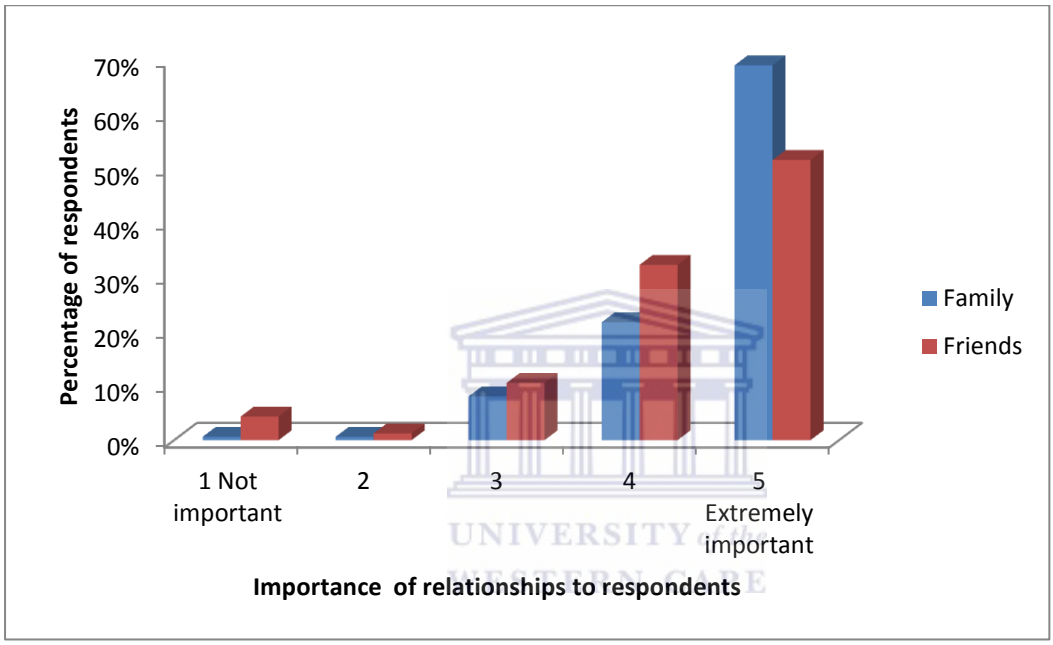
5.3.1 Social life capabilities

The majority of respondents consider support from their family members to be of utmost importance in their lives. As shown in figure 8 below, family support was ranked highly

among the participants with 69 percent rating it as ‘extremely important’ and 22 percent ‘very important’.

While none of the respondents considers relations with family not to be of any importance, a few of them (4%) do not value relations with friends as much. The majority of respondents (52%) however consider relationships with their friends to be extremely important although not quite as important as those with their family members (69%).

Figure 8: Importance of relationships to respondents



The data was further grouped into ‘highly’ and ‘not highly’ important depending on the value attached to relations with family and friends, both of which comprise social life. Those that rated family and friends as ‘very important’ and ‘extremely important’ were categorised as ‘highly important’ and the rest as ‘not highly important’.

A much higher percentage of respondents considered relations with family and friends to be highly important (91% and 84% respectively) compared to those that did not. The pie charts in figure 9 and 10 below show that only 9 percent of the respondents consider relations with family not to be highly important. Studies on children’s perceptions of social support have shown that children tend to value parental (mostly from the mother) and sibling support much more than they value other support mechanisms such as friends and teachers (Reid et al. 1989:907). Friends were however seen to also be important in providing companionship and emotional support.

Figure 9: Relationships of OVC with family

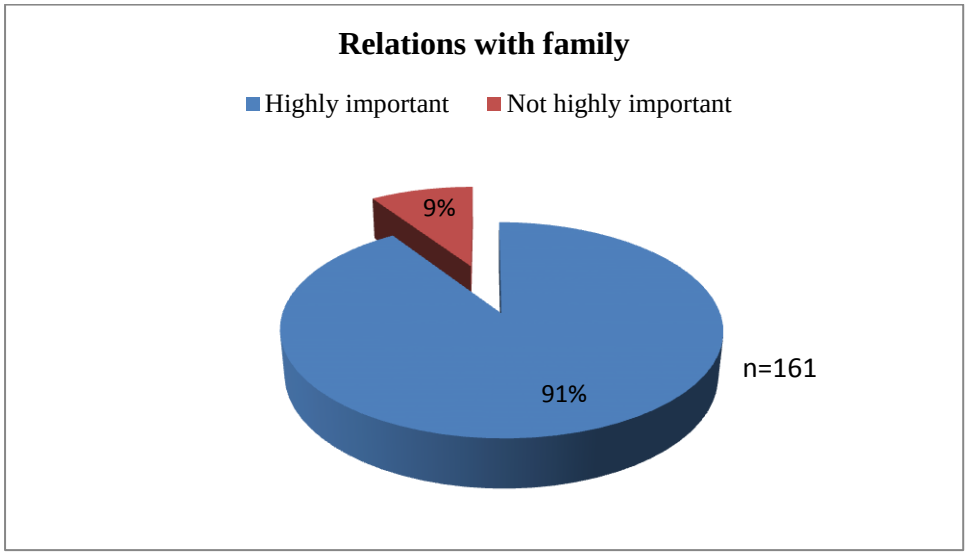
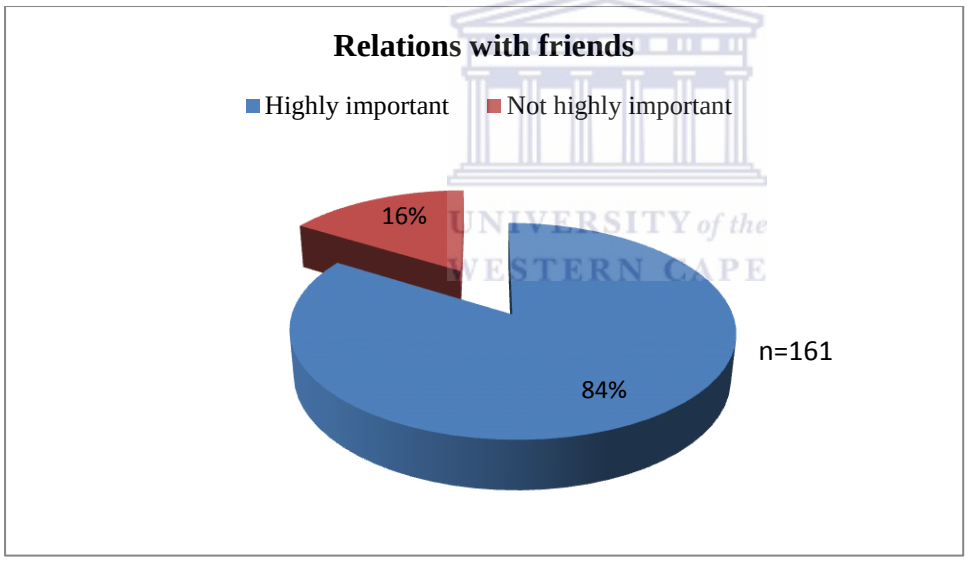


Figure 10: Relationships of OVC with friends

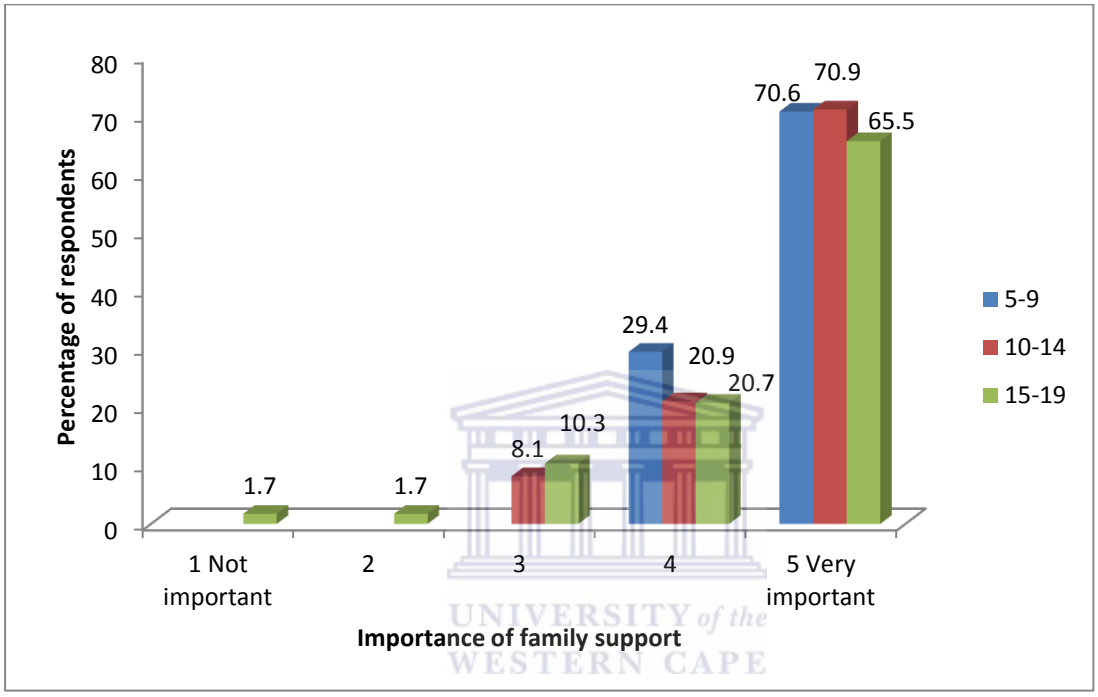


The discrepancy in the value attached to family relationships among the respondents could be explained by the different age groups within the sample. To determine this, the sample was sub-divided into different age categories based on the WHO age standardisation (World Health Organisation, 2001). Based on this age standardisation, the respondents fell under three of the proposed categories: 5-9, 10-14 and 15-19 year olds.

Findings show that the older children seemed to value family relationships much less than younger ones. As shown in figure 11 below, those who indicated that family was not important (ranking 1 or 2) for instance, were from the age category of 15-19 years. This could

be explained by the onset of adolescence, a period which has been found to affect the manner in which teenagers interact with other family members. A study by Larson et al. (1996:744) found that between the ages of 10 and 18, there was a decline in the amount of time adolescents spent with their family members, from 35 percent to 14 percent. They concluded that this was an indication of disengagement from family in this particular age group.

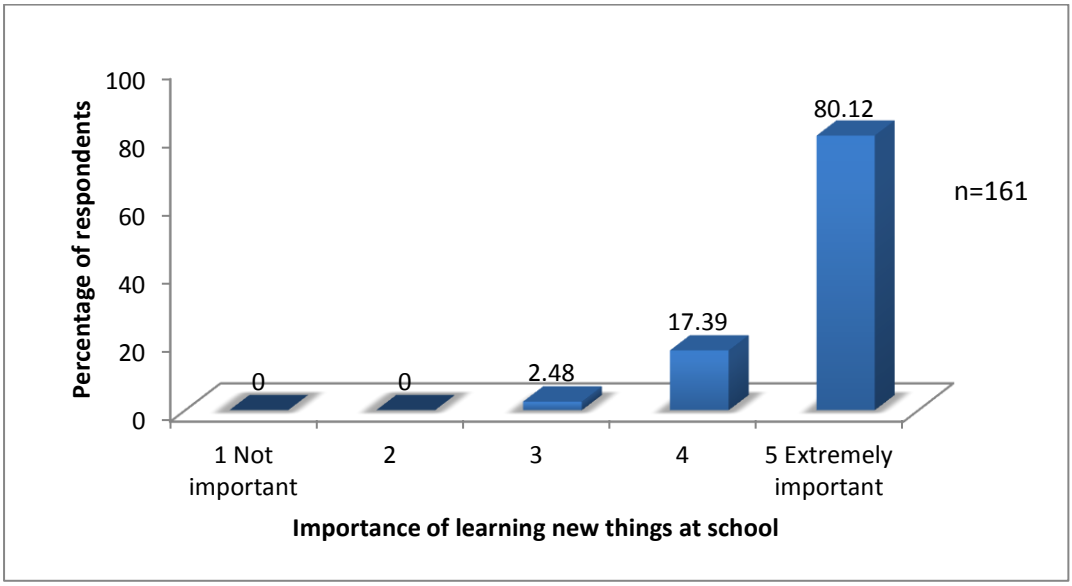
Figure 11: Importance of family relationships by age



5.3.2 Education capabilities

The findings from this study show that almost all the respondents attach a high value to education with the majority rating it as either 'extremely important' (80.12%) or 'very important' (17.39%) to them. This was in stark contrast to the ratings of importance of education as either 'not important' or 'fairly important', both of which were not selected at all. Figure 12 illustrates these findings in more detail. There was no statistically significant difference in the level of importance placed on education by respondents in the CT-OVC recipient and comparison groups using a chi-square test (chi2=3.6017 at 2 degrees of freedom, p=.165).

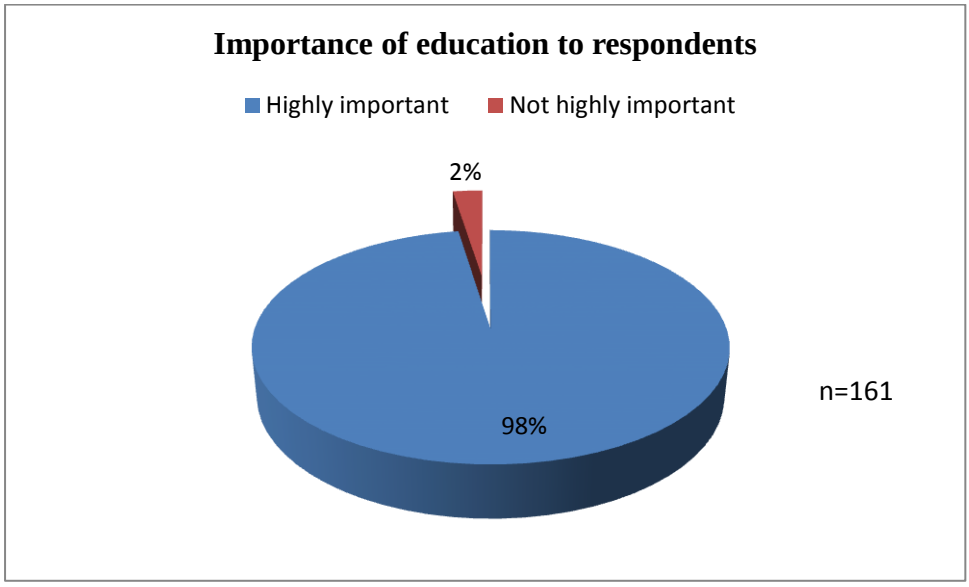
Figure 12: Distribution of the importance of education to respondents



The data was further ranked as 'highly' and 'not highly' important depending on the value attached to education by the respondents. Those that rated education as 'very important' and 'extremely important' were considered to be regarding it as 'highly important' and the rest as 'not highly important'.

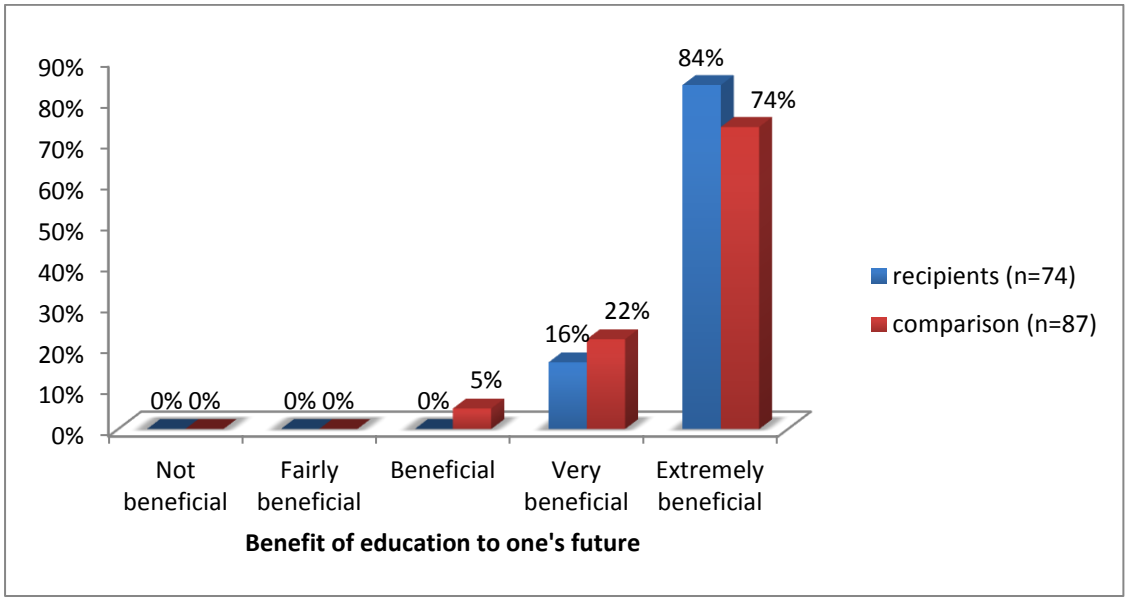
Findings indicate that only 2 percent of the orphans and vulnerable children consider education not to be highly important to them. This was in great contrast to the 98 percent of respondents that attach a high level of importance to education. Figure 13 below illustrates these results.

Figure 13: Importance of education to respondents



More respondents in the CT-OVC recipient group felt that education would be extremely beneficial to them in the future compared to those in the comparison group at 84 percent and 74 percent respectively as shown in figure 14 below. However, the differences in perceived benefits of education between the two groups were not statistically significant at the 5 percent level of significance when a chi-squared test of equal proportionality was conducted (chi2=4.5926 at 2 degrees of freedom, p=.101).

Figure 14: Perceived benefit of education to respondents



This shows that for both groups of children, education is considered a way through which major achievements may be made in the future. For children, aspirations for high attainments

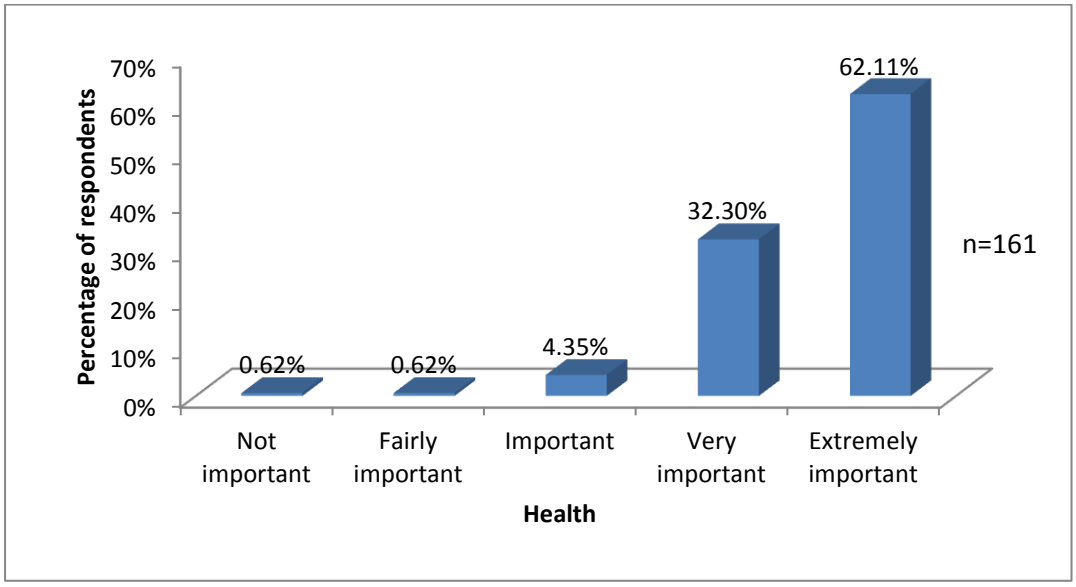
in education are manifest in the choice of careers that they aspire to have in their adulthood. A previous study in Tanzania on children's perceptions on the value of education for the future found that 80 percent of the children aspired to hold skilled professions with the majority preferring to work in the service industry. Only 10 percent of the sampled children preferred semi-skilled jobs in the production sector (Research and Analysis Working Group, 2008:26). These children acknowledged that education played a key role in the type of career that they would undertake in future. In this particular research, however, it was not explored in which ways the children perceived education to be beneficial in their future lives and therefore further research would be required to seek out an explanation for their perceptions.

5.3.3 Health capabilities

Equally highly important to participants in both the recipient and comparison groups was the health capability. Figure 15 below shows the ratings of the importance of health to the respondents. Once more, majority of the respondents consisting more than 62 percent place an extremely high value to health. Only a low percentage (0.62%) of the respondents in the survey rated health as 'not important' or 'fairly important.'

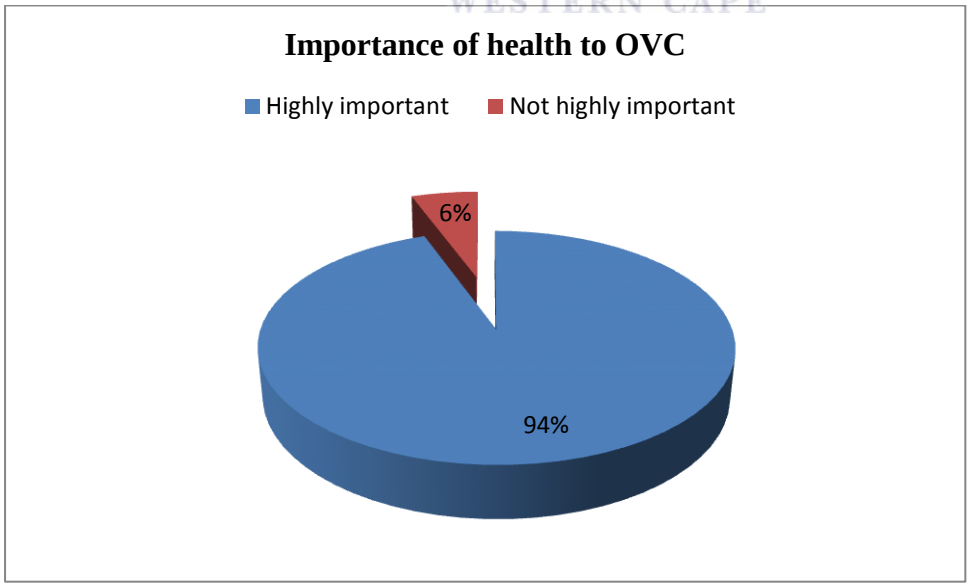
It has been found in previous studies (Uyan-Semerci, forthcoming) that a very high positive correlation exists between having an ill member of the family and children's rating of health as being important to them. Children from such families even tend to prefer professions in the medical field such as being doctors or pharmacists, for the sole purpose of solving problems that they might be experiencing in their own homes. Since the CT is primarily targeted at children who are orphaned by HIV/AIDS, it is possible that the very real encounter with illness in their families makes them more aware of the importance of good health and aspire to achieve it for themselves and their families.

Figure 15: Distribution of importance of health to OVC



When the data is further grouped into 'highly important' and 'not highly important' based on the respondents' rankings. Like in the previous two capability dimensions, 'very important' and 'extremely important' were categorised as 'highly important' and the rest of the rankings as 'not highly important'. As figure 16 shows, a very high percentage of children value health highly compared to those that do not, at 94 percent and 6 percent respectively.

Figure 16: Importance of health to OVC



The findings also show that respondents in both the CT-OVC recipient and comparison group consider it highly important to take precautions to avoid injury. A chi-test carried out shows the there is no significant difference in the perceived importance of taking precautions for

children in both groups, which was an unexpected result (chi2=4.5863 at 3 degrees of freedom, p=.205).

Qualitative data from the in-depth interviews and other secondary sources (Ward, et al. 2010: x) indicate that one of the key auxiliary services offered by the cash transfer programme is the emphasis, through advisory measures, on health service utilisation which in turn might affect precautionary measures of participants. Although there are no health conditionalities attached to the programme, recipients are regularly advised by the programme personnel to seek regular healthcare for the OVC in order to ensure that good health status is maintained. Injuries are a key determinant of child health particularly in developing countries. They contribute greatly to mortality and disability, and generally affect the wellbeing of children (WHO, 2008:2). It emerged from the interviewees that health practitioners guided caregivers and sometimes children on injury prevention particularly at the household level during visits to the medical centres. One of the orphans in the programme who has younger siblings stated this with regards to precautionary measures:

> "The nurse told us not to share pins … like if we prick ourselves with them. We have to hide them from small children"

However, for children in both groups to indicate that they considered it important to take precautions to avoid injury may be taken to be an indication of the high value they each attach to being healthy.

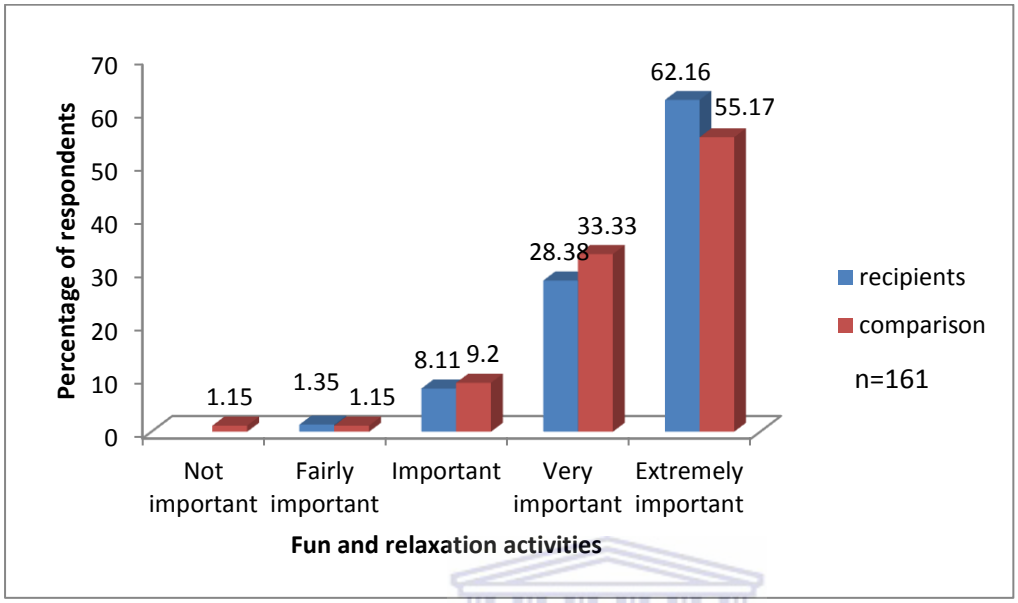
5.3.4 Play capabilities

The results show that the engagement of children in play activities was highly important to the respondents with 62.16 percent of them in the recipient group and 55.17 percent in the comparison group ranking it as extremely important. Only a small number of the respondents (1.15%) did not value play as a fundamental capability. It was however found that both groups of respondents value such activities on a similar level since results from the chi-squared tests did not reveal a statistically significant difference between them. Figure 17 below illustrates these results.

The participants saw play as a way through which they could have fun and relaxation from work both at school and at home. They also recognised that it facilitates their interaction with friends and thus has an impact on their social relationships (cf. Annex 3). In addition, they

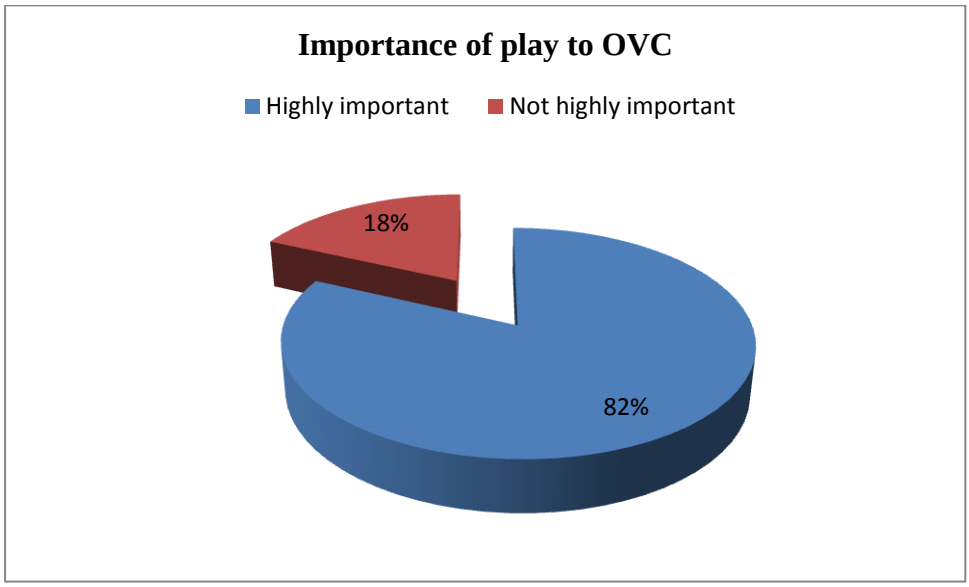
perceived play to be a fun activity and also important in the acquisition of certain skills, giving examples in sports such as football for the boys and knitting for the girls.

Figure 17: Importance of play to respondents



Further grouping of the data from the play dimension into 'highly important' and 'not highly important' indicates that 82 percent of the orphans and vulnerable children value capabilities in the play dimension highly compared to the 18 percent that do not. Figure 18 gives an illustration of the rating of the importance of play to the respondents.

Figure 18: Importance of play to OVC



The preceding segment has established that children and adolescents in the sample do indeed value capabilities in social life, education, health and play based on their rankings on how

important these dimensions are in their lives. It establishes that the children and adolescents in both groups place a similarly high importance on all four dimensions considered.

The results thus lead to the acceptance of the first hypothesis of the study that orphans and vulnerable children do indeed value capabilities in the four dimensions of social life, education, health and play.

5.4 Relationship between CT-OVC participation and attainment of functionings

The next objective of this study is to find out the extent to which the CT-OVC programme enables recipients to attain functionings within the four dimensions of social life, education, health and play through the quasi-experimental framework. This subsection examines the differences in the achieved functionings of the respondents in the four dimensions selected.

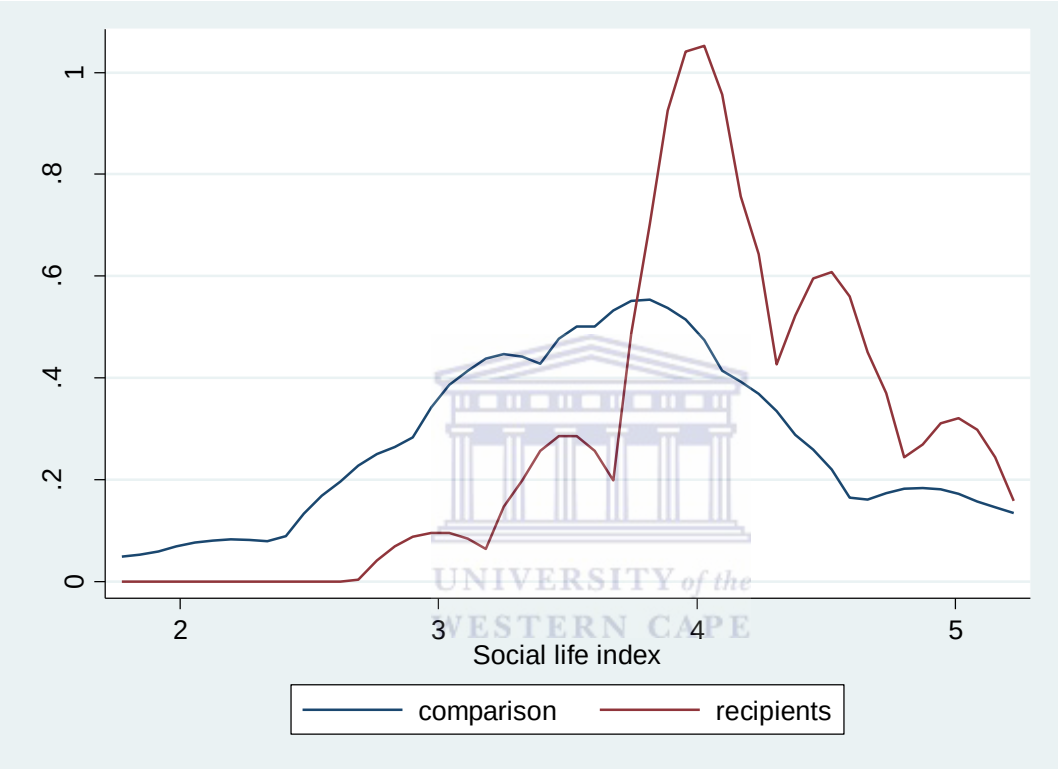
5.4.1 Social life functionings in CT-OVC recipient group and comparison group

A social life index was created by combining multiple likert questions in the questionnaire that measured the status of relationships between the respondents, and their family and friends (cf. Annex 1, question 4 and 5). The variables were recoded in order to acquire a positive alignment in which case a high value represented a high score in the social life index.

A comparison was made between the distribution of scores in the recipient and comparison groups using normality tests and is presented in the table below. The kernel density estimate is provided in figure 19 below which gives a graphical representation of the results. Both groups peaked at point 4 of the social life index which is an indication of the mode for each of them. However, the peak is higher in the recipient than in the comparison group meaning that more children in the recipient group scored 4 points in the social life index than those in the comparison. In addition, the curve for the recipient group is tilted more to the right than that of the comparison group suggesting that children in the former group tend to score higher in the social life index than their counterparts.

Figure 19: Kernel density graph of social life index scores of respondents

	n	Pr (Skewness)	Pr(Kurtosis)	Prob>chi2
Recipients	74	0.7178	0.9807	0.9365
Comparison	87	0.8369	0.8822	0.9684



These findings are consistent with those from previous studies that have sought to investigate the impact of cash transfers on social relationships of the recipients. Attanasio et al. (2009:139) for instance, found that there was more cooperation within communities which received cash transfers than those that did not, concluding that cash transfers have a positive impact on social capital. Through exploring food sharing patterns of cash transfer recipients in two communities in Kenya, Ressler (2008:13) also observes that cash transfers have helped promote social networks of vulnerable groups particularly as their credit worthiness increases. Results from the in-depth interviews discussed in further detail in the succeeding sub-section also seem to support the findings that on the whole, social relationships have improved among the recipients of the grant (cf. Annex 3). For instance, interviewees noted that there were reduced conflicts arising from inability to repay debts, greater inclusion of

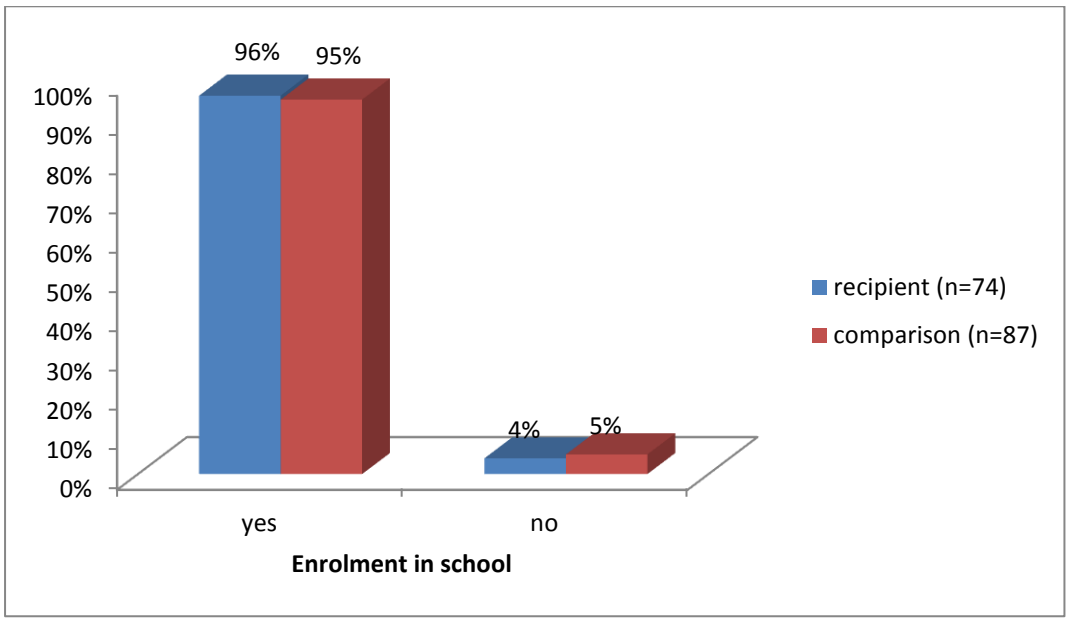
OVC in social activities as well as increased participation in informal groups such as savings groups.

Overall research results on this area have however been mixed with some findings indicating that there might be some resentment of recipients by non-recipients who consider themselves deserving (Macauslan and Riemenschneider, 2011:60). This is however not common and certainly so among children. In another study on Mexico's PROGRESA cash transfer, Adato (2000: vii) found that in a minority of cases, the cash payments seemed to ignite some envy, for instance of school uniforms, among child non-recipients. In the case of the CT-OVC, the plight of the children and circumstances which qualify them for the grant, which is mainly the loss of their parent(s), may be helping to mitigate tensions among child recipients and non-recipients arising from envy.

5.4.2 Education functionings in CT-OVC recipient group and comparison group

Almost all participants in both groups were attending school with only a small percentage of the sample not being enrolled. In the CT-OVC recipient group 4.6 percent of the respondents did not attend school while in the comparison group 4.05 percent were not enrolled as shown in figure 20 below. The differences in the two groups were however very slight and not statistically significant at the 5% level of significance in the chi-square test.

Figure 20: School enrolment among respondents



The high enrolment exhibited in the two groups could be explained by the fact that primary school education has been made free in Kenya since 2002, and failure to take children to

school is a criminal offence punishable by law. This has led to a massive countrywide increase in school enrolment by some 18 percent up from 6.06 million to 7.16 million pupils (Sawamura and Sifuna, 2008:109). The figures from the sample also compare favourably to the national statistics which have placed the gross enrolment ratio in the country at 108 percent for both boys and girls in the most recent study held in 2003 (KNBS, 2005/6).

Other studies have shown that the gap in school attendance between orphans and non-orphans in sub-Saharan African countries reduced significantly between 2006 and 2012 (UNICEF, 2013:81). Although this is attributed to the integration of different intervention programmes, for instance waiving of school fees in primary schools, social protection is considered to have played a role in realising these gains in the education realm for OVC.

The study sample showed a normal distribution in the grades of the respondents using the test for skewness and kurtosis. The mode in the distribution was in grade 7 for the recipients and grade 8 for the children in the comparison group. The recipient group had 2 children in grade 13 which was the highest grade represented in the sample. For the comparison group, the highest grade represented was grade 11. Table 5 below shows results from a t-test comparison of means of grades of the respondents in both groups in which recipients have a higher mean at 7.2162 compared to the their counterparts at 6.3563. It was found to be statistically significant at the 5 percent level of significance.

Table 5: T-test comparing grades of respondents

Group	Mean	SD
Recipients	7.2162	2.706
Comparison	6.3563	2.614
t=2.0465; df=159; p<.05; n=161		

Given that the difference in age between the recipient and comparison group was not significant, it was expected that there would not be a significant difference in their grades but this was found not to be the case based on the t-test comparison of means. Different reasons for this occurrence were considered. First, it may be the case that children in the comparison group got enrolled in school at an older age than their counterparts. It could also be that grade repetition was more common in the comparison group than in the recipient group. No mention of the age at which school enrolment took place was made in the in-depth interviews. However, grade repetition came up a number of times and was attributed to lack

of school fees, or rather the extra contributions that children had to pay to remain in school (cf. Annex III). Failure to meet these costs meant being sent home from school and a loss in learning days. Absence from school might have affected the children's academic performance thereby necessitating repetition. The next subsection investigates absenteeism from school within the two groups.

5.4.2.1 Absenteeism

The number of days of absence from school was found to be higher for children in the comparison group than for recipients of the cash transfer. The mean days of absence from school for the comparison group stood at 5.73 while that of respondents in the recipient group was 2.58 days. A Mann-Whitney test was carried out to determine whether there was a statistically significant difference in absenteeism between the two groups. This test was chosen because the data was not normally distributed in which case a t-test would have been appropriate. The results show that there is a statistically significant difference in the level of absenteeism between the two groups ($z=4.149$, $p<.05$).

As can be seen from table 6 below, based on the distribution of mean ranks, the comparison group (mean rank = 8237) had a significantly higher level of absenteeism from school than did the CT-OVC recipient group (mean rank = 4804).

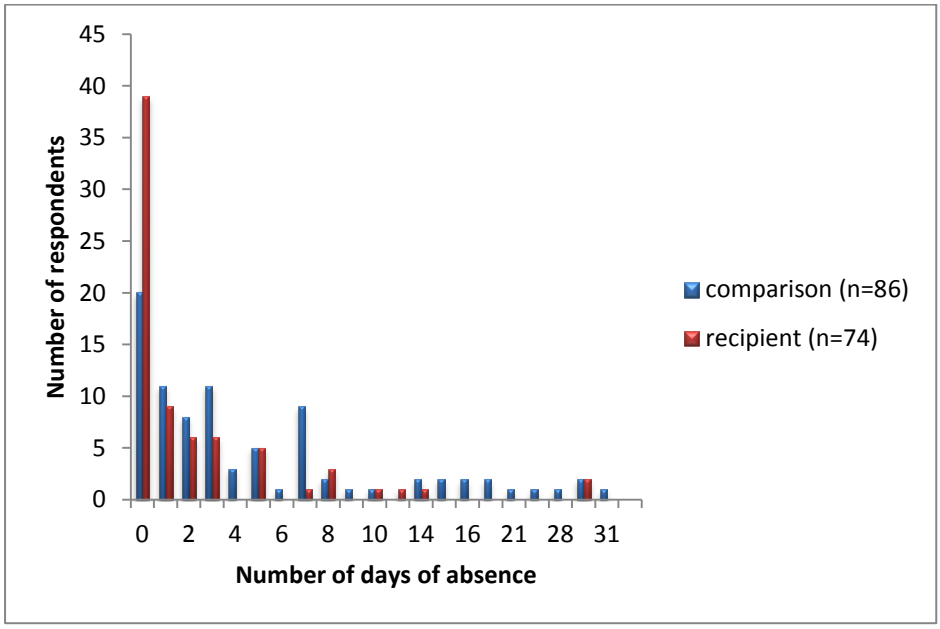
Table 6: Comparison of absenteeism among respondents

Group	Mean rank
Recipients	4804
Comparison	8237

$z=4.149$, $p<.05$, $n=160$

While the majority of respondents had not missed any school days, some had been absent for as many as 31 days as shown in figure 21 below. One respondent in the comparison group had a 90-days absence from school due to lack of school fees to join secondary school. This was however considered an outlier and is not represented in the bar chart.

Figure 21: Absence from school



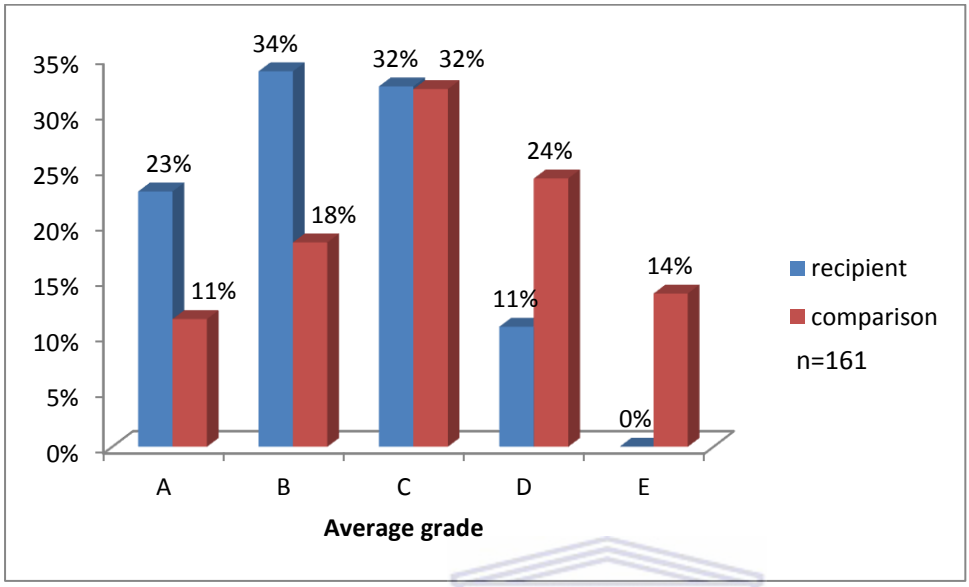
Although school fees at the secondary school level in Kenya is subsidised it is still beyond the reach of many poor households. There is a free primary education programme in the country which was launched in 2002, but despite the name, it is not entirely free to the school children. There are still some 'small' contributions made by the caregivers to support the running of the schools (Sawamura and Sifuna, 2008). This represents one of the most common reasons given for missed school days among the respondents. As findings from the interviews suggest, children sometimes also stay out of school if their guardians are unable to raise these amounts or if they are too hungry to attend school (cf. Annex 3). For households that receive the grant, the extra money helps cater for some of the education expenses and this could be the reason for the lower absenteeism from school.

5.4.2.2 Academic scores

A Pearson's chi-squared test was carried out to determine the relationship between academic scores of respondents and their participation in the CT-OVC. The results show that children in the recipient group outperformed those in the comparison group when their academic grades were compared. As shown in figure 22 below, more than double the number of students who scored a mean grade of 'A' was from the CT-OVC recipient group compared to the comparison group. There were also more students from the recipient group scoring an average grade of 'B' (34%) than those in the comparison group (18%). The difference in academic scores between the two groups were statistically significant at the 5 percent level of

significance in a chi-square test performed (chi2=21.013 at 4 degrees of freedom; p<.05; n=161).

Figure 22: Distribution of academic scores among respondents

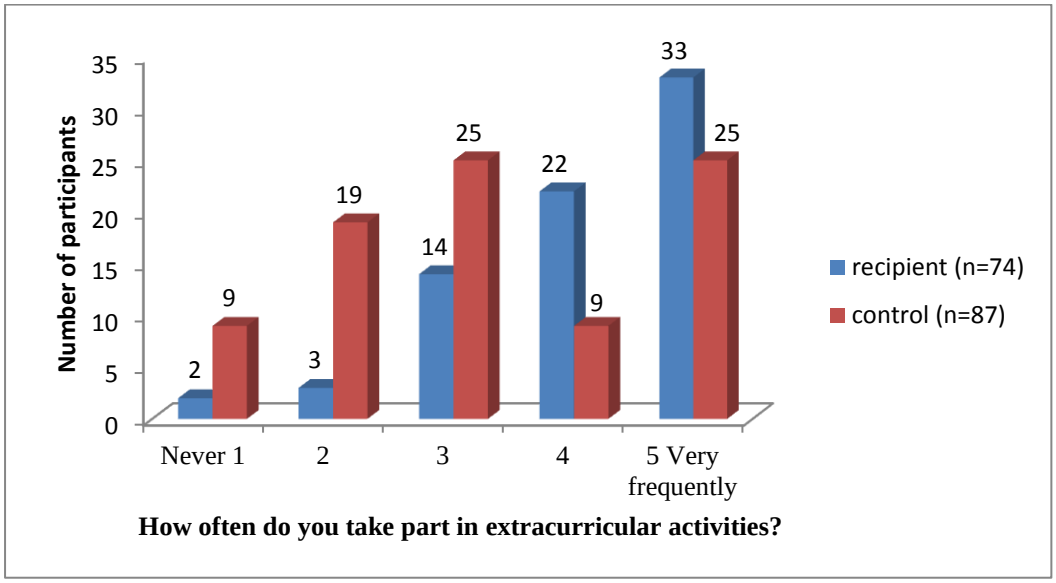


Academic achievement for school children is generally influenced by a number of factors, key of which is regular attendance to school. Missed school days have a detrimental effect on learning as they reduce the number of hours of instruction the child receives and hence their academic performance (Gottfried, 2009:3992). As has been shown in the preceding subsection, the respondents in the comparison group have a far greater level of absenteeism than their peers in the recipient group and this could be an underlying factor in their poorer academic performance than those in the recipient group.

5.4.2.3 Extracurricular activities

A likert scale was used to rate how often respondents took part in extracurricular activities. Results from a chi-squared test showed that there was a significant relationship between being a recipient of the cash transfer and participation in extracurricular activities. These results were statistically significant at the 5 percent level of significance as shown in the figure below (chi2=24.8609 at 4 degrees of freedom, n=161).

Figure 23: OVC participation in extracurricular activities



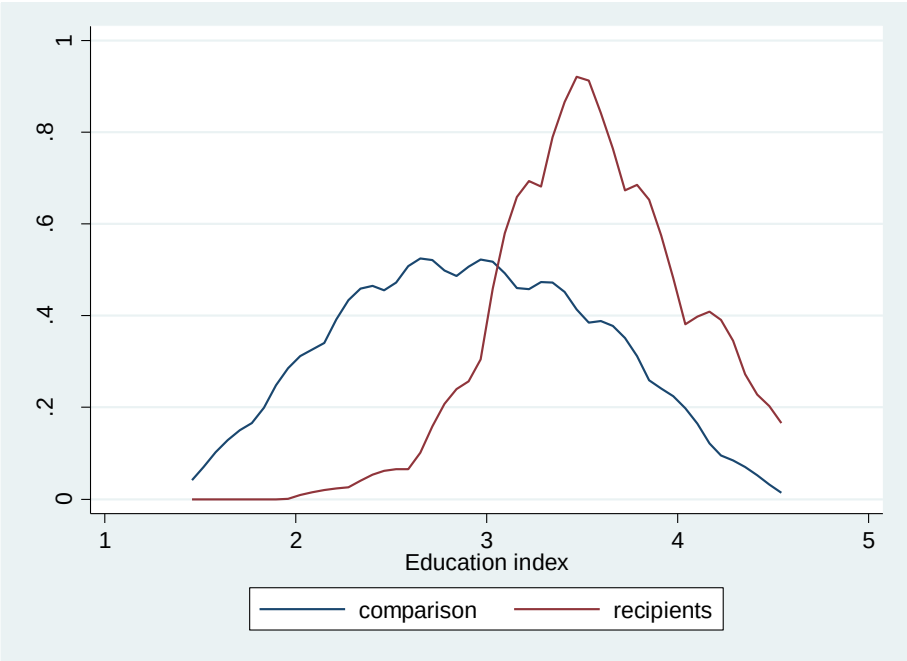
Pearson chi2 (4) = 24.8609, p<.05, n=161

An education index was created to measure the attainment of capabilities in the dimension of education by combining item 10-12 of the questionnaire (cf. Annex 1). A reliability test was conducted and the Chronbach's alpha found to be sufficiently high at 0.74. Variable 10 and 11 were recoded to give a positive direction to the scale.

From the kernel density graph in figure 24 below, the modes for the distributions of scored in the education index for the recipient and comparison groups were 3.3 and 2.7 respectively as seen from the peaks. The curve of the recipient group is also tilted more to the right than that of the comparison group suggesting that more participants in the recipient group tended to score higher in the education index than their counterparts.

Figure 24: Kernel density graph of education index scores of respondents

	n	**Pr (Skewness)**	**Pr(Kurtosis)**	**Prob>chi2**
Recipients	74	0.8146	0.9603	0.9717
Comparison	87	0.8539	0.0210	0.0728



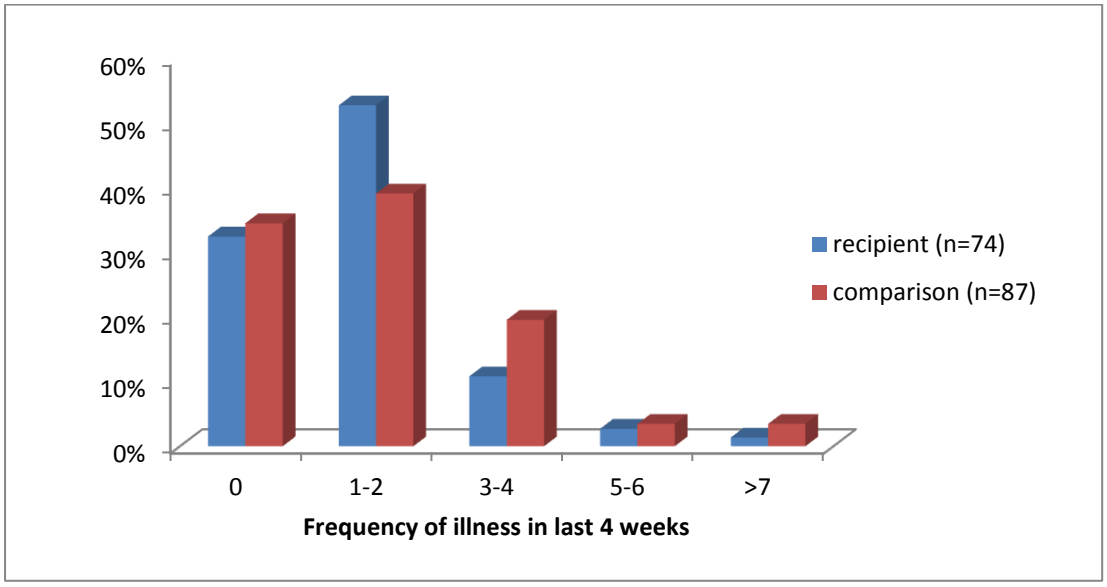
5.4.3 Health functionings in CT-OVC recipient group and comparison group

5.4.3.1 Prevalence of illness

When the data is grouped to show children who had fallen ill any given number of times and those who had not, the results indicate that slightly more respondents from the recipient group had fallen ill in the six weeks preceding the study compared to the comparison group at 68 percent and 66 percent respectively. The prevalence of illness was as graphed in figure 25 below.

A test for normal distribution was carried out (cf. Annex IV) which showed that the data was normally distributed. This was followed by a t-test which showed that the difference in the incidence of illness among the two groups was not statistically significant (t=1.2633 at 159 degrees of freedom, p=.1042).

Figure 25: Prevalence of illness among respondents



Although not statistically significant, this is an unexpected finding as the respondents in the recipient group are presumed to have better access to healthcare facilities and a generally higher health status than those not in the programme. Other underlying factors such as healthcare seeking patterns of the caregivers or genetic factors could be responsible as they have previously been identified to be important determinants of child health (Logan, 2008:16-17). In addition, the respondents have mostly been orphaned by HIV/AIDS and some are chronically ill (Ward, et al. 2010:3) which might be playing a role in the prevalence of illness within the group.

5.4.3.2 Housing

Overcrowding has an impact on health outcomes of children. According to the U.S Department of Housing and Urban Development (2007:1), it affects the physical and mental health, childhood growth and development, and also educational outcomes of children. The most common measure of overcrowding in housing is the persons–per-room (PPR) in a household (ibid: 2). The PPR measure is calculated as the number of persons per room in a household.

Given that the housing standardisation was designed by U.S standards, other measures which were proposed such as persons-per-bedroom (PPB) were found to present a measurement problem for this particular study conducted in rural Kenya where entire families consisting between 4 to 7 members in the respondent groups sometimes reside in a one-roomed housing unit, which serves as a living room, a bedroom and sometimes as a kitchen.

Therefore, using instead the persons-per-room measure of overcrowding, it was evident that the majority of the respondents experienced overcrowding in their households. A slightly higher percentage of respondents in the comparison group (89.68%) have overcrowded living conditions compared to 86.48 percent in the recipient group. As represented in table 7 below, only a small percentage of the respondents attained the recommended 1 PPR standard at 5.41 percent and 10.34 percent in the recipient and comparison groups respectively.

It was noted that in some 8.1 percent of the households of cash transfer recipients there was less than one person per room, although this was not the case in the comparison group in which none of the households had less than one person per room. Finally, the most common number of persons per room in the recipient group was 2, while for the comparison group most households had a total of 3 occupants per room. In both groups, majority of the respondents live in 2 roomed houses at 46 percent for the recipient group and 37 percent for the comparison group.

Table 7: Number of persons per room in respondents' households

Persons per room	Group	
	Recipient	Comparison
<1	8.10%	-
1	5.41%	10.34%
>1	86.48%	89.68%
	n=74	n=87

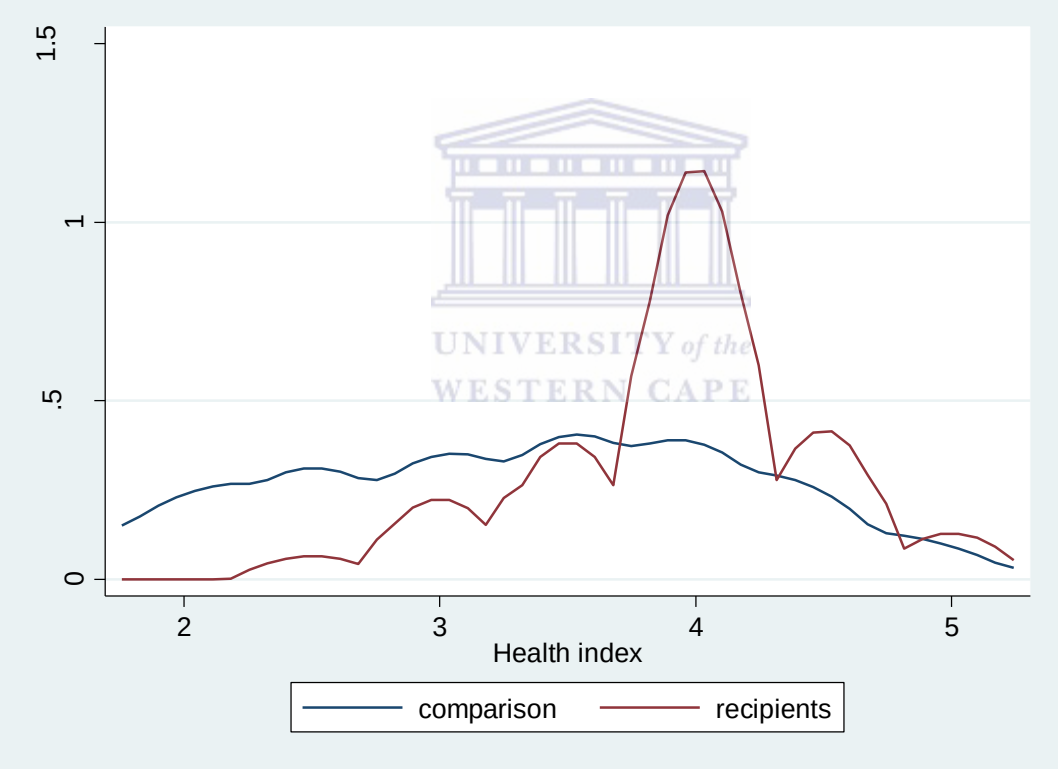
The differences in the two groups based on the PPR standard were however not found to be statistically significant when a t-test was carried out. This could perhaps be explained by the make-up of the recipient families where the caregiving role is taken up by relatives who already have their own families hence the large numbers of family members in each household. Also, the amount of subsidies received through the cash transfers may not be sufficient for housing expansions to provide adequate rooms in all households which may be rather costly.

Further analysis of health as a functioning of the respondents was conducted using an index. The index was created by combining variable 16 and 18 from the questionnaire (cf. Annex 1). Variable 16 was reverse coded to align positively with variable 18.

When aggregate scores in the health index were compared between the two groups both had the same mode, 4, but while the frequency for the recipient group was 36, that of the comparison group was only 16. Children in the recipient group tended to make scores higher up in the index than those in the comparison group as shown in the kernel density graph below.

Figure 26: Kernel density estimate of health index scores of respondents

	n	Pr (Skewness)	Pr(Kurtosis)	Prob>chi2
Recipients	74	0.1198	0.3467	0.1795
Comparison	87	0.8905	0.0006	0.0068



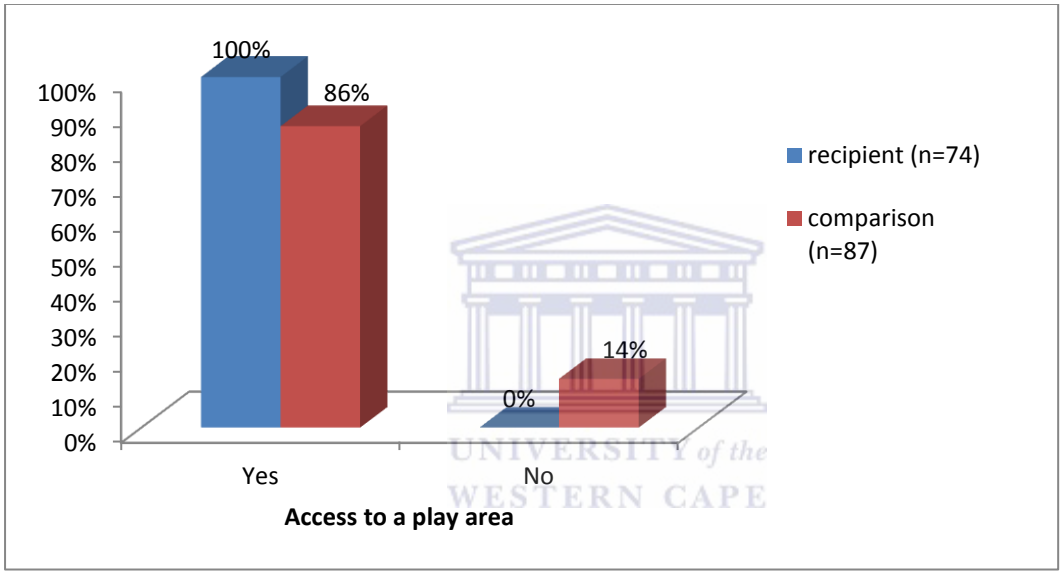
Thus, although recipients of the CT show a slightly higher incidence of illness, they fare better than those in the comparison group when proxy measures of health such as meals per day and type of housing are considered. As findings from the interviews indicate (cf. Annex 3), consumption of the CT is mainly made on basic necessities such as food and clothing, and in some households, has been used to make repairs of houses. However, further investigation from a medical perspective, for instance on anthropometrics could help give more insight into the prevalence of illness among OVC in the programme.

5.4.4 Play functionings in CT-OVC recipient group and comparison group

Recreational spaces

While all the children in the recipient group responded that they had access to a play area such as a playground in their neighbourhoods, the findings showed that 14 percent of children in the comparison group lacked such access. A chi square test performed revealed that there was a statistically significant relationship between participation in the programme and the children's access to a recreational area in their neighbourhood (chi2=11.0289 at 1 degree of freedom, p=0.001, n=161). Figure 27 below illustrates this finding.

Figure 27: Respondents' access to recreational area



Chi2(1)=11.0289; p=0.001, n=161

While it may appear that majority of the respondents have access to a recreational area, it is worth noting that most of them cited the school playground as their main and sometimes only source of recreation space. Although school playgrounds play an important role in providing recreational areas for the children in the area of study, it was observed by the researcher that most are not accessible past regular school hours, are in dire need of maintenance to at least manage dust levels, and generally lack facilities for play. Some of the respondents play by the roadside which presents the risk of injury and accidents. The likelihood of such risks happening is escalated by the natural curiosity of children and the exploratory nature of their play which exposes them to certain hazards (UN Committee on the Rights of the Child, 2013:11-12).

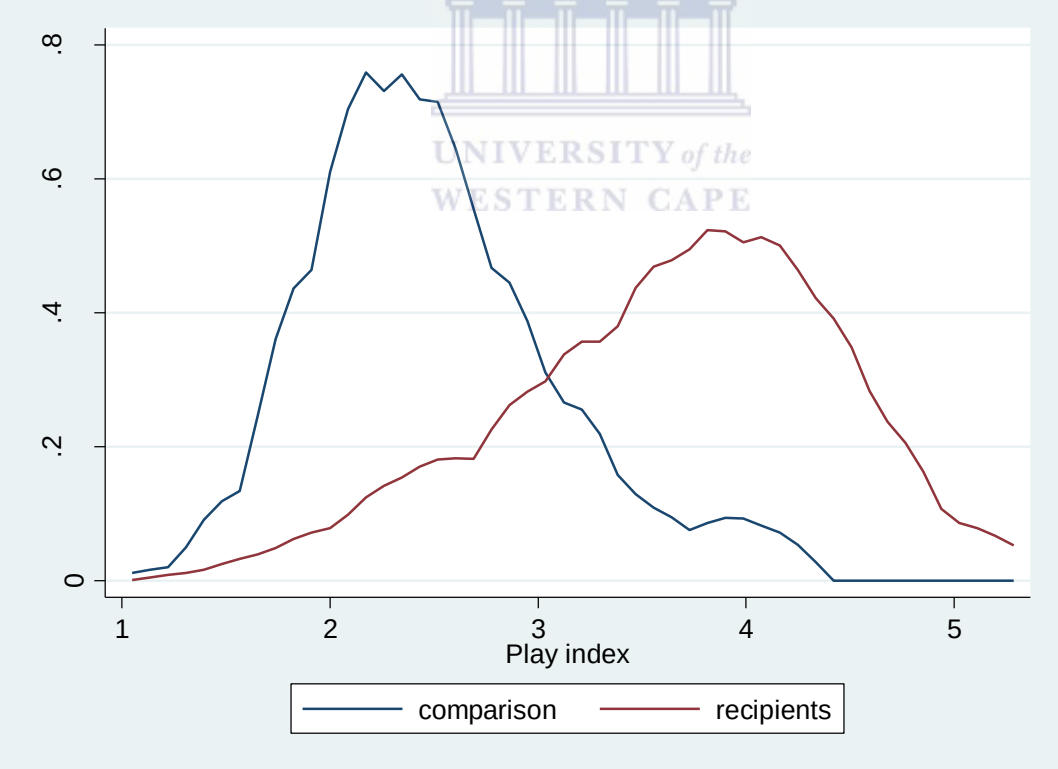
An index for play combining variables 22 to 24 from the questionnaire (cf. Annex 1) was created as a concrete measure of the attainment of functionings associated with play. The

variable in question 22 which measures the period of time that one has had to take part in recreational activities was reverse coded to align positively with the other variables in the index.

The kernel density in figure 28 below shows a marked difference in distribution of scores in the play index of recipients. While the most frequent score for recipients was 4, the comparison group had a much lower mode at 2.3. The curve for the comparison group was skewed further to the left than that of the recipient group showing that majority of the children in the former had lower scores in the index those in the latter group.

Figure 28: Kernel density graph of play index scores of respondents

	n	Pr (Skewness)	Pr(Kurtosis)	Prob>chi2
Recipients	74	0.0936	0.8895	0.2301
Comparison	87	0.0042	0.2502	0.0150



A possible explanation for this would be that it is as a result of reduction of child work whether paid or unpaid which may have freed up some extra hours per day thereafter dedicated to recreation. Although this was not tested quantitatively, there was an indication

from the interviews that children were less likely to engage in work for pay if they were receiving the cash transfer (cf. Annex 3).

Similar conclusions have been drawn in previous research on the CT-OVC programme with regard to labour (Ward et al, 2010: viii; Asfaw et al. 2012:1). According to these studies, the programme has an effect on child work in family farms. Reduction in the amount of hours spent on unpaid work is perhaps as a result of caregivers not having to work very long hours thus being available in the household more often where they are mainly in charge of house chores.

In sum, this subsection has shown through comparisons of attainments in the aggregate indicators that the recipient group has a higher achievement of functionings in the four dimensions investigated. The next sub-section tests whether the increased attainment of functionings is associated with participation in the cash transfer programme.

5.5 Association between participation and aggregate measures of functionings

The second hypothesis for this study is that being a recipient of the cash transfer for orphans and vulnerable children is associated with increased achievement of one's capabilities in social life, education, health and play.

To test whether there is an association between participation in the OVC cash transfer and the attainment of functionings, correlation analysis was carried out using the four aggregate indices of social life, health, education and play. The null hypothesis tested was that there is no significant relationship between participation and the aggregate variables in each of the dimensions.

The findings indicate that there is a strong positive relationship between participation in the programme and two of the indices: education and play. The Kendall's tau (τ) for the relationship between participation in the CT-OVC and education was 0.4349; while the correlation between participation and play was slightly higher (τ = 0.5636). The relationship between participation in the programme and attainment of functionings in the dimension of play is thus the strongest for the respondents.

A moderately positive relationship exists in the remaining two indices of health and social life where τ is 0.3322 and 0.3226 respectively. The weakest relationship based on the Kendall's tau coefficient of correlation is in the social life dimension where τ equals 0.3226.

Table 8 below illustrates the correlation tests between participation in the programme and functionings all four dimensions.

Table 8: Association between aggregate indices and participation in CT-OVC

Aggregate Index	Kendall's tau (τ) coefficient
Social life	0.3226*
Education	0.4349*
Health	0.3322*
Play	0.5636*
**Significant at .05 level, n=161*	

In conclusion, these results indicate that there exists an association between participation in the programme and the attainment of the selected functionings, thus leading to the acceptance of the second hypothesis of the study that being a recipient of the cash transfer for orphans and vulnerable children is indeed associated with increased achievement of capabilities for children and adolescents in the programme. The next subsection examines the perceptions of participants of the programme on the benefits and limitations as well as their views on possible change areas.

5.6 Participants' perceptions of CT-OVC programme

The third and final research question is: What are the participants' perceptions regarding the programme in the four dimensions of social life, education, health and play; and are there areas that the programme could improve on to better promote the capabilities of the participants?

To determine the perceptions of participants about the programme, in-depth interviews were conducted using 10 interviewees who are involved in the programme at different levels. They included OVC, caregivers, cash transfer programme personnel and community members.

5.6.1 General perception of the programme

Data from the in-depth interviews showed that participants perceived the cash transfer to be of considerable importance in transforming their lives. The receipt of regular cash payments, they felt, enabled them to access things they previously had no access to. This included tangible items like food and clothes, but also improved self-esteem and general outlook on life.

"With this programme life is much better. I have money to buy food and other things for the family" (Caregiver).

Reflecting upon their lives prior to the CT-OVC programme, interviewees considered it to be a better initiative from the government than the previous public works programme dubbed "Kazi Kwa Vijana"(KKV). The KKV was also a social protection programme targeted at the working-age population. They perceived Kazi Kwa Vijana not well targeted to meet the needs of the poorest in the community particularly those who could not work like the sick grandmothers. Selection of recipients was also viewed to be quite transparent both by the recipients themselves and by other community members which was not the case in the KKV programme.

5.6.2 Perceptions on capabilities in the 4 dimensions

The CT-OVC now forms the largest part of income for the families and in some cases is the only source of income. This has had an impact on the lives of the recipients in a number of ways linked to the four key dimensions considered in this study. The impact has largely been positive although in some instances there have been some negative effects brought about by the CT-OVC. The next sub-sections shall detail the findings on the participants' perceptions regarding the dimensions of social life, education, health and play.

5.6.2.1 Perceptions on social life

The social life of the recipients is perceived to have generally improved. The in-depth interviews showed that the consistency with which the funds were administered meant that recipients could expect payments regularly and could therefore repay any loans they had received from other family members and friends. Being able to repay their loans had helped improve their relationships with their relatives and other community members by avoiding conflicts arising from inability to settle their debts. One of the caregivers stated the following with regard to strained relationships:

"You see, when you are not able to repay your debts, you get into trouble with other people. They shun you and talk about you and in the end you are left with no one"

The children also felt less socially excluded since they were able to lend out and share some of their items with their friends, especially those who share their items with them too:

"When I get some money I buy sweets and share with my friends at school"

The participation of caregivers in social activities such as fundraising was also directly affecting the opportunities available to the children. One of the caregivers for instance was in the process of organising a fundraising event to raise school fees for her eldest daughter who was attending university. Community members viewed her daughter quite respectfully as her advanced studies gave her a higher social standing.

In addition, there is greater participation in local social groups. Recipients of the CT were beginning to join local savings and investment groups where they interacted both formally and informally with other community members. Participation in such social groups was initially difficult for them since they were not able to make required contributions. Some of the recipients have formed savings groups whose members are only CT-OVC recipients. Other than saving and investment groups, some recipients also have membership in psychosocial support groups, particularly for Persons Living with AIDS (PLWA). Support groups for PLWA are for both the adults and OVC. The researcher noted the following comments from caregivers:

> "I have joined a merry-go-round[5] where we meet twice every month."
>
> "I take my grandchild to meetings for people who have the disease [HIV] where we receive counselling on how to live positively."

There is also a reduction in poverty-related stigma for the OVC. Due to improved living standards, for instance better clothes, brought about by the programme, the OVC also feel that they can interact more freely with other children at school and in their community. Their self-esteem has improved as they are less ashamed of their poor living conditions which had been apparent to their peers and which affected their self-confidence.

The CT-OVC was also perceived to have created new networks and forged new relationships for the recipients. Location OVC committee members working on a voluntary basis in the programme, for instance, seemed to have a good working relationship with the community members. However, there was some negative impact on social life as well albeit on a low level. For instance, it was noted that on some few occasions committee members had had disagreements with CT-OVC recipients who failed to adhere to basic requirements of the programme such as prioritising the needs of the OVC.

[5] Merry-go-round is a popular term for small savings groups in Kenya. Members usually contribute a certain amount of money and give it to one or two persons per session until all members have received the contribution, then the round of contributions starts all over.

Relationships at the household level had also been affected. For instance, some of the OVC had also had disagreements with their caregivers on instances where they felt that their needs were not being met. Such differences were however a rare occurrence and none of them had escalated to the County Children Officer so far.

5.6.2.2 Perceptions on education

Findings from the in-depth interviews showed that the OVC opportunities for going through school had been expanded through the programme. Caregivers could now afford to pay extra charges for children in primary school and school fees for secondary school students. These had presented a major challenge to them before joining the programme. In addition, other school requirements could now be met such as school uniform, which is a prerequisite in all public schools in Kenya. School books, lunch money and transport costs were also met using the grant. As one of the OVC put it:

> "Before this programme, my sisters and I used to be sent home all the time to bring school fees…My mother uses the money to pay school fees and buy uniform for us…She buys books for my older sister. My sister passes them to me."

There was also a perception among interviewees that the cash transfer programme had reduced chances of OVC dropping out of school resulting from frequent absenteeism. Prior to the introduction of the programme some pupils were sent home from school so often that they eventually opted to remain at home permanently. One CT-OVC recipient explained it in this way:

> "Sometimes we didn't have things like books or clean uniform. We were sent home. Other times it's for school fees. You stay at home until you get it [the school fees]. Those who don't have stay longer."

Although the CT-OVC has helped increase access to basic education, secondary school is still not completely free in Kenya and caregivers are forced to bear the burden of raising school fees by themselves. For this reason, some of the children who participated in the study are still being locked out of school for lack of school fees. In one instance, a child reported to have stayed out of school for 90 days, which was the whole of the first term, since the caregiver could not afford the high costs involved in having her enrolled in the first year of secondary school. Several others have had to repeat grade 8 for lack of funds to enrol them in secondary schools.

"I have not yet joined form one. I was told there was no money"

"I repeated class eight because there was no money for secondary school"

5.6.2.3 Perceptions on health

The perception of the interviewees on the CT-OVC programme with regards to health is that it has somewhat helped reduce the burden of disease within the community. Consumption of the grant was made on some health related expenditures such as settling medical bills and purchase of medication. They also spend it on transport to medical centres.

Apart from direct medical expenses, recipients also spend the money on other health related expenditures. Food purchases were regularly mentioned in the interviews and could be linked to nutritional requirements of the OVC as well as other household members. It was also spent on clothes, including bedclothes. In some of the households, the funds have been used to renovate or build new houses altogether, albeit temporary ones. A community member who is also a local leader summed it in the following statement:

> "The funds are meant to cater for basic needs of the households and are mostly spent on food, education and health. Some constructions have been coming up as the families get some additional funds to cater for such things."

There is also a growing acceptance of PLWA and children orphaned by AIDS; and a collective appreciation of the support they are receiving from the government. Community members help to identify such needy cases brought about by the HIV epidemic in the area and assist them to get into the programme. They are also assisted to access the free antiretroviral therapy (ART) provided in government hospitals as well as treatment for opportunistic diseases. One of the caregivers who is also a widow had this to say:

> "My husband died of AIDS related illnesses and my youngest child is also positive. The people from the programme came to my house once they heard [from other community members] to see how we were living."

5.6.2.4 Perceptions on play

Capabilities in the dimension of play are also perceived to have improved since the programme was introduced. The OVC are seen to now have more opportunities to engage in recreational activities. They mentioned that they were now able to visit relatives or close family friends who live some distance from them as they can occasionally afford travel costs.

This was so particularly during family events such as weddings and funerals, or during school holidays.

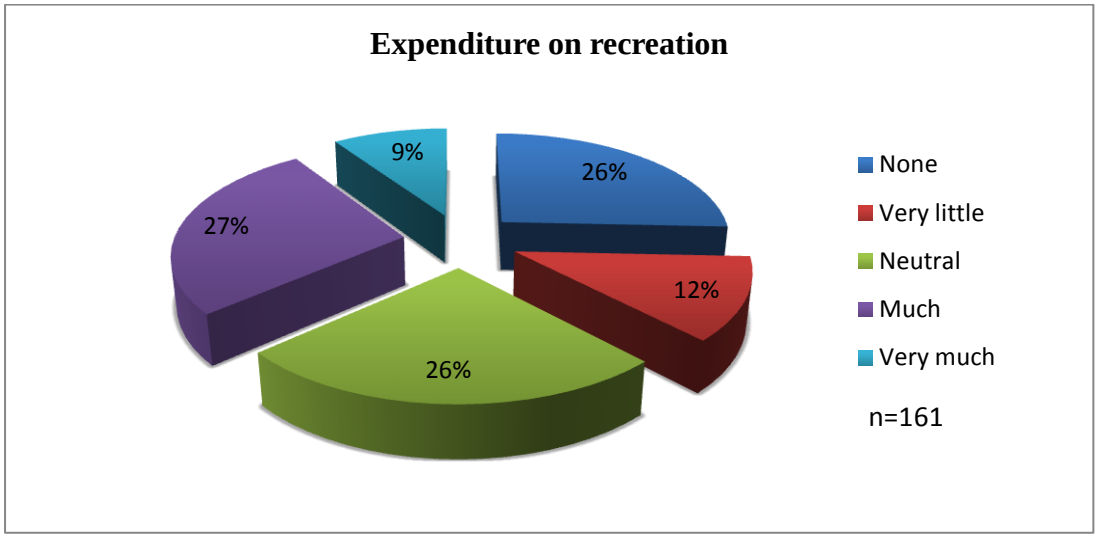
> "When we close school, I will visit my cousins in Nakuru[6]…" (OVC).

Some of them mentioned that their caregivers sometimes paid for them to go on school tours, whereas this was not the case before the programme. The tours, normally for education purposes, are organised by the schools and are usually low-cost. They typically last for a day or half a day. Children usually contribute transportation fee and perhaps carry their own lunch. The affordability of these tours to the children was however not a very common observation. From item 24 in the questionnaire (cf. Annex 1), it was observed that majority of the OVC did not feel that their caregivers spent much money on recreational activities. In fact, more than 26 percent of OVC recipients felt that their caregivers spent no money at all on entertainment and fun related activities. An additional 12 percent felt that very little money was spent on entertainment. Only 9.4 percent felt that very much money was spent on recreation. Figure 29 below represents the children's perceived recreational expenditure made by their caregivers.

It might be the case that the CT is not sufficient to meet the basic needs of the households and hence the caregivers do not have any surplus for recreational purposes. This is particularly true of households that have a large number of OVC. Although child growth and development is an important aspect of the CT-OVC (MGCSD, 2010:19 and 23), the play dimension is not emphasised in the objectives of the project and its importance has not been given as much weight as health and education.

[6] Nakuru town is approximately 156 kilometres from Kiambu

Figure 29: OVC recipients' perception of recreation expenditure



Findings from the interviews also show a reduction in the amount of time children spent on household chores which meant more time for leisure activities. This was because caregivers spent more time at home with their families and therefore took care of the household chores themselves. Spending more time with the children is likely to contribute to their general wellbeing in the long run. One of the OVC stated it this way:

> "My mother cooks supper nowadays. Before, I used to do it myself after school since mother would be working in the farm."

Although one might argue in this case that the programme is reducing cases of child labour in the community, child protection experts maintain that cash transfers might not be very effective in addressing some of the more complex forms of child labour such as slavery due to their multifaceted nature of exploitation (Child Protection in Crisis, 2012:30). There was however no indication that these forms of child labour were manifest in the study area.

5.6.3 Cross cutting issues in the CT-OVC programme

The CT-OVC is generally perceived to have improved the wellbeing of the community. It is seen to have reduced cases of child destitution and countered some of the problems that were beginning to emerge in the community such as begging and petty theft. That more and more children now have the chance to attend school and take part in other educational programmes is bound to have a positive impact on their overall development and in the development of the community as a whole. One of the community members summed it up this way:

> "You look at people and see that their lives are now changing. They do not look so helpless anymore. Children are being taken care of and do not need to beg from people or resort to stealing."

There was also an overall perception that vulnerable members of the community who are often marginalised were getting empowered through the programme. It was found that the majority of the caregivers receiving the CT were women who were often times widows, elderly or sick. Their participation in LOC meetings helped mobilise a common voice with which they could express their opinions on issues affecting them. Local leadership also recognises the existence of such groups. For instance, the area chief holds meetings with them on occasion or invites their representatives in other forums. The presence of children in such forums was however still missing. There was no apparent platform on which they could express their opinions and they remained invisible in decision making on issues affecting them. With regard to the participation of children in the field research one of the caregivers remarked:

> "This time, it is the children who are needed. All the other times, it has been the caregivers"

The process of enrolment into the programme is perceived to be open and transparent by both recipients of the CT and community members. It was observed by the researcher that community members seemed free to interact with the LOC members and to directly request the recruitment of needy children. These requests took place a number of times in the presence of the researcher. It was clear that there were a lot more needy cases than was possible to recruit due to the limited capacity of the programme. The area of study currently has more than a hundred OVC in the waiting list.

Much as the programme is limited in the number of OVC that can be enrolled, it was also observed by the researcher that some problems existed in the implementation of the exit strategy for recipients. Some of the recipients had exceeded the maximum age limit but were still receiving payments. Some of the recipients who showed up to fill out the questionnaires were older than 18 years of age. Graduation of such recipients would help create room for recruitment of the younger OVC in the community who are in need.

There was a general perception that the funds were contributing towards reducing poverty in the region especially among children. However, the funds were considered by some of the

recipients to be insufficient in meeting all of their needs given their limited sources of funds. In a considerable number of the households, the CT-OVC remained the only source of income for the family. This may be seen to limit the benefits that the OVC can draw from the programme. One of the programme's staff had this to say:

> "Due to the nature of the programme, targeting is made to the neediest members of the community. Most of these households are very poor and in some families, none of them is working. Where else can they get money to feed themselves?"

5.7 Conclusion on perceptions

In sum, the community perceives the CT-OVC programme as having by far more benefits than drawbacks. It is interesting to note that although the programme is primarily meant for orphans and vulnerable children, the positive impact seems to have been felt across the board; at the individual, household as well as at the community level. It appears from the perceptions that the programme is impacting on the capabilities and functionings of child recipients with regards to their social life, education, health and play. Some of the interviewees also pointed out to areas that were still unsatisfactory and which they felt that the programme could address, such as increment in the amount of payments made and consideration for households with many children or dependants. Additional areas of improvement were also noted through the researcher's observation such as the inconsistency in the graduation of grant recipients.

CHAPTER SIX

SUMMARY, CONCLUSION, RECOMMENDATIONS AND FURTHER RESEARCH

This chapter provides a summary of the study findings and draws conclusions to address the research questions at hand. It also makes recommendations for policy formulators and implementers of the CT-OVC programme. In addition, it notes the limitations of the study which may have had an effect on the findings and further identifies areas which future studies could address.

6.1 Summary and Conclusion

The main aim of this research was to determine the level of importance that OVC place on capabilities within the four dimensions of social life, health, education and play; and the extent to which the CT-OVC programme enables the recipients to attain functionings within the four dimensions chosen, through a quasi-experimental study. In addition, the study aimed at exploring the participants' perceptions of the programme in order to improve its delivery and better promote capabilities of the OVC in the four dimensions of interest.

Findings from the study indicate that OVC place a high value on capabilities in social life, education, health and play. In the first capability of social life, more OVC in both groups responded that they value relationships with both family and friends highly compared to those that do not value such relationships highly. It was found that family relationships are considered much more important, especially to pre-adolescent children, than relationships with friends. This was in tandem with previous research that has found adolescents not to have as close a relationship with their families as their younger counterparts. At adolescence, children begin to develop some sense of independence and spend less time with family members as they begin to engage in different activities in which they do not involve their parents or siblings (Reid et al, 1989:907).

Similarly, OVC in both the recipient and comparison groups consider education to be highly important with only a small percentage considering it not to be highly important. There was no statistically significant difference in the level of importance placed on education by both groups of respondents. Respondents from both groups felt that education would be beneficial to them in the future. For the recipients, the newly acquired ability to afford education related costs may have boosted their interest and motivation to pursue education and thus increased

their hopes and aspirations. However this phenomenon might require further research to understand better.

On the health dimension of capabilities, it was also found that OVC attach a high value to it. In both the CT-OVC and comparison groups, more respondents considered health to be highly important than those who considered it not to be highly important. Children who are experiencing ill health themselves or have a close family member who is ill tend to place a high value on health (Uyan-Semerci, forthcoming). A number of OVC respondents were AIDS orphans, had caregivers who are ill or were themselves ill. This circumstance may be associated with the high importance they attach to capabilities in the health dimension. It was found that children in both the recipient and comparison groups consider it important to take precautions to avoid injury in recognition of the methods of HIV transmission. A higher regard for taking precautionary health measures was expected of the recipient group than the comparison group due to the health service utilisation patterns emphasized by the CT-OVC programme, such as not sharing pins or any other instrument that comes into direct contact with body fluids. This is done in order to manage and prevent the risk of HIV transmission. It was however recognised that children in both groups indicating that they considered it highly important to take precautions to avoid injury could be taken as an indication of the high value they each attach to being healthy.

For OVC in both groups, the play dimension of capabilities was also highly valued. The respondents felt that it was important to set aside time for relaxation and fun activities. Play is associated with a number of benefits for children and adolescents. Besides helping them develop leadership skills, team skills, decision making skills and creativity, play also enables children to acquire self-control and develop sensitivity to the needs of their playmates. Consequently, they learn to abide by socially accepted rules and acquire morals (Gray, 2008). However, it is unlikely that they make a conscious decision to engage in play for these reasons. The respondents might have valued play for the pleasure that they derive from it as they momentarily detach themselves from the pressures of school work and house chores. Play, particularly of the unstructured type, is a simple joy that is a cherished part of childhood (Ginsburg et al. 2007:183). Children value childhood play for the pure enjoyment of it and therefore rate is as important in their lives.

The first research question: “Do the recipients of the CT-OVC value capabilities within the four key dimensions of health, education, social life and play?” could therefore be answered

based on the above findings. The findings suggest that OVC in both the CT-OVC recipient group and comparison group do value capabilities in all four dimensions.

The next objective of this study was to find out whether there was an association between participation in the CT-OVC programme and the attainment of capabilities and functionings of recipients within the four dimensions of social life, education, health and play through the quasi-experimental framework.

In the dimension of social life, there was found to be a higher attainment of the aggregate social life indicators among children in the CT-OVC recipient group than among those in the comparison group. This meant that more children in the recipient group felt that their relationships with family members and friends had improved in the period preceding the research. Further indications from the in-depth interviews were that children in the programme received better care from caregivers since they could afford to provide for them through the cash payments. This in turn could have influenced their relationships favourably as the children experienced increased support from their family. The reason given through in-depth interviews for the improvement of relationships with friends was that they could, as a result of the CT-OVC, engage in social activities with peers without shame associated with being poor and as they gained more self-confidence.

While school enrolment was found to be high for both groups, children in the comparison group had a higher rate of absenteeism than their counterparts in the recipient group. Those in the recipient group participated more in extracurricular activities such as sport and in addition, scored higher grades than their counterparts. In addition, a comparison of attainments in educational functionings and capabilities based on comparisons of the aggregate index showed the recipient group to have higher scores than non-recipients. This could be attributed to the enhanced ability to make direct payments for learning costs including school fees, books, uniform and transportation costs. It could also be a result of renewed hopes and aspirations (adaptive preferences) brought about by the increased opportunities to pursue education, for example ability to pay school fees.

There was an unexpected finding that recipients of the transfer had a higher prevalence of illness than their counterparts in the comparison group. Due to the nature of the programme which gives precedence to HIV/AIDS orphans, the discrepancy could be brought about by the targeting process. The difference was however not statistically significant. Rather, an aggregate health index showed that when proxy measures of health such as quality of housing

and meals per day are considered, the recipients appeared to have significantly higher health scores than OVC in the comparison group. However, when housing alone was considered, there was no significant difference between the two groups, which suggests that the amount of payment may not be sufficient to cater for larger expenses such as construction and renovation. In the play dimension, significantly more children in the recipient group had access to play spaces than those in the comparison group. An aggregate play index measuring amount of time and money spent on play as well as changes in play opportunities also suggested that recipients have a higher attainment than non-recipients.

In sum, the comparisons showed that respondents in the recipient group scored higher in the attainment of capabilities in all four dimensions of social life, education, health and play. Correlation analysis using the Kendall's tau correlation coefficient further showed that there was a strongly positive association between participation in the CT-OVC programme and two of the dimensions: education and play. In addition, there was a moderately positive association between participation and the other two dimensions: health and social life. Therefore, to respond to the second research question "Is there an association between participation in the CT-OVC programme and the attainment of capabilities and functionings within the four dimensions?" results from the Kendall's tau correlation coefficient suggest that such an association exists.

The final objective of the research was to determine the perceptions of participants concerning the programme insofar as it promoted the capabilities of the OVC in the four areas of interest. Results from in-depth interviews suggest that the CT-OVC has had a mostly positive effect on the recipients although a few negative ones were also noted, which shall now be discussed briefly.

On the social life dimension, results from in-depth interviews showed that the CT-OVC programme had helped reduce social exclusion of OVC and increased psychosocial support for them and their caregivers particularly in households affected by HIV. The OVC felt that there was a reduction in poverty related stigma and shame experienced by those living in deprived conditions. New social networks also developed as a result of the programme as the participants interacted with each other in different forums. However, the programme has also impacted negatively on the social life. For instance, there have been reports of conflicts between LOC members responsible for recruitment and non-compliant caregivers such as those who were negligent of the OVC needs. There was also a case of tension between

caregivers and OVC where the OVC felt that the money, despite being paid for his benefit was not being used by the caregiver to meet his needs, for instance, purchasing of clothes. However, rather than being a sign of neglect, this could be an indication that the payments made were not sufficient to meet the needs of the households, particularly the larger ones.

Capabilities in the dimension of education were also perceived by the participants to have improved. The cash transfers were used to pay school fees as well as purchase books and uniforms for the OVC which made it possible for more children to get enrolled in school and aided their retention. It was perceived that there was less absenteeism and dropout from school. Some challenges were however noted with regards to education. Some of the OVC were still unable to join secondary school due to unavailability of school fees. For these OVC, the option was either to stay at home or repeat grade eight until enough money to enrol them in secondary school could be raised. Grade repetition has been found to have a negative impact on academic achievement of children and could result in loss of self-confidence and increased negative feelings about school which could increase the likelihood of dropout and thus affect the attainment of capabilities in education for the child (Brophy, 2006:6).

Participants' perceptions of health also suggest that there was a reduced burden of disease among households receiving the CT-OVC. This was because the funds were used to meet medical fees, procure medication and pay for transportation services to the health centres. Expenditure was also made on health affecting necessities including food, housing and clothes. These are essential in promoting nutrition and protection from the elements, which in turn influence health outcomes.

With regards to the play dimension, participants considered the programme to have contributed positively. The OVC felt that they had more time to engage in play activities since they did not have to do as many household chores as they had done prior to enrolment. They attributed this to the availability of their caregivers at home more often as they did not have to stay out for excessively long hours working for pay. The cash transfer also contributed somewhat to recreation related expenditure such as paying for travel costs to visit relatives and participate in social events such as weddings. The general perception among child respondents was that not much money was being spent by their caregivers on recreational activities. This could be an indication that the transfer might not be enough to meet all basic needs including modest recreational activities.

Other cross cutting issues highlighted by the perceptions of OVC include the reduction of destitution in the community as OVC begin to receive greater care. Empowerment of marginalised groups was also noted with interviewees seeing greater engagement of the needy, or of people living with HIV/AIDS in community events. However, there was still a gap in the inclusion of children in the evaluation processes and generally in decision making which is considered useful particularly in matters affecting them. The exit strategy also seemed not to be effectively enforced as persons exceeding 18 years were still enrolled. This is perhaps due to poverty in these households where the cash transfer was the only source of income. There might also have been other OVC within these households who still needed assistance and thus the prolonged enrolment. In addition, there seemed to be a high number of OVC in the waiting lists and within the community who qualified for the CT-OVC but were left out due to the limited capacity of the programme.

In conclusion, the CT-OVC appears to have increased agency of the recipients based on indicators in the four dimensions. In the education and health dimensions, recipients and their caregivers took more action and initiative, for example, children made more effort to attain good grades in school while caregivers provided learning materials such as books and sought health services for the children. This suggests that the small regular amounts of payments enable people to commit themselves to educational and health functionings which they would have otherwise not had an opportunity to do. The transfers also seem to have had an impact on participants' agency in social life particularly of the caregivers as they engage more in collective action at the community level to take charge of decisions that affect their wellbeing. It empowered the caregivers to the extent that they were also able to affect play capabilities of the OVC, for instance in paying for their participation in school trips. This manifestation of agency in the play dimension is a clear example of people defining their own priorities in achieving things that may not conventionally be given priority in the development space, and which define human development in the true essence.

Thus, this small investment releases and activates agency among the poor and vulnerable making them act and bring about achievements which they themselves value independently of any external evaluations that might be carried out on the programme. This in effect affords them a greater opportunity to pursue goals that are of value to them. Such an impact may be of great importance in social protection policy where agency and initiative is associated with positive outcomes. Sustained achievements in promoting the agency of poor and vulnerable groups such as the OVC can then be expected to have far reaching positive outcomes in the

long run, especially when such groups are able to graduate smoothly out of the transfer programmes and lead more productive, self-reliant lives.

6.2 Policy Implications

The Universal declaration of Human Rights of 1948 (UN, 1949:6) considers the social protection of all children and caregivers to be a fundamental right and entitles them to special care and assistance. Social policy in Kenya underscores the importance of social protection as seen in its inclusion within the social pillar of the country's Vision 2030 development plan. This is one of three key pillars meant to drive development of the country into middle income status by the year 2030 through improved livelihoods for vulnerable people (Republic of Kenya, 2007:16).

This research unveiled some findings which could have some policy implications even as the country endeavours to provide social protection to some of its most vulnerable populations in the form of orphans and vulnerable children. The implications affect the health and education policy as well as policies affecting the other dimensions of social life and play.

6.2.1 Implications for Education Policy

This study found participation in the CT-OVC and educational outcomes of OVC to be strongly and positively correlated. Evidence from this research suggests that the cash transfer programme contributes to reduced absenteeism from school since caregivers can afford some school related expenditure such as purchase of books, school uniform and extra tuition costs. Children in this programme also have a higher participation in extracurricular activities in school such as sport and score significantly higher grades. Previous studies have repeatedly linked cash transfer programmes with improvement in educational outcomes for children especially in school enrolment and reducing dropout rates (UNICEF, 2009:10). Thus the implication for policy is to use such tools as cash transfers for children in regions of the country where school uptake is dismal. It could also be used to develop strategies to combat sustained poor educational outcomes of children.

It should however be taken into consideration that cash transfers alone, including conditional cash transfers may be constrained in the extent to which they can impact on educational attainment and therefore need to be interlinked with adequate service provision in the educational front. This includes sufficient, affordable and quality education facilities along with qualified educators.

6.2.2 Implications for Health Policy

Kenya has consistently ranked lowly on the health indicator in the human development reports and thus needs critical measures in addressing health challenges within the country. Policy measures that put health at the forefront or at the very least address one aspect in the quest for improved health therefore need to be identified, developed and sustained if the country is to meet its intended goals.

Although the correlation between participation in the CT-OVC programme and the attainment of capabilities in the health dimension was found to be moderately positive, it was nonetheless noted that participants scored significantly higher in aggregate health measures than non-participants. Policy measures that address health particularly in the face of the HIV/AIDS pandemic could thus integrate cash transfers in addition to other strategies such as provision of ART to help manage and reduce the burden of disease on affected households.

6.2.3 Other Implications

This research found participation in the CT-OVC to be strongly and positively associated with attainment of capabilities in the dimension of play. Although the programme does not expressly aim at promoting children's opportunities in this particular dimension, it is nonetheless an important consideration since they value play and it has been found to be of utmost importance for child growth and development (Ginsburg et al. (2007). The programme is addressing the issue of child labour indirectly through addressing income levels of caregivers and thus favours children's outcomes in the play dimension. However, strategies to promote recreational activities such as safe play areas in the neighbourhoods may also help create and expand play opportunities for the children.

The child-sensitive approach to social protection policy requires a broad understanding of the vulnerabilities and risks that face children and their caregivers while taking into account that these vulnerabilities could be addressed through comprehensive measures touching on both the children and their caregivers. It is the responsibility of social protection policy formulators and subsequent flagship project developers to ensure that the programmes meet the needs of those for whom they are developed.

6.3 Recommendations

This research found participants of the cash transfer programme to have attained higher scores in social life indicators than their counterparts in the comparison group. However there was an indication by participants that there might have been some conflicts between

committee members and caregivers of the OVC in the programme due to failure to comply with regulations. This perhaps points to a gap in the communication process where caregivers do not know what is required of them or perhaps do not agree to the laid down procedures. To address this, the programme implementers could engage the community more in all phases of the project cycle in order to reduce resistance and promote awareness.

There was also some indication of insufficiency in the amount of payments made to OVC households in the programme. This could be seen, for instance, in the high school students failing to raise enough school fees. While this is perhaps due to the limited capacity of the programme in terms of funding to make sizeable payments to households that are extremely poor, it would be helpful to make considerations of household sizes and inflation rates when deciding on payment amounts in order to achieve an even greater impact. It is also worthwhile to integrate the CT-OVC within other developmental programmes that promote alternative income generation for the needy.

While this research found that the OVC highly value capabilities in the play dimension, it was clear that the programme does not explicitly address capabilities in this area. Evaluations undertaken on the programme have not encouraged children's participation either and thus children's views are being overlooked in this regard. In line with the child-centred approach to social protection, the inclusion of children in decision making on matters affecting them also needs to be considered. One way of achieving this would be through the identification of what they consider to be of importance in their lives in order to formulate programmes which help them achieve the kind of life that they value and have reason to value.

It is also important that HIV prevention is not forgotten to reduce the loss of parents since this is ultimately what has mostly contributed to the large number of orphans in the country (UNICEF, 2005:2). This will further avert adult deaths caused by AIDS related illnesses and reduce the resulting children's vulnerabilities. These vulnerabilities include HIV/AIDS related illnesses, living with vulnerable elderly relatives, exploitation, caring for sick family members, social exclusion or stigmatization.

6.4 Limitations and Further Research

As with all other studies that use quasi-experimental designs, there is the risk that the CT-OVC recipient group and the comparison group might have differed in important ways not observed by the researcher and which may have affected the findings. However, care was taken to ensure that the two groups were as similar to each other as possible. The use of a

comparison group consisting of OVC who had already qualified for the cash transfer and who were soon to get enrolled into the program helped mitigate this problem. This is because their observable characteristics such as poverty status and demography are highly similar to those in the recipient group.

The sample used for this research was also very small and therefore findings may not be generalised to all OVC receiving the cash transfer in the country. The results are thus only valid for the participating groups within Kiambu County and should therefore be used with caution.

Based on lessons from this research, future studies should focus on further exploring child centred approaches to providing social protection by taking into consideration the kind of life that children value and the things they want to be or do. The studies also need to investigate the assumed benefits of encouraging children to be active participants in influencing programmes directed at them.

While education and health of children have been given a lot of weight in evaluation of child grants, other dimensions such as play and social life which could be argued to be equally important in the growth and development of children continue to be ignored. While this research has attempted to explore these "missing dimensions" future research could perhaps investigate how these and other less researched dimensions are affected through social protection in order to bolster efforts to make social protection for children more effective. It would also be worthwhile to determine what the long term impact of social protection programing for OVC may have on human development indicators of the recipients.

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ANNEXES

Annex I: Questionnaire

No. _____

I am a student at the University of the Western Cape, South Africa. For academic purposes, I am undertaking a study on the extent to which the Cash Transfer for Orphans and Vulnerable Children (CT-OVC) is promoting the human development of children in Kiambu. Findings from this research could help improve the CT-OVC programme. Kindly help me answer some questions regarding the programme. This will only take approximately 20 minutes of your time. Your responses are voluntary and completely confidential. I will also send you a report of the findings made if you so wish.

Would you like to participate? Yes ___/No ___ ***If No move to next household***.

Date: _____

Interviewer name: _____

Recipient of Cash Transfer for Orphans and Vulnerable Children Yes [1] ___ No [1] _____ ***If No proceed to section A***

For how long have you been in the CT-OVC programme?

1-2 years [1]☐ 2-3 years [2] ☐ 3-4 years [3]☐ 5 years [4] ☐ more than 5 years [5]☐

Section A: Social Life

Please circle a number for question I and 2.

1. How much would you say that support from your family members is important to you?
   Not important 1 2 3 4 5 extremely important
2. How much do you feel that support from your friends is important to you?
   Not important 1 2 3 4 5 extremely important
3. Please tick on the list below which of the statements you agree with. You may tick more than one.

☐I have someone who listens to me when I talk
☐I have someone that I can count on when I need advice
☐I have someone to take me to see the doctor when I need it
☐I have someone who shows me love and affection
☐I have someone to have a good time with
☐I have someone to confide in and talk to about myself and my problems
☐I have someone to get together with for relaxation
☐I have someone to do something enjoyable with

4. How would you rate the relationship between you and your family members lately? Please indicate in the scale below.
   Excellent [1] ☐ Very good [2] ☐ Neither good nor bad [3] ☐ Bad [4] ☐ Very bad [5] ☐
5. How would you rate the relationship between you and your friends lately? Please indicate in the scale below.
   Excellent [1] ☐ Very good [2] ☐ Neither good nor bad [3] ☐ Bad [4] ☐ Very bad [5] ☐

Section B: Education

Please circle a number for question 6 and 7.

6. Please indicate how important it is for you to learn new things at school.
   Not important 1 2 3 4 5 extremely important
7. How much do you agree with this statement? Going to school will benefit me in my future.
   Totally disagree 1 2 3 4 5 totally agree
8. Do you go to school?
   Yes [1]
   No [2] (*If no please skip to section C*)
9. How often in the last school term have you missed school?
   _____days
10. What was your average grade for the last school term?
    A [1] ☐ B [2] ☐ C [3] ☐ D [4] ☐ E [5] ☐
11. Which statement best describes your school pattern for the last two years?
    In the last 2 years I was…
    Promoted more than three classes up [1] ☐
    Promoted three classes up [2] [e.g. from class 4 to class 7] ☐
    Promoted two classes up [3] ☐
    Promoted one class up [4] ☐
    Not promoted at all to the next class [5] ☐
12. How often do you take part in extracurricular activities?
    Never 1 2 3 4 5 Very frequently

Section C: Health

13. How important is it for you to take precautions to avoid injuring yourself
    Not important 1 2 3 4 5 highly important
14. To what extent do you agree or disagree with this statement? I consider my health to be highly important in my life.
    Totally disagree [1] ☐ disagree [2] ☐ neutral [3] ☐ agree [4] ☐ totally agree [5] ☐
15. How many times have you fallen sick in the last 6 weeks? ___ times
16. How often do you eat 3 balanced meals in a week?
    Always [1] ☐ Often [2] ☐ sometimes [3] ☐ rarely [4] ☐ never [5] ☐
17. What is your household's main source of water?

a) Piped water (water in dwelling/compound) [1] ☐
b) Public tap [2] ☐
c) Borehole (onsite/offsite) [3] ☐
d) River/stagnant water [4] ☐
e) Other (specify)[5] _____ ☐

18. The walls of the house you live in are made of
    a) Plastic/cardboard/tent [1] ☐
    b) Mud [2] ☐
    c) Iron sheets [3] ☐
    d) Wood [4] ☐
    e) Stone/bricks [5] ☐
19. What is the total number of rooms in your house? Please note that this excludes toilets and bathrooms. _____ rooms
20. How many persons live in your house? _____persons

Section D: Play

21. To what extent do you agree with this statement? It is important for me to engage in hobbies for fun and relaxation.
    Totally disagree [1] ☐ disagree [2] ☐ neutral [3] ☐ agree [4] ☐ totally agree [5] ☐
22. In the last 2 years my opportunities to take part in recreational activities have…
    Highly increased [1] ☐
    Increased [2] ☐
    Remained the same [3] ☐
    Reduced [4] ☐
    Highly reduced [5] ☐
23. How many hours per week do you set aside for recreational activities?
    0[1] ☐ 1-3[2] ☐ 4-7[3] ☐ 8-10[4] ☐ More than 10[5] ☐
24. Would you say that your family has spent no money at all or very much money on entertainment and fun related activities in the past one week? Please circle a number.
    No money at all 1 2 3 4 5 very much
25. Do you have access to an area that is dedicated for play in your neighbourhood e.g. a park, playing field?
    Yes [0] ☐ No [1] ☐

Section F: Demography

26. Which is your year of birth? _____
27. What is your sex? Female [0] ☐ Male [1] ☐
28. Who is the person in charge of your household?
    a) Parent [1] ☐
    b) Grandparent [2] ☐
    c) Other relative e.g. aunt, uncle [3] ☐
    d) Sibling [4] ☐

29. Educational level of guardian

a) None [1] ☐
b) Primary [2] ☐
c) Secondary [3] ☐
d) Higher education [4] ☐

Thank you very much for your time!

DODOSO (Swahili translated questionnaire)

Tarehe:_____

Habari yako. Jina langu ni _____. Mimi ni mwanafunzi wa chuo kikuu katika University of the Western Cape, Afrika Kusini. Kama shurutisho la chuo, ningependa kufanya utafiti ili niweze kujua jinsi mradi wa kutoa fedha kwa watoto yatima mjini Kiambu unavyowapa uwezo wa kustawisha maisha yao. Naomba unisaidie kuyajibu maswali yafuatayo. Itakuchukua muda wa kama dakika ishirini kuyajibu. Kumbuka ya kwamba kujibu ni kwa hiari yako mwenyewe na kwamba majibu yako yatabaki siri. Pia nitakutumia ripoti ya matokeo ya utafiti iwapo ungependa kuipata. Je, ungependa kuyajibu maswali haya? Ndio/La. Shukrani.

SEHEMU A

Tafadhali onyesha kwa kuchora mviringo jibu lifaalo kwenye swali la 1 na la 2.

1. Kupata usaidizi kutoka kwa familia au jamii yako kuna umuhimu gani katika maisha yako?
   Hakuna umuhimu wowote 1 2 3 4 5 Kuna umuhimu mwingi sana
2. Kupata usaidizi kutoka kwa marafiki zako kuna umuhimu gani kwako?
   Hakuna umuhimu wowote 1 2 3 4 5 Kuna umuhimu mwingi sana
3. Tafadhali onyesha kwa kupiga tiki kwenye orodha ifuatayo ni sentensi ipi unayoikubaliana nayo. Unaweza kuchagua zaidi ya sentensi moja.
   - ☐ Nina mtu ambaye huniskiliza wakati ninapozungumza
   - ☐ Nina mtu amabaye hunipa wosia kila ninapohitaji
   - ☐ Nina mtu ambaye hunipeleka kumuona daktari ninapohitaji kwenda
   - ☐ Nina mtu ambaye hunipa upendo
   - ☐ Nina mtu ambaye naweza kuwa na wakati mwema naye
   - ☐ Nina mtu ambaye naweza kuambia kuhusu maisha yangu na shida zangu
   - ☐ Nina mtu ambaye naweza kuja pamoja naye kwa mapumziko
   - ☐ Nina mtu ambaye naweza kuwa pamoja naye kwa burudani
4. Waweza sema uhusiano baina yako na watu wa jamii yako umekuwaje hivi karibuni? Tafadhali onyesha kwa kupigia tiki.
   a) Mzuri kabisa [1] ☐
   b) Mzuri [2] ☐
   c) Si mzuri wala mbaya [3] ☐
   d) Mbaya [4] ☐
   e) Mbaya kabisa [5] ☐

5. Waweza sema uhusiano baina yako na marafiki zako umekuwaje hivi karibuni? Tafadhali onyesha kwa kupigia tiki.
   a) Mzuri kabisa [1] ☐
   b) Mzuri [2] ☐
   c) Si mzuri wala mbaya [3] ☐
   d) Mbaya [4] ☐
   e) Mbaya kabisa [5] ☐

SEHEMU B

Tafadhali onyesha kwa kuchora mviringo jibu lifaalo kwenye swali la 6 na la 7.

6. Je, ungesema kwamba kiwango cha umuhimu unaoambatanisha na kuyasoma mambo mapya shuleni ni upi?
   Hakuna umuhimu wowote 1 2 3 4 5 Kuna umuhimu mwingi sana
7. Unakubaliana na sentensi hii kiwango gani? Kwenda shuleni ni muhimu kwa maisha yangu ya siku zijazo.
   Nakubaliana nayo kabisa 1 2 3 4 5 Sikubaliani nayo kamwe
8. Je, wewe huenda shuleni?
   Ndio [1]
   La [2] *(Iwapo la, tafadhali ruka hadi sehemu ya C)*
9. Ni siku ngapi katika muhula uliopita ambapo hukupata kwenda shuleni? Siku _____
10. Gredi ulioipata katika muhula uliopita ni ipi?
    A [1] B [2] C [3] D [4] E [5]
11. Ni sentensi ipi ambayo inakufaa kuonyesha jinsi masomo yako yanavyoendelea? Kwa miaka miwili iliyopita…
    ☐ Nimeidhinishwa kusonga zaidi ya madarasa matatu juu [1]
    ☐ Nimeidhinishwa kusonga madarasa matatu juu (k.m. kutoka darasa la nne hadi la saba) [2]
    ☐ Nimeidhinishwa kusonga madarasa mawili juu [3]
    ☐ Nimeidhinishwa kusonga darasa moja juu [4]
    ☐ Sijaidhinishwa kusonga darasa lolote juu [5]
12. Ni mara ngapi huwa unajihusisha na michezo au uigizaji na mambo mengine bali na masomo ya kawaida shuleni?
    Hakuna 1 2 3 4 5 Kila wakati

SEHEMU C

13. Je, ni kiwango gani cha umuhimu ambacho unahusisha na kujikinga kutokana na ajali?

Hakuna umuhimu wowote 1 2 3 4 5 Kuna umuhimu mwingi sana

14. Tafadhali onyesha ni kiwango gani unachokubaliana au kutokubaliana na sentensi hii. Ninafikiri ya kwamba afya ina umuhimu mwingi sana katika maisha yangu.
    a) Sikubaliani nayo hata kidogo [1] ☐
    b) Sikubaliani nayo [2] ☐
    c) Sikubali wala sikatai [3] ☐
    d) Ninakubaliana nayo [4] ☐
    e) Ninakubaliana nayo kabisa [5] ☐
15. Je, ni mara ngapi umepatwa na ugonjwa katika miezi 6 iliyopita? Mara _____
16. Je, wewe hula chakula kilicho na afya mara ngapi kwa wiki?
    ☐ Kila wakati [1]
    ☐ Wakati mwingi [2]
    ☐ Wakati mwingine [3]
    ☐ Wakati usio mwingi [4]
    ☐ Sili wakati wowote [5]
17. Huwa mnatoa maji ya matumizi ya nyumbani wapi?
    ☐ Bomba (uwanjani/nje ya uwanja) [1]
    ☐ Mfereji unaotumiwa na kijiji kizima [2]
    ☐ Kisima (uwanjani/nje ya uwanja) [3]
    ☐ Kwenye mto [4]
    ☐ Mahala pengine (fafanua) [5] _____
18. Kuta za nyumba ninayoishi zimejengwa kwa
    a) Plastiki au hema [1] ☐
    b) Matope [2] ☐
    c) Mabati [3] ☐
    d) Mbao [4] ☐
    e) Mawe [5] ☐
19. Nyumba unamoishi ina jumla ya vyumba vingapi? [*Tafadhali usijumuishe choo na bafu*].
    Vyumba_____
20. Ni watu wangapi wanaoishi nyumbani unamoishi? Ni watu _____

SEHEMU D

21. Ni kiwango gani unachokubaliana na sentensi hii? Ni muhimu kwangu kujihusisha na burudani na mapumziko.
    a) Sikubaliani nayo hata kidogo [1] ☐
    b) Sikubaliani nayo [2] ☐

c) Sikubali wala sikatai [3] ☐

d) Ninakubaliana nayo [4] ☐

e) Ninakubaliana nayo kabisa [5] ☐

22. Kwa muda wa miaka miwili iliyopita fursa yangu ya kujihusisha na matumbuizo…

a) Imeongezeka kupindukia [1] ☐

b) Imeongezeka kiasi [2] ☐

c) Haijaongezeka wala kupungua [3] ☐

c) Imepungua [4] ☐

d) Imepungua kupindukia [5] ☐

23. Ni masaa mangapi kwa wiki ambayo unatenga kwa burudani?

0[1] ☐ 1-3[2] ☐ 4-7[3] ☐ 8-10[4] ☐ Zaidi ya 10[5] ☐

24. Waweza kusema kwamba jamii yako imetumia kiwango kipi cha pesa kwa burudani kwa muda wa juma moja lililopita?

Haijatumia pesa zozote 1 2 3 4 5 Imetumia pesa nyingi sana

25. Kuna mahali popote pa kuchezea karibu na mahali unapoishi ambapo unaweza kuchezea k.m uwanja wa mpira?

Ndio [0] ☐ La [1] ☐

SEHEMU F

Tafadhalil jaza mapengo kwenye maswali yafuatayo

26. Mwaka wa kuzaliwa: _____

27. Jinsia:

Mke [0] ☐ Mme [1] ☐

28. Ni nani ambaye ni kichwa katika jamii yako?

a) Mzazi [1] ☐

b) Babu au nyanya [2] ☐

c) Jamaa wengine k.m shangazi [3] ☐

d) Ndugu [4] ☐

Shukran sana kwa kuyajibu maswali! Iwapo ungependa kuuliza maswali yoyote tafadhali nipigie simu Joyce Marangu, Nambari: 254 720173906.

Annex II: Interview Guide

No. _____

Hallo. My name is _____. I am undertaking a study on the extent to which the Cash Transfer for Orphans and Vulnerable Children (CT-OVC) is promoting the human development of children in Kiambu. Findings from this research could help improve the CT-OVC programme. Kindly help me answer some questions regarding the programme. This will only take approximately 25 minutes of your time. Your responses are voluntary and completely confidential. I will also send you a report of the findings made if you so wish.

Would you like to participate? Yes ___/No ___ ***If No move to next household***.

Section A

1. In which way are you involved with the Cash Transfer for Orphans and Vulnerable Children Programme?
2. What do you like about the CT-OVC programme?
3. Which challenges have you faced related to the programme? In which ways have you tried to resolve the challenges?
4. If the CT-OVC programme were to be changed, how would you want it to be?

Section B

1. In your opinion, in which way has the life of the children [or your life if interviewee is child] changed, if at all, since they joined the programme?
2. What would you say are the changes, if any, in terms of:
    a) Health
    b) Education
    c) Social life
    d) Play
3. What do you think are some of the opportunities that the children in the programme have?
4. In your view, how do the children in the programme compare to those who are not?
5. According to you, what are the most pressing needs that the children had before they got enrolled into the programme?
6. What do you think are their most pressing needs now after being enrolled?

Section C

Other Comments…

Thank you for your time!

Mwongozo wa Mahojiano (Swahili translated Interview Guide)

Habari yako. Jina langu ni _____. Mimi ni mwanafunzi wa chuo kikuu katika University of the Western Cape, Afrika Kusini. Kama shurutisho la chuo, ningependa kufanya utafiti ili niweze kujua jinsi mradi wa kutoa fedha kwa watoto yatima mjini Kiambu unavyowapa uwezo wa kuimarisha maisha yao. Naomba unisaidie kuyajibu maswali yafuatayo. Itakuchukua muda wa kama dakika ishirini hivi kuyajibu. Kumbuka ya kwamba kujibu ni kwa hiari yako mwenyewe na kwamba majibu yako hayatatolewa kwa watu wengine. Pia nitakutumia ripoti ya matokeo ya utafiti iwapo ungependa kuipata. Je, ungependa kuyajibu maswali haya? Ndio/La. Shukrani.

Sehemu A

5. Je, wewe unahusika na mradi wa kutoa fedha kwa watoto yatima, yaani CT-OVC, kwa jinsi gani? [dakika 3]
6. Unahisi kwamba mradi huu umekunufaisha au umekutia hasara? Tafadhali fafanua. [dakika 3]
7. Ni matatatizo yepi ambayo yamekukumba katika uhusiano wako na mradi huu? Je, umejaribu kuyatatua kwa njia gani? [dakika 3]
8. Kama kungekuwa na uwezekano wa kuubadilisha mradi huu, ungependa ubadilike uweje? [dakika 2]

Sehemu B

7. Kwa maoni yako, maisha ya watoto yamebadilika kwa njia gani tangu walipojiunga na mradi huu?
8. Je, wadhani kuwa kuna mabadiliko katika…
   a) Afya
   b) Masomo
   c) Uhusiano na watu
   d) Kucheza [dakika 4]
9. Wadhani kuwa ni fursa zipi ambazo watoto wameweza kuzipata tangu walipojiunga na mradi wa CT-OVC? [dakika 3]
10. Kwa maoni yako, watoto walio kwenye mradi wanalingana vipi na wale ambao hawako kwenye mradi? [dakika 3]
11. Kwa maoni yako mwenyewe ni shida zipi za dharura zilizowakumba watoto kabla ya kujiunga na mradi huu [dakika 3]
12. Wadhani kuwa ni shida zipi za dharura zinazowakumba watoto hao hivi sasa baada ya kujiunga na mradi? [3 min]

Sehemu C

Maoni mengine yoyote…

Ahsante sana kwa muda wako!

Annex III: Summary of In-depth Interviews

Dates: 22nd to 28th July, 2013

Place: Kiambu

No. of participants: 10

Interviewer: Joyce Marangu

Participants perceptions of the Cash Transfer programme for Orphans and Vulnerable Children		
Participants	**Perceived impact on social relationships**	
Children (OVC) (4) Caregivers (2) CT-OVC personnel (2) Community members (2)	**Benefits**	**Challenges**
	Facilitates interaction e.g. exchange of items or gifts (not necessarily expensive ones)	Creates tensions between CT-OVC personnel and recipients
	Builds social networks- getting to know more people within the community	Strains family relationships when caregivers cannot afford to buy all that the child needs
	Increases the credit worthiness of recipients (caregivers)	Feelings of envy towards recipients
	Reduces stigma related to poverty, discrimination due to not being able to afford basic needs or pay up one's debts.	
	Participation in social/investment groups	
	Participation in, or organising fund raisers	
	Having money to spend improves self esteem	
	Retention of orphans in families (although this was already happening before CT-OVC programme)	
	Perceived impact on education	
	Benefits	**Challenges**
	Able to afford school fees	Secondary school costs are high and still beyond the reach of many of the needy people
	Ability to meet education related needs e.g. books, school uniform, transport costs	Grade repetition (in grade eight) due to lack of school fees to proceed to secondary school

Higher school enrolment for children	
Children are fed and thus able to attend school	
Less chores at home meaning more time for study	
Reduced dropouts	
Higher aspirations e.g. to join secondary school	
Less absenteeism, repetition	
Perceived impact on health	
Benefits	**Challenges**
Direct expenditure on medical costs	Insufficiency of payments to meet needs involving higher costs such as housing, most recipients still live in
Ability to afford nutritious foods which were hitherto unaffordable such as meat, poultry; on a more regular basis	
Emotional health through psychosocial support groups e.g. in support groups for PLWA	
House repairs-protection from the elements	
Somewhat reduced stigma on PLWA-people want to help	
Perceived impact on play	
Benefits	**Challenges**
Less chores at home means more play (free) time	Barely any surplus to spend on leisure activities
Children travel to distant places e.g. to visit relatives	Negative impact proved to be a bit difficult for recipients to pinpoint
Enabled some children to have school tours paid for. These are usually very low cost trips for education purposes lasting a day or half a day.	
Cross cutting issues	

	Child participation in the programme particularly in evaluation is still missing
	Empowerment of marginalised groups of people i.e. the very poor, elderly caregivers, sick (HIV), OVC
	Issues to do with graduation from the CT-OVC programme
	Few households beginning to make investments albeit small ones, e.g in livestock

Annex IV: Tests for normal distribution

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. sktest age grade rooms sick
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Skewness/Kurtosis tests for Normality

Variable	Obs	Pr(Skewness)	Pr(Kurtosis)	joint adj chi2(2)	joint Prob>chi2
age	161	0.0600	0.3069	4.65	0.0978
grade	161	0.4441	0.1487	2.71	0.2578
rooms	161	0.0458	0.4351	4.67	0.0970
sick	161	0.0000	0.0000	67.48	0.0000