UNICEF Innocenti – Global Office of Research and Foresight

REPUBLIC OF KENYA

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RESEARCH BRIEF

The Universal Child Benefit Pilot in Kenya: A qualitative study

About this brief

In response to the COVID-19 pandemic, the Government of the Republic of Kenya piloted a Universal Child Benefit (UCB) Programme with support from UNICEF from December 2021 to December 2022, targeting children aged 0–36 months in Kajiado, Embu and Kisumu Counties. The UCB pilot provided KES 800 per month per child, distributed bi-monthly via M-Pesa to female caregivers, and included complementary services to address malnutrition, negative parenting practices and disability exclusion. A qualitative study assessed the pilot's implementation, accessibility, impact and sustainability, using interviews and focus groups to inform future policy development and scale-up opportunities. This brief presents a summary of this study.

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Background

The Government of the Republic of Kenya has made significant progress in expanding social protection coverage in the country and has a solid commitment to ensuring 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 the vulnerable.[1] As a result, 10.9 million children in Kenya find themselves in monetary and multi-dimensional poverty.[2] In response to the COVID-19 pandemic, the government piloted a UCB Programme for Kenyan children aged 0–36 months, with these objectives: 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 12 months in select locations in Kajiado, Embu and Kisumu Counties.

The UCB Pilot

The UCB pilot was implemented in three selected 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 female caregivers through Safaricom's M-Pesa mobile payment facility, with the payments totalling KES 800 per month. They 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 recognized 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), which were rolled out in conjunction with the cash transfers.

Research questions

The study aimed to generate evidence on the implementation process and impacts of the UCB, which would inform future policymaking on the scalability and sustainability of the programme, as well as contribute to the wider evidence base on child-sensitive social protection in Kenya and the wider region.

The study sought to answer the following research questions:

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

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?

3. What were the significant changes that beneficiaries identified in their lives in the period of the pilot implementation as a consequence of the pilot? And what were 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?

Methodology

The study 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 data collection was carried out between April and March 2023. The study is analytically structured into two components:

Process research: Assessed the implementation of the pilot, appropriateness, accessibility, acceptability and sustainability (i.e., answering research questions 1, 2 and 4).

Qualitative impact assessment: Incorporated causal analysis using the QuIP method[3] (Qualitative Impact Protocol) to assess the changes experienced by the beneficiaries in their lives and the causal drivers of these changes (i.e., answering research question 3). An online data analysis and visualization program called 'Causal Maps' was then used to visualize these causal drivers of change.

Key findings

Research question 1 – Implementation of the UCB

Fidelity of implementation

As intended, the government and its partners collaboratively implemented the programme in all three counties. **The registration of beneficiaries was successful with 91 per cent 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 finalization of the Management Information System (MIS) also necessitated manual payroll generation by an external firm with support from the local community, rather than carrying out this process through the Consolidated Cash Transfer Programme (CCTP) MIS. The subsequent 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 per cent, **suggesting a broadly successful payment delivery record** (see figure below).

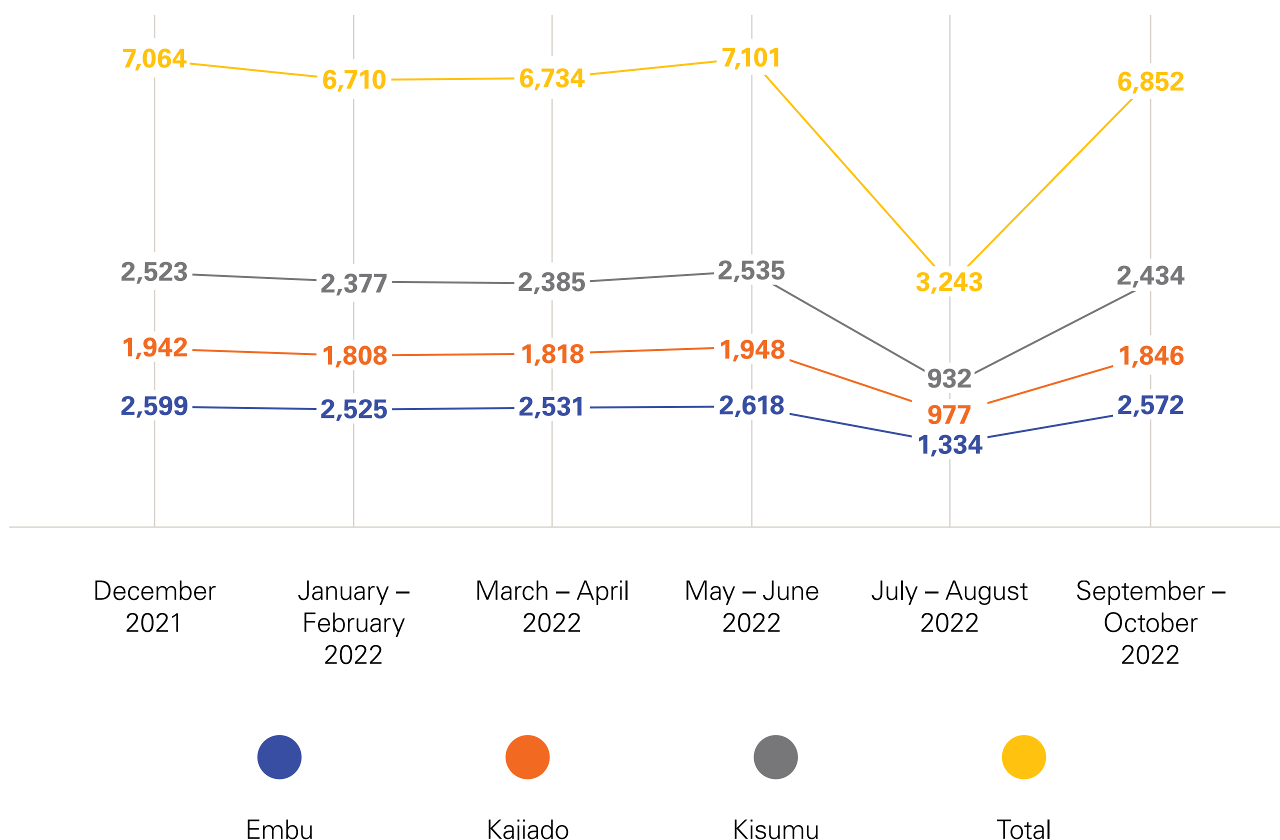
Community health volunteers (CHV) and child protection volunteers (CPV) played an integral role in implementation of complementary services as they were the first points of contact in the community. CHV carried out home visits, initiated dialogue with household members, delivered key messages, registered 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 (e.g., the Directorate of Children's Services), gathering data and providing first aid and referrals.

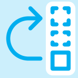
The main modules of the complementary services were the positive parenting and nutrition training through mother-to-mother support groups and training groups. In certain communities, beneficiaries revealed that they used the groups to organize a rotating savings fund, in which members take turns to receive accumulated funds. Beneficiaries and volunteers suggested that these activities highlighted the value of the groups for strengthening community and social cohesion.

Regarding the disability component, **according to volunteers the focus of the disability training 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 engaged male spouses.

Monitoring 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, which was 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**.

Delivery of payments across sub-counties





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.

- **Successful cross-sectoral coordination at 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 causing 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 prioritized income generation over the programme's activities.

Research Question 2 – Programme appropriateness, accessibility and acceptability for women, men, girls and boys

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. More than two thirds 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 Kenyan context, in which 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 accessing cash transfers 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. The complementary services were 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.

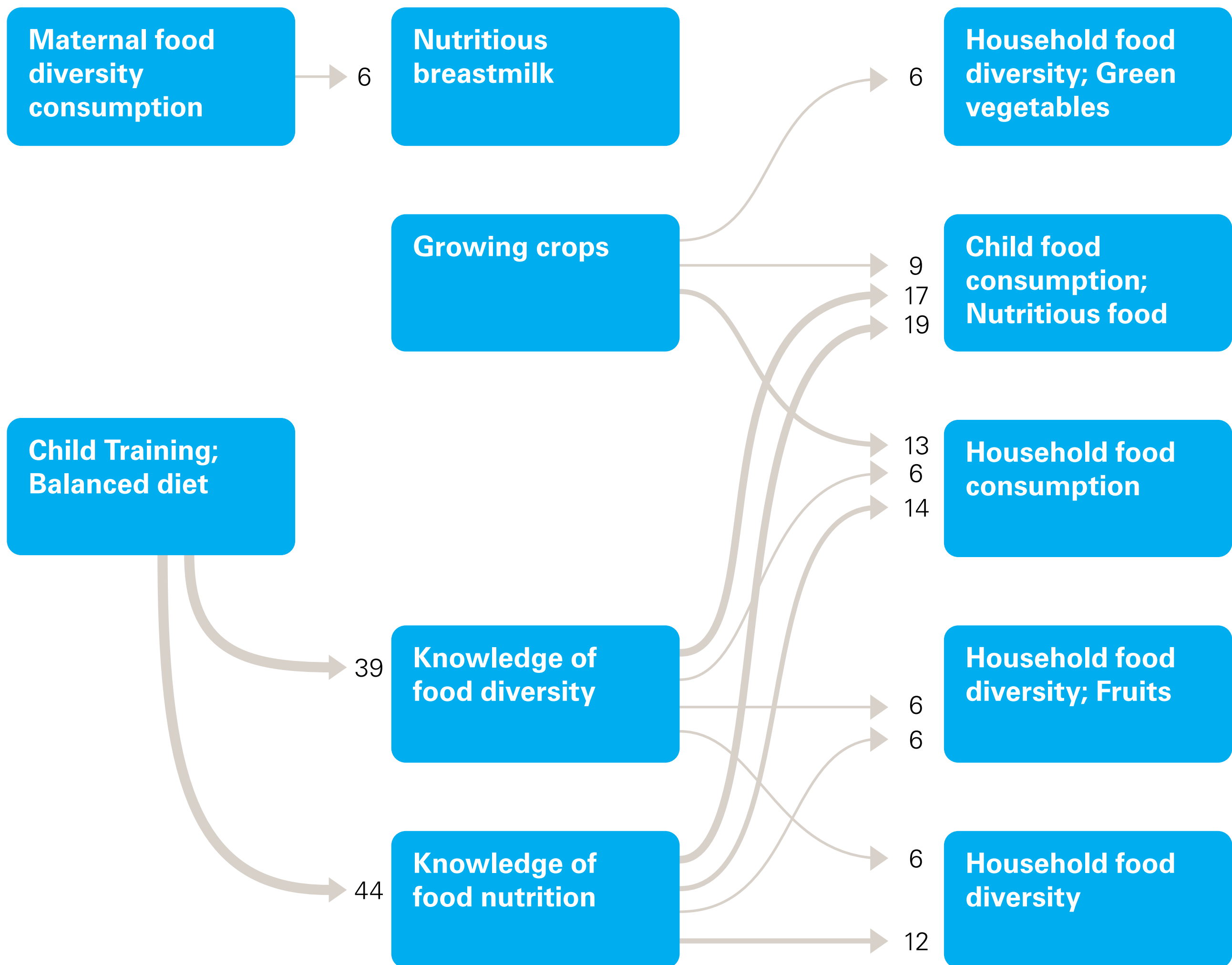
Acceptability

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 of the transfers**, 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.

Research Question 3 – Significant changes in the lives of beneficiaries during and after the pilot

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

QuIP Causal Map: Impact of child benefits on household food consumption[4]



Training in childcare resulted in **better childcaring practices for both mothers and fathers** in households, with noted reductions in the use of caning as a disciplinary method and improved relationships with children. Further positive impacts on spousal marital relationships were also 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), with both experiencing reductions in income and food consumption, which was detrimental to child and household health outcomes. Comparing outcomes from before and after the pilot suggests that **the pilot had protective impacts on the lives of recipients during these external shocks**.

Research Question 4 – Sustainability and scalability of the pilot's design features and implementation mechanisms

Complementary services in the UCB programme are scalable and sustainable due to the smooth horizontal coordination between the variety of sectoral actors and existing institutional structures in communities (CPVs, CHVs and Community Health Extension Workers), which 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 save time and effort 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 that the integrated approach from government institutions such as the Ministry of Health and the Directorate of Children's Services contributed to 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, **the eventual transition to the CCTP MIS proved to be an efficient step in providing a solid data management structure for future scaling**.

At the validation workshop,[5] stakeholders also pointed out 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**. 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 link these programmes with other social protection efforts to gradually build up to universal coverage.

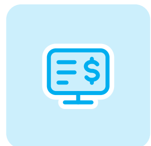
Fiscal constraints were the main obstacle to scaling up the programme, but leveraging existing systems and institutions helped minimize additional costs such as hiring additional community-level actors.

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, build resilience against future economic shocks 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 men as positive parenting 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 sensitize all beneficiaries about disability inclusion. The training would also be strengthened through adequate engagement of CPVs and linkages with the National Council for Persons with Disabilities.

Regarding the pilot's implementation

1. **Strengthen communication and sensitization**: Improve communication and sensitization 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 harmonizing 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, CCTP 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 harmonize and integrate the UCB into the national social protection system.

   c. Provide continuous sensitization to communities on the need for child-birth certificates and identification documents to reduce the chances of exclusion from the programme.

   d. Newly born children at health facilities to be registered at birth and parents sensitized on the need for immediate certification. Creating linkages between CHVs 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., CT-OVC and NICHE. This would also enable progress towards a lifecycle approach for social protection coverage of children.

ENDNOTES

1 Development Pathways, *Child Vulnerability and Social Protection in Kenya*, UNICEF Kenya and WFP Kenya, 2018.

2 *UNICEF Kenya Country Office Annual Report 2023*, UNICEF Kenya Country Office, Kenya, 2023.

3 For more information on this methodological approach see: https://bathsdr.org/wp-content/uploads/2021/03/English-Annotated-QuIP-Guidelines-1.pdf

4 To read a QuIP Causal Map: each factor has an arrow (link) which contributes to another factor. Numbers on the arrows represent the number of respondents that have mentioned this specific link. For example, 44 respondents suggested training in balanced diet led to an improvement in their knowledge of food nutrition.

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

ACKNOWLEDGEMENTS

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