Evaluation of Kenya Cash Transfer for Orphans and Vulnerable Children: Sample Design and Description

By Sudhanshu Handa, University of North Carolina at Chapel Hill

The programme

The Kenya CT-OVC is the government's flagship social protection programme, reaching over 130 000 households and 250 000 OVC across the country as of the end of 2011. In response to a concern for the welfare of OVC, particularly AIDS orphans, the Government of Kenya, with technical and financial assistance from the United Nations Children's Emergency Fund (UNICEF), designed and began implementing a pilot cash-transfer programme in 2004. After a successful demonstration period, the CT-OVC was formally approved by cabinet, was integrated into the national budget and began expanding rapidly in mid-2007 across Kenya. The objective of the programme is to provide regular cash transfers to families living with OVC to encourage fostering and retention of children and to promote their human capital development. Eligible households, those who are ultra-poor and contain an OVC, received a flat monthly transfer of US$21 (KSh 1 500). The transfer level was increased to KSh 2 000 per household in the 2011-12 Government of Kenya budget. An OVC is defined as a household resident between 0 to17 years old with at least one deceased parent, or who is chronically ill, or whose main caregiver is chronically ill. Beneficiary households are informed that the care and protection of the resident OVC is their responsibility for receiving the cash payment. Currently there are no punitive sanctions for noncompliance with this responsibility, although the next expansion phase of the program, scheduled for late 2012 and 2013, is expected to test conditionality.

The impact evaluation

Prior to programme expansion of the CT-OVC in 2007, UNICEF designed a social experiment to track the impact of the programme on a range of household welfare indicators including child health and schooling and economic productivity. The evaluation was contracted to a private consulting firm, Oxford Policy Management (OPM), and entailed a cluster randomised longitudinal design, with a baseline household survey (and related community survey) conducted in mid-2007 and a 24-month follow-up in 2009. The ethical rationale for the design was that the programme could not expand to all eligible locations at the same time, so locations whose entry would occur later in the expansion cycle could be used as control sites to measure impact. Thus within each of the seven districts that were scheduled to be included in this expansion phase four locations were identified as eligible, and two were randomised out of the initial expansion phase and served as control locations. Targeting of households was carried out in the intervention locations according to standard programme operation guidelines. Each location forms a committee of citizens that is charged with identifying potentially eligible households based on criteria of ultra-poverty and containing at least one OVC as defined above. The list of eligible households is sent to the programme's central office (located within the Ministry of Gender, Children and Social Development, the ministry responsible for the programme), which then administers a detailed socio-economic questionnaire to confirm eligibility and to assess poverty in order to rank households. The final number of households that enter the program in each district depends on funding to that district but approximately 20 percent of the poorest households in each location are enrolled in the programme. Since the programme was not scheduled to be implemented during this phase in the control locations, programme targeting was 'simulated' in order to identify a sample of households that were comparable to those in identified as

eligible in treatment locations. Households in either arm ('Intervention' or 'Control') were surveyed prior to their knowing that they were selected into the programme.

The Carolina Population Center obtained funding from the NIMH (1R01MH093241-01) to conduct a second follow-up survey of the evaluation sample in 2011, with a special focus on understanding the impact of the programme on the successful transition of OVC into young adulthood. The 2011 survey focused on the eligible sample only and included a special module for young people 15-25 on sexual activity, mental health and peers, administered face-to-face. The main household survey was also expanded to include more detailed information on economic activity, fertility and time preference.

Characteristics of evaluation sample, attrition and balance

The OPM evaluation sample includes four groups of households: treatment and control households, and non-eligible OVC households in intervention and control localities. The latter two groups were included in the initial study in order to assess the targeting effectiveness of the programme but these were not surveyed in the 2011 round.

Table A1 reports the sample sizes for each survey round for eligible intervention and control households only. Approximately one-third of the sample is control households and the sample size at the 2007 baseline is 2 294. Attrition was fairly substantial between 2007 and 2009 at 18 percent, but was reduced considerably to only 5 percent in the 2011 round. All three rounds of fieldwork were conducted by Research Solutions Africa, a private research firm based in Nairobi; the fieldwork report for the 2011 survey is provided by Otienoh (2011).

Table A1 Sample sizes by wave (eligible households only)

Treatment	Control	Total
	Round 1 2007	
1 542	755	2 294
	Round 2 2009	
1 311 + 15 (new)	571 + 13 (new)	1 910
	Round 3 2011	
1 280	531	1 811

Table A2 shows selected characteristics at baseline for households from each of the three survey rounds for treatment and control households. This table helps us understand the degree of non-random attrition as well as the comparability of households in the two arms.

As mentioned earlier, targeting in control areas was 'simulated'. Targeting in the programme was conducted in two stages. First, location OVC committees identified potential programme beneficiaries who were subsequently enumerated by ministry designates. Second, because the potential list of eligible households exceeded programme budget households were prioritized according to age of the household head, with child-headed households (of which there were very few) receiving the highest priority followed by the oldest household heads. The first stage of targeting was replicated in control locations but the second stage was not as a final eligibility list was not actually required in control locations.

Table A2 indicates that the first stage of targeting (based on OVC and poverty) was accurate in control households. Both treatment and control households are comparable across poverty indicators. However there are small differences in demographic composition between the two groups in 2007; treatment households have heads who are about five years older than control households (due the priority ranking of the programme), and who are more likely to be male and have less education. Control households also have more prime-age adults (aged 18-64) in the household relative to treatment households.

Table A2 Household characteristics by wave and intervention status

Sample:	2007		2009		2011	
	T	C	T	C	T	C
Demographics						
Household size	5.48	5.79	5.54	5.81	5.53	5.82
Residents 0-5 years	0.66	**0.86**	0.68	0.85	0.67	**0.86**
Residents 6-11 years	1.21	**1.33**	1.23	1.32	1.23	1.31
Residents 12-17 years	1.40	1.38	1.40	1.39	1.40	1.40
Residents 18-45 years	1.12	**1.45**	1.13	**1.46**	1.13	**1.46**
Residents 46-64 years	0.59	**0.36**	0.60	**0.37**	0.60	**0.38**
Residents 65+ years	0.51	0.42	0.50	0.41	0.51	0.41
Female head	0.65	**0.57**	0.65	**0.59**	0.65	**0.59**
Age of head in years	62.34	**56.06**	62.21	**56.20**	62.55	**56.55**
Head not completed primary schooling	0.53	**0.38**	0.53	**0.38**	0.53	**0.38**
Poverty						
Per adult equiv. monthly exp. (KSh)	1 533.30	1 501.25	1 541.77	1 459.94	1 550.14	1 441.99
Walls of mud/dung/grass/sticks	0.75	0.84	0.75	0.86	0.74	0.87
Roof of mud/dung/grass/sticks	0.23	0.22	0.23	0.23	0.22	0.22
Floor of mud/dung	0.66	0.74	0.65	0.77	0.66	0.79
No toilet	0.55	0.56	0.55	0.56	0.54	0.56
Unprotected water source	0.62	0.68	0.61	0.70	0.61	0.70
Region						
Garissa	0.10	0.06	0.11	0.06	0.09	0.05
Homa Bay	0.12	0.13	0.12	0.13	0.12	0.14
Kisumu	0.18	0.23	0.18	0.22	0.18	0.22
Kwale	0.08	0.09	0.08	0.10	0.08	0.11
Migori	0.23	0.23	0.22	0.25	0.22	0.26
Nairobi	0.13	0.10	0.13	0.07	0.13	0.06
Suba	0.15	0.16	0.16	0.16	0.17	0.17
N	1 540	754	1 325	583	1 266	545

Statistically significant (at 10%) differences of t-test between Treatment (T) and Control (C) within each wave shown in bold. Standard error of t-statistic clustered on location. Sample sizes do not exactly match those in Table A1 because of missing values and because new households are not included.

Note that these differences are essentially the same across households in each of the three waves of the study. In other words, there is no significant change in the composition of households across the two arms over time, which supports the idea that attrition is random and not systematic across the survey rounds.

Annex References and Bibliography

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