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Qualitative Assessment of the Implementation and Impact of the **Pilot Universal Child Benefit Programme in Kenya**

Authors

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Acronyms

BCFI	Baby Friendly Community Initiative
CCTP	Consolidated Cash Transfer Programme
CHV	Community Health Volunteer
CHEW	Community Health Extension Worker
CPV	Child Protection Volunteer
CSG	Child Support Grant
FGD	Focus Group Discussion
ECD	Early Childhood Development
IDI	In-depth Interview
KII	Key Informant Interview
MIS	Management Information System
NCPWD	National Council for Persons with Disabilities
NCPD	National Council for Population Development
NSPS	National Social Protection Secretariat
OVC-CT	Orphans and Vulnerable Children Cash Transfer
PWSD-CT	Persons with Severe Disabilities Cash transfer
QuIP	Qualitative Impact Protocol
SBCC	Social and Behaviour Change Communication
SDG	Sustainable Development Goals
TWG	Technical Working Group
UCB	Universal Child Benefit
UNICEF	United Nations Children's Education Fund

Executive Summary

Introduction

The Government of Kenya has made significant progress in expanding social protection coverage in the country and has a solid commitment to ensure coverage across the lifecycle. Although there have been substantial investments in Kenya's social protection system, children, particularly young children, are still not covered by social protection except for orphans and vulnerable children (Development Pathways, 2018). As a result, 10.9 million children in Kenya find themselves in monetary and multi-dimensional poverty (UNICEF, 2023). In response to the COVID-19 pandemic, the Government of Kenya piloted a Universal Child Benefit Programme for Kenyan children aged 0-36 months, with the objective of 1) cushioning children and their families from the lasting socio-economic impacts of the COVID-19 pandemic, 2) generating lessons for the introduction of a long-term UCB, and 3) strengthening advocacy efforts and visibility for the UCB. The Kenyan government piloted this programme over twelve months in select locations in Kajiado, Embu and Kisumu Counties.

The UCB Pilot

The focus of the research is the **Universal Child Benefit** (UCB) pilot implemented in three select sub-counties in Kenya **between December 2021 and December 2022**. The pilot provided universal cash transfers to all households with children under the age of 3 years. The Kenyan government transferred the cash to beneficiaries through Safaricom's M-Pesa mobile payment facility, totalling KES 800 monthly. Payments were delivered every other month to balance the costs of sending a transfer with the need for regular payments. During the design process of the UCB, the government of Kenya recognised the need for integrating complementary services alongside the cash transfers in response to the country's below-average scores across a range of human development indicators related to nutrition, violence against children (VAC), and disability inclusion. As a result, the programme incorporated various complementary services (or, cash plus) that were rolled out in conjunction with the cash transfers.

Key Design Elements of the Pilot UCB programme

- Universal design – All children aged 0-36 months residing in target areas
- KES 800 per month per child
- Transfers made bi-monthly to female caregiver, provided digitally through mobile money transfer for Safaricom known as M-Pesa
- "Cash plus" – Transfers combined with complementary interventions to address child malnutrition, negative parenting practices and the exclusion of persons with disabilities and their families from basic services

Objectives of the research

The research seeks to:

- Review the pilot's implementation, understanding how it was adjusted over time and why, identify barriers and facilitators to its implementation and examine how contextual factors may have affected its implementation.
- Investigate the extent to which the pilot's design was appropriate, accessible and acceptable for women, men, girls and boys that directly or indirectly benefited from it, as well as the wider community, implementers and government stakeholders.
- Investigate the experienced outcomes and reported causal pathways of change (unintended and intended consequences) for programme beneficiaries: men, women, boys and girls, and the wider community.
- Investigate the extent to which the pilot's design features and implementation mechanisms are sustainable and scalable.

Research Questions

1. **Was the programme implemented as intended and how did it adapt to lessons?**
   - 1.1 To what extent was the programme implemented as per the approved initial design? How was the pilot adapted over time, and if so, how and why?
   - 1.2 What were the main facilitators of, and barriers to, the pilot's implementation (including institutional structures)? What were the remaining challenges?
   - 1.3 How did contextual factors, such as economic and political context, and sub-national (county) legal frameworks affect the implementation of the pilot?
2. **To what extent were the components of the programme appropriate, accessible and acceptable for women, men, girls and boys that directly or indirectly benefit from it, as well as the wider community, implementers and government stakeholders?**
   - 2.1 To what extent did barriers exist for the beneficiaries in accessing the programme? Were girls, boys, women and men equally able to access UCB and associated services?
   - 2.2 How was the pilot, in terms of its design and objectives, perceived/accepted by women and men, including the wider community? How in particular was the targeting design, in terms of its universality and women as the main recipients, perceived by the community?
3. **What are the significant changes that beneficiaries identify in their lives during the pilot implementation because of the pilot? And what are the perceived causal drivers of those changes (causal pathways)?**
4. **To what extent are the pilot's design features and implementation mechanisms sustainable and scalable?**

Research Approach and Methodology

The research is qualitative in its research design, drawing on primary data collected through key informant interviews, focus group discussions and in-depth interviews with implementers, beneficiaries, and community members. The study is analytically structured into two components: a process research component, with the purpose of assessing the implementation of the pilot and informing future scale up opportunities, and a qualitative impact evaluation component, with the purpose of incorporating an impact analysis. The research methodology is further summarised in the table below.

TABLE 1: **SUMMARY OF RESEARCH APPROACH**

Research Question	Data Sources and Collection Methods	Analysis Approach
RQ1: Was the programme (UCB and complementary services) implemented as intended and adapting to lessons?	Desk review of programme documents, secondary literature, KIIs with programme implementers, FGDs with volunteers and beneficiaries, IDIs with beneficiaries	Thematic Analysis
RQ2: To what extent were the components of the programme appropriate, accessible and acceptable for women, men, girls and boys that directly or indirectly benefit from it, as well as the wider community, implementers and government stakeholders?	KIIs with implementers and FGDs and in-depth interviews with volunteers, beneficiaries and community members	Thematic Analysis
RQ3: What are the significant changes that beneficiaries identify in their lives (selected domains) in the period of the pilot implementation as a consequence of the pilot? And what are the perceived causal drivers of those changes (causal pathways)?	In-depth interviews with beneficiaries (women and men)	Causal Map Analysis
RQ4: To what extent are the pilot's design features and implementation mechanisms sustainable and scalable?	KIIs with implementers, FGDs with volunteers and beneficiaries	Thematic Analysis

Key Findings

RQ 1: Was the programme implemented as intended and how did it adapt to lessons?

Implementation of the UCB

As intended, the government and its partners collaboratively implemented the programme in all three counties. **The registration of beneficiaries was successful, with 91 percent of the originally identified households eventually being validated at the community level for participation in the pilot.** However, areas for improvement included communication around programme objectives and goals, and potential beneficiaries missed due to challenges in providing the necessary registration documents, such as birth certificates or national identification documents. Caregivers identified the distance required to travel to the civil registrar as a barrier to accessing birth certificates. Community volunteers and traditional leaders supported households in acquiring birth certificates, with local chiefs providing letters of support. Delays in the finalisation of the Management Information System (MIS) also led to manual payroll generation by an external firm with support from the local community, rather than through the Consolidated Cash Transfer Programme (CCTP) MIS. Later, the migration to the CCTP MIS resulted in a low cash transfer receipt in the months of July-August 2022, an exception in an otherwise regular cash transfer process. Overall, the number of recipients between first and last payment only differed by 3 percent, **suggesting a broadly successful payment delivery record**.

Community Health Volunteers (CHV) and Child Protection Volunteers (CPV) played an integral role in implementation of complementary services as they were the first points of contact in the community. CHV carried out home visits, initiated dialogue with household members, delivered key messages registered households, treated common ailments and implemented relevant protocols for Community-based Maternal and Newborn Health. CPV were trained in relevant child protection skills and they acted as advocates and bridges between local NGOS and child protection officers (Directorate of Children's Services), gathering data, providing first aid and referrals. The main modules of the complementary services were the positive parenting and nutrition training through mother-to-mother support groups and training groups. In certain communities, beneficiaries revealed they used the groups to organise a rotating savings fund, in which members take turns to receive accumulated funds. Beneficiaries and volunteers suggested that these activities further highlighted the value of the groups for strengthening community and social cohesion.

Regarding the disability component, according to volunteers, the fact that the disability training focused on referral mechanisms and support systems rather than broader sensitisation limited its effectiveness in terms of the popularity of these groups and, consequently, its effectiveness in increasing disability inclusion. In all communities, training was provided to the wider community members, not restricted to the registered household, and some groups eventually included engaged male spouses.

Regarding the monitoring of the pilot, it relied on information from monthly activity reports, MIS reports, financial reports, telephone interviews, and spot-checks. The post-disbursement monitoring was infrequent, however, due to resource constraints. Feedback mechanisms existed but were occasionally slow, particularly problematic for urgent cases, and volunteers struggled with limited sub-county officer capacity. The most common issue was non-receipt of cash transfers due to data discrepancies, leading to confusion about payment schedules. Delays in addressing grievances were attributed to data management challenges and lack of real-time data updates, complicating beneficiary support.

Facilitators and Barriers to implementation of the UCB

Facilitators of implementation

- Existing institutional structures in communities facilitated the programme rollout, leveraging primary care facilities, nutrition services, social development offices, and local government resources. The programme's successful rollout demonstrated capacity for scaling up.
- Successful cross-sectoral coordination at both community, county and national levels promoted smooth delivery of services, engaging all relevant stakeholders and increasing the programme's reach and support.

Barriers to implementation

- Limited capacity of social service officers in some areas, such as Embu, caused delays in referrals, highlighting the need for sufficient referral capacity to enhance programme effectiveness.
- Volunteers faced challenges including high workload, transport costs, delayed stipends, and lack of information about the UCB, affecting their capacity to implement the programme and respond to beneficiary inquiries.

Contextual factors affecting the implementation of the UCB

The implementation of the UCB was significantly affected by economic, political, and climate-related factors. Inflation from the global cost of living crisis reduced the purchasing power of the cash transfers, while droughts hindered the effectiveness of complementary nutrition training by making it difficult for households to maintain home gardens and leading to livestock deaths. These challenges made households more vulnerable, leading them to use the cash transfers for family-wide needs rather than for children. Political factors, such as the timing of the Kenyan general election in August 2022, also disrupted the programme, with rumours of forced voter registration affecting participation and delays in cash transfers being linked to political changes. Migration and economic pressures also reduced attendance at training sessions, as many participants prioritised income generation over the programme's activities.

RQ 2: To what extent were the components of the programme appropriate, accessible and acceptable for women, men, girls and boys that directly or indirectly benefit from it, as well as the wider community, implementers and government stakeholders?

Appropriateness

A majority of beneficiaries reported that the cash transfers and complementary services were appropriate, and they addressed their needs by increasing income and knowledge about good

nutrition and positive parenting practices. 67 percent of respondents in the QuIP research claimed to have improved their parenting practices during the intervention, with a majority of parents claiming to have reduced the use of violence in their parenting styles, suggesting the training was appropriate to the context.

The delivery of the transfers via mobile money was appropriate given the context where there is a high volume of mobile money transactions and existing knowledge of mobile money practices. Caregivers appreciated the benefits of the cash transfers, but also noted that the transfer amount was low and should have been increased in response to inflation. While this opinion was widely shared, QuIP findings suggesting the cash transfer led to improvements in health and food consumption outcomes imply that the amount was in fact broadly appropriate for the health and nutritional needs of beneficiaries.

Accessibility

Beneficiaries and programme implementers found the transfer component accessible to the majority of caregivers. There were, however, issues around access for beneficiaries who used other people's phones. Additionally, eligible caregivers lacking national identification were not able to register for mobile phone accounts which lead to their exclusion from the programme. Conversely, the plus component was found to be accessible to both beneficiaries and non-beneficiaries, in large part due to the volunteers who lived in the same communities as the caregivers.

Acceptability

A majority of beneficiaries and non-beneficiaries accepted the programme, and women were generally accepted as the primary beneficiaries of the transfer. While some volunteers and programme beneficiaries suggested **there were some tensions at the start of the programme related to women being chosen as the primary beneficiaries**, participation in positive parenting proved key to alleviating concerns. The universality of the design was also widely accepted. **While some implementers raised concerns about the economic sustainability of a universal cash transfer programme design, others emphasized its efficiency, particularly in simplifying the registration process and reducing the challenges of targeting specific groups. Finally, participants in all counties recommended that men should be included in the plus component**, as this was claimed to improve intrahousehold communication on a range of behaviours such as nutrition and positive parenting.

RQ 3: What are the significant changes that beneficiaries identify in their lives during the pilot implementation that can be attributed to it? And what are the perceived causal drivers of those changes (causal pathways)?

Cash transfers increased household income and the quantity and diversity of food consumption. These outcomes were particularly notable for food consumption by children. Participation in the training increased the diversity and quality of food for households, children and infants. This in turn led to positive health outcomes for children and households.

Training in childcare resulted in **better childcare practices for both mothers and fathers** in households, with noted reductions in the use of caning as a method of discipline, and improved relationships between parents and children. Further positive impacts on spousal marital relationships were reported by a majority of the beneficiaries.

After the pilot ended, recipients noted increased vulnerability to two external factors: the drought and the increase in the cost of living. In Ildamat, Kajiado County, the drought resulted in nearly all the livestock dying which destroyed the local livelihoods of the mainly pastoralist community. The high cost of living impacted both locations equally (Ildamat and Gitiburi, Embu County), which experienced reductions in income and food consumption, which was detrimental to child and household health outcomes. Comparing outcomes from before and after the pilot suggests **the pilot had protective impacts on the lives of recipients during these external shocks**.

RQ 4: To what extent are the pilot's design features and implementation mechanisms sustainable and scalable?

Complementary services in the UCB programme are sustainable and scalable due to the successful coordination between the variousactors in the sector, and existing institutional structures in communities (Child Protection Volunteers, Community Health Volunteers, Community Health Extension Workers). This promoted a common delivery front to the beneficiaries and the wider community. Training volunteers may have long-term benefits by strengthening the local social service workforce.

The cash transfer delivery mechanism through M-Pesa payments has both advantages and disadvantages to scalability. Mobile payments represent a reduction in opportunity costs as compared to account-based modalities such as the INUA JAMII programme. Furthermore, the pervasiveness of the mobile money infrastructure along with the existing know-how make this an attractive medium for scaling the UCB. However, the findings suggest that registration faced some challenges, and issues with phone ownership were cited. If these can be solved, mobile money payments provide a good method of efficient scaling of the programme.

At the national level, key informants suggested the integrated approach from Government institutions such as the Ministry of Health and the Department of Children Services contributed to a successfully coordinated communication with local delivery services, even if this communication may need to be improved across referral mechanisms and in defining institutional roles. The **success of this integrated approach suggests strong viability for the sustainability and scalability of the programme**.

While the data management structure went through significant changes during the pilot, t**he eventual transition to the CCTP MIS has proved to be an efficient step in providing a solid data management structure for future scaling**.

At the validation workshop, stakeholders also pointed out that **clarity was needed regarding the exit criteria for the programme and there were no linkages to other social protection programmes for children graduating from the UCB**. Stakeholders suggested that the government should

work towards universal coverage by first expanding programmes like Cash Transfer for Orphans and Vulnerable Children (CT-OVC) and Nutrition Improvements through Cash and Health Education (NICHE), and then linking these programmes with other social protection efforts to gradually build up to universal coverage.

Fiscal constraints were the main obstacle to scaling up the programme, but leveraging existing systems and institutions helped minimise additional costs.

Recommendations

Based on the findings, the study concludes with the following recommendations:

Regarding the pilot's design:

1. **Adjust the transfer value:** Ensure the cash transfer value is sufficient by adjusting it in real-time during economic shocks or indexing it to account for annual inflation. Consider differentiated rates for rural, peri-urban, and urban areas to curb the effect of inflation. The adjustment will safeguard the purchasing power of the transfer and enhance the programme's effectiveness in improving child well-being and nutrition.
2. **Expand the payment model:** Expand the options for receiving cash transfers to include banks in order to provide more accessibility for beneficiaries opting for bank institutions rather than M-Pesa.
3. **Engage male spouses:** Involve men in the training on nutrition and positive parenting to promote gender-transformative outcomes and a reduction in potential tensions as a result of women being the main targeted beneficiaries. This may also take the form of supporting positive parenting male champions in the community to enhance male involvement.
4. **Strengthen disability inclusion:** Disability training should go beyond the provision of information on referral systems and broadly sensitise all beneficiaries about disability inclusion. The training would also be strengthened through adequate engagement of Child Protection Volunteers and linkages with the National Council for Persons with Disabilities.

Regarding the pilot's implementation:

1. **Strengthen communication and sensitisation:** Improve communication and sensitisation processes during registration and programme implementation to increase procurement of identification documents, increase uptake, reduce exclusion, and enhance community awareness. Address misinformation and rumours through effective early and continuous communication.
2. **Strengthen targeting and registration processes:** By harmonising registry and information systems and promoting timely birth registrations. Specifically:
    a. Enhance interoperability and the integration of various government systems (National Registration Bureau, Civil Registration Services, Pension Scheme, CCT MIS, enhanced single registry) to streamline the targeting and enrolment process and ensure maximum validation of beneficiaries.
    b. Embed the registration process of the programme into the unified social registry. This will help to harmonise and integrate the UCB into the national social protection system.
    c. Provide continuous sensitisation to communities on the need for child-birth certificates and identification documents to reduce the chances of exclusion of the programme.

d. Newly born children at health facilities to be registered at birth and parents sensitised on the need for immediate certification. Creating linkages between Community Health Volunteers and community leaders to promote community birth registration and certification and hence enrolment into the UCB programme at the same "service window".

3. **Establish a comprehensive institutional framework:** Create a comprehensive institutional framework that defines the roles, responsibilities, and monitoring processes. According to several national key informants, a framework clearly defining the responsibilities of each department would improve the efficiency of government stakeholders in addressing challenges that range from child social protection to health and nutrition.
4. **Ensure cash transfer regularity:** The regularity and predictability of cash transfers are essential. Implement improved planning, data collection, verification processes, and monitoring to promptly address payment delays.
5. **Improve feedback mechanisms:** Develop effective feedback mechanisms to address implementation challenges. Problems and complaints regarding the delivery of cash transfers were not addressed on time, highlighting the need for better structural allocation of responsibilities for monitoring, and grievance response mechanisms.
6. **Invest in community-level social service and volunteer capacity:** To improve the implementation of the UCB, consider improving the referral system and providing additional support for volunteers. Increasing the availability of social service officers and improving the existing feedback mechanism would ensure timely action on referrals. On the other hand, volunteers need greater financial and logistical support, including higher stipends and timely payments to cover transport costs. Additionally, providing clear, up-to-date information about the programme will enable volunteers to address beneficiaries' concerns effectively.
7. **Ensure scalability and greater coverage for children:** Consider increasing the fiscal space for the UCB by ring-fencing funds. In order to attain progress towards universal coverage, the government can strengthen linkages to other social protection programmes for children graduating from the UCB e.g. Cash Transfer for Orphans and Vulnerable Children (CT-OVC) and nutrition improvements through cash and health education (NICHE). This would also enable progress towards a lifecycle approach for social protection coverage of children, while building resilient families.

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1 Introduction

The Government of Kenya has made significant progress in expanding social protection reach in Kenya, displaying evidence of a solid commitment to ensuring coverage across the lifecycle. Expansion of the Older Persons' Cash Transfer (OPCT) to everyone over 70 is one of the commitments representing an essential step towards the universalisation of social protection. While investments in Kenya's social protection system have led to significant developments across the last decade, children, particularly young children, still often do not have access to social protection. As per the last sector review, in 2017, only 10 per cent of children in Kenya were part of a household receiving a social protection transfer (Kidd et al., 2019). The coverage levels of children under five are likely even lower, despite the importance and value of investing in children in the first 1,000 days (Cusick & Georgieff, 2016). Considering the demographic distribution in Kenya, in which children under 14 make up over 39 per cent of the total population (KNBS, 2019), this represents a significant gap. It is crucial to improve coverage to build human capital and allow the country to harness potential demographic dividends.

Given this gap, a pilot for a Universal Child Benefit (UCB) was conceived, informed by the following guiding elements: a) the impact of COVID-19 on households and children, b) the commitment to ensuring that no child is left behind, and the potential errors that poverty targeting can result in, c) the administrative ease with which a universal benefit can be implemented, d) the UCB as a priority item in the Social Protection Policy, Sector Review and Strategy, and e) the increased support that a universal scheme will have in communities. Not only can universal benefits minimise the administrative costs of targeting, serve as an additional economic stimulus, and increase the shock-responsiveness of households and communities, but specifically targeting children at an early age is a smart investment due to the high returns that investing in children reaps (Barba et al., 2020; Kidd et al., 2020). Furthermore, protecting and ensuring the well-being of children through social protection is a pathway to supporting the realisation of rights and the fulfilment of basic capabilities (ODI & UNICEF, 2020).

BOX 1: RATIONALE FOR THE UCB PILOT PROGRAMME IN KENYA

The High-level design of the UCB recognizes the rationale for a UCB in Kenya to be driven by:

- Covid-19 exacerbated poverty and created the need for an economic stimulus
- UCBs are recognized globally as effective and shock-responsive measures for addressing child poverty and giving every child a great start in life
- A UCB would fulfil children's rights while boosting socio-economic development
- Poverty-targeting mechanisms are often expensive and not fully accurate

Source: Design of the UCB Pilot programme

Since 2020, a Technical Working Group (TWG)[1], led by the National Social Protection Secretariat (NSPS) has been spearheading work on the realisation of a Universal Child Benefit programme in Kenya. Work so far has included a study mission to South Africa, to learn from the experiences of the implementation of the Child Support Grant (CSG), technical assistance in the form of research exploring the potential challenges of a UCB, roll-out options and a fiscal space analysis.

These efforts culminated in the agreement to test the potential of a UCB in a pilot intervention rolled out over a year in select locations in three counties in Kenya. With the support of, and in collaboration with UNICEF, the World Food Programme and Save the Children, the pilot UCB programme was rolled out at the end of 2021. This pilot consisted of a universal cash transfer, complemented with a variety of services (cash plus), driven by the recognition of the need to integrate complementary services in response to the country's below-average scoring across a range of human development indicators related to nutrition, violence against children (VAC) and disability inclusion.

This pilot UCB programme forms the focus of this research. The research seeks to generate evidence in terms of its implementation and its impact on communities, with the objective of informing future investments into child-sensitive social protection in the country.

1 Members of the TWG include: DSA, NSPS, NCCS, Division of Nutrition and Dietetics, MoH, NCPWD, DCS, Child Welfare, UNICEF, WFP, ILO, Save the Children, KNBS, SDSP Planning Unit, DSD, and the Street Families Rehabilitation Trust.

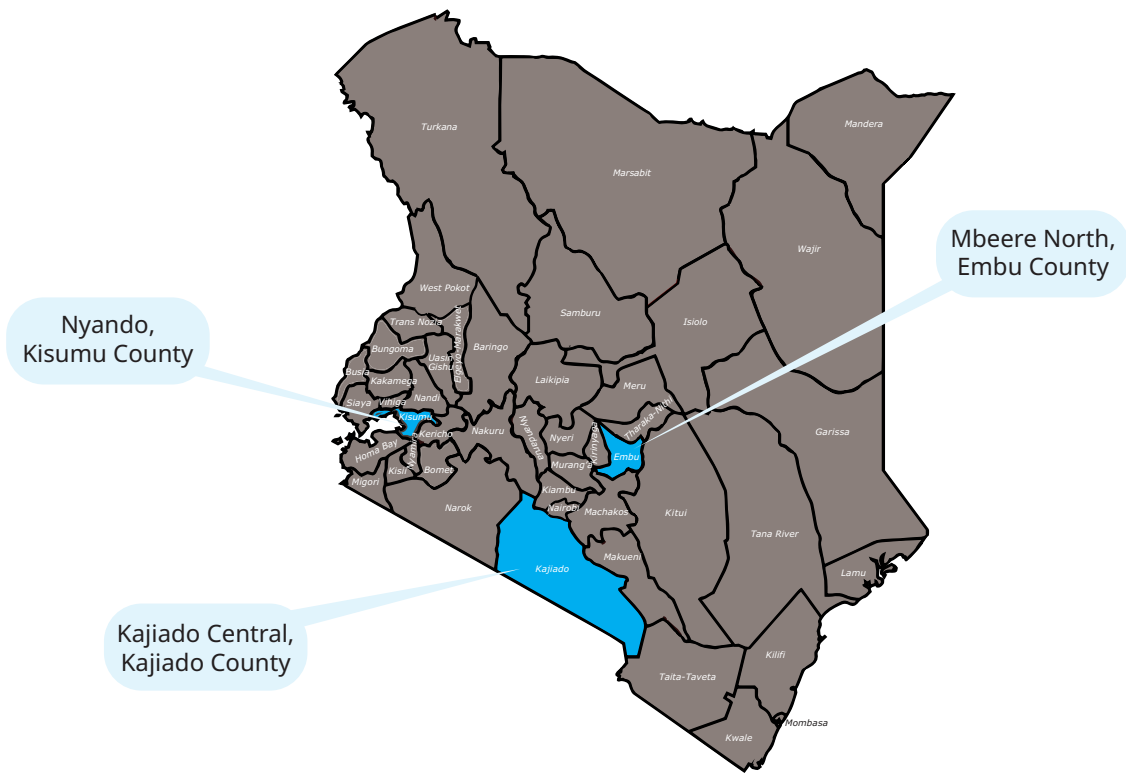
2 The Universal Child Benefit Pilot Programme

This chapter presents and introduces the object of the research, the Universal Child Benefit (UCB) pilot programme. It draws on the programme's operational manual, the UCB design note, as well as additional documents such as the Baseline Report (Ministry of Public Service, Gender, Senior Citizen Affairs and Special Programme , 2022), the Registration Report (CHASP Advisory 2021) the feasibility study for the design of a UCB in Kenya (Development Pathways, 2020).[2]

2.1 Scope and location of pilot

The Government of Kenya implemented the pilot in locations selected based on 1) their representation of diverse contexts (mixing rural, peri-urban and urban contexts), 2) the number of children relevant to the fixed budget of the programme, and 3) a good presence of implementing institutions and relatively high malnutrition rates (CHASP Advisory, 2021). These included Nyando in Kisumu County, Kajiado Central in Kajiado County, and Mbeere North in Embu County. Within each sub-county, communities were selected.

FIGURE 1: **LOCATION OF PILOT**



2 Such as the Baseline report for the study which provides an overview of the locations of the pilot, the Process Registration report, which provides insight into the registration processes.

Kajiado County's programme locations included: Kajiado Township and Ildamat in Kajiado Central. In Embu County, the programme locations included Riandu, Nthawa, Gitiburi and Thura in Mbeere North Sub-County. While in Kisumu County, the sites were Kakola and Kochogo in Nyando Sub- County.

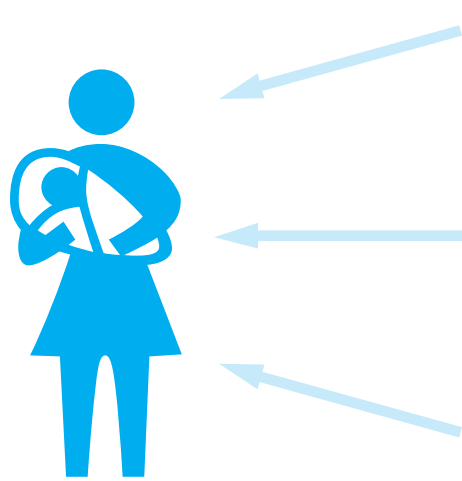
Evidence collected in the baseline survey confirms that most households in all areas are income poor, with households earning between KES 6,000 and 10,000 per month and only a very small percentage earning above KES 30,000 (1.9 per cent). Incomes are slightly higher in Kajiado Central due to increased employment opportunities and proximity to Nairobi. In Mbeere North, over 50 per cent of caregivers were engaged in farming activities, while in Kajiado Central, this constituted less than 10 per cent. Across all locations, formal employment formed the least common income source. Across the sub locations, the mean age of the household was 35.5 years and 79 per cent of them were male- headed.

2.2 Design of the programme

2.2.1 Design of the cash transfer

The pilot's design outlines the provision of a universal cash transfer of KES 800 to all households with a child under the age of three. The transfer was to be paid every other month to balance the costs of delivering the transfers versus the benefits of providing regular transfers to households. In deciding upon the value amount, there was a trade-off between the transfer value and the number of children who could participate: a higher transfer value meant fewer children could be included. However, a higher transfer value also led to greater impacts on child wellbeing. The chosen transfer value was KES 800 per month, which was intended to strike a balance between delivering significant benefits to children and maximizing the number of children who could be included within the fixed budget. This amount was approximately the minimum recommended to boost family spending and enhance child wellbeing. The KES 800 monthly transfer represented about

FIGURE 2: SUMMARY OF UCB PILOT DESIGN



Universal Design

- Children aged 0-36 months
- Female caregivers as the primary recipient

UCB Transfer

- Payments made bi-monthly, diitally through Safaricom's M-PESA platform
- KES 800 per month

Cash plus

- Nutrition
- Positive Parenting/Chid protection
- Disability Inclusion

39 percent of the consumption for a young child in Kenya and 71 percent for a young child in the poorest 30 percent of the population (Development Pathways, 2020). It amounted to around 4.7 percent of GDP per capita for each recipient child, which is roughly the median transfer value provided by universal child benefits globally (Ortiz et al, 2017).

The cash transfer is designed to be provided to households with pregnant mothers and with children under 3 years of age. While neither the programme design nor the operational manual outline the rationale for this, it is informed by the wider global evidence around the effectiveness of providing transfers to women. Even so, the operational manual recognises that in many cases the female caregiver may not be the mother but rather grandparents or other family members. In the case of no female caregiver, the transfer would go to an alternative caregiver.

When deciding on the age range for child beneficiaries, a key consideration for the pilot was balancing the scope of the programme with its effectiveness. By limiting eligibility to children aged 0-2 years (up to their third birthday), the programme could be implemented across three counties more effectively. This age range ensured that the pilot covered the critical first 1,000 days of life, a period crucial for establishing a child's developmental foundations (Cusick & Georgieff, 2016). Evidence shows that investing in this early stage yields the highest returns as it is essential to provide good nutrition to prevent stunting and micronutrient deficiencies (Heckman, 2008).

2.2.2 Design of the complementary services

The programme incorporated various complementary services that were implemented alongside the cash transfers, intending to improve human development outcomes across several domains. The activities and services are structured around three thematic areas – nutrition, positive parenting, and disability – with services offered and links in the community to be driven by existing infrastructure. These complementary services included a range of social and behavioural change communication (SBCC), counselling and training opportunities, facilitated by Community Health Volunteers and Community Protection Volunteers, and referrals that would allow the volunteers engaging with the households to refer them to specialist services as needed. The programme consisted of the following:

- **Nutrition:** The nutritional component of the programme included nutrition counselling, social and behaviour change communication (SBCC) and referrals to specialised nutrition services. The national guidance from the "Baby Friendly Community Initiative (BFCI)" formed the cornerstone of this.
- **Positive Parenting:** The positive parenting component of the programme focused on positive parenting practices through the delivery of community dialogues, parent groups, and sensitisation through home visits. The information was drawn from existing national guidelines and national positive parenting guidelines that were under development at the time of programme design.
- **Disability:** The disability component was designed to be integrated across the nutrition and positive parenting components. Activities included community dialogues, parent groups and weekly and monthly home visits as well as disability certification and support for assistive devices applications.

Beyond the above, a variety of broader awareness-raising and SBCC activities for each area were outlined, as can be seen in the following table, which summarises the type of services initially designed and the outlined objective of each area of activities.

TABLE 2: **OVERVIEW OF COMPLEMENTARY SERVICES AS OUTLINED IN THE OPERATIONAL MANUAL**

Area	Type of Services	Objective
Nutrition	Services provided by community volunteers and programme staff: • Radio jingles • Distribution of IEC materials • Voice Messaging • Bulk messaging • Individual counselling and monthly growth monitoring home visits • Mother-to-mother support groups and other caregivers support groups	1. Seek to increase demand for available services. 2. Drive the adoption of recommended practices among caregivers.
	Referrals to External Services: • Drama groups or pre-recorded dramas • Food demonstrations • Malnutrition treatment • Micronutrient supplementation • ECD-baby Friendly Spaces	
Positive Parenting	Services provided by community volunteers and programme staff: • Parent groups • Household sensitisation through weekly household visits by community volunteers • Social media Campaign (targeted at communities) • Community dialogues (to communities) • Distribution of Information, Education, Communication (IEC) materials on positive parenting	1. Help parents feel confident by validating the love and care they already provide to children. 2. Help parents learn more about how children develop based on evidence. 3. Give parents the chance to practice skills and techniques that may make parenting easier and are based on evidence. 4. Help caregivers give information on COVID-19 and manage its effects on children.
	Referrals to external services: • Psychosocial support services • Legal services (linked to child protection issues) • ECD/baby-friendly spaces • Linkage and reporting into the Child Protection Information Management System (CPIMS)	

Area	Type of Services	Objective
Disability	Services provided by community volunteers and programme staff: • Social media campaign • Community dialogues • Distribution of IEC materials • Voice messaging • Bulk messaging • Parents groups • Weekly and monthly home visits for positive parenting and nutrition support • Disability Certification • Support in applying for funding to acquire assistive devices	1. To ensure disability inclusion within the programme. 2. To support better stimulation, counselling, and parenting of children with disabilities to ensure better development and protection of children with disabilities. 3. To focus on increasing access to social services for children and caregivers with disabilities by linking them to the National Council for Persons with Disabilities (NCPWD) through the Department of Social Development (DSD) for disability registration and certification process.
	Referrals to external services: • Psychosocial support services • Specialised health services	

Source: Authors' elaboration based on the Operational Manual of the Programme

2.3 Programme implementation

2.3.1 Roles and responsibilities in implementation

The programme was implemented by the State Department of Social Protection (SDSP), Senior citizens affairs and Special Programmes under the Ministry of Public Service, Gender, Senior Citizens Affairs and Special Programmes (MPSYG), and the National Social Protection Secretariat (NSPS) served as the coordinating lead. Additional departments involved in the implementation included the Directorate of Social Assistance (DSA), the Department of Children's Services (DCS), and the Department of Social Development (DSD). The Ministry of Health (MoH) provided cross-sectoral support, along with the National Council for Children's Services (NCCS), and the National Council of Persons with Disabilities (NCPWD).

The programme was implemented in collaboration and with the support of UNICEF, WFP and Save the Children. The support included technical and financial assistance split between the three partners. WFP financed the baseline study and provided technical advisory to the development of the Management Information Systems for the programme, UNICEF financed and supported the delivery of the cash transfers, and Save the Children supported the rollout of the complementary services by providing capacity building for the communities and implementers.

At county and sub-county levels, programme delivery is embedded in the existing institutions and local structures. These include the relevant County and Sub-County departments of the national institutions, and the National Government Administration Officers (NGAO). In particular, the complementary services and their delivery draw on existing capacity and structures, including sectoral officers and volunteers.

2.3.2 Implementation of the cash transfer

The high-level design for the programme outlines that the programme is to make use of the existing Consolidated Cash Transfer Programme (CCTP) Management Information Systems (MIS), through a complementary module specifically designed for the programme.

The delivery of the transfer was to be made by Safaricom (under an existing UNICEF contract with the provider). The Operational Manual also outlines alternative payment processes for households using other mobile money providers. Requirements for the receipt of payment therefore included a SIM card registered with Safaricom in their name or an alternative provider and a mobile phone.

2.3.3 Implementation of the complementary services

The design and delivery of these services drew on existing capacity and social service workforce in the communities and therefore did not involve additional staffing. At the local level, this includes the departmental offices of the Department of Children's Services (DCS), Department of Social Development (DSD) and the Ministry of Health. Volunteers were directly engaged in the delivery of the complementary services. The term volunteers is used to refer to the Community Health Volunteers (CHVs), Child Protection Volunteers (CPVs) and Lay Counsellors, all of which are lay people in the community who received training to provide additional support in the community across specific areas (see Box 2 for further detail on the role of these volunteers).

BOX 2: ROLE OF VOLUNTEERS IN SOCIAL SERVICE DELIVERY IN KENYA

The design of the pilot designates the community volunteers as the first point of contact regarding the programme in the community. Volunteers are engaged across specific sectors to support the delivery of government services in this sector.

- Community Health Volunteers, supervised by Community Health Extension Workers, carry out home visits, initiate dialogue with household members, deliver key messages and necessary action, register households, treat common ailments and implement relevant protocols for Community-based Maternal and Newborn Health (CHW central, 2020)
- Child Protection Volunteers have been trained in relevant child protection skills. Their specific functions include acting as advocates and bridges between local NGOS and child protection officers, gathering data, providing first aid and referrals (CPC Learning Network, 2021)

The operational manual outlines that volunteers will form the first point of contact for the programme beneficiaries, while the government officers have wider implementation and coordination responsibilities (roles further summarized in Table 3).

TABLE 3: **Overview of Roles in the Local Delivery of the Programme**

Community officers/Volunteers involved in implementation	Role
County Social Development Officer	Supervision, oversight and technical guidance for programme implementation and delivery of programme components
County Children's Coordinator	
County Child Protection Officer (SCI)	
County Nutrition Coordinator and Nutrition officer (SCI)	
Sub-county Social Development Officer	Supervise all lay counsellors and positive parenting activities
Sub-county Children's Services Officer	Supervise all Child Protection Volunteers and coordinate all case management and referral services
Sub-county Nutrition Officer	Supervise all Community Health Volunteers and coordinate all nutrition activities
Community Health Extension Worker (CHEWs)	Professionally trained health workers supervising and monitoring activities
Community Health Volunteer (CHV)	Implement nutrition sensitisation, counselling, monitoring and referral activities
Lay Counsellor (volunteer)	Lead on all counselling and sensitisation activities for the positive parenting component
Child Protection Volunteer (CPV)	Lead and implement case management and referral activities for the positive parenting component

3 Research scope and methodology

This chapter provides an overview of the overall study design and the rationale of the two research approaches. It introduces the conceptual framework, sampling design, and provides an overview of the data collection processes and ethical considerations. It concludes with an overview of the analysis methods and the limitations of the study design.

3.1 Research objectives and questions

3.1.1 Research objectives

The purpose of this research is to evaluate the pilot programme, with a focus on its implementation and impact. The research serves to generate insights to inform the potential design and implementation of a wider national UCB programme, as well as build the evidence base for child-sensitive social protection. Aligned with the objectives of the pilot, the relevance of a universal programme for children in Kenya and the on-going work around its development, the study seeks to:

- Review the pilot's **implementation**, understanding how it has been adjusted over time and why, identifying barriers and facilitators, and understanding how contextual factors may have affected it.
- Investigate the extent to which the pilot's **design was appropriate, accessible and acceptable** for women, men, girls and boys that directly or indirectly benefitted from it, as well as the wider community, implementers and government stakeholders.
- Investigate the **experienced outcomes and reported causal pathways of change** (unintended and intended consequences) of the programme for its beneficiaries: men, women, boys and girls, and the wider community.
- Investigate to what extent the pilot's design features and implementation mechanisms are.

3.1.2 Research questions

The study is structured around the following four key research questions. These research questions are complemented by a variety of sub-questions that allow for their unpacking.

1. **Was the programme implemented as intended and how did it adapt to lessons?**
   - 1.1 To what extent was the programme implemented as per the approved initial design? How was the pilot adapted over time, and if so, why?
   - 1.2 What were the main facilitators of, and barriers to, the pilot's implementation (including institutional structures)? What were the remaining challenges?
   - 1.3 How did contextual factors, such as economic and political context, social and gender norms, affect the implementation of the pilot? And, how did gender norms affect the implementation of the cash transfer delivery to women?
2. **To what extent were the components of the programme appropriate, accessible and acceptable for women, men, girls and boys**

that directly or indirectly benefit from it, as well as the wider community, implementers and government stakeholders?

2.1 To what extent did barriers exist for the beneficiaries in accessing the programme? Were girls, boys, women and men equally able to access UCB and associated services?

2.2 How was the pilot, in terms of its design and objectives, perceived/accepted by women and men, including the wider community? How in particular was the targeting design, in terms of its universality and women as the main recipients, perceived by the community?

3. **What are the significant changes that beneficiaries identify in their lives (selected domains) in the period of the pilot implementation as a consequence of the pilot? And what are the perceived causal drivers of those changes (causal pathways)?**
4. **To what extent are the pilot's design features and implementation mechanisms sustainable and scalable?**

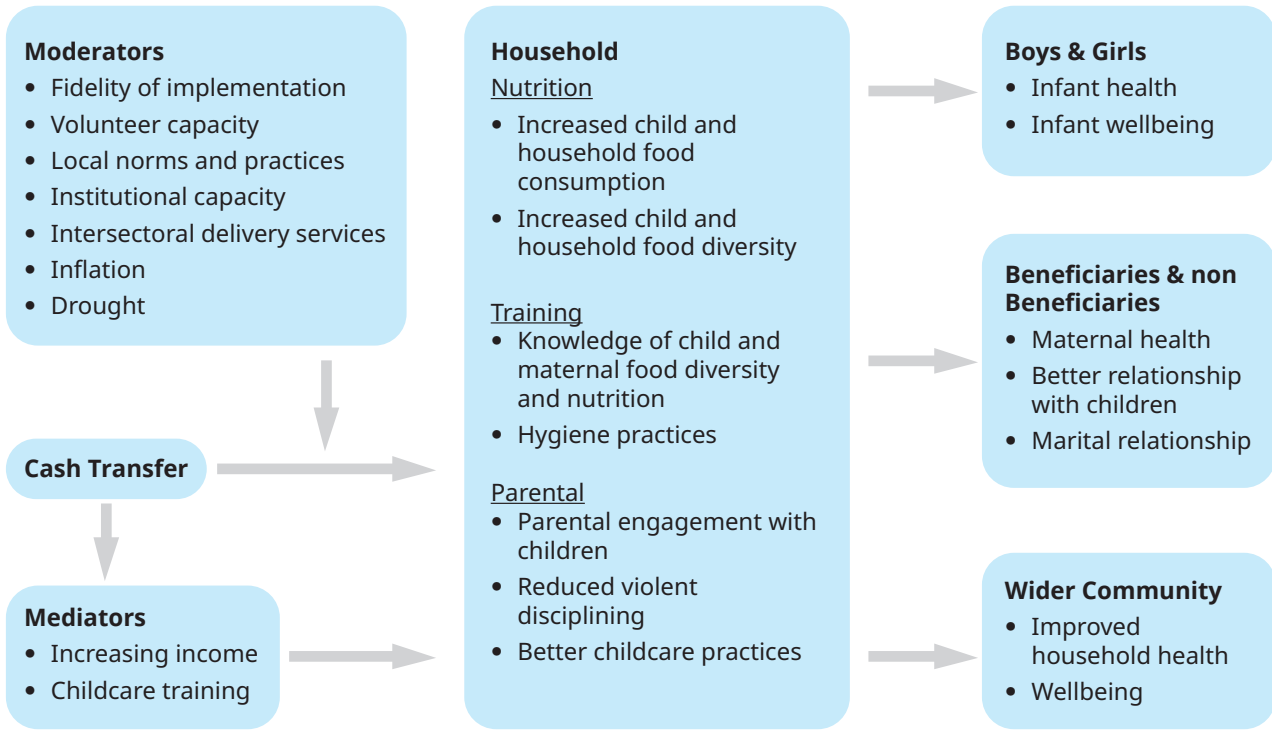
3.2 Conceptual framework

In framing the research design and analysis of the report, Figure 2 was conceived as the guiding conceptual framework. This framework exemplifies how the UCB can influence household activity, the causal pathways involved, and the potential moderator and mediator factors. The impact of the transfer is likely to work through key mechanisms (mediators). Women's bargaining power is one such key mechanism, since the cash transfer recipients of the UCB are female caregivers. Additionally, community level mechanisms such as the fidelity of implementation, institutional capacity, volunteer capacity, intersectoral delivery of services, local norms and practices, inflation, and drought, will also be critical mediators of outcomes.

The impact of the programme on children, adults, and the community will be achieved through household-level changes. For example, the cash transfer is expected to increase spending on more diverse nutritious foods, which improves food security and nutrition. The cash transfer can also be used to invest in non-farm and farm activities which generate income and can influence the labour allocation to unpaid and paid work by household members, with paid work generating income.

Regarding complementary services, training such as the nutrition counselling and SBCC can enhance nutrition knowledge, while positive parenting sensitisation can improve parenting practices such as child discipline. These household-level impacts would ultimately lead to improvements in child health, nutrition and wellbeing, enhanced wellbeing of adults (men and women) better relationships (parent and child, spousal), and ultimately better health and wellbeing in the wider community.

FIGURE 3: **CONCEPTUAL FRAMEWORK FOR UNIVERSAL CHILD BENEFIT UCB PILOT**



3.3 Research design

The research utilises a qualitative research design split into two components, that align to the research questions. The study consists of:

- **a process research component,** which focuses on Research Questions 1, 2 & 4 to assess and capture how the pilot was implemented and inform future scale-up opportunities; and
- **a (qualitative) impact evaluation component,** focussing on Research Question 3, with the purpose of incorporating an impact perspective.

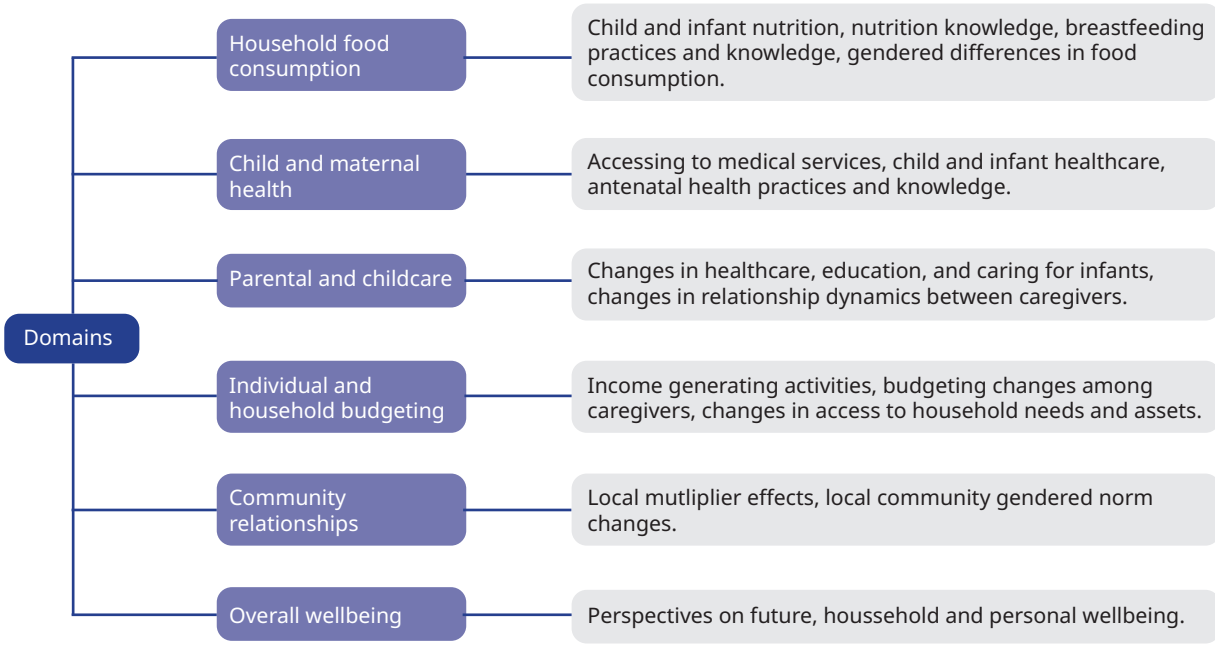
A process study is concerned with the first three segments of the programme logic model (inputs, activities and outputs) and how they work together to produce outcomes, thus focusing on understanding the how's and why's of implementation. The process research seeks to understand how the Kenyan government implemented the programme, its successes and challenges, bottlenecks and facilitators, and specifically generate evidence around lessons learned and what worked. The study assesses the fidelity of the implementation by assessing

the various programme elements: registration and delivery of payment, the provision of complementary services (nutrition, positive parenting and disability inclusion), and the grievance management processes. Furthermore, the study seeks to investigate the enablers, barriers, constraints, and challenges experienced at the various stages of implementation. These include consideration across a breadth of areas, including institutional capacity and coordination – the extent to which implementing partners and contributing sectoral stakeholders can create synergies, the perceived issues faced by implementers at the various levels of governance – national, subnational and community, financial and budgetary constraints as well as any other. Finally, the study also seeks to explore the relevance of the programme design by considering the appropriateness, acceptability, and accessibility of the programme. The study also explores how the programme interacts with local gender norms by considering the acceptability of women as the primary recipients of the cash transfer.

The Qualitative Impact Protocol (QuIP) is an impact assessment method devised by the Centre for Development Studies at the University of Bath, United Kingdom (now developed and curated by Bath Social & Development Research Ltd – www.bathsdr.org). It is designed to collect credible information directly from intended beneficiaries on significant drivers of change in selected domains of their life (based on the project's theory of change) and what respondents perceive to be the reasons for those changes over a predefined period. The method is beneficial in complex contexts where various factors that are hard to disentangle could influence the outcomes of an intervention. Narrative data collected by 'blindfolded' independent field researchers (who have little, or no knowledge of the hypotheses being tested) is cross analysed against the project activities to identify unexpected and anticipated drivers of change. Partial or total 'blindfolding' -the method by which researchers and respondents are not made aware of the commissioning partners of the specific objective of the study - is an essential element in mitigating the problem of pro-project or confirmation bias that is otherwise regarded as a significant weakness in qualitative research on Universal Child Benefit interventions.

While the QuIP methodology does not seek to quantify the impact, and therefore does not provide treatment effects or statistically representative results, it serves to highlight evidence and stories around change. It checks the consequences of a given intervention, such as the cash transfer and associated services. The QuIP involves focusing on specific domains or outcome areas related to the programme's theory of change, which are examined to understand whether any changes across the outcome areas (see Figure 4) can be attributed to the intervention. The following domains were selected for the study, based on the outlined conceptual framework in the operational manual: household food consumption, child and maternal health, parenting and childcare, individual and household budgeting, community relationships and overall well-being, which are captured in Figure 4 below.

FIGURE 4: **QUALITATIVE COMPONENT DOMAINS EXPLORED BY THE QUIP**



Source: Authors own

3.4 Sampling

3.4.1 Process Research sampling

The process research draws on primary data collected through Key Informant Interviews (KIIs) focus-group discussions (FGDs) and in-depth interviews (IDIs). Data collection took place at the national level and in one community in each of the counties. Locations for data collection were selected based on variation in size of the location and number of children registered for the programme and in collaboration with the QuIP sample selection process to minimise any possible cross-contamination between the two. Data collection took place in Kajiado Central in Kajiado County, in Riando and Thura in Embu County and in Kakola in Kisumu County. In each location, focus group discussions, key informant interviews and in-depth interviews were carried out, with the objective of understanding local pathways of implementation and experiences with the programme. These interviews sought to gather different perspectives around programme implementation and experiences of the programme in the select communities.

The data collection methods purpose and sampling strategies are outlined below.

• Key Informant Interviews

Ten key informant interviews were carried out with relevant programme implementers and stakeholders at the national level, while at subnational level, eight key informant interviews were carried out with implementers. Participants were purposively selected based on their involvement in the implementation of the pilot. At the county and sub-county levels, selected informants included were Children's Officers, Nutrition Officers and Social Development Officers.

Informants were selected based on the information provided in the programme manuals and other documents and with support from the UNICEF Country office and the National Social Protection Secretariat. At local level, in Kajiado Central, Mbeere North and Nyando, respondents were identified through appropriate procedures with local-level implementers.

TABLE 4: **KIIS FOR PROCESS RESEARCH**

Type	Number
KIIs with national governm ent representatives and implementers, and development partners	10
KIIs with sub-county officers, including nutrition officers, social development officers and child protection officers	8
Total	**18**

• Focus Group Discussions (FGDs)

Focus group discussions with members from beneficiary households were carried out. These were split into focus group discussions with female primary caregivers (the direct recipients of the cash transfer) to better capture the caregiver's direct experience with the programme and with spouses of female caregivers to also capture other household members' experience and perceptions, in particular, perceptions regarding women as the transfer recipient.

In addition, focus group discussions were also held with non-beneficiaries, with the objective of understanding perceptions and knowledge on the programme.

In addition, focus group discussions with the various volunteers involved in delivering the complementary services were also held. These served to gather information around the implementation of the programme, the involvement of the volunteers in the delivery of services and their perceptions on the overall programme. Each focus group was formed of 8-12 participants.

TABLE 5: **FGDS FOR PROCESS RESEARCH**

Type	Number
FGDs with Female Caregivers	3
FGDs with spouses of female caregivers	3
FGDs with volunteers	6
FGDs with non-beneficiaries	4*
Total	**16**

*One additional in one of the communities

• In-depth Interviews

In addition to the focus group discussions, in-depth interviews with female caregivers and spouses of female caregivers were used to further explore and probe on aspects that may not be uncovered in a group setting.

TABLE 6: **IDIS FOR PROCESS RESEARCH**

Type	Number
IDIs with female caregivers	3
IDIs with spouses of female caregivers	3
Total	**6**

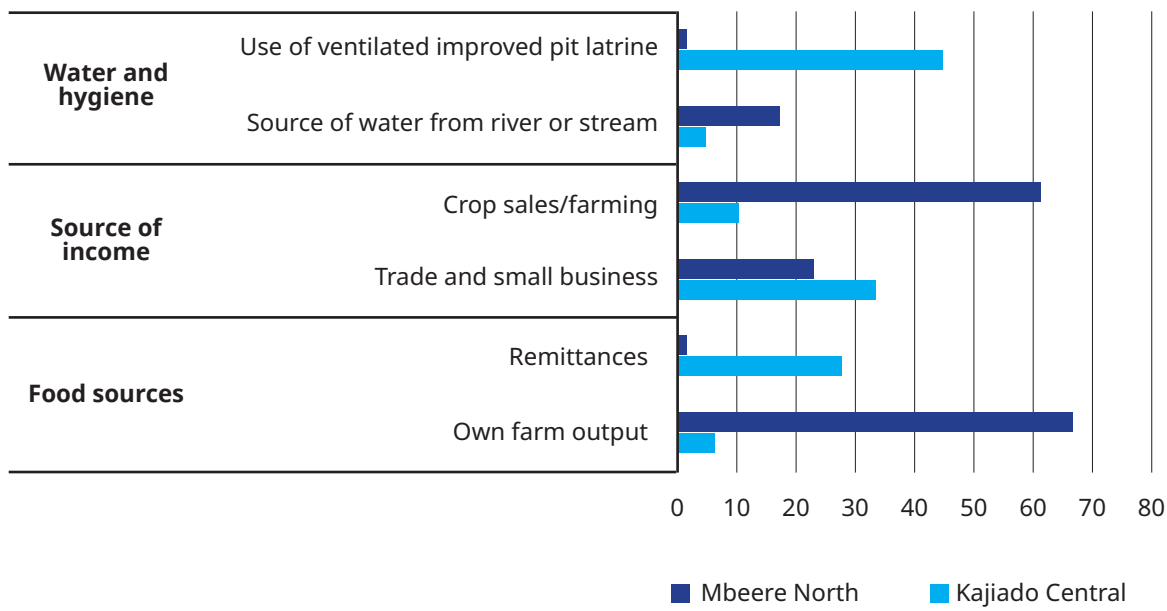
3.4.2 QuIP sampling

QuIP Sampling strategy

The sampling strategy for QuIP data collection is purposive, and based on exploring key demographic and infrastructural differences, or 'confounding factors', between two recipient communities. The aim behind this selection strategy is to explore how these factors contribute to drivers or barriers of change, and to further explore potential 'external' factors

that impact causal pathways to change. To determine which two communities represented the highest number of confounding factors, the UCB Baseline Report (Ministry of Public Service, Gender, Senior Citizen Affairs and Special Programme, 2022) was used as a key database providing information on the socio-economic characteristics across the three recipient counties and sub-counties. Of the three, the strongest variance was found between Mbeere North and Kajiado Central. Among the strongest variances are differences in food sources, in source of income, and water and hygiene factors. Of note, these two locations were not included in the process research, in order to minimize the risk of research contamination. Furthermore, only two locations were selected following the limitations of the research scope, which drove the design to select, of all subcounties, two locations which represented areas with the largest differentiating drivers and barriers to change.

FIGURE 5: **KEY DEMOGRAPHIC DIFFERENCES BETWEEN MBEERE NORTH AND KAJIADO CENTRAL**



As the chart above indicates, these two sub-counties show strong variation in these three key areas. Consistent with the QuIP sampling strategy, these sub-counties were selected as the most appropriate sampling areas in order to explore whether differences in economic, demographic and infrastructural factors play a role in shaping the causal pathways or outcomes of the intervention. Within these two sub-counties, the two specific communities chosen were Gitiburi and Ildamat.

Under the QuIP approach, 24 individual interviews were conducted in the two sub-counties and further divided by gender between female and male caregivers in the respective households. The households were selected from the national database provided by UNICEF Kenya.

TABLE 7: **QUIP DATA COLLECTION ACROSS SELECTED SAMPLE COMMUNITIES**

Location	Respondents	Quantity
QuIP Component		
Gitiburi, Mberee North	With female caregivers from beneficiary households	12
	With spouses of female caregivers/male caregivers	12
Ildamat, Kajiado Central	With female caregivers from beneficiary households	12
	With spouses of female caregivers/male caregivers	12

3.5 Data collection

3.5.1 Instruments

The research team drafted semi-structured tools to guide the KIIs, IDIs and FGDs. These instruments were tailored to address the respective research questions.

Topics covered in the process research instruments:

- Context
- UCB programme
- Implementation of the programme
- Appropriateness of the programme
- Acceptability of the programme
- Sustainability and scalability mechanisms

Topics covered by the QUIP

- Household food nutrition and consumption
- Child and maternal health
- Parenting and childcare
- Individual and household income activities and budgeting
- Community and relationships
- Overall wellbeing and hopes for the future.

The tools were first designed in English and then translated to Swahili. The tools were reviewed, piloted and readjusted during the fieldwork training exercise together with members of the local research firm.

3.5.2 Data collection operations

The primary data collection for the research was designed around these two separate streams and consisted of two fieldwork data collection exercises, carried out in May and June 2023. The data collection for the process research took place between the 8th and the 19th of May, while the data for the QuIP was collected subsequently in June. The two separate data collection exercises ensured that the blindfolding requirements of the QuIP component were upheld.

For the data collection, UNICEF Innocenti worked in collaboration with a local research firm, Pan African Research Services (PARS). The data collection was carried out by two separate fieldwork teams. Each fieldwork exercise was preceded by a comprehensive data collection training, lasting a week, focused on familiarisation with the study, the interview guides, the study protocol and ethics for data collection and fieldwork. Each training was tailored to the specific requirements of each research component. The blindfolding requirements of the QuIP study were therefore carefully taken into consideration during the training as well, to ensure that the field researchers themselves remained blindfolded to the programme.

The interviews across both research processes were recorded using audio recorders and kept on secured UNICEF databases. All ethical considerations were applied to ensure the

strictest access rights to these recordings. Upon the publication of this report, the recordings will be deleted. A verbatim transcription process (word per word) was conducted for the Process research interviews and a causal statements transcription approach for the QUIP interviews. All transcripts were then anonymised before the analysis.

3.6 Analysis

3.6.1 Process research analysis

The process research utilized a classic thematic analysis, in which the data was organized, coded and analysed based on identification of major themes across the findings. The analysis was carried out along the following three steps, utilizing the qualitative software NVivo. Familiarization with the data: The audios and transcripts were reviewed by the research team members. A codebook was developed based on priori themes, based on the interview guides and the initial familiarization with the data. This formed the initial coding frame, that was then tested by the research team and further revised as necessary. The final coding frame was then agreed upon amongst the team, before initiating coding.

1) **Coding of data:** The transcripts (47) were distributed across the three-person research team and coded using the finalized codebook, yet with space for identification of emerging themes throughout the process. The coding was carried out using the qualitative coding software NVivo (QSR International) in late June to mid- July 2023.
2) **Analysis, Interpretation and write-up:** During the final stage of analysis and interpretation, the separate coding by the researchers was compiled into one file in order to initiate reviewing and interpretation. Analysis took place thematically per research question. Across the analysis, triangulation of data, in terms of methods, sources and geographic regions, was used to further validate and confirm findings.

3.6.2 Qualitative Impact Protocol (QuIP) analysis

Producing causal maps

The causal maps used in this report for the analysis of the pilot's impacts show a visualization of the narrative data collected in interviews, using a form of causal qualitative data analysis. The maps show where respondents have made a causal connection between factors, and how many times that was made by different respondents in the sample. To analyse the data, an analyst trained in qualitative data analysis (QDA) reviewed the summary transcripts and coded the data looking for causal claims within the stories of change shared by respondents. These transcripts are coded in a QDA software called Causal Map – designed specifically to capture and analyse causal mechanisms. All the maps in this report have a link to the map and the source data in Causal Maps referenced by the small grey number at the bottom of the map.[3]

3.7 Research ethics

Adherence to ethical principles was a cross-cutting aspect of every phase of the study. The study team sought Ethical Clearance from the KEMRI Review Board, and it was granted on 26th April 2023.

Comprehensive ethical protocols and procedures were developed to guide data collection and safeguard the rights and respect of individuals and communities. All fieldwork was carried out in alignment with designed and agreed upon field

3 See Annex 3 for an overview of interpreting Causal Maps.

research protocol which outlined procedures to ensure the ethical safeguarding of respondents and communities. Prior to each data collection exercise, all researchers participating took part in training on ethical principles in qualitative research and data collection.

In the case of the process research, respondents were informed about the purpose of the study, their participation, confidentiality and privacy principles and their right to voluntarily participate and also withdraw from the study. Informed consent was sought for participation as well as recording of the interview. The interview guides were aligned with the principles of do-no-harm, privacy, respect for dignity and fair representation and diversity. Interviewers were further trained on the importance of not causing distress to participating individuals.

In the case of the QuIP research, while blindfolding entails limiting the information about the commissioning organization and the intervention, the specific research domains can and should be outlined and discussed with participants. In order to put participants at ease, the qualitative approach provides as much information as to the specific life domains addressed in the interview, and the commissioner will be named as the research agency. This approach thus posits itself as an exploratory qualitative study, in which participants are encouraged to discuss the broad changes in their lives without specific references to the intervention.

3.8 Limitations

A key and major limitation of this study is the timing of its execution. The data collection for the research took place 4-6 months after the pilot programme had officially been completed. This meant that the data collection had to rely significantly on recall questions and the overall data may also be subject to recall bias.

3.9 Summary

The following table provides an overview of the data collection and analysis methods that were used to answer each of the questions for each of the two research components.

TABLE 8: **SUMMARY OF RESEARCH APPROACH**

Research Question	Data Sources and Collection Methods	Research component	Analysis Approach
RQ1: Was the programme implemented as intended and adapting to lessons?	Desk review of programme documents, secondary literature KIIs with programme implementers, FGDs with volunteers and beneficiaries, IDIs with beneficiaries	Process research	Thematic Analysis
RQ2: To what extent were the components of the programme appropriate, accessible and acceptable for women, men, girls and boys that directly or indirectly benefit from it, as well as the wider community, implementers and government stakeholders?	KIIs with implementers and FGDs with volunteers and in-depth interviews with beneficiaries and non-beneficiaries	Process research	Thematic Analysis
RQ3: To what extent are the pilot's design features and implementation mechanisms sustainable and scalable?	KIIs with implementers, FGDs with volunteers and beneficiaries	Process research	Thematic Analysis
RQ4: What are the significant changes that beneficiaries identify in their lives (selected domains) in the period of the pilot implementation as a consequence of the pilot? And what are the perceived causal drivers of those changes (causal pathways)?	In-depth interviews with beneficiaries (women and men)	QuIP	Causal Maps Analysis

Source: Authors own

4 Implementation process of the UCB pilot

This chapter unpacks how the programme was implemented and how it diverged from its initial design. The chapter draws on information provided by implementers and volunteers involved in the delivery of services, as well as beneficiaries' experiences with the programme. It is also complemented with data from the UCB Baseline Survey Report (Ministry of Public Service, Gender, Senior Citizen Affairs and Special Programme, 2022) and the Registration Process Report (CHASP Advisory, 2021).

4.1 Fidelity of implementation

4.1.1 Community sensitisation and registration process

The initial step in the implementation of the pilot included a wide sensitization and registration exercise carried out in the three communities. A consultancy firm was contracted to carry out sensitisation and a once-off registration exercise with the support of the local communities over two weeks in October and November 2021.

Community sensitisation

Beneficiaries and community members alike reported hearing about the programme from a variety of sources. These included relevant departments and offices such as the Department of Children's Services, the Department of Social Development, Chief and village elders, as well as through church services. While information generally reached the community, many beneficiaries also noted that information was incomplete in the beginning:

> **"The information was that the people with children under 3 years old should go with the children's birth certificate or notification of birth to the chiefs. Initially even parents did not know why they are taking them to the chief. That information was given to them when they got to the chiefs."**
> (FGD2, Volunteers, Kajiado)

The team that carried out the sensitization and registration also documented the challenges that were experienced, noting that various delays resulted in the sensitization period being short resulting in community members potentially receiving inadequate information.[4]

Perhaps as a result of the paucity in information in certain communities, rumours regarding the purpose of the programme emerged during the initial sensitisation and registration process including the suggestion that the registration was associated with election campaigns.

4 "The delays in stakeholder's meetings delayed the onset of sensitization activities at the community level. This meant that some of the households may have missed out on the information on the upcoming registration. The delays had the implications of a very short period between the sensitization time and registration time. We recommend that in future, an exercise of this nature requires at least three clear weeks of intense community sensitization before onset of Registration. That said, the teams were able to innovate and adopt a more community-based approach to sensitization." (CHASP Advisory, 2021, p. 17).

Registration process

According to the initial registration process report (CHASP Advisory, 2021), a total of 8,216 children were registered into the programme during the registration exercise in November 2021. UNICEF monitoring data however notes that a total of 8 204 children were registered, from a total of 7,546 households. Households were recruited through a process which included community-level listing, household-level registration and a final community level validation. The full registration process is detailed in Box 4.

BOX 4: SUMMARY OF REGISTRATION PROCESS

1) Stakeholder meetings, through which the team introduced the UCB registration process to stakeholders and created consensus on the programme objectives and steps as well as the formulation of a Sensitisation Plan, Listing Plan and Country specific work plan.
2) Training of data enumerators was provided through a two-day workshop for everyone involved. A total of 149 enumerators were trained.
3) Centralised community listing involved the following activities: gathering basic demographic data, assessment of beneficiary eligibility and details captured by the relevant enumerators. This occurred at a locally designated registration centre in preparation for household registration.
4) Household registration exercise during which the 149 enumerators were assigned households from the listing exercise to visit. The visits involved gathering further demographic data and capturing supporting documents for eligibility and a malnutrition assessment.
5) During community-based validation chiefs and village elders reviewed the total list of households. Data errors, such as missing ID numbers, children's and caregivers' birth dates, and telephone numbers were noted.

Source: CHASP Registration Report (2021)

As said, registration was a one-off exercise for the pilot programme and there was no continuous enrolment and registration. As a result, it was not possible to register later, leading to potential exclusion for those that could not access the required documents in the specified time period. The sensitisation exercise was also carried out concurrently to the registration process, leaving little time for households to gather the required documents. Nevertheless, as Table 11 shows, the registration of identified households was broadly successful, with 91 percent of the total identified households being validated and registered to take part in the pilot.

TABLE 9: **OVERVIEW OF HOUSEHOLD REGISTRATION**

County\Sub-County	Community Level Listing	HH Level Registration	Community level Validation
	# of HHs	# of HHs	# of HHs
Embu	3,071	3,036	2,812
Kajiado	1,876	2,322	2,111
Kisumu	2,488	2,906	2,623
Total	**7,435**	**8,264**	**7,546**

Source: UNICEF Programme Monitoring Data

Recertification exercise

Several volunteers, implementers and beneficiaries reported data inconsistencies during the initial registration, which is confirmed by the monitoring data (see Table 12).

TABLE 10: **REGISTRATION DATA DISCREPANCIES IDENTIFIED**

Checks and exception categories	Kajiado	Kisumu	Embu	Total No. of beneficiaries
Missing surname	49	31	4	84
Missing birth certificate no	658	1,089	265	2,012
Missing member role	128	204	105	437
Missing relationship	17	22	23	62
Invalid relationship (legal guardian/blank/caregiver)	43	127	72	242
Duplicates beneficiaries by birth cert no	12	19	19	50
Duplicate beneficiaries by names	27	46	137	210
Total	**934**	**1538**	**625**	**3097**

Source: Programme Monitoring Data

Due to these discrepancies, there was need for a complete recertification exercise, that was conducted ahead of the migration to the MIS system, as explained by an implementer as follows:

> "It was agreed that before we migrate these UCB beneficiaries into the government system, there was a need for a data clean up exercise to be undertaken."
> (KII 6, National level)

Overall, this recertification and re-registration exercise carried out in July 2022 was reported to have been implemented well, utilising community level capacity and following comprehensive certification procedures, ensuring that no data errors occurred, as explained by the following respondent:

> "The task was now to go out to the field, train sub county and county officers who later on trained the enumerators and whose primary task was to do a kind of recertification exercise. That means using a tool going to all the households under UCB and collecting the information fresh. Bio data like names, mismatch, national ID mismatch, telephone number mismatch and so on. Correct this information and update the same under the clean-up environment."
> (KII 6, National level)

Registration requirements

Several households did not have the necessary documents to meet the eligibility criteria (detailed in Box 5), with the most frequently occurring obstacles being the lack of national IDs for caregivers and the lack of birth certificates for children. Indeed, according to the baseline survey report, beneficiaries were required to show a health card or birth certificate to confirm the age of children, and while the majority had health cards (76.9%), less than 30 per cent of caregivers had birth certificates – with the highest rate in Mbeere North (28%), Kajiado Central (24%), and Nyando (7.4%).

BOX 5: ELIGIBILITY CRITERIA FOR UCB REGISTRATION

1. Beneficiary children under the age of 3 (0-36 months) at time of registration, and Kenyan citizen. Requirement to show national ID of caregiver and birth certificates/foster care certificates for child.
2. Children only eligible if members of a household and the household/caregiver had been a resident in the area for 12 months.
3. No cap on the number of children per household and still eligible if in receipt of another cash transfer
4. A child can only belong to one household.

To address this issue, households were sensitized during registration, on the need to have a birth certificate, which reportedly facilitated its uptake in the communities. Many volunteers also supported households in acquiring birth certificates. An unintended positive effect of the programme was therefore reported by caregivers: the increased acquisition of birth certificates in the communities. This is explained by two female beneficiaries:

"Those who did not have, they were referred to go and get the birth certificates. And later even the office itself came and registered, helped them to register, those who didn't have... It made the community know that once you give birth you should register your child so that they don't miss such opportunities."
(IDI 12, Female caregiver, Kisumu).

"Before, most parents would ignore or not be in a hurry to get the certificates for their kids, but when this project came most parents rushed to acquire the documents for their children, because you couldn't be taken in by the programme without the birth certificate."
(FGD12, Female caregivers, Embu)

Further, caregivers identified the distance required to travel to the civil registrar as a barrier to accessing birth certificates. In response, the programme partnered with the relevant local government office and addressed various barriers including supporting potential beneficiaries to access the different types of identification so that their children could be registered. In some cases, a letter from the chief validating the child as being under three years and resident in the community could be used in lieu of a birth certificate. While a successful strategy during registration, local government officials raised various concerns around the potential misuse of this function, that were also echoed by volunteers.

The registration report also highlighted the challenge regarding the registration of displaced households who may have lived in the community for the required amount of time, but for whom future residency was still unknown. In the end, children from displaced households were still registered if they had lived in the target area.

4.1.2 Beneficiary data management and payroll generation

The programme was intended to be operationalised using the CCTP Management Information Systems (MIS) however initial data management was carried out manually due to reported delays in the finalisation of the CCTP MIS, which caused delays in generating the original payroll as indicated by this implementer:

"I think the payroll generation was quite hectic, because we did not have a management information system in place and the process of preparing that payroll took a little longer. And having to clean up that data with the county coordinators at the sub national level took a bit of time."
(KII 8, National level)

Once the UCB CCTP module was approved and tested and the re-certification exercise carried out, the updated data were migrated into the MIS system to facilitate the delivery of payments. This recertification and the migration to the MIS system mid-programme generated a large share of households being temporarily excluded from the programme in the months of July-August 2022.

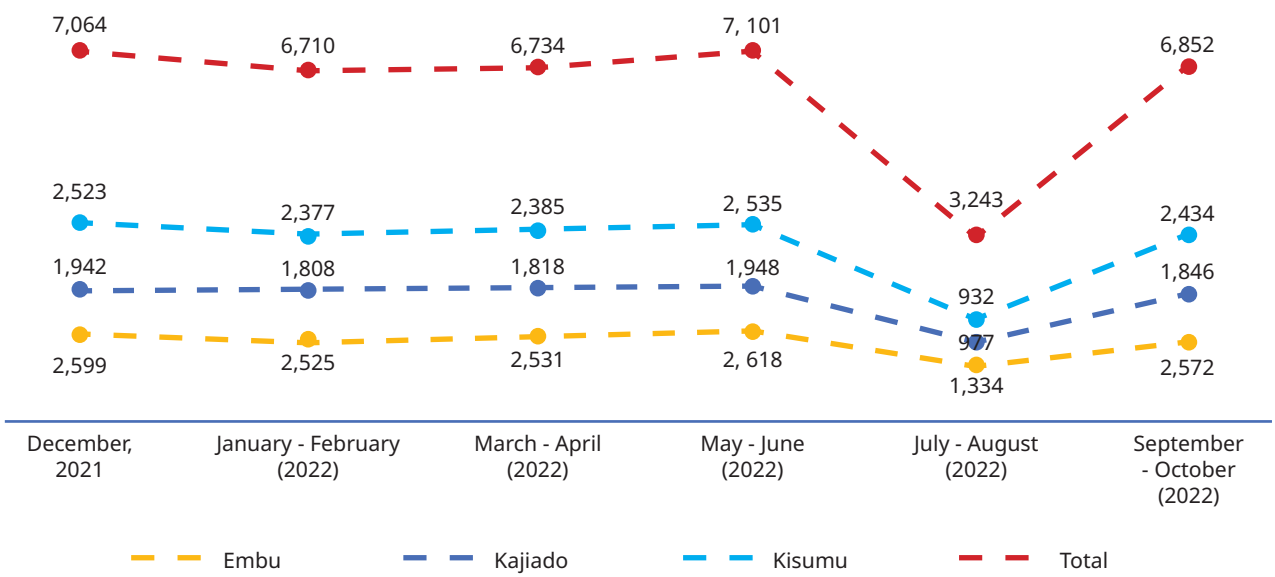
4.1.3 Delivery of transfers

The number of households receiving the transfer varied between each payment cycle, as indicated in the Figure 10 as well as in Annex 3 which provides an overview of the transfer delivery success rates. The fifth payment cycle, which took place following the recertification exercise, had the biggest decrease in beneficiaries, with only 3, 243 (42%) of the total households receiving the transfer. However, the low cash transfer receipt in the months of July-August 2022 is an exception in an otherwise regular cash transfer process. Overall, the number of recipients between first and last payment only differed by 3 percent, suggesting a broadly successful payment delivery record.

Some interviews indicate nevertheless that the cash transfers were not always provided according to the planned timeline and with the intended frequency. While the cash transfers were intended to be delivered to households every other month, some beneficiaries revealed in interviews that they received lump sums covering three months (KES 2,400), as explained by the following female caregiver:

"When they started giving us the money, we were first sent for KES 2,400, and then later we were given KES 800. That was the last one. So, when they started giving it to us it was KES 2,400, then it reduced so the very last day we were given KES 800, so we were even wondering what was happening..." (FGD16, Spouse of beneficiaries, Kisumu).

FIGURE 6: **OVERVIEW OF PAYMENTS DELIVERED ACROSS THE SIX PAYMENT CYCLES**



Source: Programme Monitoring Data

4.1.4 Delivery of the complementary Services (Cash Plus)

The complementary services consisted in training activities, home visits and wider sensitisation sessions to communities, with community health volunteers (CHV) and child protection volunteers (CPV) playing a key role in their roll-out. Households were largely included in the groups' formation and access to the services of the volunteers was not based on the registration process.

Training

The primary component of the complementary services consisted in training and mother to mother support groups through which beneficiary caregivers engaged with each other and with the community volunteers. Groups were formed in different locations with a maximum of 15 participants. Each group designated a lead mother, who was trained on relevant topics and supported the training of the wider groups. The group would collectively set the day and location of the meeting, after which the volunteer would confirm and provide the training.

Nutrition and positive parenting components formed the core of the training. The disability component of the programme was not included as its own module but planned to be mainstreamed within the other components. However, its inclusion in the training was described by volunteers as minimal and only focused on referral mechanisms and support to the households with children with disability rather than a wider community sensitization on disability inclusion.

The training was based on national guidelines and manuals. However, the content was also adapted based on the priorities of the local governments, as a national key informant explained it:

> **"Like in Kisumu, we had, for instance, issues on community development that were targeted at these structures formed within the program. The programme formed small groupings of mothers where they would meet to be given bits and pieces of both positive parenting and nutrition guidance, but because Kisumu County prioritizes making sure we build resilience within the small groups, you will find they also like to push some bits of support into giving mothers some entrepreneurial skills even if it was one or two times of a social development officer, visiting a group and trying to guide groups. You start to see some mothers coming together to rear animals like goats in the cash transfers and growing that into some enterprise to help themselves in the households."**
>
> (KII 7, National level).

The training and the group setting were also innovative in that they could cover additional topics, such as household budgeting. This served as an opportunity for group members to support each other with income-generating activities. In Kajiado, beneficiaries revealed they used the groups to organize a rotating savings fund, in which members take turns to receive accumulated funds. Beneficiaries and volunteers suggested that these activities further highlighted the value of the groups for strengthening community and social cohesion.

Home visits and referrals

In addition to the group meetings and training sessions, volunteers carried out home visits. One respondent explained that "there were home visits because there is information you cannot give in a public meeting and this was also good because, again, you will meet the husband" (FGD1, Volunteers, Kajiado). Both volunteers and beneficiaries reported that the volunteers,

through home visits and the support groups, checked up on the mothers and their care and nutrition practices.

Volunteers were also trained to facilitate referrals to further services, as explained by a volunteer in Embu:

"Even referrals, we would refer them. Those who had challenges, the children were not going to the clinics, delayed milestones, malnutrition and there is a need to boost it. There are those instances where you need to go to the hospital to get counselling from the experts. In those instances, we would give referrals."
(FGD3, Volunteers, Embu)

Volunteers revealed that the uptake of the referrals by the relevant offices and departments was at times limited (see 4.2.2 for more information on referrals).

Community sessions

The programme also included wider community sessions which brought together the groups. Non-beneficiaries in the three communities demonstrated knowledge of these community sessions and confirmed participation in some of the trainings.

Some of these community gatherings also engaged male spouses on the topic of positive parenting related to male involvement:

"After two months, we would hold a gathering as a unit even the husbands used to attend, and they would become part of the system. We would tell the husbands that when you go to the market, do not buy jubilee but come with banana and githeri (local food consisting of boiled maize and beans)."
(FGD3, Volunteers, Embu).

4.1.5 Monitoring and grievance systems

Monitoring relied on the collection of information from the following sources:

- Qualitative data captured in the monthly activity reports
- Reports generated by the MIS
- Financial reports
- Regular monitoring interviews undertaken by telephone
- Spot-checks undertaken by the County Coordinator or the Department for Social Assistance monitoring and evaluation team

Monitoring of the programme utilized a top-down approach, with programme staff gathering information from various sources. Stakeholders noted that post distribution monitoring was occasional, and monitoring did not take place after each disbursement of cash transfers.

"Issues of resources; we had a certain amount UNICEF had set aside for paying the cash transfers, we needed other facilitating resources to make sure we made frequent monitoring and follow up checks. There's a time we did monitoring after two or three cash transfers, by the time we got the resources for a follow up, we had done two or three payment cycles which was a barrier. Also, spot checking where all stakeholders go to the ground and check how the programme was being implemented, did not take place because of limited resources."
(KII 4, National level)

Grievance mechanisms for caregivers and their families were first communicated to volunteers and transferred onto local structures and services. Broadly, this system was well conceived, however, there were delays in providing responses for families with grievances, as this volunteer from Embu noted:

"I would also love to emphasize on this, we had written so many referrals but never got any feedback. There was a lady who had been kicked out of her home with the baby and they were staying in the woods, you forward such a serious and urgent case but there was no one to follow up and help."
(FGD4, Volunteers, Embu)

Beneficiaries also lacked awareness about which institutions to contact for specific issues, which limited their ability to address grievances effectively. As noted by a local level nutrition officer, there was a need for "a better structure of feedback, so that whatever challenge arises, the flow of information and feedback should be streamlined"
(KII16, Volunteer, Embu).

It should be noted that the grievance mechanisms and structure were well understood by volunteers, the challenges were suggested to be at the level of the sub-county officers who seemed to have limited capacity to respond. The most common complaint was the non-receipt of the UCB transfer itself, mostly as a result of data discrepancies. Perhaps explaining these delays in responding to grievances were the challenges with the registration process and lack of real-time updates to beneficiary data. A key informant provided the following explanation:

"At the point of registration, the government should be more involved. This is because during the implementation, they are the ones available to address grievances, yet they have no data with them."
(KII 13, Kajiado)

Indeed, due to the initial registration process being carried out by an external organization, it was not always clear to the community who was in charge and to whom they should raise their concerns. Many respondents highlighted that while they went to the central community offices, they were provided with limited support and were also referred to the national office.

4.2 Facilitators and barriers to implementation

As mentioned earlier, the delivery of the cash transfers faced a range of challenges while the complementary services were implemented largely as intended. This section discusses the factors that either promoted and facilitated the successful implementation of the programme and the specific barriers or factors that inhibited or caused the various implementation challenges.

4.2.1 Facilitators

4.2.1.1 Existing systems and structure for implementation

The existing institutional structures in the communities facilitated the implementation of the programme. The delivery of complementary services in particular drew on existing services and institutional structures including primary care facilities run by the Ministry of Health, which include nutrition, social development and children's office and the local government, as the following national level key informant suggests:

"I think... first the existence of the systems at the county at the sub national level where you have the child protection. Child Protection Volunteers... Just having that is already a good thing."
(KII 8, National level)

4.2.1.2 The coordination for the intersectoral delivery of services at the local level

At the national level, a major facilitator for the delivery of the complementary services was the successful cross-sectoral coordination. Cross-sectoral coordination enabled the implementation of the cash plus elements. At the local level, the horizontal coordination between the variety of sectoral actors (Community Protection Volunteers, Community Health Volunteers, Community Health Extension Workers) was smooth and it promoted a common delivery front to the beneficiaries and the wider community. This was acknowledged by several sectoral officers as well as national key informants from the government and development partners.

As emphasized by a national key informant, "working together with stakeholders on the ground, as well as the Ministry of Health, Department of Children Services, all those stakeholders. I think there was that togetherness in terms of implementing. The coordination in implementing the UCB programme was actually key and was critical to the success of the pilot. (KII 1, National level). This successful coordination at the national level was vital for the successful implementation at the community level, as also expressed by two sub-county informants:

"I have learned that it is possible to work together as a... different people integrated. You know previously, I was wondering, if I continue with my (anonymized) and the other thing to do with children and the other one health, but I have also learned that it is possible to work together focusing on one goal."
(KII 14, Implementor, Mbeere North)

"What worked on the programme for me was issues related to synergy in the implementation of government services. This is because we were able to identify the key government services that a household requires and were being delivered at the same time unlike when we were working separately as a department. There was great coordination due to synergy and we were working together."
(KII 13, Implementor, Kajiado)

Another officer from Kisumu, pointed out that cross-sectoral coordination was successful due to the constant communication between departments and with a lot of support from volunteers. In Kajiado, the cross-sectoral engagement extended beyond the official implementing partners of the programme, driven by local initiatives to improve the content of the trainings:

"We really brought on board other sectors that are really close to us and help us meet our objective. The ministry of agriculture was brought on board due to food security and how to plant food and crops. The techniques of kitchen gardens, social protection was also there in terms of cash transfer. So, we had the treasury department to educate mothers. That was more of our own initiative to bring them on board to educate mothers on cash transfer. Not cash transfer but income generating activities. The savings, the village loans and savings. To save the small monies they get and to carry out income generating activities like the chicken rearing."
(KII 11, Volunteer, Kajiado)

Various volunteers shared similar sentiments on the successful cross-sectoral coordination

and collaboration. They identified cross-sectoral coordination as a key factor for facilitating the successful delivery of the trainings, increasing the reach of the programme and ensuring the ability to support multiple groups in one area. Communication was facilitated through WhatsApp groups for the CHVs and CPVs which facilitated the coordination of trainings, and knowledge exchange with volunteers inviting each other to their respective groups to train on specific topics.

"They were active (WhatsApp Groups); they were for the CHVs or the CPVs. I would invite them to my groups, I would welcome them to come and train my group on positive parenting. They would invite me to their group to train on breastfeeding of the child. We would exchange; I would not do the training all alone. There was a change."
(FGD2, Volunteers, Kajiado)

While the coordination at the national level was broadly successful, key informants also noted challenges with communication. To address this challenge, implementers identified the need for a detailed institutional framework that clearly described the roles of all stakeholders so as to enable clearer responsibilities regarding communication and necessary actions to be taken.

4.2.2 Barriers and challenges to implementation

4.2.2.1 Community level social service referral capacity

At the community level, several factors were identified as barriers to the implementation of the complementary services. The implementation of the complementary services utilizes the structure of the mother-to-mother support groups but draws on the existing social service delivery capacity in the communities. Through their engagement with households, volunteers carried out referrals to social services, particularly in the case of children with disabilities and for health-related check-ups. However, as highlighted by volunteers, there were some challenges in ensuring timely referral responses and action:

"Some of the challenges we encountered is on referrals. If it is a parent, the challenge is bigger than we can help them. If you refer them to an officer who will be in a position to help them, you find that there are no officers available to help. So they do not get the help that they need. So, they had to wait for a long time to get to the officer. So that was a challenge."
(FGD 3, Volunteers, Embu)

"I think about the referrals, we were referring and making a lot of referrals, but there was no feedback, therefore the referrals need to be improved. After we make the referrals, they do not act but then expect our feedback immediately."
(FGD 4, Volunteers, Embu)

While several volunteers in Embu brought up these perspectives, the extent to which similar challenges may have occurred in the other counties is unclear. However, this case still highlights the importance of ensuring sufficient referral capacity which is integral for enhancing the effectiveness of the programme. This was a particular challenge for the disability component, which was mainly implemented through referral mechanisms. A volunteer in Kisumu reported that while their work involved the identification of persons and children with disabilities and facilitating linkages, the services were not always provided.

"At least on disability we managed to identify some cases…. they were optimistic like they could be given maybe a support from the government through our intervention but that was not the case because we only did the linkage and the assessment."
(FGD5, Volunteer, Kisumu)

Furthermore, the extent to which referrals for undernourished children were provided is not clear.

4.2.2.2 Barriers affecting volunteers' implementation capacity

Volunteers and local-level officers identified several challenges that affected volunteers' capacity to implement the programme. First, while many volunteers enjoyed their work and felt a sense of accomplishment in contributing to community cohesion and positive outcomes, a few suggested that the workload could sometimes feel demanding. Managing multiple groups and responsibilities occasionally created a sense of stress and being overburdened.

Transport costs were then highlighted as a major issue by the volunteers. The need to travel to facilitate different groups in various areas incurred substantial expenses, which were exacerbated by the rising cost of living. Although volunteers received some reimbursement for their time, it was often insufficient to cover these high transport costs, adding a financial burden that impacted their ability to provide the intended support.

Another concern raised during the interviews was the delay in receiving stipends. Volunteers noted that these delays sometimes affected their engagement and motivation, as many relied on these payments to cover their expenses, including transport and time dedicated to the program.

Finally, volunteers reported challenges due to a lack of access to relevant and up-to-date information about the UCB program. This lack of information made it difficult for them to respond effectively to beneficiaries' questions, particularly concerning issues like payment delays. The inability to provide clear and accurate responses diminished their effectiveness and the credibility of the program, leaving beneficiaries without the necessary support and guidance.

4.3 Contextual factors

4.3.1 Economic context

Inflation stemming from the global cost of living crisis affected the programme. Implementers, volunteers and beneficiaries, explained that it negatively influenced the impact of the cash transfers by reducing their purchasing power:

During that time, we haven't had any harvest since we had the programme, so economic inflation, having no food, it affected the implementation because the cost of food was high, so it was not enough for 800 to cater for the basics for the child and then the other thing is that in that household, during inflation, this household had not only that child, so the money was being shared by the family." (KII 16, Mbeere County)

Drought also affected programme implementation in communities such as Kajiado. The complementary training in nutrition encouraged caregivers to increase the utilization of nutritious food using home gardens. However, the drought made it difficult for households to maintain home gardens as it deprived rural farmers of water. Furthermore, the drought resulted in the deaths of many cattle, in a community that relies on livestock for income generation.

Together, the drought and cost of living crisis made households even more vulnerable and increased the demand for additional disposable income. Due to these pressures, several beneficiaries reported that the cash transfer was used to cover costs for the whole household instead of the child.

Furthermore, because of these economic challenges, some households migrated, which affected the re-registration exercise, as some households could not be traced. The economic circumstances also decreased attendance of the complementary training sessions. Many volunteers noted that participants would forgo the training sessions in order to generate income. This absenteeism was compounded by the lack of an incentive to encourage participation in the training sessions.

4.3.2 Political context

Political factors affected the implementation, specifically the registration exercise. The timing of the registration exercise was close to the Kenyan general election in August 2022. Rumours swirled during the initial registration exercise that the registration was a form of forceful voter registration. Some beneficiaries believed that these rumours affected the registration exercise to a certain extent, as they discouraged potential beneficiaries registering for the programme. Other community members noted that participation in the trainings may have been hampered by political rallies and events in the community.

Furthermore, some beneficiaries linked the delay and inconsistency of cash transfers to the political environment around the general election, which happened during the pilot:

"Well, the economy has risen making the funds being given not to be enough to help with the needs. On the politics, the change of leaders affects its operation causing delays in funds. This made us feel like they have used the money in campaigns."

(FGD4, Spouses of beneficiaries, Kajiado)

5 Appropriateness, accessibility and acceptability

This chapter discusses the programme's appropriateness, accessibility and acceptability. The findings are based on the perspectives of caregivers, beneficiaries and non-beneficiaries, volunteers, implementers, policymakers and development partners.

5.1 Appropriateness

The study assessed the extent to which the programme is perceived to be relevant and responsive to the needs of households and communities.

Beneficiaries reported that the programme was appropriate and addressed the needs of households by increasing household income and encouraging good nutritional and parenting practices. The programme was positively received by beneficiaries, implementers and volunteers who recognized the value of the programme as beneficiaries reported positive changes which included an increase in knowledge around nutrition practices and positive practices of child discipline (see Chapter 7 for further findings on the impacts of the programme). Training on child parenting practices was particularly appropriate in changing disciplining behaviours (see 6.4 for more on this), as multiple respondents noted important changes in parenting practices in their households;

> "Since she started this [training] her behaviour changed. And if she was slapping the kid before, now she stopped and started explaining to them instead. If I quarrel with them, she would tell me that was not correct and tell me how it was done and that really changed, and the neighbours saw the change too."
> (FGD14, Spouse of beneficiaries, Kajiado)

The transfer value of the cash transfer was deemed to be too low by both beneficiaries and implementers. This was the most common complaint raised by beneficiaries, community members, including the volunteers and implementers. A sub-county officer noted:

> "The support of that money. it was not adequate because considering the inflation that we are having, the cost of food items was high, and there were no rains, the drought situation complicated things [however] when there is something little, it's better than when there is nothing, so that amount helped somehow supplement the provision of food that would probably not been there."
> (KII16)

The extent to which a proper nutritious diet can be facilitated with the transfer amount is also highly dependent on its frequency as well as the availability of local markets. The programme provided KES 800 every other month to all households with a child under the age of three. Comparatively, a contemporaneous programme for senior citizens, the Inua Jamii programme, provides a transfer of KES 2,000 per month and this difference was highlighted by implementing and volunteer respondents. Even so, many beneficiaries still acknowledged the benefits of the cash transfer as it enabled them to purchase

different items for their children depending on each child as perceived by the parents.

The use of mobile phones for cash transfers was a successful payment medium. The prevalence of mobile money outlets and pervasive knowledge of mobile money related practices resulted in respondents being at ease with this method of transfer.

5.2 Accessibility

The study considers the extent to which the programme reached its intended beneficiaries, the household and the community and identifies the barriers to accessing cash transfers and complementary services.

5.2.1 The UCB transfer

Beneficiaries who registered the phones in their names were able to access the cash transfers. Unlike the standard banks where access is often hindered by distance, the use of mobile banking enhanced accessibility to the transfers. One volunteer provided the following assessment in response to the accessibility of the transfer:

> **"R5: [the beneficiaries] could access it easily because in other organizations they work with banks, but you find some other people don't even have accounts. So, on my side I think [the payment method] was well done."**
> (FGD5, Volunteers, Kisumu)

Most volunteers were thus able to confirm the receipt of the transfers by most beneficiaries. As discussed in section 5.1.3, however, the receipt of transfers in the July-August 2022 period during the recertification exercise was heavily impacted. However, the migration of the data to the CCTP MIS was the primary reason for non-receipt rather than issues with the payment modality.

Noted issues with the payment modality mainly concerned beneficiaries using other people's phone numbers to register for the programme. In these cases, access to cash transfers was not always guaranteed. Additionally, as explained earlier in section 4.1.1, some eligible caregivers were excluded from the programme as they lacked a national ID which was required for registration into the programme, and registration of any mobile phone connection. Women who were under the age of 18 also resorted to using other people's phone numbers.

5.2.2 Complementary services

Complementary services were delivered by volunteers who were based in the communities and were therefore easily accessible to beneficiaries, as described by a volunteer in Embu:

> **"The service was accessible because each village has a CHV (Community Health Volunteer). It has CPV (Community Protection Volunteers) too. Therefore, if they do not get the CHV, they can call the CPV. There was also the lead mother who was the leader of the other women. So if the lead mother couldn't assist, there was the CHV, then there was the CPV. So, the network was okay. So CPV on protection, CHV and the lead mother on matters health."**
> (FGD3, Volunteer, Embu)

Although cash transfers were given to female beneficiaries of children under the age of three, the plus component was available to any community member who wished to attend. It is nevertheless unclear whether the women with older children or men who were non-beneficiaries were included in the mother-to-mother groups or whether they were able to attend. Also, non-beneficiaries were not formally registered in

the programme, therefore monitoring their attendance and outcomes after the training was not feasible. However, all counties confirmed that non-beneficiaries could attend, as expressed by the following volunteer:

"In the groups, we were not only reaching the beneficiaries but everybody. I had 22 households, they all had to come for trainings, not the beneficiaries alone. That helped even those without children."
(FGD2, Volunteer, Kajiado)

The findings also suggest that non-beneficiaries had positive experiences with complementary services, with several respondents claiming to have learned valuable lessons across a range of subjects such as nutrition and health of children;

"As for me, the training helped me with feeding the child, looking after the child's life, foods that he should eat when he is young, things like that."
(FGD9, Non-beneficiaries, Kisumu)

Complementary services were also well accepted by non-beneficiaries who cited the spillover effects of the programme:

M1: "Okay. And for those who never benefited directly do you think they accepted the program?

R2: "Yes, they accepted the programme because these beneficiaries are just part of the community and part of the family and when your partner or your in-law gets such a thing you are very happy, yeah.

R4: "At some point, the cash plus component programme organized a programme for children with disabilities. So many people who were not even part of the programme came out for a child assessment for their children living with a disability, yes so it was accepted."
(FGD 5, Kisumu Volunteers, Kisumu)

Including parents with children with disabilities in this way, even when they are not registered in the programme, ensured that children with disabilities face less stigma. This acceptance of the programme by non-beneficiaries may therefore have facilitated wider diffusion of the training.

For beneficiaries and non-beneficiaries, barriers to participation included the opportunity cost of participating in training sessions. Furthermore, if households moved to a different area during implementation, the travel requirements to participate in these sessions deterred participation.

5.3 Acceptability

5.3.1 Universality of the programme

The universality of the programme was largely accepted and positively received by the communities. The focus of the programme on children may have contributed to the acceptance of universality of the programme, as demonstrated in the following quotes.

Respondent 1: "I think it was okay, even if a baby is from a rich family for as long as they are below three years they should be considered. It doesn't matter whether they are rich or poor for as long as it's a baby within the age range that is okay."

Respondent 2: "Earlier we mentioned that we were happy that the programme did not discriminate against any child, even the rich are hustling just like the poor and that is why we loved the programme."
(FGD 15, Spouses of beneficiaries, Embu)

Participants also accepted the programme's universality because it served to unify the community and remove class divisions, which may happen when programmes target specific types of households. One non-beneficiary commented that the universality removed tribalism, which is pervasive in some cultures.

R1: "The programme the way it was designed to be universal to all, it is very important because you know in this world everyone needs help, so help doesn't matter whether you are up the ladder or you are still down the ladder, it cuts across. So, when this is being done universally then it also creates some unity within the village.

R3: Yes also, in general what you did (programme) deals away with nepotism here because you take people equally. Number two, tribalism. Here we have Luos, we have Kikuyus, you have taken all of them, that is the great thing, nepotism doesn't favour any family."
(FGD10, Non-beneficiaries, Kisumu).

However, there were also few negative perceptions of universality, framed around the need to better support the poorest, as exemplified by the views of a volunteer in Kajiado:

"And I am not trying to be bad or segregating, if they could strictly go to the poor, then it could be better...Yes, universal child benefit is good but some people need money more than others. If it could go to the strictly poor parent then that could be better..."
(FGD1, Volunteer, Kajiado)

A few community members also believed that the programme targeted poor households:

"There were issues of perception on matters concerning targeting where people thought and still think that the programme was open to the vulnerable kids only. The concept of universality is yet to be fully embraced."
(KII 13, Implementor, Kajiado)

Some households did not register for the programme because of this belief. In some communities, volunteers rectified this problem through house visits, and further sensitizing households about design and universality of the programme.

On implementers' side, while some of them did raise concerns around the economic sustainability of a universal design, others pointed out the efficiency of a universal design, particularly during registration.

"We will greatly need to monitor to avoid ghost receivers, but it is an easier project to implement because the target need addressed is universal. Those programs where the target is not universal are much harder to implement. Explaining the criteria and using the criteria correctly is not going to be easy. When it is a universal program, it may not be hard during the implementation unlike now when we have to convince people that it is not for the vulnerable alone."
(KII13, Implementor, Kajiado)

5.3.2 Women as the main beneficiary

5.3.2.1 Cash transfer

While the majority of men and women agreed that women were the main caregivers in households, and that the cash transfers were rightly sent to them, there are nonetheless important findings regarding initial reservations about women being the recipient of the cash transfers:

"The women had no issue but the men, however, had that initial fear of why the money was being given to women. It took a lot of time to explain why we were using women and not men as the setting of the area dictates. This led to a few isolated cases where there were family disagreements due to funds. This is why we were involving the gender officers in the implementation of the program. We received some cases of some of the men who had been registered were not disclosing that they had received the money. This was a challenge. That is why I earlier said that there needs to be better and sufficient communication to the community as to why we are targeting the mothers and not the fathers. In normal practice, it is the mother who handles a small child, but people were questioning why money was being given to mothers and not fathers who were the heads of the households... but this was addressed over time."
(KII 13, Implementer, Kajiado)

Both volunteers and beneficiaries claimed that this perception was eventually reduced as a result of participation in positive parenting training. Indeed, several respondents suggested that training was key in alleviating certain tensions that arose at the start of the programme regarding the gender of the main recipient of the cash transfers. Specifically focusing on the caregiving aspect proved to be efficient at reducing tensions that arose from men being the traditional heads of households, as this volunteer in Embu noted:

"Because when the men started attending the gatherings, we explained to them that the money was meant for children and not money to be misused. So, what would help is more training so that they understand better."
(FGD3, Volunteers, Embu)

The overall acceptance of female caregivers as the main transfer recipient among the general community was high, however, and driven by attitudes that consigned women as the primary caregivers of children.

"The women are so important in the community and when you empower a woman you've empowered the whole community. A project that involves both the mother and the children is more important since [men are] involved in looking for hustle to be done. Most of the time a child spends their time with their mothers."
(FGD 14, Spouses of beneficiaries, Kajiado)

"We never came across complaints that since women are the major recipients, the men should be the ones receiving the money. We have not heard of such complaints."
(FGD11, Female caregivers, Kajiado)

For some men, the acceptance of women as the primary recipients for the cash transfers was premised on the perception that it alleviated their roles as "sole providers":

MODERATOR: "Who benefitted from this programme indirectly?

RESPONDENT 8: "It is us the men. For example, I had to buy milk on credit everyday so when the money came, I forgot that and my wife started sorting it out."
(FGD 14, Spouse of beneficiary, Kajiado)

As a result, the cash transfer was widely understood to be child-focused and having women as direct recipients was justified. This was echoed by a volunteer who explained that they believed the cash transfer should be provided to the female caregiver:

"let the recipient be the mother but the plus component to benefit the whole house."
(FGD1, Volunteers, Kajiado)

5.3.2.2 Complementary services

Overall, the targeting of women for the complementary services was widely accepted. Male spouses revealed that their wives would share the knowledge imparted in trainings with them. Other male spouses also expressed interest in greater involvement to improve overall family cohesion and awareness:

"They should include us as fathers in those teachings, because probably the mother has gone and has been taught and comes home and tells us what she has learnt, and you could find some do not understand even when explained to. Maybe for example they are taught that a child is supposed to be breastfed for six months with no food, the father may think she is lying and maybe you want ill for the child. Some men's understanding is low, so even if you explain to them what was taught, they may not understand. Adding the fathers during the teachings helps to bring the family together, because when we are taught together, we know what we are supposed to do." (FGD16, Spouse of beneficiary, Kisumu)

"Only the women knew most of the things and sometimes we wouldn't know what is going on so maybe next time it can be a programme for the whole family so that we are not left out. We want the men to be involved."
(FGD16, Spouse of beneficiary, Kisumu)

5.3.3 Infants' nutrition practices

Beneficiary interviews also highlighted the differences in attitudes and perspectives on child nutrition and parenting practices that exist in the communities. For example, in a discussion in Embu, beneficiaries reported that the elderly or older generations did not agree with the practice of exclusive breastfeeding for six months as taught in the nutrition sessions, which could have adversely affected the adoption of this practice:

"Yes, grandmothers were not for the idea that a child should stay for 6 months without food, especially a child that is named after her, they would often complain, "when I am born, I should be given food immediately, you will not kill me with starvation". So that was a problem."
(FGD2, Spouses of beneficiaries, Embu)

The older generation believes that a few months after birth, breast milk is insufficient for satisfying an infant's hunger. As such, the nutritional counselling on exclusive breastfeeding directly contradicted the widely held belief that a mother's milk needs to be complemented with other food before an infant reaches six months of age. Hence, mothers who live with grandmothers may have faced challenges convincing them of the need to apply the lessons on exclusive breastfeeding.

6 Impact of the UCB pilot on recipient households

To explore the impact of the UCB pilot on beneficiary households, the following analysis uses the established domain structure (see Figure 4 in section 3.3) which covers household food consumption, child and maternal health, parenting and childcare, individual and household budgeting, community relationships, and overall wellbeing. The reader will find guidance on how to read the causal maps in Annex 3.

6.1 General overview of causal pathways in Ildamat and Gitiburi

Figure 7 and Figure 8 present the findings of the most frequently stated causal links by respondents (caregivers and spouses) for each of the two locations without specifically filtering for UCB pilot impacts. As a result, these causal pathways provide an indication of the most important changes during and after receiving cash transfers and participating in the complementary services.

FIGURE 7: **OVERVIEW OF MAIN CAUSAL PATHWAYS IN GITIBURI**

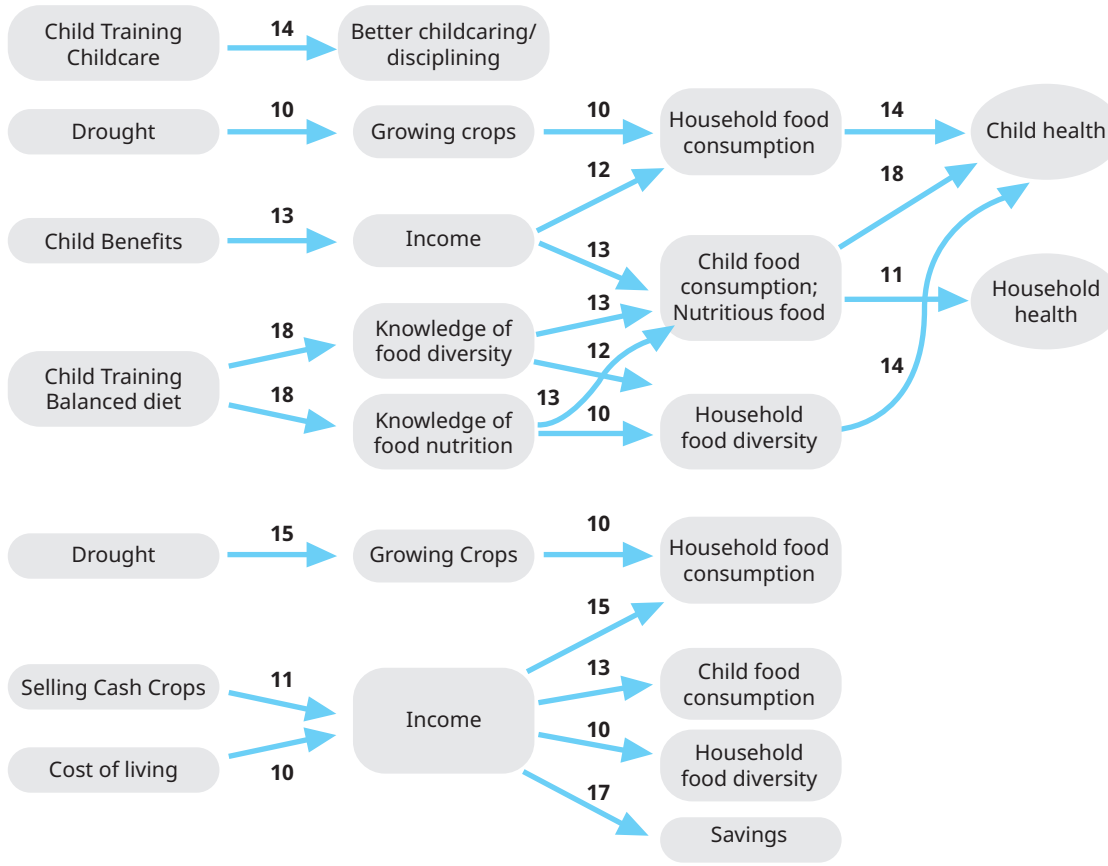
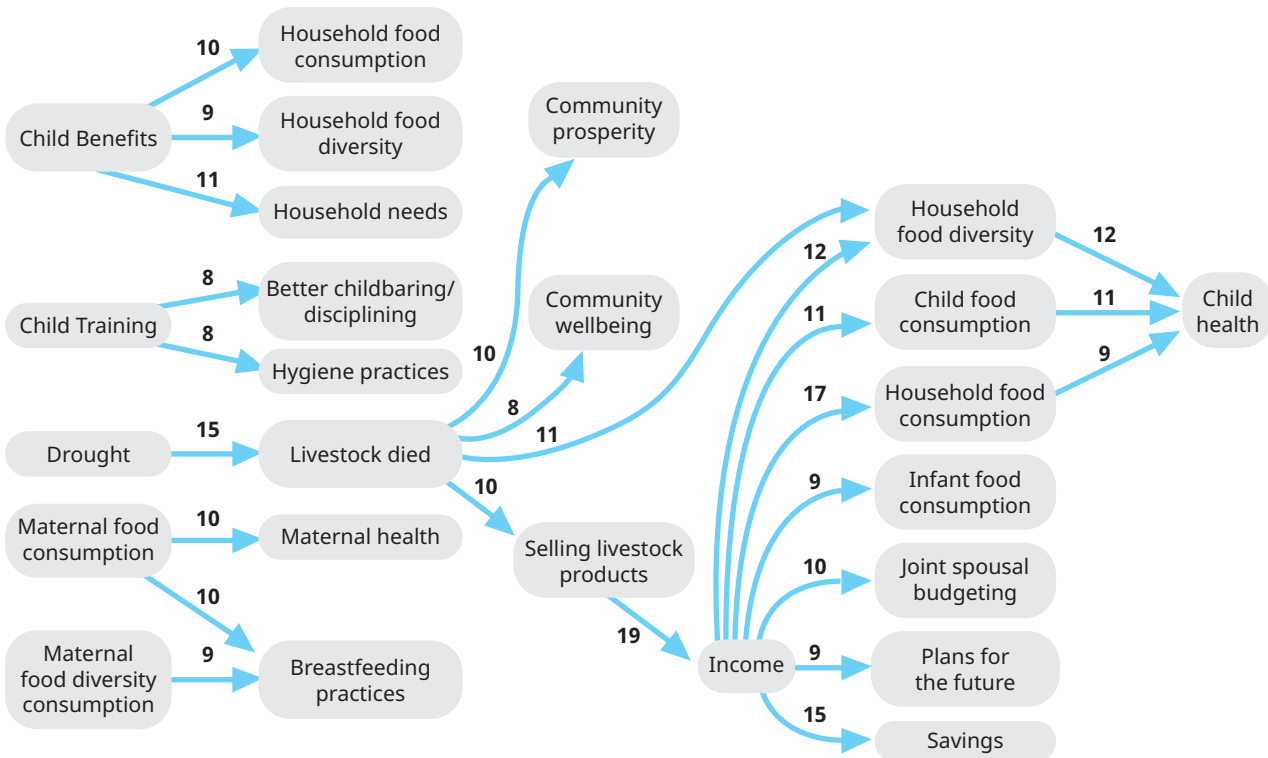


Figure 7 shows several key causal mechanisms that influenced the outcomes of beneficiaries in Gitiburi. The most important of these is the training on balanced diets for children. Respondents explained that this had a positive impact on their knowledge of food nutrition and diversity, which subsequently improved food consumption[5] and ultimately child and household health[6]. In terms of child health, the largest impact was attributed to increased child food consumption, with 18 out of 24 respondents in Gitiburi suggesting this was the case.

The second key causal mechanism highlighted by respondents was the drought. More than half of the respondents reported that the drought had negatively impacted their ability to grow crops which, in turn, reduced income generation. Both the drought and the increase in cost of living adversely affected household food consumption, child food consumption, household food diversity, and the ability to generate savings. This was generally mentioned as an outcome after the intervention period.

Figure 12 depicts the causal mechanisms for outcomes in Ildamat. The results show that the most important causal mechanisms relate to the drought and the subsequent reduction in sales of livestock products as a result of livestock losses, which ultimately reduced the income of virtually all respondents. Juxtaposed with Gitiburi, the severity of the drought overshadowed positive impacts of the UCB pilot on household and child food consumption. Instead, the reduction in income adversely affected all food consumption related factors and, critically, child and maternal health.

FIGURE 8: **OVERVIEW OF MAIN CAUSAL PATHWAYS IN ILDAMAT**



5 Unless otherwise specified, all references to the 'food consumption' label refers to the quantity of food consumed. Other factors may include a nested code (ie. Food consumption; Nutritious food), in which case it is referring to increased consumption of the nested code.

6 Across the QuIP analysis, health is primarily defined as an absence of illness.

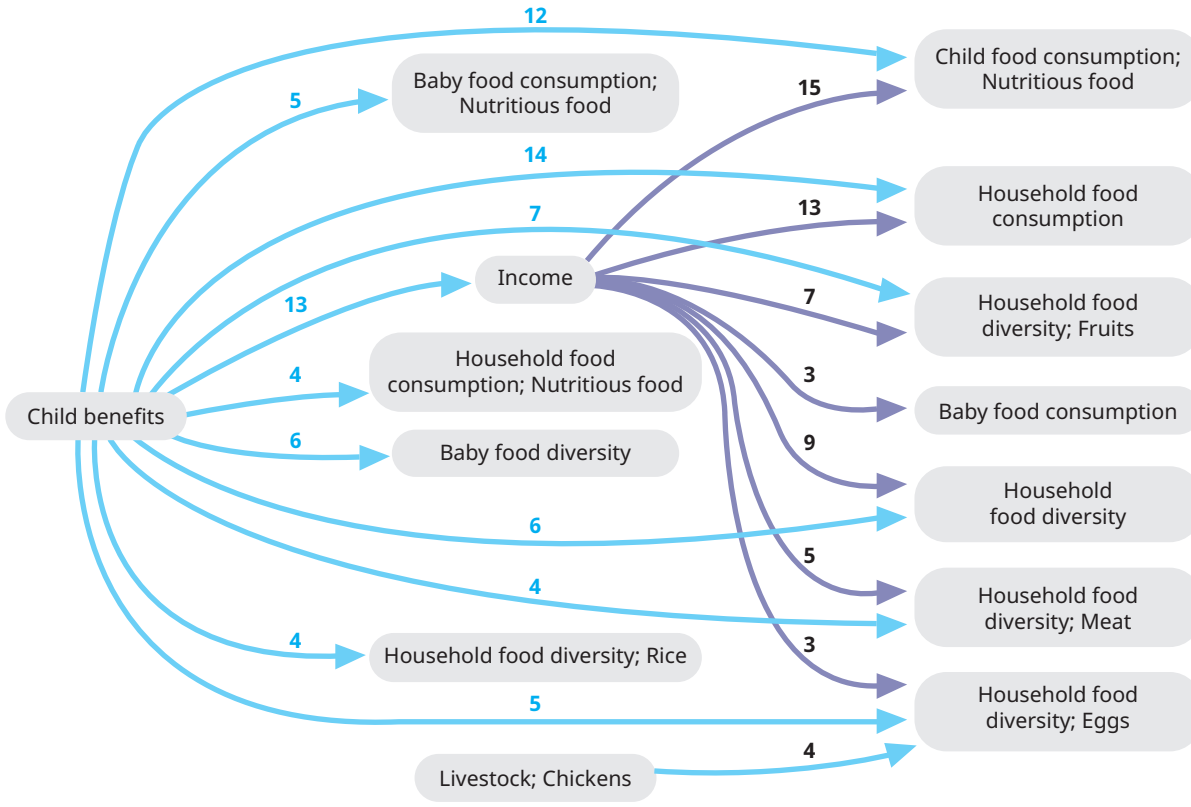
A key finding from both locations is that the negative outcomes were primarily experienced during the period after the end of the UCB intervention. As the drought and inflation were external factors that were prevalent during the UCB pilot, this finding suggests that the UCB programme had a protective effect during the intervention period.

6.2 Impact of the UCB cash transfers on household food consumption

The most cited causal mechanism across both research locations is the impact of receiving cash transfers. Figure 9 depicts the direct causal outcomes of the cash transfers in both locations. The outcomes are differentiated according to the direct uses of cash transfers and how this translates to an increase in the quantity and the diversity of food consumed, and how cash transfers increase the total household income, which in turn increases food consumption outcomes. As Figure 9 indicates, 27 respondents (out of the 48) reported that either their increased income or child benefits payments directly influenced an increase in their child's consumption of nutritious foods. 26 respondents reported an increase in general household consumption. Fruits, meat, and eggs were the most often cited food items that respondents were able to purchase due to the increased income. Moreover, as the following quote suggests, the cash transfers helped to mitigate the impact of the drought during the intervention.

"The cash they sent us enabled us to buy more food such as fruits, liver and eggs for the children. That programme helped us because there was a drought."
(S.95 GCF6)

FIGURE 9: **IMPACT OF CHILD BENEFITS ON HOUSEHOLD FOOD CONSUMPTION**



The training on cooking nutritious and balanced meals proved to have an important impact on the general food consumption of the respondents, and it also improved the food consumption for children and infants. As Figure 10 suggests, almost every respondent in the sample reported that the training in nutrition had increased their knowledge of nutritious foods. The increased knowledge led to an increase in the diversity of food consumption for households, children (defined as older than three years old), and to a lesser extent, infants (defined as less than three years old).

"I changed how I feed my children since I received training from the mother-to-mother programme, I have learnt to give them balanced foods. The babies have visibly gained weight and they are glowing. I am happy to see them healthy. It means that I'm taking good care of them."
(S. 100. GCF6)

FIGURE 10: **IMPACT OF CHILD BENEFITS ON HOUSEHOLD FOOD CONSUMPTION**

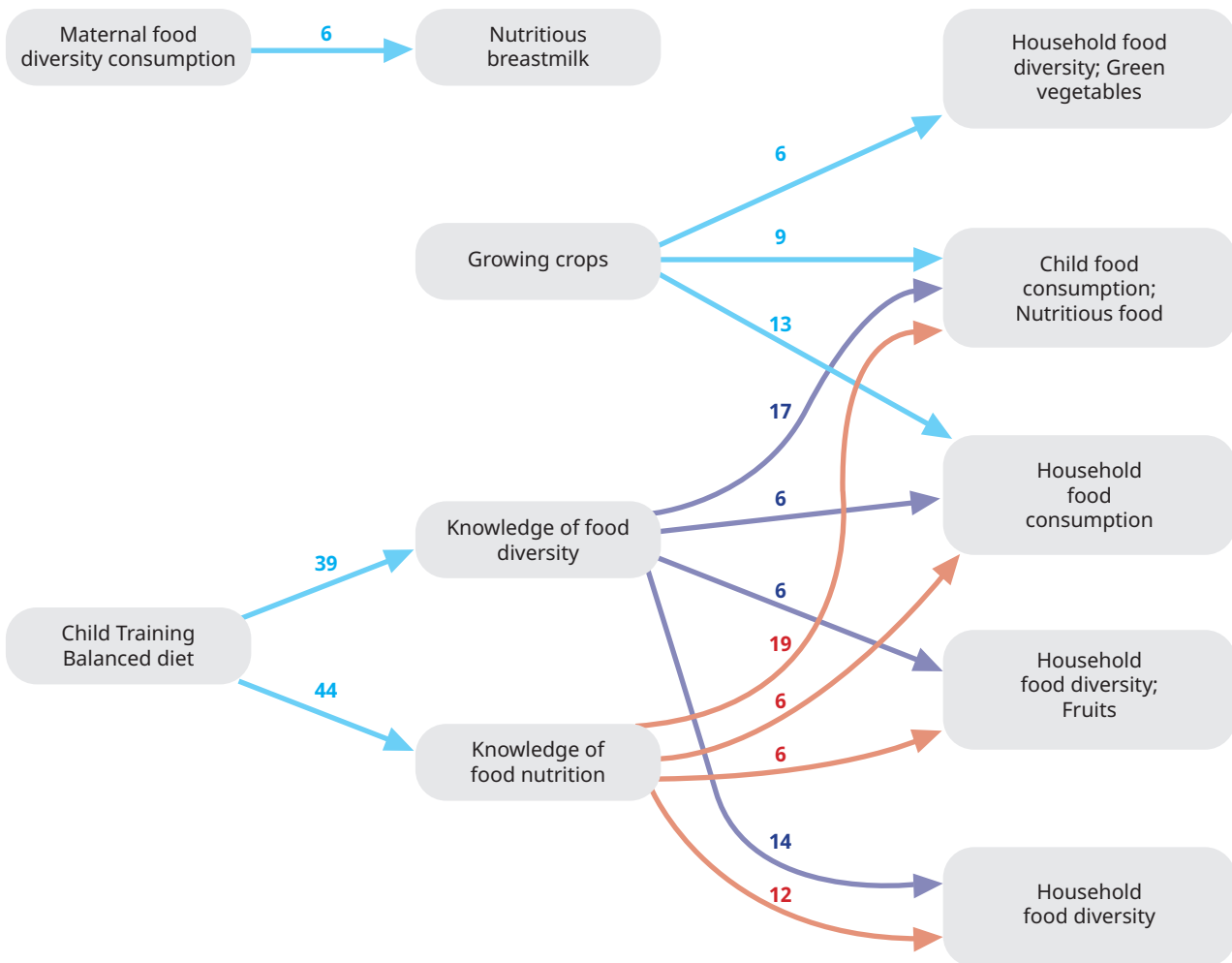
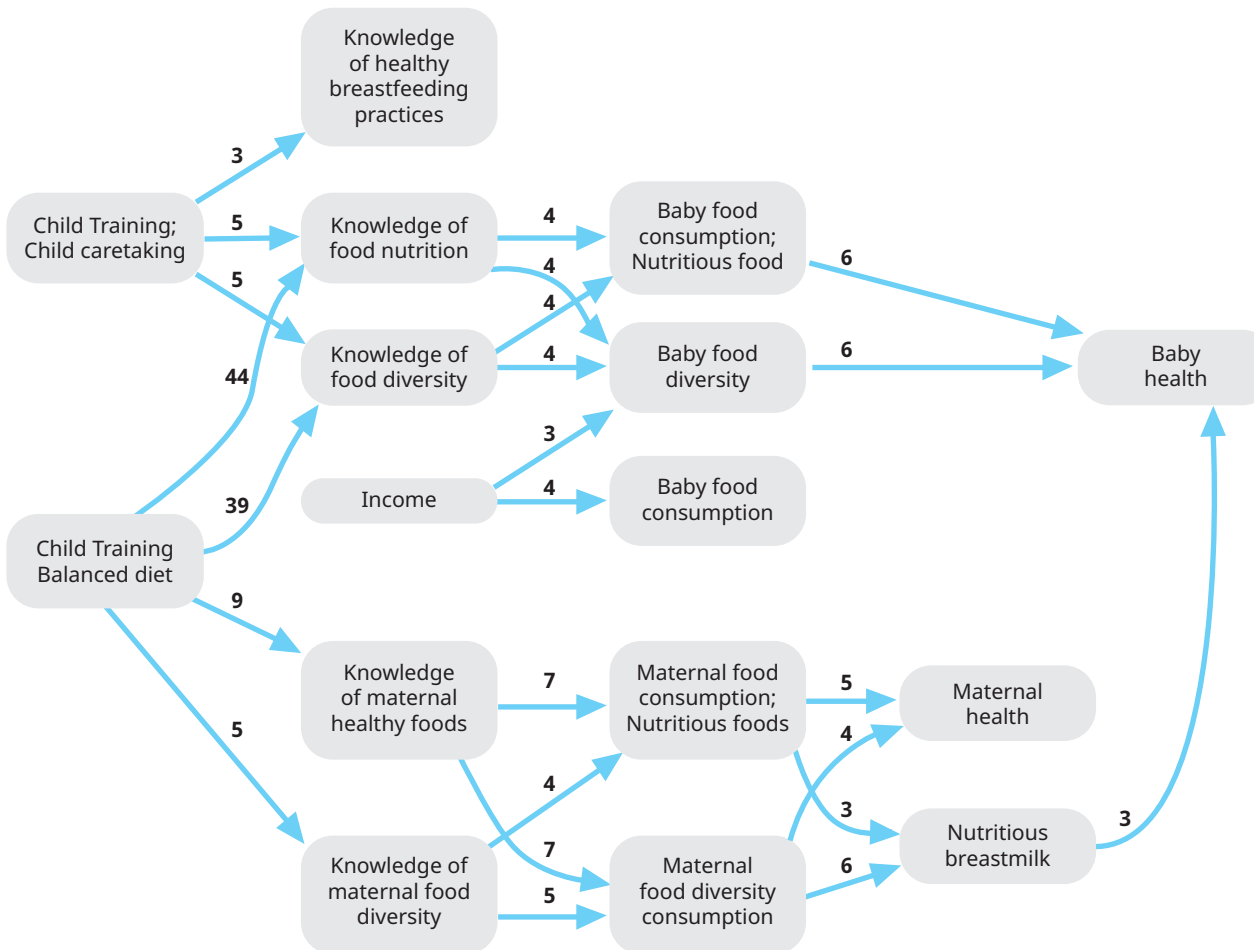


Figure 11 shows the impact of child benefits and training on the nutrition of young infants and mothers. Responses were considerably lower as a minority of mothers in the sample had not given birth in the previous year. Specifically, the training increased the knowledge of nutritious and diverse food consumption during pregnancy, which consequently improved consumption and, ultimately, the nutritional quality of the mother's breast milk. Likewise, increased knowledge of a balanced diet led to an improvement in food consumption for non-breastfeeding infants, as one male respondent from Gitiburi states:

> "There have been some changes in her breastfeeding practices compared to before. According to the teachings she received from the child nutrition organisation, she has continued breastfeeding our three-year-old child on demand and is planning to breastfeed her until she is five years old. [...] The teachings she received [also] talked about the importance of a nutritious diet for both her and the baby's well-being. Eating a variety of nutritious foods is believed to support the baby's growth and development through breast milk."
> (S. 408 GMM7)

FIGURE 11: **IMPACT OF THE CHILD BENEFITS, NUTRITION AND PARENTAL PRACTICE TRAINING ON INFANT AND MATERNAL FOOD CONSUMPTION**



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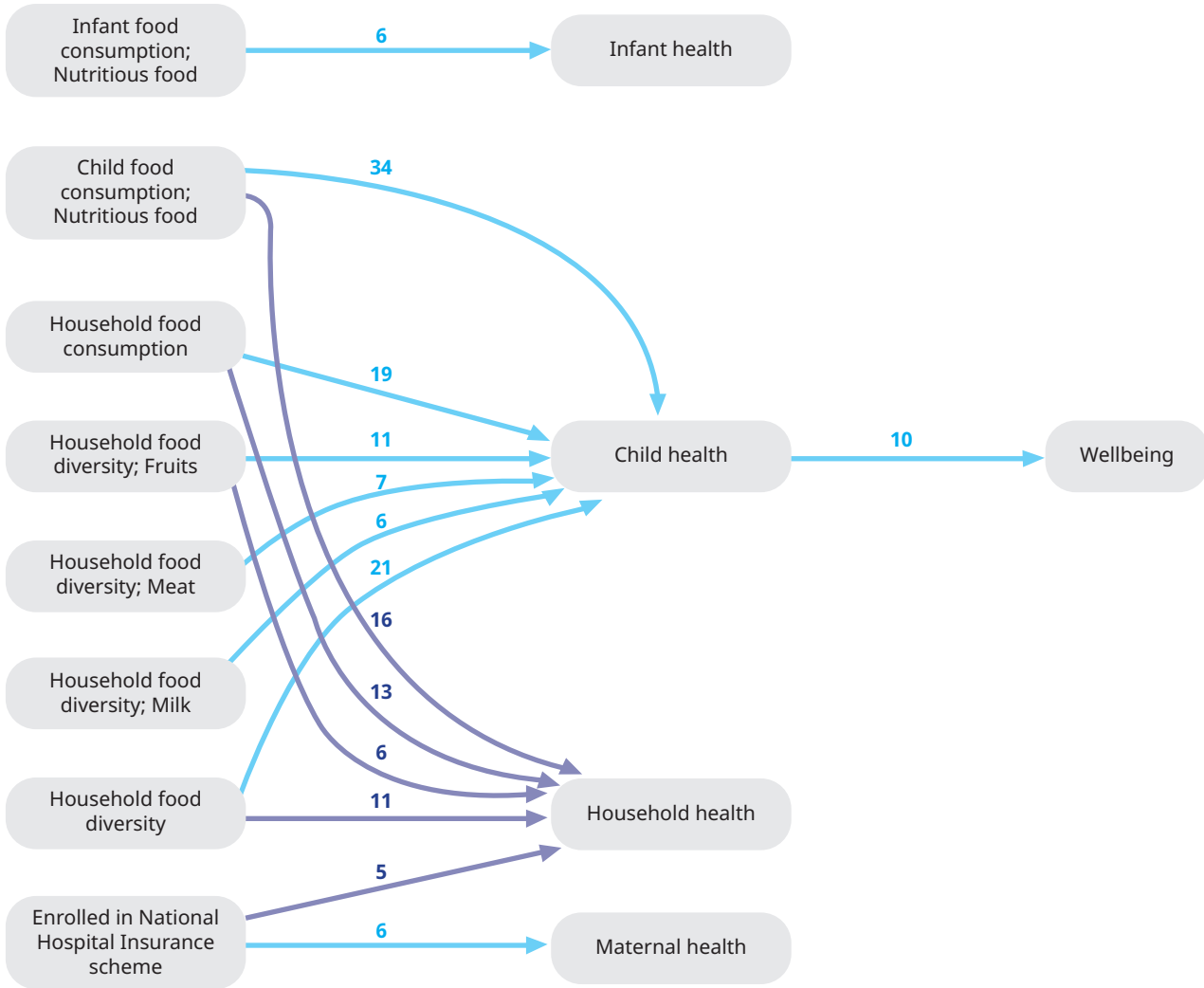
6.3 Impact of the UCB on child and maternal health outcomes

Figure 12 shows that the increased household food consumption positively influenced the child health outcomes in beneficiary households. Respondent narratives point towards meat, milk, and fruit as particularly valuable for children's health. In these narratives, child health is most often described as an absence of illness. This causal link underlines the role of increased knowledge on nutritious food consumption and diversity.

"There was a programme called *Lishe Bora*[7] and they provided us some money which we could now use to buy meat to eat with ugali or rice, eggs, milk, different vegetables and fruits and this led us and the children to having a good diet. [...] They are now very healthy."
(S. 226. GMF3)

FIGURE 12: **IMPACT OF CHILD BENEFITS ON HEALTH OUTCOMES FOR CHILDREN, MOTHERS, AND HOUSEHOLD**

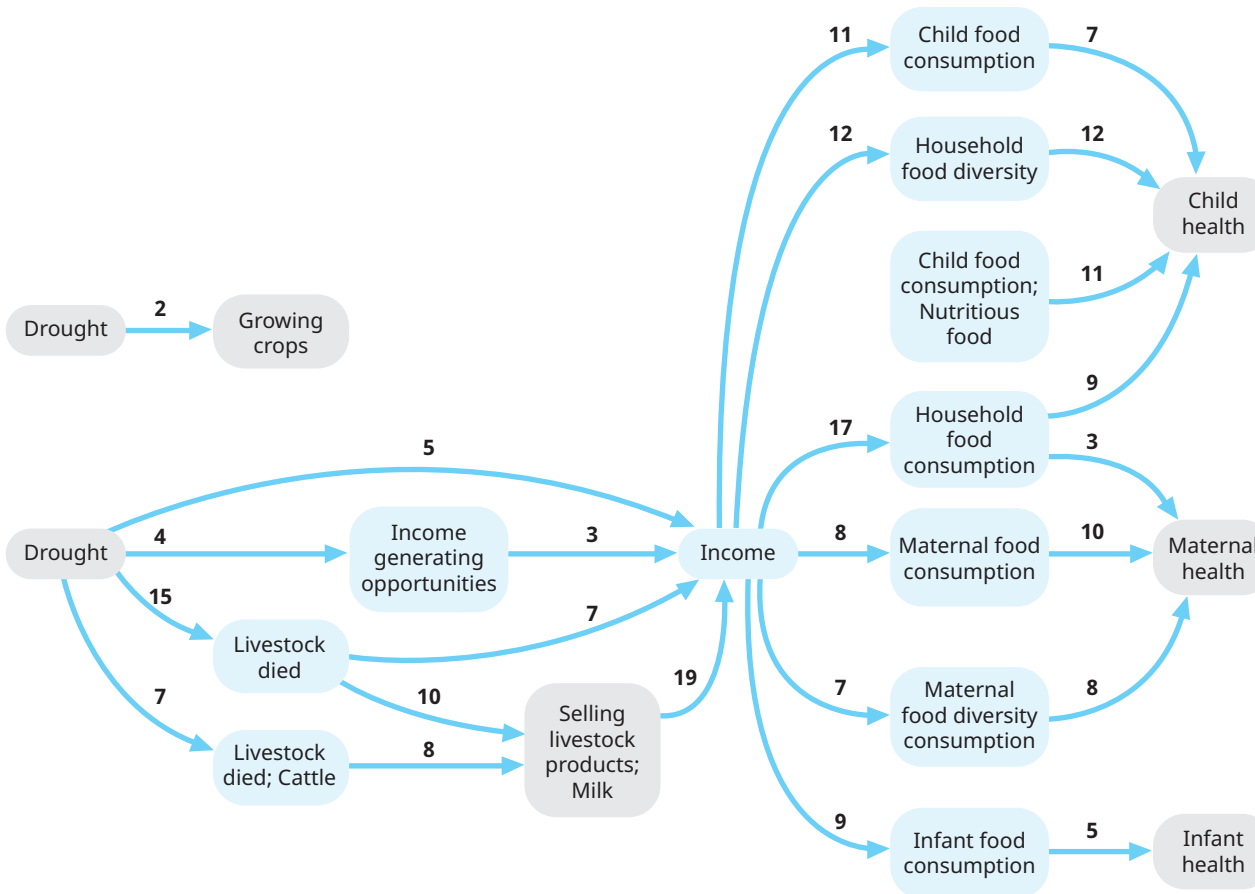


7 The child training services provided along with the UCB programme is variably called Lishe Bora across respondents in Gitiburi.

However, these impacts may not have been sustained post-UCB intervention, due to the drought which negatively affected health outcomes of households. This was especially notable in Ildamat, where the community is mostly made up of pastoralist farmers. The loss of their cattle as a result of the drought, and the loss of income from the UCB, drastically reduced their food consumption which was detrimental to household health, including that of children and infants. Figure 13 shows that recipients in Ildamat relied almost exclusively on selling milk from their cattle for their income. Additionally, the milk from their cattle would supplement their children's nutrition. As this mother from Ildamat recalls:

> "I can say my baby is not jovial and lively as she used to be. She is always asking for food because she is not getting enough to eat. Before, when she was breastfeeding, I was eating well and she used to be fine. Now that she has stopped breastfeeding, the food we get is not enough for all of us. This has affected her health."
> (S. 1316 ISF6)

FIGURE 13: **IMPACT OF LOSS OF INCOME ON CHILDREN, MOTHER, AND HOUSEHOLD HEALTH IN ILDAMAT**



Poor maternal food consumption was also highlighted in the causal narratives, as it led to the deterioration of the mother's health and the premature discontinuation of breastfeeding, as this respondent recalls:

"Due to food scarcity that was brought up by droughts, I could not get enough food to eat and because I was breastfeeding, my body grew thin each and every day and I had to stop the baby from breastfeeding."
(S. 1092 IDF7)

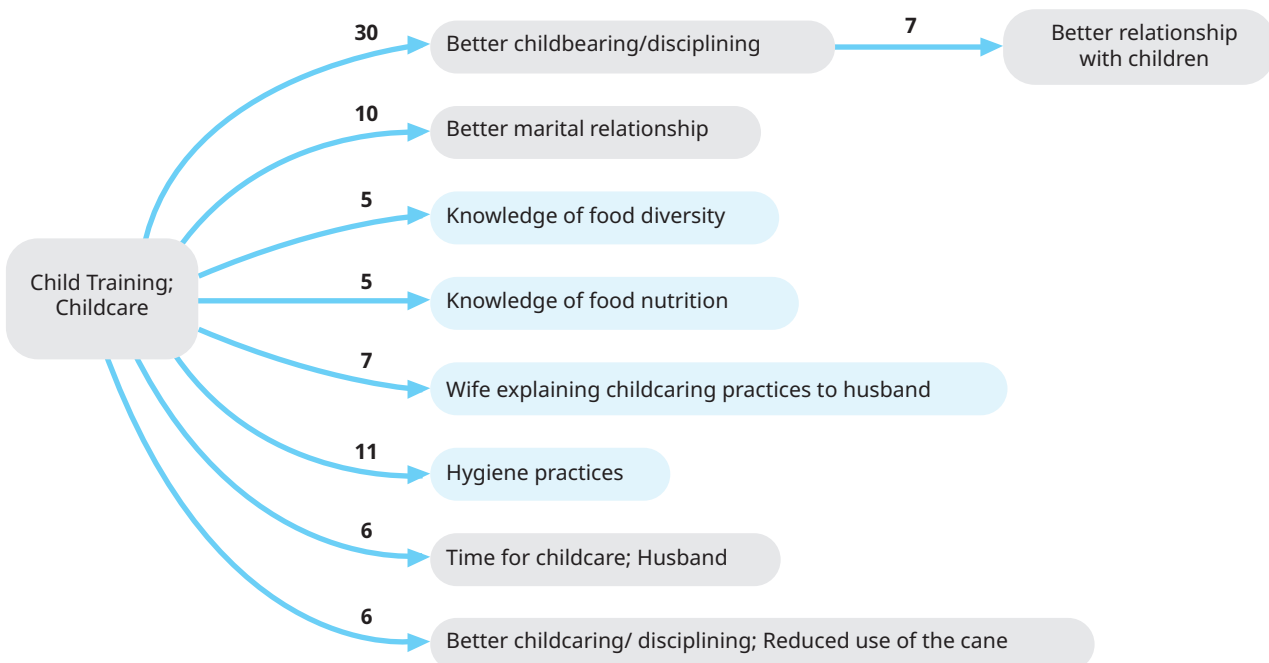
According to some respondents, childcare training also increased hygiene practices. However, these responses were too few to suggest a strong influence.

6.4 Impact of the UCB on parenting and childcare

Within this domain, the QuIP explored several aspects of parenting and childcare, including changes in the relationship between caregivers, changes in childcare, and changes in educational attendance. Figure 14 provides an overview of changes across these areas, and the results suggest that the training in positive parenting had a positive impact on childcare practices. A total of 36 out of 48 respondents reported this impact. Additionally, as already demonstrated in section 5.1, several of the male respondents claimed to have learnt better childcare practices as a result of discussions with their spouses who had attended the training, as this male respondent from Gitiburi explained:

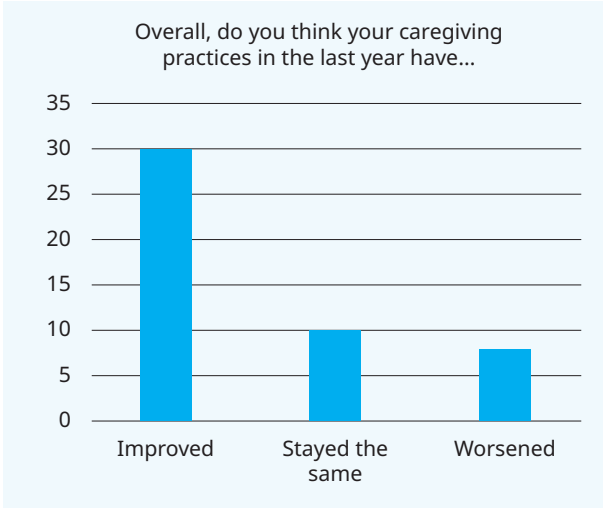
"The training that my wife attended on childcare was not limited to her alone; she kindly shared the knowledge with me as well. That influenced and improved my own caregiving practices. The willingness to pass on the information and insights gained from those seminars has enabled me to develop a better understanding of childcare techniques and the importance of nurturing our children's well-being."
(S. 291. GMM3)

FIGURE 14: **THE IMPACT OF CHILDCARE TRAINING**



As Figure 19 shows, a large majority of the respondents reported that their caregiving practices had improved.

FIGURE 15: **OVERALL IMPROVEMENTS IN CHILDCARING PRACTICES**



Several respondents further clarified that attending the training reduced their use of caning when disciplining their children:

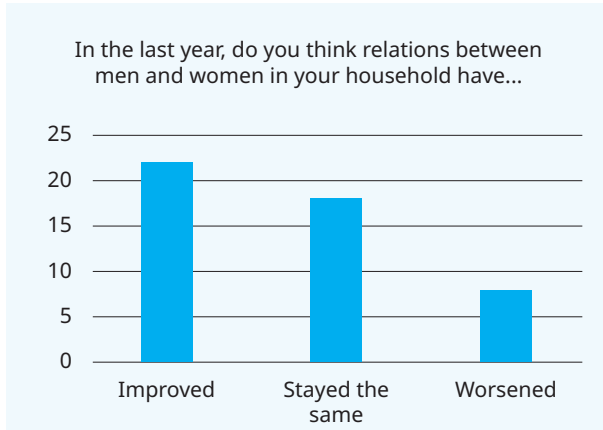
> "Previously disciplining meant caning them if they went against my expectations. I am no longer quick to anger, and I know to have a conversational approach to correcting mistakes. Also, my child would retract and run from me and fail to eat after caning and blame me for not telling her that it is wrong, only to cane her later. Also, like I said before the training, I was very rude with the kids but after the training I am now friendly, and we have become friends."
> (S. 334. GCF8)

The training in positive parenting also led to improvements in marital relationships. One female respondent from Gitiburi reported that the knowledge she gained from the training and her improvements of childcaring practices increased the harmony between her and her husband:

> "Our relationship has changed, he has become more supportive, and we are able to plan for the future of our children. I actually think that it is because of my reduced anger that he loves me more nowadays and we have consultative meetings on what to do and when."
> (S. 112. GCF6)

This was apparent in the global closed questions, which suggests that most respondents found that their marital relationship had improved over the course of the UCB pilot (see Figure 20).

FIGURE 16: **IMPROVEMENTS IN HOUSEHOLD RELATIONS BETWEEN MEN AND WOMEN**



It should be noted that there were important differences in childcare and relationship outcomes between locations, with Ildamat once again showing a reduced number of positive causal links across all related outcomes. Only 8 respondents out of 24 reported that the childcare training improved their childcare practices. Furthermore, a considerable number of respondents reported that their relationship with their spouses and children remained

unchanged and aligned to local customs:

"Men in our community feel it is our work as women to take care of the children and so they don't involve themselves in taking care of the children because it is my duty as a woman to ensure that the kids are taken care of."
(S. 1099. IDI 7)

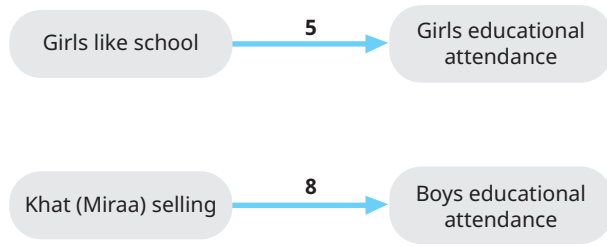
Similarly, educational attendance among the children of beneficiaries considerably varied across both locations. In Ildamat, most respondents did not observe any major changes in educational attendance between boys or girls. A minority of respondents revealed that the free school meals provided as part of a recent government initiative had encouraged their children to attend school:

"There is a lot of willingness from children to go to school mainly because of the feeding programmes that were introduced in schools in this area. In the past they could stay at home looking for anything to eat."
(S. 1918. ISF2)

In Gitiburi, however, school attendance for girls seemed to be high and motivated by a local cultural norm that encouraged girls' educational achievements. Conversely, young boys seemed to be drawn away from schooling due to the pressure to work in the Khat (a drug/stimulant known as Miraa in the local dialect) growing sector (see Figure 17):

"In the community the girls hold education with high esteem while boys mostly drop out of school due to this business of farming and selling Khat (Miraa)."
(S. 118. GMM1)

FIGURE 17: **EDUCATIONAL ATTENDANCE IN GITIBURI**



6.5 Impact of the UCB on individual and household budgeting

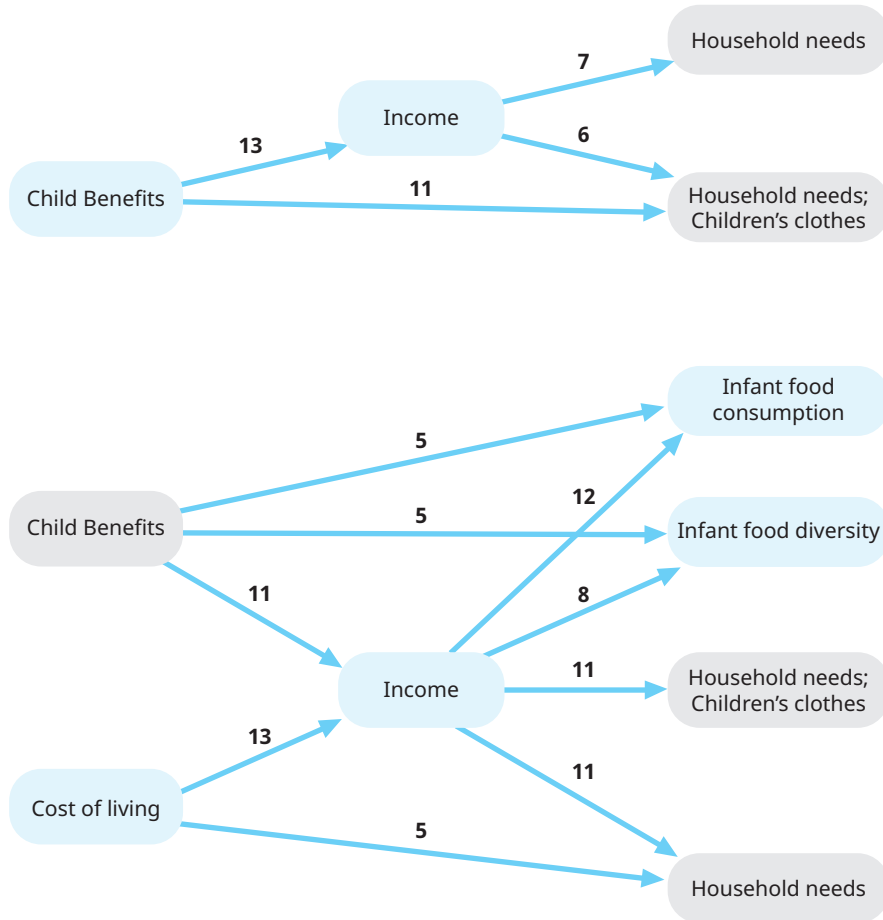
The impact of the UCB on individual and household income is uncertain in the findings. The most important causal pathway is the increased income as a result of the cash transfers and the increased ability to purchase clothes and medication for children. One Gitiburi respondent stated that the UCB was instrumental in this impact:

"My wife used to receive money to buy food for children from Lishe bora children programme. She used the funds to buy necessary food items like rice, meat, and unga to make ugali. She also bought clothes for the child and paid for medical expenses whenever the child got sick." (S. 676. GMM4)

Figure 22 indicates that both the cost of living and the discontinuation of cash transfers are key causal mechanisms in reducing the amount of household goods purchased by recipient households, as explained by this female respondent:

"The economic times are tough, and I do not have enough to buy adequate food and basic needs. My income has not changed yet; prices of food have gone up. I buy less food because of a lack of money. Also, the support from the children programme stopped last year so I'm not able to buy the number of things that I used to buy."
(S. 545 GCF10)

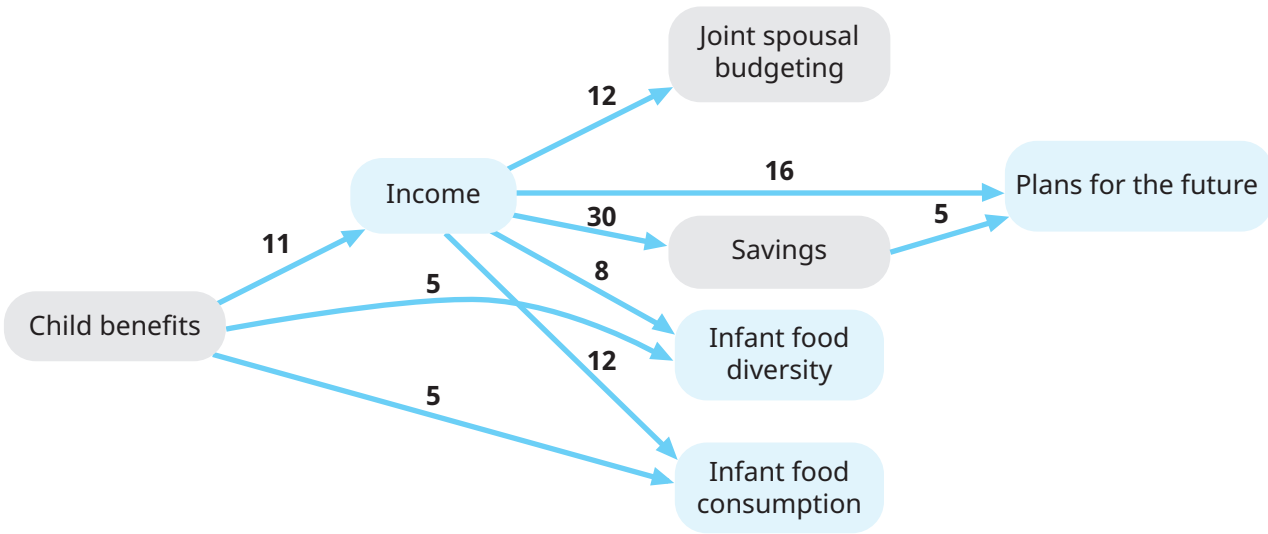
FIGURE 18: **IMPACT OF THE DISCONTINUATION OF THE UCB ON HOUSEHOLD NEEDS**



The reduction in income had a negative impact on several other key domains, such as savings and spousal joint budgeting (see Figure 19). As one respondent states:

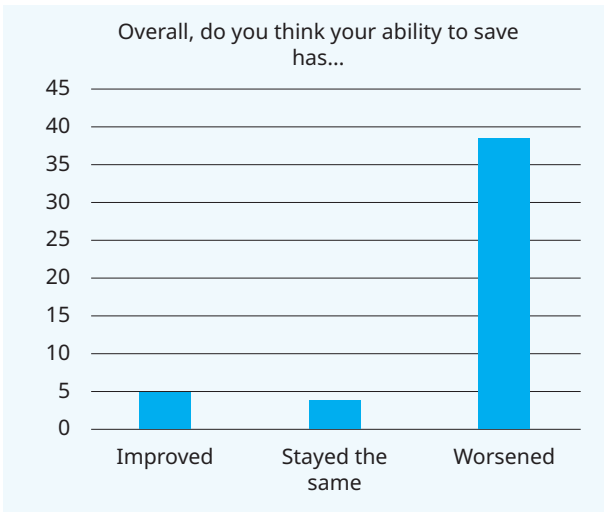
> "The only time that we have ever sat down to discuss spending and saving is when I started receiving money from Save the Children project and he insisted that we do something important and that is when we started the chicken project. Ever since we don't make decisions together, he decides alone. He involves me in decision making when I have money and when I don't, he doesn't."
> (S. 71. GMF1)

FIGURE 19: **SAVINGS AND JOINT SPOUSAL BUDGETING**



Overall, the respondents indicated that their ability to save had worsened (see Figure 20).

FIGURE 20: **OVERALL HOUSEHOLD ABILITY TO SAVE**



The impact of low income on savings has further ramifications on beneficiaries' ability to make plans for the future. In both locations, the reduction in income led to a loss of general resilience or income generating strategies, such as investments in new enterprises or the expansion of farmsteads:

"I had plans to grow my income generating business but since the end of the Save the Children project and my chicken business went down, these plans came to an end, and I can only wish for it to come back so that I am able to fulfil my dreams."
(S. 85. GMF1)

The research found little evidence of an important or lasting impact on women's income generating activities and women's empowerment. This may be because the UCB pilot had ended for at least six months before the research, and the cost of living and drought curtailed any positive outcomes that women in the sample may have experienced during the pilot.

"So, I had that motivation because of the money I used to get from Save the Children but this year with no cash from the project and the little money I can get, it all goes to food and there is nothing that can go towards starting any income generating activity. The kitchen garden I used to have dried up due to the drought, but I still have the chicken and the rabbits though they don't generate any income for me. I slaughter them whenever I am out of cash."
(S. 69. GMF1)

6.6 Impact of the UCB on community relations and wellbeing

The QuIP analysis did not provide meaningful insights into the drivers of wellbeing among beneficiaries and communities. However, based on the Causal Map in Figure 21 it is possible to identify certain trends that positively or negatively affected wellbeing during and after the pilot intervention. The most often cited causal mechanism to positive wellbeing was child health, with several respondents reporting that their children's health played an important role in the wellbeing of their household:

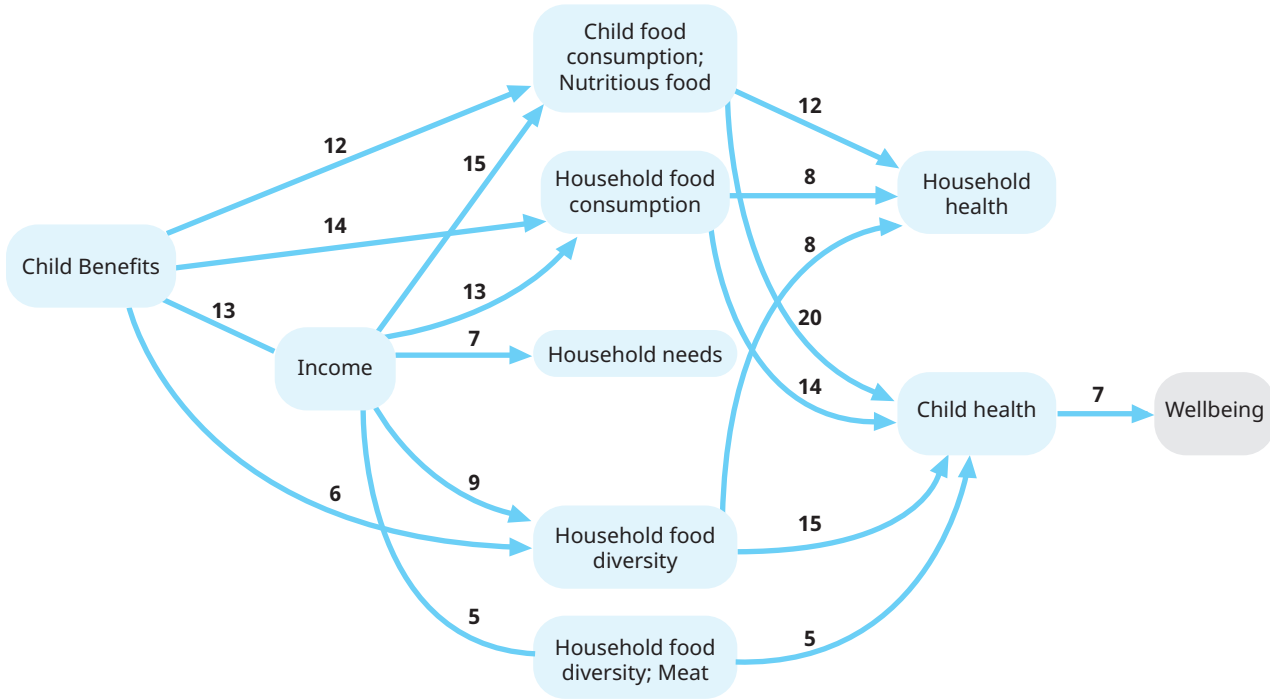
"My children's health means a lot of joy and happiness to me. There is no peace of heart when a child is sick. The more a child is sick and not in good health, you have a lot of stress and yourself you might be in and out of hospital because you are depressed."
(S. 1045. GMF4)

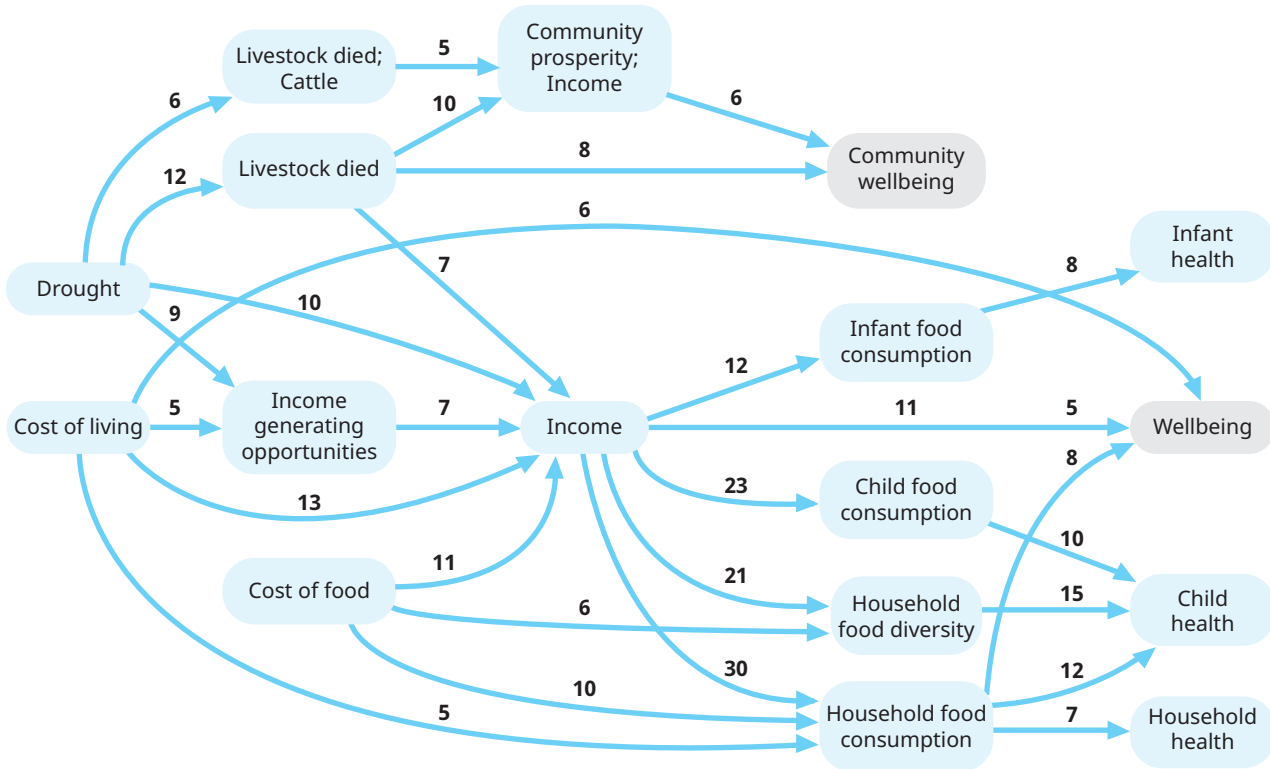
Conversely, the most important factor negatively impacting wellbeing was the decrease in child and household food consumption and income. This was most commonly cited when referring to the experiences of the beneficiaries after the intervention had ended.

The differences between Ildamat and Gitiburi were especially important. A majority of the respondents explained that the discontinuation of the UCB pilot and the drought and subsequent livestock deaths had deleterious effects on income and wellbeing in Ildamat:

"There is some change in the social life because the drought has killed people's animals and that has made life to be very difficult. There are some cases of depression."
(S. 1248. ISF2)

FIGURE 21: **COMMUNITY RELATIONS AND WELLBEING OUTCOMES**





7 Sustainability and scalability

7.1 Sustainability

The UCB programme's sustainability is significantly bolstered by a strong consensus among stakeholders that it represents a valuable investment in Kenya's future. The programme's focus on addressing malnutrition, improving parenting practices, and ensuring that every child has the best possible start in life aligns closely with human capital development goals, which are critical for the country's long-term prosperity. Stakeholders recognise the vital importance of investing in children's well-being, with high levels of buy-in from both implementers and communities. This broad endorsement underscores the programme's relevance and appropriateness, even in the face of challenges such as data management.

In terms of the sustainability elements built into the programme, the training of CHVs and CPVs was by far the most promising aspect of the UCB pilot. The training provided to volunteers was a crucial component of the programme, equipping them with the skills and knowledge necessary to facilitate counselling, social behaviour change communication (SBCC), check-ups, and referrals. The foundational knowledge imparted to volunteers has had enduring effects. As one informant acknowledged, "we worked on continuous education because the knowledge is still there" (KII 11, Kajiado).

This training is perceived to have long-term benefits, not only by enhancing the capacity of local social service delivery but also by promoting community cohesion and support through the formation of mother-to-mother support groups. The sustainability of these groups is highlighted by the continuation of activities beyond the program's pilot phase. As one volunteer noted, "the groups still exist even now" (FGD1, Volunteers, Kajiado) and continue to meet, fostering a lasting community network that supports mutual assistance and ongoing education. As another beneficiary shared: "even if the finances stopped, we still continue with the group up to date…we are still growing vegetables; we have never left each other since we started." (FGD 11, Female beneficiaries, Kajiado).

While these findings point towards a strong basis for sustainability, stakeholders nevertheless pointed out at the validation workshop[8] that clarity was needed regarding the exit criteria for the programme and that there were no linkages to other social protection programmes for children graduating from the UCB. Additionally, stakeholders suggested that the government should work towards universal coverage by first expanding programmes like Cash Transfer for Orphans and Vulnerable Children (CT-OVC) and Nutrition Improvements through Cash and Health Education (NICHE), and then linking these programmes with other social protection efforts to gradually build up to universal coverage which should ensure the sustainability and scalability of the programme.

8 A validation workshop was held between 28th and 30th of May 2024, gathering all key stakeholders to discuss the findings of this study.

Overall, the UCB programme design is viewed as a sustainable investment with the potential for significant long-term benefits to the community. This perception is supported by the programme's integration into local practices and its focus on building community capacity, ensuring that its positive effects will endure beyond the programme's direct intervention.

7.2 Scalability

The study concluded that the design parameters and foundational implementation structure for a national rollout are well established. While the pilot phase revealed several challenges, most of these issues are addressable and provide valuable lessons for improvement.

Overall, respondents generally agree that the programme is scalable. However, perspectives differ on which aspects should be replicated or scaled. Some see an opportunity to refine and repackage specific elements, such as adding modalities to the cash component and overall design. This is highlighted by a key informant at the national level, who suggests, "scaling up allows us to take those elements [cash component and design] and shape what we have now into a new package" (KII8, National level). On the other hand, most respondents believe the current programme design is already well-suited for expansion.

Regarding foundational implementation structure, according to several national key informants, the existing local institutional structures are adequate and can support the transition of the programme to a national scale.

> **"At the moment it worked well because we used local structures to implement the programme. If we can continue using local structures trust me, the amount of funding that can go to the beneficiaries will be over 90 to 94%. So, the administrative cost can be lower to around 6%. But if we start doing the things around again, the cost of administration will be higher, the programme will never be viable, and of course, it won't be sustainable in the long run... Leveraging on the existing structures, the existing capacity, and the existing infrastructure is the only way for programmes to run in Africa. We have a very robust structure both at local and national, we have a very robust MIS system that can take in anything"**
>
> (KII 3, National level)

The use of existing structures, in terms of human resources and underlying systems (CCTP MIS) is perceived as the biggest facilitator for a scale up. While challenges occurred with the delivery of the transfers due to the data management challenges, these can be rectified and further improved now that the CCTP MIS is in place. The CCTP MIS now includes the relevant module for the programme, which will reduce the costs and inefficiencies of utilising a manual system.

Key informants cautioned, however, that future scaling up should consider the extent to which the mobile transfer through M-Pesa is the most suitable payment modality. While a mobile money platform can reduce the opportunity costs of receiving cash transfers in terms of the transport and time required, the registration requirements may also drive exclusion. Inua Jamii and other national programmes deliver as per the bank choice model, allowing users to choose the type of bank transfer they want. However, banks also utilise forms of identification. Future scale-up should therefore consider either; 1) addressing the challenges or exclusion issues associated with the M-Pesa modality, or, 2) choose the bank choice model, aligned with the rest of the social protection sector.

"So for me, I think if you were to scale up this programme to a national programme for example, then, there should be a thinking around the delivery... the payments delivery systems and what model to apply."
(KII 6, National Level)

"It is very critical as a stakeholder as we sit and agree on the mode of payment. I know Inua Jamii uses an account-based payment model. The UCB uses mobile money platform, so I think it is good to sit down as stakeholders and see what the best economic and effective mode of payment for this particular programme is."
(KII 1, National level)

Regarding the cash plus elements, the strength of the programme and the potential for scalability derives from the smooth cross-sector coordination between the variety of local and national actors. Additionally, using existing institutional structures in the communities, particularly the existing social service workforce through its engagement with volunteers, contributed to effective programme delivery and is a key strength and potential for scalability. While some volunteers highlighted challenges with the workload, the majority of the volunteers did not perceive the group formation as significantly adding to their workload. As a result, implementation of the groups and the services can be cost-efficient as the human resources for delivery are already present. Regarding the potential for scale-up, one national level informant explains;

"we already have the structures, the implementation structures in place. We have volunteers who are within the community; we have the different departments who are the employees of the government whether national or county."
(KII 14, Implementor, Mbeere North).

From a financial perspective, the fiscal space is perceived to be the biggest challenge for future scale-up opportunities. Yet, there is potential to reduce administrative and implementation costs by leveraging existing structures.

"The main limitation is fiscal space...There is limited funding and all that. So that would be one of the major limitations.... I think that would be the only limitation... Most of the things are good to go."
(KII 8, National level)

"But in terms of rolling it out I think the challenge would be availability of resources, once the resources are there, we can put structures that can reduce the cost of operating the programme."
(KII 3, National level)

Finally, a gradual scale-up is perceived as a realistic way of expanding the programme. Most implementing and volunteer respondents also indicated that a gradual roll-out that is geographically targeted to vulnerability and malnutrition rates or a gradual increase in coverage over time, would help alleviate some of the implementation challenges. A gradual scale up can potentially build on the lessons from the South African experience where the coverage of Child Support Grant increased from 7 per cent in 1998 to 17 per cent in 2019, or the Nepalese geographical expansion of the Child Grant (Bastagli et al., 2020).

8 Conclusion

The UCB pilot was implemented as intended, with the government and partners collaborating effectively to roll it out across three counties. The registration process was successful, with 91% of identified households validated for participation. However, some areas for improvement included communication about the programme's goals, which left some beneficiaries unclear about its objectives. Additionally, challenges in acquiring necessary registration documents, like birth certificates or national IDs, led to potential beneficiaries being excluded. Community volunteers and traditional leaders played a key role in helping families access the necessary documentation, though barriers such as long travel distances to civil registration offices remained. The transition to the Consolidated Cash Transfer Programme (CCTP) Management Information System (MIS) caused some delays, particularly in the July-August 2022 payments, but overall, the payment system functioned smoothly, with only a 3% difference in recipients between the first and final payments.

The Community Health Volunteers (CHVs) and Child Protection Volunteers (CPVs) were instrumental in delivering complementary services. These volunteers conducted home visits, registered households, and linked communities to child protection services. The complementary services, which focused on positive parenting and nutrition training, were widely praised for strengthening family and community bonds. Some training groups eventually organised rotating savings schemes, which further underscored the value of these groups. While some male spouses eventually joined the training groups, participants widely recommended expanding the programme's male engagement to foster better intra-household communication around topics like nutrition and parenting.

Monitoring of the pilot was conducted through a mix of activity reports, MIS data, and spot checks, but post-disbursement monitoring faced resource constraints, leading to occasional delays in addressing grievances. Common issues included non-receipt of payments due to data discrepancies, compounded by a lack of real-time data updates. In some cases, volunteers reported struggling with high workloads, transport costs, delayed stipends, and limited information about the programme, all of which hindered their ability to support beneficiaries effectively.

The implementation faced both facilitators and barriers. Institutional structures within communities, such as primary care facilities and local government offices, facilitated smooth programme delivery. Cross-sectoral coordination at local, county, and national levels helped engage stakeholders. However, local service delivery capacity was limited in some areas, delaying referrals and reducing programme effectiveness. Economic, political, and climate-related factors also presented significant challenges. Inflation eroded the purchasing power of the cash transfers, while droughts compromised households' ability to maintain home gardens, killing livestock and straining already vulnerable households. The timing of the Kenyan general election in August 2022 caused political disruptions, with rumours about voter registration deterring some households from participating in the programme.

The UCB's design and delivery mechanisms were largely appropriate, accessible, and acceptable to beneficiaries. Cash transfers, delivered through mobile money, were a suitable method, given the widespread use of mobile payments in the region, though some beneficiaries who lacked personal phones or identification documents faced accessibility issues. While many beneficiaries appreciated the income support, they felt the transfer amount should have been increased to keep pace with inflation. The complementary services, particularly the positive parenting and nutrition training, were well received, with many beneficiaries reporting improved parenting practices, reduced violence, and better spousal relationships. Volunteers and community members alike recommended more engagement with male caregivers to enhance the programme's impact within households.

In terms of sustainability and scalability, the UCB programme demonstrated a high degree of potential. The use of mobile money infrastructure, coupled with strong community-based volunteer networks, provided a scalable model for future expansions. The integration of government departments, such as the Ministry of Health and the Department of Children's Services, promoted coordination at national and local levels, enhancing the programme's viability for scaling. However, fiscal constraints and challenges in data management and referral systems need to be addressed. Stakeholders emphasised the need for clear exit criteria and linkages to other social protection programmes to ensure continuity of support for graduating beneficiaries. They also advocated for the expansion of the UCB programme to cover more children and to integrate it with existing social protection efforts like the Cash Transfer for Orphans and Vulnerable Children (CT-OVC) and Nutrition Improvements through Cash and Health Education (NICHE) programmes.

Overall, the UCB pilot made substantial progress in improving child health, nutrition, and parenting practices despite external challenges like drought and inflation. The programme's design, particularly its universality and reliance on mobile money, proved both accessible and acceptable to beneficiaries, with clear potential for scale-up if operational and fiscal hurdles can be overcome.

Regarding the limitations and opportunities for further research, a significant methodological limitation identified was the timing of the assessment. Although the study aimed to examine the implementation process of the pilot, it was conducted nearly six months after the intervention had concluded. This delay could have introduced recall bias among participants and restricted the ability to investigate the programme's effects on infants and the dynamics of ongoing implementation.

Further, the research primarily focused on the pilot's implementation to provide evidence for future expansion. However, some findings indicated areas needing further investigation or enhancement to inform the scaling up or nationwide rollout of the programme. These areas include:

- Additional research is needed to determine the most effective payment modality by comparing the issues with mobile payments to broader evidence from other cash transfer programs in Kenya. Exploring the advantages and drawbacks of mobile payments versus the bank-based model used in other government cash transfers could help ensure the best payment option for the programme. Implementers frequently raised concerns about exclusions associated with the mobile payment system.
- Since the study took place several months after the programme ended, the children born at the start or during the pilot were no

longer infants. The absence of newborns in the sample limited the ability to assess the pilot's impact on infants effectively. Future research could benefit from being conducted shortly after the pilot to include mothers with newborns, allowing for more actionable insights.

9 Recommendations

The recommendations are split into design recommendations, which seek to address experienced issues in the programme's design, and implementation recommendations, which focus on the aspects of implementation necessary to address during the potential scale-up or rollout of a similar programme.

9.1 Regarding the pilot's design

1. Ensure that the transfer amount is sufficient, ideally by adopting mechanisms to adjust it in real time during shocks or indexing it to account for annual inflation

The evidence from this pilot suggests that the value of the cash transfer was not perceived as sufficient for its intended outcomes. Exacerbating this was the reduced purchasing power as a result of the national and local inflated prices for goods, and the droughts which reduced the availability of food.

While many respondents indicated that the cash transfer proved to be an important source of income during the shocks experienced by households (as seen in the QuIP but also process results), the extent to which a cash transfer can provide adequate support is still embedded in it being sufficient for the local context. It is therefore imperative that a cash transfer is adjusted as needed to account for inflation over time and ideally adopts functions that allow adjustments to be made during crises.

2. Expand the payment model

Expanding the options for receiving cash transfers to include banks, in addition to existing channels like M-Pesa, can significantly enhance accessibility and convenience for beneficiaries. Many individuals, especially those in urban or peri-urban areas, may prefer the reliability, security, and additional financial services offered by traditional banks. By integrating banks into the cash transfer system, beneficiaries can choose the institution that best suits their needs, whether for ease of access, lower transaction costs, or the availability of savings and credit facilities. This inclusive approach not only broadens the reach of the programme to cover people who are unbanked or underbanked but also promotes financial literacy and inclusion by encouraging the use of formal banking services. Moreover, it can facilitate larger or more complex financial transactions that are sometimes restricted by mobile money platforms, thus accommodating a wider range of financial behaviours and preferences.

3. Engage men and spouses in the trainings in order to foster gender-transformative outcomes

The programme should aim to incorporate more elements that engage men in training on nutrition and positive parenting, to enhance the potential in delivering gender-transformative outcomes. While positive parenting modules refer to the role of men in the household, the potential of this to change practices and norms is limited if only women are present. Moreover, by targeting only women the programme may implicitly be reproducing existing norms around care and reproductive work allocation. Ensuring the husbands and men in the targeted communities understand the reasons for choosing women as the main target beneficiaries across the programme will also ensure that tensions over who

receives the cash transfers can be mitigated. As demonstrated in the findings, respondents suggested this training was key in eventually assuaging concerns men had over the use of the cash transfers.

4. Strengthen disability inclusion

Disability training within programmes and services should extend beyond merely providing information on referral systems to encompass comprehensive sensitisation on disability inclusion for all beneficiaries. Such training should aim to foster a deeper understanding and appreciation of the diverse needs and rights of individuals with disabilities, emphasising the importance of inclusivity in all aspects of service provision and community engagement. The training would also be strengthened through adequate engagement of Child Protection Volunteers and linkages with the National Council for Persons with Disabilities.

9.2 Regarding the pilot's implementation

The following implementation recommendations draw on the lessons learned from the pilot and are drafted in the context of considering how a nationally scaled programme would operate.

1. Strengthen communication and sensitisation processes from registration and throughout programme implementation

Effective communication before and during registration is essential to increase uptake. It is essential that the Government of Kenya is at the forefront of sensitisation efforts to increase overall awareness in the community. As evidenced by the pilot, the paucity of information led to misinformation and the perpetuation of rumours during the early stages which may have hindered registration and resulted in issues around the acceptance of the programme. It is thus crucial to have good communication from early registration and throughout programme implementation to ensure continual awareness of the programme's design, purpose, and their expected involvement.

2. Strengthen targeting and registration processes

This can be achieved by harmonising the registry and information systems and promoting timely birth registrations. Specifically:

- Enhance interoperability and the integration of various government systems (National Registration Bureau, Civil Registration Services, Pension Scheme, CCT MIS, enhanced single registry) to streamline the targeting and enrolment process and ensure maximum validation of beneficiaries.
- Embed the registration process of the programme into the unified social registry. This will help to harmonise and integrate the UCB into the national social protection system.
- Provide continuous sensitisation to communities on the need for child-birth certificates and identification documents to reduce the chances of exclusion from the programme.
- Newborns at health facilities to be registered at birth and parents sensitised on the need for immediate certification. Creating linkages between Community Health Volunteers and community leaders to promote community birth registration and certification and hence enrolment into the UCB programme at the same "service window".

3. Create a more detailed institutional framework which promotes national level coordination

Creating a comprehensive institutional framework that defines the roles, responsibilities, and monitoring processes for each department would improve the efficiency of government stakeholders in

addressing challenges that range from child social protection to health and nutrition.

4. Ensure the regularity and frequency of cash transfers

The frequency, regularity and predictability of cash transfers are essential to consider in the design of a programme (Bastagli et al, 2020). While the pilot aimed to provide regular payments every two months, this was not achieved due to the data migration mid-intervention. While the data issues have been resolved, there were valuable lessons learned from this process around planning the data collection and verification processes and improving the monitoring processes so that any issues, inconsistencies, or delays in payments can be addressed in a timely manner.

5. Improve feedback mechanisms

The programme would benefit from a more timely and efficient feedback mechanism. The data and associated case management and monitoring, linked to the beneficiaries' registration and payment processes, did not always run smoothly and the processes for rectification were not always quickly managed. Ensuring that feedback mechanisms for both grievance and monitoring mechanisms function well is imperative for a well-run programme. This will involve ensuring that the programme has a detailed monitoring framework in place as well as sufficient resource allocation to carry out these activities.

6. Continue investing in the volunteer and social service capacity and coordination at the community level to increase the programme capacity to deliver results

To overcome barriers in implementation, it is essential to strengthen both the referral system and volunteer support. First, the government should increase the availability and responsiveness of social service officers at the community level to ensure timely follow-up and action on referrals, particularly for vulnerable groups such as children with disabilities. Establishing a feedback mechanism between social service officers and volunteers would help ensure that referrals are acted upon and reported back to volunteers, improving communication and service delivery.

Second, volunteers' capacity should be enhanced through a combination of financial and logistical support. This includes increasing stipend payments and ensuring timely disbursement to cover transport costs and alleviate financial burdens. Additionally, clear and up-to-date information about the UCB programme must be provided to volunteers, enabling them to respond effectively to beneficiaries' questions and strengthen the credibility of the programme. By addressing these key logistical, financial, and communication challenges, the programme's overall impact and sustainability can be significantly improved.

7. Ensure scalability and greater coverage for children

Consider increasing the fiscal space for the UCB by ring-fencing funds. In order to attain progress towards universal coverage, the government can strengthen linkages to other social protection programmes for children graduating from the UCB e.g. Cash Transfer for Orphans and Vulnerable Children (CT-OVC) and nutrition improvements through cash and health education (NICHE). This would also enable progress towards a lifecycle approach for social protection coverage of children.

Annex

Annex 1: Institutions involved in the implementation of the pilot

Institution	Role
Directorate of Social Assistance	• Overall operational management of the pilot; • Communications to beneficiaries to build awareness about the programme, through the development of a Beneficiary Outreach Strategy (BOS); • Coordinate the registration and enrolment of beneficiaries into the programme • Drawing up payment lists and reconciling payments; • Grievance and change management system at national level; • The management information system (MIS); • Support baseline survey, evaluation and dissemination of findings • Monitoring of the pilot; • Reporting on progress with the pilot to the Principal Secretary and the National UCB Technical Working Group; and, • Sensitisation and capacity building for workforce involved in the pilot
NSPS	• The overall coordination and lead of the programme (including budgetary and financial management); • Convene and chair meetings of the National UCB Technical Working Group; • Reporting on progress with the pilot to the Principal Secretary and Steering Committee, through the National UCB Technical Working Group; • External communications on programme/ public and international dissemination of news about the pilot; • The evaluation of the pilot programme; • Regular publications on the pilot, including its progress and impacts;
Department of Children's Services	• Providing policy and technical guidance, oversight, and quality assurance for the implementation of child protection activities. • Use of existing structures of NCCS for the effective coordination in child protection case management and referral (County and Sub-county level). • Liaison among implementing agencies at field level (County and Sub-county level) • Implementation of sensitization activities for communities and potential beneficiaries, based on the BOS (County and Sub-county level) • Implementation of the pilot at field level through Children's Officers (enrolment, targeting, data collection, link with BWCs…), in coordination with DSA and DSD (at both County and Subcounty level) • Handling of the G&CM at field level and escalation to DSA (County and Sub-county level)

Institution	Role
Department of Social Development	• Policy and technical guidance and coordination of all positive parenting and disability components of the programme. Policy and technical guidance on volunteerism. Recruitment, training and orientation of Lay Councillors who are responsible for implementing positive parenting and disability activities at community level. • Coordination of disability mainstreaming and support activities (e.g. certification and referral to external services) at County and Sub-county level. • Implementation of community mobilisation activities.
Ministry of Health	• Providing technical guidance and quality assurance for the implementation of the nutrition component of the programme in line with national standards and existing programmes. • Providing technical guidance and quality assurance for health services delivery and capacity building of Community Health Volunteers. (CHVs) • Support linkages with beneficiaries of other programmes at County and Sub-county level. • Support referrals to other health services at County and Sub-county level
Department of Nutrition	• Policies standards and guidelines on nutrition in the country. • Capacity building of the counties/National programmes in the area of nutrition in order to effectively deliver services. • Implementation of nutrition surveillance, screenings and treatment at County and Sub-county level. • Monitoring and Evaluation system for Nutrition. • Coordination of partners that support and implement nutrition activities and programmes in the country. • Logistics systems that ensure timely availability of quality essential live saving commodities.
National Council for Childrens Services	• Definition and formulation of policies on children's issues • Coordination and support of Child Rights issues • Planning, monitoring and evaluation of children's activities • Resources management for child welfare activities • Supervision and control over the planning, financing and coordination of child rights and welfare activities and to advise the Government on all related aspects.
National Council of Persons with Disabilities	• Technical guidance in the field of disability and child disability. • Coordination to the DSD to support the implementation of the disability component of the programme, by processing disability registration and certification, and facilitating linkages with facilities and suppliers able to provide specialized assistance to persons with disabilities (PwDs)

Institution	Role
Other	
UNICEF	• Provide overall support to the government in the design and implementation of the pilot, both at national level and at county level. At county level, one staff to support and coordinate the pilot implementation will be deployed in each county • Support the government in mobilisation and registration of beneficiaries, through a specialize firm or entity • Managing payments to beneficiaries through Safaricom
WFP	• Managing the evaluation/research and MIS components of the pilot, together with Save the Children
Save the Children	• Co-designing with government, UNICEF and WFP the "plus" component of the pilot and support its implementation • Support cash transfers for the first months of 2021 • Design protocols for nutrition components of the evaluation/research and participate in the analysis of nutrition indicators • Contribute to the implementation of the complementary services in close collaboration with the relevant government structures.

Source: Compiled based on data as present in the Operational Manual

Annex 2: Overview of Payments made across the Sub-counties

County	Households Registered for the programme	Payment Cycles					
		Transfer 1 (Dec, 2021)	Transfer 2 (Jan – Feb (2022)	Transfer 3 (Mar – Apr (2022)	Transfer 4 May – Jun (2022)	Transfer 5 Jul – Aug (2022)	Transfer 6 (Sept – Oct (2022)
Embu	**2,812**	2,599	2,525	2,531	2,618	1,334	2,572
		92.4%	89.8%	90.0%	93.1%	47.4%	91.5%
Kajiado	**2,111**	1,942	1,808	1,818	1,948	977	1,846
		92.0%	85.6%	86.1%	92.3%	46.3%	87.4%
Kisumu	**2,623**	2,523	2,377	2,385	2,535	932	2,434
		96.2%	90.6%	90.9%	96.6%	35.5%	92.8%
Total	**7,546**	7,064	6,710	6,734	7,101	3,243	6,852
		93.6%	88.9%	89.2%	94.1%	43.0%	90.8%
Not Paid		**(482)**	**(836)**	**(812)**	**(445)**	**(4,303)**	**(694)**

Annex 3: Reading Causal Maps

The causal maps in this report have been produced by filtering the data to only show links with a frequency above a certain number (typically more than 3) in order to show the most commonly cited links across the interviews – the key stories of change in the narratives. Maps will also be filtered for specific factors which are identified as important drivers of change or outcomes in the interviews and in some cases for specific groups of respondents.

Causal maps use two different counts:

1. Frequency count - refers to the number of times that particular link or factor was mentioned across all the interviews – this can be more than once per respondent.
2. Source count - refers to the number of respondents who mentioned that particular link or factor – this value is a maximum of one per respondent (a maximum of 24 in this dataset).

For example, if a respondent mentions the lack of work leading to decreased income five times in the interview – the number of times this link is mentioned in total would be the frequency count, 5, whereas the source count would be limited to 1 for this particular link. If a map link is labelled with '3', this means the link was used by 3 separate respondents, but it does not tell you how many times they mentioned it.

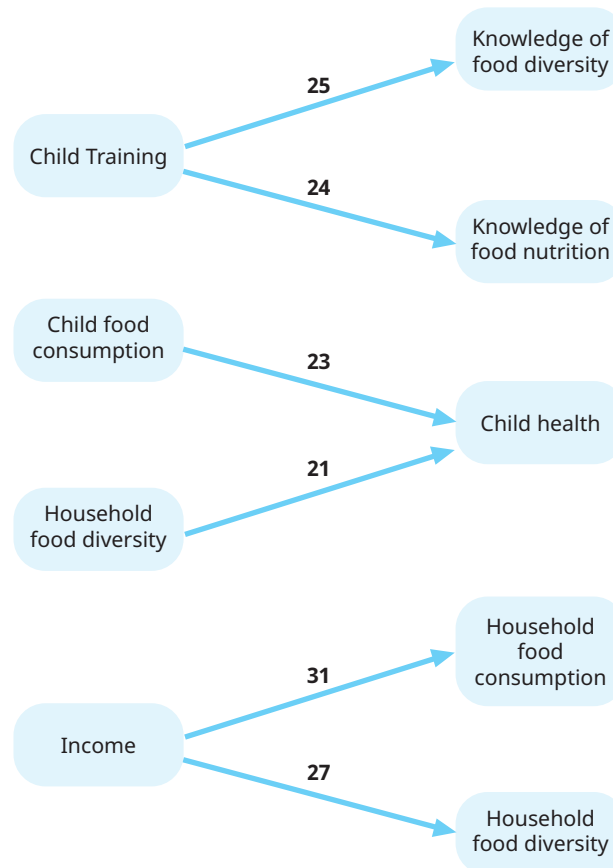
While maps may have been produced searching for links with a frequency above a certain number (e.g., more than 3), the label used over the links in the map is the source count so lower values may appear. For example, one respondent may have mentioned that link more than 3 times across the interview, therefore a link label of 1 would appear. If only one person has mentioned a link only once, then it would not appear in a map which filters out low frequency counts. The causal maps produced in this report all use source counts to scale the links (the size of the arrow) and label the links. Given the small sample size of 48, counts in the maps are expected to be fairly low.

Figure 22 shows an example of a Causal Map from this research presenting an overview of the top 8 links found in the narrative statements. Each factor label (e.g. 'Child training') is an identified cause or consequence coded from the narrative statements of the respondents by the analyist. The arrows between each factor label represent a positive causal connection (i.e.. an improvement or increase of) or a negative causal connection (i.e.. a reduction or deterioration of). Where the causal connection is negative, the factor labels will usually contain a '~' as a prefix to the label. For example, 25 respondents claimed that their participation in child training led to an increase in their 'knowledge of food diversity', while 31 respondents claimed that a reduction in income (~Income) reduced their household food consumption (~Household food consumption). As mentioned above, the stated numbers of respondents are denoted by the number above each arrow.

It is worth noting that these factor labels are not predefined labels but were selected on the basis of the data. As a result, the causal pathways differ substantially between respondents depending on the depth of their responses. For example, in the respondent narratives several respondents claim that cash transfers had a direct impact on household food consumption, while others stated that cash transfers increased their disposable income, which in turn increased their access to nutritious and diverse food. Still others claimed that an increase in disposable income allowed for the purchase of seeds which eventually contributed to household consumption. Thus,

a reduced source number included above the causal links does not indicate that many of the respondents found the opposite to be true. Rather, it indicates there may be important variations among narrative causal claims in how similar outcomes were achieved. The QuIP analysis method therefore serves to highlight the most common direct causal outcomes between factor labels, which underlines the strength of these causal mechanisms along impact pathways.

FIGURE 22: **EXAMPLE OF A CAUSAL MAP**



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REPUBLIC OF KENYA

Save the Children

Sweden
Sverige

WFP
World Food Programme

unicef
for every child