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Influence of CT-OVC Programme Support Services on the Wellbeing of Beneficiaries' Households in Kinango Sub-County, Kenya

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Abstract:
Despite the implementation of Cash Transfer for Orphans and Vulnerable Children (CT-OVC) programme in Kinango Sub-County for over 10 years, there is little systematic evidence regarding its impact on beneficiaries. The purpose of this study was to examine the influence of support services on the wellbeing of beneficiaries' households in Kinango Sub-County. The study used mixed research methods and employed a descriptive survey research design. The target population was 2,134 individuals comprising 2,100 caregivers in households that benefited from the CT-OVC programme between January 2016 and December 2018 and 35 programme administrators (2 officers from department of children services at the sub-county, 4 Social Assistance Unit officers at the national level, 14 chiefs, and 14 members of beneficiary welfare committee). The sample size was 227 individuals, who were obtained from 10 percent of the beneficiary households (210) as well as 50% of the programme administrators in Kinango Sub-County. The study applied clustered random sampling where the sub-county was divided into 14 clusters in line with the 14 administrative locations. Seven (7) clusters were selected from the 14 clusters using simple random sampling. Quantitative data was collected from the caregivers using questionnaires while qualitative data were collected from the programme administrators using interview guides. Quantitative data were analysed using descriptive and inferential statistics, while qualitative data were analysed using the thematic analysis technique. Results showed that the CT-OVC programme has improved the well-being of beneficiaries' household by increasing access to education, healthcare and nutrition. However, the programme has had little influence on access to water and sanitation and quality housing. It was also found that support services, such as nutritional education, have a positive and statistically significant influence on wellbeing (X2 = 47.915, df=1, p=.000). Based on these findings, the study recommends the National Safety Net Programme should create awareness regarding existing support services and integrate additional services.

Keywords: *Cash transfer, wellbeing, support services, orphans, vulnerable children, social safety nets, households Kinango, Kenya*

1. Introduction

1.1. Background of the Study

Cash transfer programmes are social safety nets (SSNs) that are implemented by world governments, the private sector, communities, family units, and other non-state actors in support of social and economic constraints of vulnerable households. These are generally non-contributory welfare programmes that seek to help individuals and families to eliminate poverty and other livelihood problems, and improve their standards of living (World Bank, 2018). The programmes target poor and vulnerable people, and may comprise a wide range of services including housing, job placement, food, and cash transfers. SSNs have become popular interventions for addressing destitution and vulnerability. According to the World Bank (2019), some 2.5 billion people were under social safety net programmes in 2019 globally.

Developing and transition nations devote approximately 1.5% of their GDP on SSN programmes, while developed countries spend an average of 2.2% of their GDP on SSNs (World Bank, 2018). SSNs have been found to have a significant impact on poverty reduction. According to the World Bank (2019), SSNs have helped 36% of beneficiaries to escape abject poverty. In US, SSNs have had positive impact on working poor parents including improvements in child health and development since the early 1990s, but those focusing on non-working parents have collapsed (Tach & Edin, 2017).

However, SSNs have had little effect on marriage and births out-of-wedlock. Caribbean and Latin American countries spend an average of US $150 per citizens per annum on safety net programmes, while sub-Saharan African (SSA) countries spend an average of US$ 16 per citizen.

According to Handa and Davis (2015), conditional cash transfers (CCTs) are increasingly being promoted as the best practice in the social sector for developing countries. Although the use of cash transfer as instruments of social protection has been noted to have originated in Europe, the first well known CCT programs were implemented in Latin America in the early 1990s to alleviate poverty and create conditions for upward social mobility through human capital investments (Teixeira, 2009). In Brazil, CCT was adopted in 1995 when the government implemented a programme called Bolsa Escola and Bolsa Familia (Oosterbeek, Ponce & Schad, 2008).

Mexico effected *Progress*, later called *Oportunidades*, whereas Nicaragua embraced the *Red de Proteccion Social* (Teixeira, 2009). Additional CCT schemes, that were initiated in the 1990s, included Chile's *Subsidio Unico Familiar* and Honduras' *Programa de Asistencia Familiar* (Son, 2008). The CCT programme implemented in these nations as instruments of protecting vulnerable members of society had a broad assortment of positive consequences (Royat, 2009). The most essential gains brought about by CCT programme included improved nutrition and enhanced enrolment to school among recipients (World Bank, 2011). In spite of the fact that CCT programs were embraced by nations in all continents, the programs were received most in Asia and Africa. In Asia, far-reaching CCT programmes were executed in Indonesia, Bangladesh and the Philippines (Royat, 2009).

The Indonesian administration began by actualizing the unlimited cash exchange programme in October 2005, in which qualified family units received a monthly disbursement of 100,000 IDR (Royat, 2009). Philippine embraced a CCT Programme named the Pantawid Pamilyang Pilipino Program. The Pilipino Programme adjusted from the CCT Programmes in Latin America was a deprivation diminishment technique that gave cash gifts to destitute families to permit the individuals in the families to attain essential human advancement objectives (Cuizon & Cuizon, 2016). The Pantawid Pamilyang Pilipino Program made a difference that entailed reducing destitution and starvation, decreasing child death, enhancing wellbeing of mothers, and supporting gender equality (Son, 2008).

Social transfers are progressively being viewed as a vital device for battling the tripartite hazard of constant poverty, starvation and HIV/AIDS in East and Southern Africa. With the coming of the worldwide money related, fuel and food crises, and the tall rate of either irresistible or non-transmittable infections, there are mounting demands for the enlargement of such programmes to secure the destitute and advance human rights. As these programmes grow an assortment of planning and execution issues have started to rule the arrangement talk about, counting support levels of the beneficiaries, the financial practicality, focusing on the measurability of the effect of the programs. In South Africa, the government began actualizing unrestricted cash exchange program called Child Support Grant (CSG) in 1998 as a framework for providing unlimited assistance to children, individuals with incapacities, and elderly individuals. By early 2006, the South African administration was given the triple primary gifts to 11 million people out of the country's population of 44 million (Lund, Noble, Barnes & Wright, 2008).

In Somalia, the arrangement of credit is a fundamental adapting component. A cash-based response program offers assistance to destitute family units. An assessment of Adeso's programme that began with the cash-based venture in Somalia, executed beneath the title Horn Help in 2003, found that the response was compelling in engaging recipients to prioritize their needs such as getting food, water, animals and healthcare (UNICEF, 2015). Most imperatively, the assessment found that cash exchange revitalized credit, an essential adapting component for pastoralists. The extent, moreover, revitalized the nearby economy by encouraging the reviving of small shops.

It is estimated that there are 2.8 million orphans and vulnerable children in Kenya (Waweru, 2016). A report by UNICEF (2017) also found that 45% (9.5 million) of Kenyan children below the age of 18 were living in a state of deprivation in 2017 where they did not have enough food, access to safe drinking water, health services, and basic education. The CT-OVC programme was launched in 2004 with the wide intention of reinforcing the capabilities of households' providing care to orphans and vulnerable children (OVC) through regular cash transfers (Ouma, 2012). It was envisaged that the programme would encourage retention of OVC in their kinfolks to promote their optimal development. CT-OVC is presently the leading CT programme in Kenya. Kenya's CT-OVC programme was launched in three districts of Garissa, Kisumu and Kwale as a trial project covering 500 OVC households (Kenya Poverty and Inequality Assessment, 2009). By the year 2009, funding of the CT-OVC programme by the government had risen to US $9 million up from USD US$ 8 million that was allotted in 2005. The programme's coverage was also expanded to 47 districts, now referred to as counties.

The CT-OVC programme offers steady sustenance to socio-economically disadvantaged households caring for OVCs in the target areas. Its topographical targeting is directed by a CT-OVC programme expansion plan, which is crafted at the national level using vulnerability and poverty criteria (National Gender and Equality Commission, 2014). After determining the location, operational structures of the programme are formed, data on household level collected and analysed, and a list of potential beneficiary is developed and entered into the management information system (KNBS 2006). According to the operational manual for the Consolidated Cash Transfer Programme (CCTP), CT-OVC maintained households receive outlays of Ksh.4, 000 every two months via Payments Service Providers such as Kenya Commercial Bank, Cooperative Bank, Post Bank, and Equity Bank Limited (Republic of Kenya, 2020).

Kwale County is among the expansive beneficiary counties of CT-OVC programs because of the socio-economic vulnerability of its residents owing to it being an Arid and Semi-Arid Land (ASAL). There are a total of 5429 beneficiary households in the county distributed in the four sub-counties based on their vulnerability. This includes 2,100 beneficiaries in Kinango, 1079 beneficiaries in Mswabweni, 900 beneficiaries in Mutuga and 1450 beneficiaries in Lunga

Lunga. From this statistics, Kinango Sub-County has the highest population of vulnerable and orphan children as compared to the rest of the sub-counties in Kwale County.

Despite the implementation of CT-OVC programme in Kinango Sub-County for over 10 years, statistics shows that there are still a large number of children living in deplorable conditions in Kinango Sub-County. The Kenya Food Security Steering Group (2017) found that children under the age of 5 in Kinango Sub-County are more likely to experience malnutrition and childhood illnesses like diarrhoea, pneumonia, malaria, typhoid, dysentery, and upper respiratory tract infection. The rate at which children are dropping out of school is also high at 22.16% most of whom end up engaging in child labour. Among the children involved in child labour, 37.5% are involved in illicit sex trade that exposes them to diseases, 25% work as domestic helpers, 25% run bodaboda businesses, and 12.5% engage themselves in other trades (Otieno, 2016). These statistics put to question the effectiveness of the CT-OVC programme in promoting the well-being of orphans and vulnerable children and their households.

A review of literature established that there were major inconsistencies among various authorities. Some authorities indicated cash transfers to have positive influence on well-being of households, while others noted the cash transfer do not have a significant influence on families' well-being. This inconsistency is an indication that there are specific aspects of a cash transfer programme that determines whether it will have an impact on beneficiaries or not. The review of literature has established that there is a paucity of studies that delve into factors that determine the effectiveness of a cash transfer programme on improving the well-being of beneficiaries. This research sought to address this gap by examining the influence of CT-OVC programme support services on the well-being of beneficiary households in Kinango Sub-County.

2. Literature Review

2.1. Household Well-being

Household well-being is quite a contentious concept that has attracted a wide array of interpretation by scholars. Traditionally, household well-being was associated with material measures such as total household income, per capital income, and household expenditure (Zereyesus, Shanoyan, Ross, & Boadu, 2016). This traditional approach was, however, criticized for laying a lot of emphasis on economic well-being and ignoring non-material aspects of well-being. In modern literature, the concept of household well-being has been expanded to encompass social, political, cultural, and economic dimensions. Sen (1999), who is one of the proponents of the expanded concept of well-being, argued that while the economic dimension is necessary for one to maintain a decent standard of living, it is not sufficient. One may have high income and wealth, but without adequate healthcare facilities, education amenities, and water and sanitation services, adequate security infrastructure, he or she may not get a decent life.

The multi-dimensional human development index was developed to address the limitation of the traditional approach of assessing well-being (Zereyesus *et al.,* 2016). This index uses several indicators to assess well-being including education attainment, life expectancy and income. Sen (1999) also developed the Capability Approach that focuses on assessing a person's ability to utilize the resources at his or her disposal including public health, transport, and education infrastructure. The Capability Approach also recognizes that different individuals prioritize different dimension of well-being. Western and Tomaszewski (2016) noted that well-being can be measured using objective approach or subjective approach. The objective approach uses easily quantifiable indicators such as income, housing, life expectancy, mortality rates, employment, years of schooling, crime rate, political and social inclusion and environmental quality. On the other hand, the subjective approach uses indicators that are not easy to quantify such as life satisfaction, happiness, relationships, social support and networks.

There have also been attempt to develop social indicators for assessing well-being that cover aspects such as personal satisfaction, participation, equality, and peace and security. Hicks and Streeten (1975) also proposed a set of six indicators for measuring development and well-being. These indicators include health, education, food, water supply, sanitation, and housing. Social indicators have several advantages over economic indicators such as income and employment. One of the advantages is that they assess both the end and the means unlike economic indicator that only assess the input that a person needs to live a decent life (Hicks & Streeten, 1975). The economic approach is blind to the fact that input may not always translate to the desired quality of life, especially where there are limited supply of essential services and amenities.

In this study, household well-being of CT-OVC beneficiary was measured using five indicators: access to education, access to healthcare, access to food, quality of water and sanitation, and quality of housing. Access to education was measured in terms of trend in school enrolment, school attendance, access to educational resources such as books, and transitioning from one level of education to another by children in the CT-OVC beneficiary household. Access to healthcare was assessed in terms of trends in access to medical insurance, vaccination, treatment, and out-of-pocket healthcare expenditure in CT-OVC beneficiary households. Access to food was evaluated in terms of number of meals on a normal day, quality of meals taken on normal days (balanced diet), quantity of food taken in meals, and access to preferred food in CT-OVC beneficiary households. Quality of water and sanitation was assessed in terms of access to clean water, time taken to get water for household use, access to water collection equipment, and access to improved sanitation facilities such as flush toilets in CT-OVC households. Quality of housing was measured in terms of types of roofing, type of flooring, type of wall material, and connection to electricity in CT-OVC beneficiary houses.

2.2. CT-OVC Support Services on Household Well-being

To ensure sustainability and long-term success, cash transfer programmes should be integrated with complementary services such as nutrition education, entrepreneurship training, and financial management training among others (DFID, 2011). The addition of complementary programme into CT interventions has been observed in various jurisdictions. In Mexico, the Propera programme incorporates the provision of income generating opportunities and employment training as part of the cash transfers (Molyneux, Jones, & Samuels, 2016). The programme also offers subsidized childcare services through a subsidiary scheme.

According to Roelen, Delap, Jones, and Chettri (2017), augmenting the cash transfers with additional services such as grants, commodities, education and training can amplify the impact of the programme. Roelen *et al.* (2017) noted that CT beneficiaries in Nicaragua, who received productive business grants in addition to the cash transfers, were more likely to venture into self-employment than those who only received the cash. Bastagli *et al.* (2016) noted that integrating CT programmes with complementary services can magnify the impact of the programmes by enhancing the beneficiaries access to information on a wide range of issues such as nutrition and hygiene, granting beneficiaries access to other programmes such as school feeding or health insurance, developing the beneficiaries skills in areas such as parenting or financial management, and transferring additional resources such as assets.

In a study examining the 'Cash Plus' programme in Ghana, Davis, Handa, Hypher, Rossi, Winters, and Yablonski (2016) found that incorporation of ancillary services such as financial management training and nutritional education ensured the effectiveness of cash transfer programs. It was noted that cash transfer on its own cannot attain optimum efficiency and thus need behaviour strainers in the form of nutrition education and financial security (Davis *et al*., 2016). The project was found to provide the necessary knowledge to mothers on matters concerning their kid's dietary issues, Psychological and social counselling, as well as making it easy to access social amenities.

In another study, Roelen *et al*., (2017) examined three CT programmes, namely - INSCT in Ethiopia, Leap in Ghana, and Chile Solidario. The plans were found to have played a critical role in ensuring long-term success is achieved in terms of health, poverty eradication, and the provision of quality education. These programs have eliminated barriers that the less fortunate groups face in terms of non-financial and structural barriers. According to DFID (2011), linking CT programme with complementary interventions help to tackle the multi-dimensional aspect of poverty. CT programmes that are implemented in isolation are less likely to ensure successful graduation of beneficiary from destitution.

One of the aims of CT-OVC programmes in Kenya is to reduce AIDS prevalence among adolescents. According to Cluver *et al*. (2015), social protection plays a critical role in ensuring there is an eradication of HIV. A combined effort of CT programs, social security, and classroom education can synergize this and produce a tremendous effect. From the data collected, adolescents, with no social support, had a 43% HIV infection rate, whereas those under CT programs stood at 26% and lastly the ones with Cash Plus programs stood at 16%. The findings by Cluver *et al*. (2015) provide a clear indication that cash plus programs boost the effectiveness of CT programs.

In their research, Ariagada *et al*., (2018) investigated the effect of combined efforts between CT programs, and parenting programs to Turkana parents with children below four years. They found evidence that there was an improvement in parenting techniques and advancement in language cognition, compared to letting CT programs run alone. However, the evidence was not enough to determine the cost-effectiveness of the CT plus programmes and ethical considerations. According to Mercy Corp (2015), integrating CT programmes with complementary services such as life-skills training and financial education becomes appropriate when the CT programme is being used as a transitional activity rather than as an emergency response. They also noted that integration of complementary services can also introduce logistical and coordination challenges that lower the efficiency of the programme.

In Bangladesh, Sulaiman *et al*. (2016) explored the effectiveness of CT programme known as Graduation program. The program focuses on giving a small amount of cash transfer, as well as, teaching entrepreneurship skills to those who are extremely poor. Poverty stricken families were identified, business activity that they can engage in identified, and financed. After teaching and imparting skills to them, assets such as livestock and other business activities outside the farm were transferred to them to help elevate their status. The program recorded 95% affectivity in changing the economic and social status of the beneficiaries' families (Sulaiman *et al*., 2016). In an interview with a sample of the beneficiaries, 56% of respondents agreed that the Graduation Program had a positive impact. On the other hand, cash transfers were found to have an insignificant effect on elevating livelihoods. Cash transfer programs with no enhancement are thought to be encouraging laziness.

In Uganda, Moret & Ferguson (2018) examined the effectiveness of two CT programmes known as Economic Strengthening to Keep and Reintegrate Children in Family Care (ESFAM) and Family Resilience (FARE). Besides transferring cash to beneficiaries, the FARE programme also entailed training beneficiaries and advising them on expenditure issues. Beneficiaries were equipped with knowledge on health and nutrition, parenting, reinvesting, finding less costly business, current market trends, planning on household expenditure and business expenditure, how to manage income, and how to make wise decisions. The beneficiaries were also required to submit a presumed household budget for scrutiny and only received their monthly remunerations after their budgets were assessed. Moret & Ferguson (2018) found that besides strengthening the households' economic position, the FARE programme also enhanced the quality of parenting, health and nutrition, and children's education.

3. Research Methodology

The study used mixed methodology that combines both quantitative and qualitative research methodologies. This choice of mixed methodology was to generate an in-depth and contextualized insight on CT-OVC influence on beneficiaries'

households that can be generalized to other settings (Creswell, 2014). The exact type of mixed methodology that the study used was the concurrent triangulation method where both the quantitative and qualitative data were collected simultaneously (Bryman, 2016). The study employed a descriptive survey research design. This design is suitable to the study because the goal of the study is to assess and describe the CT-OVC programme including its structure, support services, and M&E as well as the well-being of beneficiary households.

3.1. Location of the Study

The study was conducted in Kinango Sub-County in Kwale County, Kenya. It is one of the four sub-counties that make-up Kwale County. It is located 4° 8' 21.6204'' South and 39° 19' 4.908'' East. It has an estimated human population of 2,09,560 people and an approximated area of 4,011.7 square kilometers. It is divided into 14 administrative locations managed by area chiefs. This location was selected because there is evidence of existence of poor standard of living in the area. In Kinango Sub-County, cases of school dropouts, teenage pregnancies, child marriages, beach boys and beach girls, and child prostitution have been on a rising trend in recent years (State Department for Social Protection, 2018). Moreover, Kwale County has a high level of socio-economic vulnerability among its residents owing to it being an ASAL area.

3.2. Target Population, Sample Size and Sampling Technique

The target population for this study was 2,134 individuals comprising 2,100 caregivers in household that benefited from CT-OVC programme between 2016 and 2018, and 34 administrators of CT-OVC programme in Kinango Sub-County. The CT-OVC administrators include 2 officers from the sub-county department of children services, 4 Social Assistance Unit officers at the national level, 14 chiefs, and 15 members of the beneficiary welfare committee (BWC).

For this study, 10 percent of the households benefiting from CT-OVC in Kinango Sub-County were sampled to participate in the study. Since the other categories of respondents have smaller populations, a sampling proportion of 50% was used. The sampling plan is summarize in Table 1

Respondent Category	Population	Sampling Proportion	Sample Size
Caregivers	2,100	10%	210
BWC	14	50%	7
Chiefs	14	50%	7
Social Assistance Unit	4	50%	2
Children officers	2	50%	1
Total	2,134		227

Table 1: Sample Size

The sample size of 227 respondents was deemed adequate because the population in Kinango Sub-County is relatively homogenous in terms of ethnicity, economic activities, and social cultural variable. Consequently, this sample was adequate to offer representative views regarding the influence of CT-OVC on the well-being of beneficiaries' households.

The sample of caregiver was selected using the clustered random sampling method. The population of households that had benefited from the CT-OVC programme between 2016 and 2018 were divided into 14 groups according to the 14 administrative locations within the sub-county. Seven (7) locations were selected from the 14 locations in Kinango Sub-County using simple random sampling. The chiefs and BWC chairpersons in the 7 locations were automatically included in the study. Further, 30 households that benefited from the CT-OVC were systematically selected from the list of beneficiary picking every 10th person. The selection interval was informed by the following formula:

$$Interval\ (k) = \frac{N}{n}$$

Where N= Target population (2,100)
n= desired sample size

Two Social Assistance Unit officers at the national level and 1 children officer at the sub-county level were selected purposively. The following inclusion criteria was used: (1) must have been directly involved in the administration of the programme between 2016 and 2018, (2) must have been available during the study period, (3) must have been willing to participate in the study, and (4) must not have any direct interest in the study.

3.3. Research Instruments

Two instruments of data collection were used: (1) questionnaires for caregivers in beneficiary households, and (2) interview guide for programme administrators.

3.3.1. Questionnaires for Caregivers in Beneficiary Households

The questionnaire was used to collect quantitative data from caregiver of beneficiary households. The questionnaire had three sections: demographic section, dependent variable section and independent variable section.

3.3.1.1. Dependent Variable

The dependent variable of the study was the well-being of households of CT-OVC beneficiaries in Kinango Sub-County. Well-being was measured using a Likert scale comprising 20 items assessing the five indicators of well-being (food, health, education, quality of water, and housing). Each indicator had four items that prompted respondents to indicate whether these aspects had become better after enrolling to the CT-OVC programme or worse. The rating was done on a five point scale: 1= much worse, 2= worse, 3= same as before, 4= better, 5= much better.

3.3.1.2. Independent Variable

The independent variable in the study is the influence of cash transfer support services. Three forms of support services were examined: advice to beneficiaries on how to use the cash, nutrition education, and entrepreneurial training. The questionnaire was comprised of three questions, one for each support service. They were Yes/ No questions that promoted respondents to indicate whether they have access to these services.

3.3.2. Interview Guide for Programme Administrators

The interview guide was used to collect qualitative data from administrators of the CT-OVC programmes in the sub-county (see Appendix B). The administrators included 2 officers from the Department of Children Services, 14 chiefs, and 15 members of the welfare beneficiary committee. The interview guide was semi-structured in nature meaning that it comprised a set of uniform initial questions that were directed to the interviewees and follow-up questions that varied from one interviewee to the next depending on his or her responses to the initial questions.

3.4. Data Analysis Techniques and Procedures

Quantitative data that was gathered through questionnaires was sorted, assessed for completeness, edited for errors, coded, and then, entered into the Statistical Packages for Social Sciences (SPSS) version 25. Descriptive statistics were used to describe the support services integrated in the programme and well-being of the households. The cross-tabulation with chi-square test was used to examine the influence of the independent variable on the dependent variable. Findings of the quantitative analyses are presentable using Tables and Figures. Data collected through interviews was analysed using the thematic analysis technique.

4. Results

4.1. Response Rate and Respondents' Demographics

The study obtained data from 178 beneficiary households out of a proposed target of 210. This figure translates to a response rate of 84.8%, which is higher than the 63.9% reported for household surveys conducted in the United States of America (U.S) in the 2011-2019 periods (U.S. Bureau of Labour Statistics, 2021). Most of the non-responses were mainly due to difficulties in tracking down some of the beneficiaries that were selected for the study and failure by some respondents to answer many of the questions. 16 out of the 17 individuals that were targeted for the interviews participated in the study translating to a response rate of 94.1%. The high response rate among the interviewees is attributed to the ease of locating the targeted individuals given that most were holding official positions in the CT-OVC programme.

The majority of the respondents (75.3%) were females, while males constituted the remaining 24.7%. This finding is consistent with a survey by the World Bank (2019), which also found that majority of CT-OVC beneficiaries in Kenya were women. This implies that the sample used in the study is a close representation of the national population of CT-OVC beneficiaries. Asfaw (2012) also observed that the usage and impact of CT-OVC money varied by gender with programme having more impact on female-headed household than on male-headed households. The sample was quite diverse in terms of age with the largest segment (34.3%) being in the 31-40 years brackets followed by the 20-30 years bracket at 24.2%.

In terms of education, the majority of the respondents (69.7%) had primary or below primary level of education, while the remaining 30.3% had the secondary level. This finding implies that the majority of the beneficiary had low level of education, which is consistent with the data from the County Government of Kwale (2018), which showed there is low enrolment to secondary schools in the area, which has a gross enrolment of 35%. The study presumed that education levels of the beneficiaries are bound to have an impact on how they utilize the CT-OCV money.

Demographic Trait	Categories	Frequency	Percent
Gender	Male	44	24.7
	Female	134	75.3
Age	20- years or below	23	12.9
	21-30 years	43	24.2
	31-40 years	61	34.3
	41-50 years	41	23.0
	Above 50 years	10	5.6
Highest Education Level	Primary level or below	124	69.7
	Secondary level	54	30.3
Occupation	Crop/ Livestock farming	100	56.2
	Trade	45	25.3
	Causal employment	33	18.5
Year of CT-OVC Enrolment	2016	78	43.8
	2017	67	37.6
	2018	33	18.5

Table 2: Respondents' Demographic Profile

The majority of the respondents (56.2%) indicated that crop and livestock farming was the main occupation, which is consistent with the County Government of Kwale (2018) plan, which indicated that crop and livestock farming was the main economic activity in the County. About 25.3% of the respondents were involved in trade, while the remaining 18.5% were employed on casual basis. About 43.8% of the respondents enrolled to the CT-OVC programme in 2016, 37.6% joined in 2017 and 18.5% joined in 2018. Therefore, most of the respondents had been in the programme for at least 2 years and; therefore, they were privy to in-depth information regarding the programme structure, support services, and M&E practices.

4.2. Well-being of CT-OVC Households in Kinango Sub-County

The first objective of the study was to assess the well-being of CT-OVC beneficiaries' households in Kinango Sub-County. Well-being of these households was the dependent variable of the study. This variable was measured in terms of access to education, access to health, access to food, quality of water and sanitation, and quality of housing. Respondents were presented with a set of items that rate whether these elements of well-being have improved or become worse after enrolling in the programme. A five point rating scale was used (1= much worse, 2= worse, 3= same as before, 4= better, 5= Much better). Results are summarized in Table 3.

Items from A1 to A4 were geared to assess how access to education by children in CT-OVC households had changed after the families were enrolled in the programme. Results show that respondents on average held the view that there was better enrolment of children of school going age into early childhood development and education (ECDE) after they started receiving CT-OVC money (Table 4, A1, mean=3.88). Respondents also reported that the CT-OVC programme had led to better school attendance by school going children (A2, mean= 3.88), better access to books, stationaries, and other essential learning materials by school going children (A3, mean= 3.87), and better transitioning to secondary schools to secondary school (A4, mean=3.75). The standard deviation values for all the four items was less than 1 indicating that there was little dispersion in the respondents views from the average position. These findings imply that the majority of CT-OVC beneficiaries use the money they receive to cater for the education needs of children in their households. This conclusion is reinforced by qualitative data collected during the interviews of CT-OVC administrators. 15 out of the 16 administrators that were interviewed identified provision of education as one of the area to which CT-OVC money is directed.

> *Most beneficiaries use the money to finance the children education needs like buying uniforms, books, and paying school fees for those with children in ECDE and secondary schools. (Respondent4, Interview, 2021)*
>
> *The money has helped many families to support the education of their children particularly in secondary schools. Cases of school dropout in the family have declined. (Respondent9, Interview, 2021)*

Items from A5 to A8 sought to examine how CT-OVC has affected access to health care in beneficiaries' household. Results in Table 4 indicate that on average, access to health insurance in beneficiaries' households after enrolling to the CT-OVC programme has remained the same (A5, mean= 3.12). Findings also suggest that the programme had led to better access to all the necessary immunization by children in the household (A6, mean= 3.62) and better access to health care facilities (A7, mean= 3.98). However, on average, the data indicates that the amount of out-of-pocket healthcare expenses, such as medicine and dental care, has remained the same as before the beneficiaries enrolled to the CT-OVC programme (A8, mean= 3.44). Item A7 had a standard deviation value that was greater than one suggesting that respondents held divergent views regarding the influence of the programme on access to healthcare facilities. These findings imply that the CT-OVC programme has helped to improve some aspects of health care such as access to immunization but not others such as access to health insurance.

S/N	Item	N	Mean	S.D
	Education			
A1	Enrolment of children of school going age into early childhood development and education (ECDE)	178	3.88	.330
A2	School attendance by school going children	178	3.88	.598
A3	Access to books, stationaries, and other essential learning materials by school going children	178	3.87	.601
A4	Children transitioning to secondary school	178	3.75	.662
	Health			
A5	Access to health insurance cover such as NHIF by all children	178	3.12	.864
A6	Access to all the necessary immunization by children in the household	178	3.88	.924
A7	Access to healthcare facilities	178	3.98	1.338
A8	Amount of out-of-pocket healthcare expenses such as medicine and dental care	178	3.44	.865
	Food			
A9	Access to at least three meals in a day.	178	3.41	.999
A10	Access to a balanced diet on normal day (carbohydrates, protein, vitamin, minerals)	178	4.12	.330
A11	Access to sufficient amount of food during meals by all household members.	178	3.87	.601
A12	Consumption of foods that we prefer	178	3.37	.484
	Water Supply and Sanitation			
A13	Access to clean water in your household	178	3.43	.899
A14	Time it takes to collect water for household use	178	3.23	.336
A15	Access to improved water collection equipment such as water tanks by the household	178	3.14	.831
A16	Access to improve sanitation facilities such as flush toilet or pit latrines in your household	178	3.37	.694
	Housing			
A17	The quality of roofing in your house	178	3.22	.478
A18	The quality of flooring in your house	178	3.34	.486
A19	The quality of walling in your house	178	3.30	.459
A20	The quality of lighting in your house	178	3.39	.512
	Aggregate mean score	178	3.63	.321

Table 3: Well-being of CT-OVC Households in Kinango Sub-County

Items from A9 to A12 delved into the influence of the CT-OVC programme on access to food in beneficiaries' households. Results in Table 4 suggest that the programme has contributed to better access to a balanced diet on normal day (A10, mean= 4.12) and improved access to sufficient amount of food during meals by all household members (A11, mean = 3.87). However, the data shows that access to three meals a day (A9, mean= 3.41) and consumption of preferred food (A12, mean =3.37) has remained the same as before enrolling to the programme. All the items had standard deviation values of less than 1 suggesting that there was a high level of consensus among respondents on these issues. These findings indicate the CT-OVC programme has contributed towards improving access to food in beneficiary households. This position is also supported by the interview data where 11 out of the 16 interviewees acknowledged beneficiaries use cash transferred to them to feed their families.

A good portion of the money given to beneficiaries is used to feed the family especially during the dry season when produce from livestock and crops is very little. The cash has become a lifeline for many of these families. (Respondent2, Interview, 2021)

Many use the money to buy food for their families. The families were previously relying on relief food during droughts that are common in this area. (Respondent13, Interview, 2021)

Items from A13 to A16 probed the influence of CT-OVC programme on access to water supply and sanitation. Findings also reveal that the access to clean water in beneficiaries' household (A13, mean=3.73), the time it takes to collect water (A14, mean= 3.53), access to improved water collection equipment such as water tanks by the household (A15, mean=3.14), and access to improve sanitation facilities such as flush toilet or pit latrines in the beneficiaries' household (A16, mean= 3.37) has remained the same as before they were enrolled to the CT-OVC programme (Table 4). These findings imply that the programme has not had a major influence on access to water in most of the households. This position is supported by qualitative data as no interviewee mentioned anything about CT-OVC money being used to improve access to water and sanitation.

Lastly, items from A17 to A20 queried the influence of CT-OVC on quality of housing. Results show that the quality of roofing (A17, mean= 3.22), flooring (A18, mean= 3.34), walling (A19, mean= 3.30), and lighting (A20, mean= 3.39) has remained the same as before the households were enrolled to programme. These findings imply that most beneficiaries' households do not use the money to improve the quality of housing. The study sought to determine how several elements

of the CT-OVC programme influence its effectiveness in improving the well-being of the beneficiaries' households. These elements include the programme structure, support services, and programme M&E.

An aggregate mean score was computed from all the 20 items that were used to measure well-being in order to determine the overall change in the household well-being after the kin was enrolled to the CT-OVC. Results show that the aggregate mean was 3.63, which indicate that on average, the well-being of the household on all the five indicators had become better after enrolling to the programme. The aggregate mean score was recoded to form a categorical variable for well-being with two categories (1= low improvement and 2= high improvement). Respondents, whose household had an aggregate mean score of less than 2.5, were categorised as 1 (low improvement), while those, that had an aggregate mean score of 2.5 and above, were coded as 2 (high improvement). This recoding sought to transform the data into the categorical form so as to enable the use of chi-square test. Table 4 summarizes this information.

Level of Well-Being Improvement	Frequency	Percent
Low Improvement	87	48.9
High Improvement	91	51.1
Total	178	100.0

Table 4: Distribution of Respondents based on Improvement in Household Well-Being

Results show that 87 respondents accounting for 48.9% of the sample had low improvement in their household well-being after enrolling to the CT-OVC programme (Table 4). On the other hand, 91 respondents accounting for 51.1% had high improvement. These results showcase that although, on average, the well-being of beneficiaries has improved, the improvement in not uniform in all household. There is a substantial section of the beneficiaries who have recorded low improvement in well-being after enrolling to the programme.

4.3. CT-OVC Support Services and Household Well-being

The third objective of the study was to examine the influence of CT-OVC programme support services on the well-being of beneficiary households in Kinango Sub-County. To assess this issue, respondents were asked to indicate whether they had received any additional services from the CT-OVC programme. Figure 1 sums up their responses:

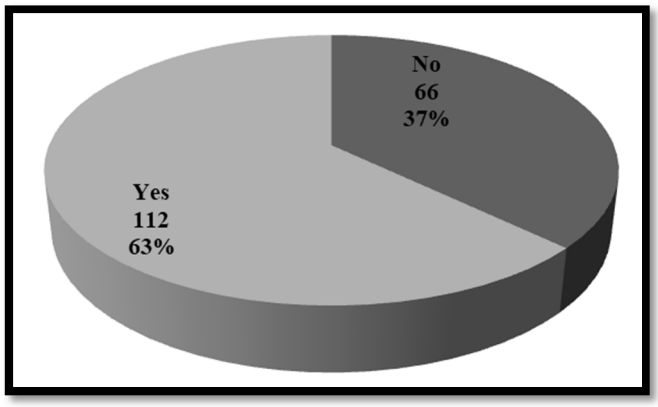

Figure 1: Whether Respondent Has Received Any Additional Services

The majority of the respondents (63%) have received additional services from the CT-OVC programme (Figure 1). These findings confirm that the programme does have support services and the majority of beneficiaries are recipient of the services. Respondents, who acknowledged receiving additional services, were asked to specify the type of additional service that they received in a follow-up question. Table 5 presents their responses.

		Responses		Percent of Cases
		N	Percent	
Type of Support Service	Financial Training/Advice	25	17.6%	22.3%
	Nutritional Education	51	35.9%	45.5%
	Entrepreneurial Training	44	31.0%	39.3%
	Bursary	22	15.5%	19.6%
Total		142	100.0%	126.7%

Table 5: Type of Support Service Received by Respondent

Results illustrate that nutritional education was the most frequently reported type of support services with 51 out of the 112 respondents who reported receiving additional services mentioning health insurance (Table 12). This figure means that 45.5% of all the respondents, who acknowledged to have received additional services, had received health insurance. This claim is also supported by qualitative data where one of the interviewees explained that the State

Department of Social Protection work with other partners and ministries to provide training to beneficiaries on areas such as reproductive health and nutrition.

The department works closely with development partners and other ministries to provide training to beneficiaries of government cash transfer programme in areas such as reproductive health and nutrition. We also provide guidance related to HIV/AIDS and refer cases to relevant ministries and partners for further assistance. (Respondent10, Interview, 2021)

Entrepreneurial training emerged second with 39.3% of respondents who receive support services having received this service. This finding implies that entrepreneurial training is also a central component of the CT-OVC programme. The finding is also supported by the interview data where some interviewees affirmed that CT-OVC beneficiaries are trained on how to start income generating activities.

The beneficiaries are organized into groups and trained by official from microfinance institutions on how to start income generating activities. (Respondent 13, Interview, 2021)

Bursary emerged third in the list of the most common support services having been cited by 19.6% of respondents who had received additional services. This implies that the CT-OVC programme also has provision for bursaries for individuals living with orphans and vulnerable children. This assertion is also confirmed by the qualitative data which revealed that the State Department for Social Protection runs the Presidential Bursary Fund that aims to provide education financing for vulnerable children. The data also showed that the department works with other partners to provide bursaries.

The department has the Presidential Secondary School Bursary Fund that we use to give bursary to very needy cases. Beneficiaries of the CT-OVC programmes are given priority in the allocation of this bursary. We also receive additional funding from USAID that also goes into provision of bursary to support needy cases. (Respondent10, Interview, 2021)

The final support service was financial advice cited by 22.3% of respondents who had received additional services. To examine the influence of support services on household well-being, the data on whether respondent had received support services or not was cross-tabulated with aggregate household well-being data. Table 6 presents the results.

		Improvement in Well-being		
		Low Improvement N (%)	**High Improvement N (%)**	**Total N (%)**
Whether respondent had received any support service	Yes	33 (29.5)	79 (70.5)	112 (100)
	No	54 (81.8)	12 (18.2)	66(100)
	Total	87 (48.9)	91 (51.1)	178 (100)
Pearson Chi-square (X2 = 47.915, df=1, p=.000)				

Table 6: Cross-Tabulation of Support Services and Well-being Improvement

In the category of respondents that had received some form of support service, the majority (70.5%) had recorded high improvement in their household's well-being (Table 13). On the other hand, in the category of respondents who had not received any support service, the majority (81.8%) recorded low improvement in the well-being of their households. The Chi-square test showed that the difference in the distribution of respondents across the four categories in the cross-tabulation is statistically significant. These results suggest that inclusion of support services has a significant influence on the well-being of beneficiaries' households. Household that receive some form of support service are likely to record high improvement in well-being than their counterparts that do not receive any support service. The qualitative data supported the position that support services have an influence on household well-being. The most domineering theme was that these services confer additional benefits that supplement the cash provided by the programme. Some interviewees also explained that some services such as nutritional training help to improve non-material aspects of well-being.

Support services provide additional benefits that complement the CT-OVC cash. For instance, HISP enables beneficiaries to access healthcare saving from spending the cash received from CT-OVC on health. Bursary also helps to pay education fee that the CT-OVC money cannot cover. (Respondent10, Interview, 2021)

The health and nutritional trainings ensure that beneficiaries are not only 'sorted' materially, but also get knowledge that will enable them to improve their lives. Family planning trainings have particularly helped women to manage their reproductive health leading to more manageable family size. (Respondent16, Interview, 2021)

These extracts from the interview suggest that support services have largely had a positive influence on the well-being of the CT-OVC beneficiaries' households. The findings support the position that integration of support services into cash transfer programmes adds value to the programmes.

4.5. Discussion of Findings

Findings revealed that the well-being of beneficiaries' households has improved since their enrolment in the programme mainly in terms of access to education for children, access to health care, and food and nutrition. These findings suggest that the CT-OVC programme has had a positive influence on these aspects of well-being. The findings are consistent with a survey by the World Bank (2019) which found that the implementation of cash transfers to households with orphans and vulnerable children increases birth registration, vaccination, and levels of education resulting in

enhanced child welfare both in the short and long-term. Specifically, the survey showed that 95% of children in households receiving the CT-OVC cash had enrolled or completed basic education, 81% had received all the recommended immunization, and 67% had birth certificates.

The findings are also congruent with the survey conducted by the Republic of Kenya (2020), which found the CT-OVC programme had led to increased attendance of schools, dietary diversity, enhanced food consumption, and utilization of health care services in beneficiary households. According to the Capability Approach theory, improving access to education, nutrition, and health enhances the freedom and capabilities of individuals and households leading to greater well-being (Sen, 1999). The sustainable livelihood framework also contend that enhancing household's access to food, education, and health leads to sustained improvement in well-being because these items enhance the households capabilities, assets, and means of living (Chambers & Conway, 1992). However, findings revealed that the situation in the households has remained the same as before they were enrolled to the programme in regards to access to water and sanitation and quality of housing. These findings imply that the CT-OVC programme has had little influence on the households' access to water and sanitation as well as their quality of housing.

The finding is inconsistent with the survey by the Republic of Kenya (2020), which found some evidence that households that benefitted from the Hunger Safety Net Programme (HSNP) were using the money to acquire non-productive assets such as housing materials and household items. The inconsistency could be attributed to the difference in HSNP disbursement amount and that of the CT-OVC programme. The HSNP allocates a higher amount of Kshs. 5400 per cycles as opposed to the Kshs. 4000 allocated in the CT-OVC programme. The inconsistency may also be explained by differences in contexts within which the two programmes are implemented. The HSNP programme mainly targets households that are affected by food shortage and is mainly implemented in the Northern counties of Marsabit and Turkana.

The study has found that the CT-OVC programme has integrated a number of support services with the most common being nutritional education followed by entrepreneurial training. Other support services include bursaries and financial advice. Results showed that the incorporation of these support services has a moderate and positive impact on well-being of beneficiaries' households. These findings are congruent with the study by Roelen *et al.* (2017), who observed that CT beneficiaries in Nicaragua, who received productive business grants in addition to the cash transfers, were more likely to venture into self-employment than those who only received the cash.

The findings are also consistent with Bastagli *et al.* (2016), who noted that integrating CT programmes with complementary services can magnify the impact of the programmes by enhancing the beneficiaries' access to information on a wide range of issues such as nutrition and hygiene, granting beneficiaries access to other programmes such as school feeding or health insurance, developing the beneficiaries skills in areas such as parenting or financial management, and transferring additional resources such as assets. Davis *et al* (2016) also noted that cash transfer on its own cannot attain optimum efficiency and thus need behaviour strainers in the form of nutrition education and financial security. According to DFID (2011), linking CT programme with complementary interventions help to tackle the multi-dimensional aspect of poverty. CT programmes that are implemented in isolation are less likely to ensure successful graduation of beneficiary from destitution.

5. Conclusions and Recommendations

Results show that access to education in beneficiaries' household has improved after they enrolled to the CT-OVC programme. This improvement is marked by improved enrolment of children of school going age into ECDE centres, enhanced school attendance, increased access to essential learning materials such as books and stationaries, and enhanced children' transitioning to secondary school. Access to some aspect of healthcare has also improved after CT-OVC enrolment signalled by enhanced access to all the necessary immunization by children in the household. The study also found that nutritional status has also improved with most families being able to access a balanced diet on normal day and get sufficient amount of food during meals. However, access to water and sanitation services as well as the quality of housing has remained the same as before the beneficiaries were enrolled into the programme.

The study established that the CT-OVC programme has integrated a number of support services with the most common being nutritional education. Other support services include entrepreneurial training, bursaries, and financial advice. The majority of the respondents held that the integration of such support services has a moderate and positive impact on the well-being of their households. The cross-tabulation with chi-square test showed that CT-OVC support services have a positive and statistically significant influence on the well-being of beneficiaries' households. Households, that receive some form of support service, are more likely to record high improvement in well-being than those that do not receive any support service. The study, thus, concludes that integration of support services has a positive and statistically significant influence on the well-being of beneficiaries' households and cash alone is not sufficient.

The findings have several implications on NSNP that is responsible for managing the CT-OVC programme in Kenya. NSNP should partner with Ministry of Health should roll-out the health insurance support programme to complement the cash transfers by providing access to subsidized health insurance to the beneficiaries' households. Results have shown that access to health insurance has remained same as before the programme. The NSP should consider investing integrating support services for helping beneficiaries to acquire water harvesting devices such as tanks or water pans. This will improve their access to water for use in the homes reducing the time and cost of getting water. Harvesting water may also support irrigation agriculture that could further boost the income and nutritional status of the households.

The NSNP should create awareness among beneficiaries regarding the existence of support services such as nutritional education, entrepreneurial training and bursaries. It was noted that despite all beneficiaries of CT-OVC being

eligible for HISP, not all beneficiaries have accessed this health insurance programme. The NSNP should also strengthen the health and nutritional awareness among CT-OVC beneficiaries. This will equip beneficiaries with the knowledge that they need to improve their health and nutritional status, which are critical aspects of well-being.

This study was limited to Kinango Sub-County in Kwale County. To facilitate generalization of findings, future studies should replicate this research in other areas so as cater for geographical and contextual differences. This study also limited its analysis to the CT-OVC programme. Future researches should consider comparing two or more cash transfer programmes so as to capture differences in structure, support services, and M&E as well as how each influences the well-being of beneficiaries' household. Future studies should also delve into factors that moderate the influence of CT-OVC programme on the well-being of beneficiaries' households. The study should consider how factors such as beneficiaries' education level, gender, family size, and family relation moderate the impact of the programme on household well-being.

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Appendix

Caregivers' Questionnaire

This questionnaire aims at getting your opinion on the Influence of cash transfer for orphans and vulnerable children programme on wellbeing of beneficiary households in Kinango Sub-County in Kwale County, Kenya. You are requested to participate in this study by filling in this questionnaire. You are assured that your responses will be for the purpose of this study. The information given will remain confidential. Do not write your name anywhere in this questionnaire. Answer all the questions by indicating your choice by a tick (✔) where appropriate or fill in the blank spaces.

Section A: Demographic Information

1. Please Indicate Your Gender
Male ( )
Female ( )

2. Kindly indicate your age in years
20 years and below ( )
21-30 ( )
31- 40 ( )
41-50 ( )
Above 50 yrs. ( )

3. What is your highest education level?
Primary level and below ( )
Secondary level ( )
Post-Secondary ( )

4. What is your occupation?
No economic activity ( )
Crop or Livestock Farming ( )
Trade ( )
Casual employment ( )
Long-term employment ( )

5. Which year did you start receiving the CT for OVC?
In 2016 ( )
In 2017 ( )
In 2018 ( )

Section B: Information Relating to Study Variables

I. Wellbeing of beneficiary households

6. How would you rate your household in the following areas since receiving the cash transfer? Use the following scale:

S/N	Statement	Much Worse,	Worse	Same As Before	Better	Much Better
	Education					
A1	Enrolment of children of school going age into early childhood development and education (ECDE)					
A2	School attendance by school going children					
A3	Access to books, stationaries, and other essential learning materials by school going children					
A4	Children transitioning to secondary schools to secondary school has improved					
	Health					
A5	Access to health insurance cover such as NHIF by all children					
A6	Access to all the necessary immunization by children in the household					
A7	Access to healthcare facilities					
A8	Amount of out-of-pocket healthcare expenses such as medicine and dental care					
	Food					
A9	Access to at least three meals in a day.					
A10	Access to a balanced diet on normal day (carbohydrates, protein, vitamin, minerals)					
A11	Access to sufficient amount of food during meals by all household members.					
A12	Consumption of foods that we prefer					
	Water Supply and Sanitation					
A13	Access to clean water in your household					
A14	Time it takes to collect water for household use					
A15	Access to improved water collection equipment such as water tanks by the household					
A16	Access to improve sanitation facilities such as flush toilet or pit latrines in your household					
	Housing					
A17	The quality of roofing in your house					
A18	The quality of flooring in your house					
A19	The quality of walling in your house					
A20	The quality of lighting in your house					

Table 7

II. Support Services

10. (a) Have you received any additional services along the cash transfers?

No ( )

Yes ( )

b). If yes in 11 (a) above, which additional services have received? Tick (✔) all that apply

Financial training/ advice ( )

Nutritional education ( )

Entrepreneurial training ( )

Others (Please specify) _____

Thank you for your participation.

Appendix B: Interview Guide for Programme Administrators

1) What is your gender? Male ( ) Female ( )
2) What is your age in years? ----------
3) What is the highest level of education you have completed? ----------
4) For how long have you served in your current position?.....
5) For how long have you served in this area.....

Household Wellbeing

6. How would you describe the wellbeing of the beneficiaries households since the stated receiving the cash transfers?
7. What do caregivers mainly use CT-OVC money for?
8. In your opinion, how has the cash transfer programme influenced the wellbeing of the beneficiaries' household?

Support Services

9. What support services does the CT-OVC programmes offer in addition to the cash disbursement?
10. What are your views regarding the influence of the support services on the wellbeing of the beneficiary households?