University of Applied Sciences
VAN HALL LARENSTEIN
PART OF WAGENINGEN UR

CASH TRANSFER FOR OLDER PERSONS

Mitigating the Effects of HIV/AIDS among the Elderly in Thika District, Kenya

Research Project Submitted to Larenstein University of Applied Science in Partial Fulfillment of the Requirements for the Degree of Masters in Rural Development and HIV/AIDS

By

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Abstract

Background

The HIV/AIDS epidemic in Kenya has caused untold suffering to all the people in the country. If not infected one is affected in one way or another. The older persons in Kenya have not been spared and they today carry one of the biggest burdens as a result of AIDS- the burden of caring for hundreds of thousands of AIDS orphans. Already a poor and disadvantaged lot, this phenomenon has only compounded their situation. To improve their livelihoods the government came up with a social protection program to aid the households of the extremely poor older persons. The Older Persons Cash Transfer (OPCT) was thus born and launched in the year 2007.The aim of this study is to establish whether the cash transfer mitigates the impacts of HIV/AIDS on the older persons headed households in Thika District- Kenya.

Methods

A desk study was carried out to establish/gather information on cash transfers, their roles and how they are implemented. The study then went to the ground where respondents both beneficiaries and non-beneficiaries were interviewed on various issues in regard to impact of HIV/AIDS and the cash transfer on older persons headed households. Implementing officers and community leaders were also interviewed.

Results

The study revealed that HIV/AIDS had a lot of effects among the older persons. They were financially and socially constrained due to the emerging demands associated with the disease. High expenditures in food, education and health as a result of the care for orphans were reported. As it would be the older women were said to be worse affected by the disease as they are commonly providing care to the sick and to the orphans. This leaves them with very little time and money to expend in improving their lives.

The introduction of the cash transfer was on the other hand said to have improved the situation considerably. The beneficiaries livelihoods were found to have improved and they can now manage to provide the basic necessities more easily. The cash transfer was found to be utilized in buying food, covering medical expenses and education among others. One of the unintended results was that it sparked growth of small- scale businesses and IGAs, for example rearing of goats and chicken.

Conclusion

The study indeed did establish that the cash transfer mitigates the impacts of HIV/AIDS by supporting the older persons who care for an estimated 50% of the 1.8M AIDS orphans not forgetting that they also provide care to their affected children and that they are also at times infected.

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List of Acronyms

ACU	Aids Control Unit
ARV	Anti- Retroviral Drugs
AIDS	Acquired Immune Deficiency Syndrome
CBO	Community Based Organization
CT	Cash Transfer
DGSD	Department of Gender and Social Development
DGSDO	District Gender and Social Development Officer
DPHO	District Public Health Officer
HIV	Human Immuno-deficiency Virus
KAIS	Kenya AIDS Indicator Survey
KNBS	Kenya National Bureau of Statistics
KNHCR	Kenya Human Rights Commission
MDGs	Millennium Development Goals
MGCSD	Ministry of Gender, Children and Social Development
NACC	National AIDS Control Council
NASCOP	National AIDS & STI Control Program
OPCT	Older Persons Cash Transfer
OVC	Orphans and Vulnerable Children
RRI	Rapid Results Initiative
SHG	Self Help Group
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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Glossary

Baraza

A local or local meetings usually convened by the local administration, usually the chief or his assistant to brief community members on any development issues or to discuss any problems affecting them.

Githeri

A local dish of boiled maize and beans and popular in Central Province

Harambee

Is a motto for “Let us pull Together” used when and where people are supposed to make contributions towards a certain objective.

Shamba

Farm or a garden

Ugali

A local dish from maize mealy boiled and stirred to harden.

Chapter 1 - Background

1.1 HIV/AIDS in Kenya

HIV/AIDS was first reported in Kenya in 1984 (NACC, 2005) and the numbers of those infected grew rapidly in the following years. By 1994 it was estimated that around 100,000 people had already died from AIDs (NACC, 2005). The first cases were mainly among those considered as high risk groups (core groups) who could also be considered as most susceptible. Among the groups worst affected were the commercial sex workers, drug users and truck drivers. Soon after, HIV spread to the general community and by 1999/2000 the national HIV prevalence reached the pick at almost 14%. AIDS was declared a national disaster in 1999 by the then President. The most affected are the productive age group between 15-49 years. According to Kenya AIDS Indicator Survey KAIS report of 2007, approximately7.1% of adults in this group were infected with HIV. In 2009, the prevalence rates among provinces in Kenya ranged from 0.81% (N. Eastern) to a high of 14.9% in Nyanza province (NACC, 2009). Moreover, in the same year, it was estimated that about 1.5 million adults were already infected with the virus, however the epidemic level is currently generalized. The annual HIV incidence rate is 0.5% which translates to 55,000-100,000 new infections every year (KAIS, 2007). The infection rate is higher in the urban areas but majority of the infected live in the rural areas. Adult HIV prevalence is greater in urban areas (8.4%) than rural areas (6.7%) of Kenya. However, as around 75% of people in Kenya live in rural areas, the total number of people living with HIV is higher in rural settings (1 million adults) than urban settings (0.4 million adults) (Kenya- Avert,n.d.).

The current national HIV/AIDS prevalence rate is estimated at 6.4% while the cumulative mortality due to AIDS is estimated at over 1.5m. This has left in its wake over 1.8m orphaned children (NACC, 2009). The deaths of youthful and most productive population as a result of HIV/AIDS and the deteriorating social cohesion has drastically increased the number of older persons especially women taking care of orphaned children, particularly in the rural areas in Kenya. Modest estimate indicate that between 40% - 50% of orphans are under care of guardians aged 60 years and above. “Poverty compounded by AIDS has contributed to collapse of the extended family support as a result of which older persons increasingly face hunger, malnutrition, lack of food and failure to access essential social services like health, water and sanitation” (DGSD, 2012). This poses wider problems since they themselves require care and support. According to the report of the last national census held in 2009, there were approximately 1.9M older persons aged over 60 years, of whom close to 900,000 were male and 1 million female.

1.2 Older Persons Cash Transfer Program (OPCT)

It is under these circumstances that the Ministry of Gender, Children and Social Development embarked on a cash transfer program to improve livelihoods of older person’s households in 2007. Currently the program covers a total of 36,000 households nationwide each receiving a monthly transfer of KES 2000 covering 2.8% out of 1.3m older people over 65 years of age (DGSD, 2012). There are 750 beneficiaries in Thika District of whom 258 are male and 492 female.

The overall objective of the program is to strengthen the capacities of older persons and improve their livelihood while alleviating integrated poverty through sustainable social protection mechanisms.

The specific objectives of the program are

- To provide regular and predictable cash transfer to vulnerable older persons in identified households
- To build capacities of beneficiaries in order to improve their livelihoods.

Thus, the program aims at alleviating some problems faced by the older persons headed households, among them lack of basic necessities including food, health and shelter. This was through provision of cash at the end of every month which could be used to purchase food, medicine, clothing, care for those under them or even improve their dwellings. The transfer is currently provided bi-monthly.

1.3 OPCT Program Organization

The OPCT is organized in the following ways:

National Level: There is a national older persons cash transfer (OPCT) committee and unit which provides policy guidelines on the program. Among the OPCT unit work is; compiling data, responding to district committee reports, information management, monitoring, updating payrolls, financial management, receiving and addressing grievances.

District Level: At this level there is a district older person cash transfer (OPCT) committee which implements the program in the district. The committee appoints any of its members to chair meetings but the secretary is the District Gender and Social Development Officer. The committee at this level is primarily to assist the DGSDO in handling grievances, coordination of targeting procedures, planning of disbursements to beneficiaries, monitoring and compliance maintenance and of all creating community awareness about the aims and objectives and entitlement.

DGSDO responsibilities include; coordination activities, financial management, registration of beneficiaries, ensuring payments, handling grievances, monitoring and information management.

Locational level: The locational OPCT committee is comprised of community representatives among other persons and assists the DGSDO in mobilization of

communities, targeting of beneficiaries, informing beneficiaries on pay dates, informing beneficiaries about existence of grievance mechanism and attending locational meetings.

1.4 Selection of Beneficiaries

Though the program is eventually expected to spread to all districts, initial district targeting was done using the country's poverty indexes. The targeting of locations was also done using the poverty indexes. To identify the most poor and vulnerable older persons/households, community targeting was used.

The district OPCT committee which had already been trained on the program was used to train the locational committees after which the locational (OPCT) committees were ready to assist in targeting. With assistance from the DGSDO, the locational OPCT committee and the communities in specific locations arrange open community meetings and using own community poverty indicators identify elderly persons they consider as most needy for inclusion in the program. Personal information on the targeted community members is then collected using targeting forms which are later used by the DGSDO to consolidate reports on persons identified.

The DGSDO then organizes for validation meetings where all community members are invited to confirm whether the persons identified during the targeting community meetings are the ones in the final list. The final list/report is then forwarded to the national program office for analysis and clarifications from the district if any. The headquarters then compiles a payment list and sends a copy to the district to confirm if all the beneficiary names have been included and correct names used. The headquarters then sends a cheque to the DGSDO or currently wire funds to the Post Bank and inform the DGSDO.

The DGSDO then agrees with the Post Bank management when the payments should be done which normally is organized within a day. The DGSDO through members of the locational OPCT committee then invite the beneficiaries to go to the bank for their payments. After the payments, copies of the payrolls are forwarded to the DGSDO and the headquarters.

1.5 Eligibility Criteria and Coverage area

The older persons cash transfer is not a universal program and a number of conditions have to be met for one to qualify to be a beneficiary. The following conditions apply and the more conditions a household exhibits, the stronger its eligibility consideration.

- An older person above the age of 65 years
- An extremely poor household

- Taking care of orphans (grandchildren)
- Is HIV/AIDS infected /severely ill person
- Having severely disabled person
- Must not be receiving any pension
- Must not be enrolled in any other cash transfer program
- Resident of the particular location/district in the program

The above mentioned factors are similarly used to rank the persons to benefit and other community indicators e.g. number of animals, household equipment, materials used in construction of house, land ownership etc are also used.

National considerations for areas to benefit include; Poverty incidence in the different regions and geographical or regional balancing and other political considerations.

1.8 Exit Strategy

Though it is rare, there are a number of factors which can lead to exit from the program and which are enumerated here below.

- After the death of the older person, the household continues to receive the cash for the next three payments which means six months after which the program exits.
- When the condition of the household changes dramatically, the program exits immediately.
- If a household willingly withdraws from the program.
- If a household is discovered to have given false information to benefit from the program, it also faces exit
- The program operates in specific locations and if the beneficiary moves out of the program district then they are exited.
- If the beneficiary does not collect their cash for three (3) consecutive payment's, that is six (6) months then exit is considered.

1.9 Problem Statement

The elderly persons in Kenya face diverse problems and are among the most poor, vulnerable and disadvantaged sector of the population. The majority lack reliable source of income and barely eke a living. Their situation has been worsened by emergence of HIV/AIDS which has decimated a sizeable proportion of the most productive youthful population leaving hundreds of thousands of orphans under their care. To alleviate some of

the problems faced by the older persons, the government in recent years embarked on a cash transfer program to assist them.

Even though some general literature available indicates that the older persons headed households are affected by HIV/AIDS and benefit from this program, it is not exactly clear how HIV/AIDS affects livelihoods of the older persons headed households neither is it clear whether the mentioned cash transfer program could help mitigate the effects of HIV/AIDS on the livelihoods of such households. Current information about the program also does not indicate who and how many among the beneficiaries are infected/affected by HIV/AIDS. Available information indicate that there is limited dissemination of information on these kind of programs, lack of comprehensive planning on their implementation, and lack of reliable data on which policies for the programs could be based, among other problems (Mutangadura, 2009). It is generally accepted that cash has an improved influence on livelihood strategies and increases sense of well-being and dignity of a household. Cash transfer is believed to contribute towards improving livelihoods of the participating older persons households nutrition, clothing and shelter, increased savings and small scale investments, increased confidence and participation in social and development activities (DGSD, 2008). Despite this, contribution of cash transfer to the social and financial assets of the households is not well known, according to Devereux (2006),cash transfers impact on local markets, gender relations and social networks of the households is not fully understood and the total and long-term well-being of the household could therefore be in question (Devereux, 2006).

1.10 Research Objectives and Research Questions

The objective of this study was to get an insight in the effects of HIV/AIDS on the social and financial assets of older persons headed households and assess the beneficiaries' and non-beneficiaries' perception on the Older Persons Cash Transfer program currently being implemented by the Government in Thika District. The thought is that with this insight we will contribute to generating information about OPCT and its impact among households headed by older persons infected /affected by HIV/AIDS.

The main research questions and corresponding sub questions were therefore as follows:

1. What has been the effect of HIV/AIDS on the livelihoods of older persons headed households?
    a. How does HIV/AIDS affect the financial assets of older persons headed households?
    b. How does HIV/AIDS affect the social assets of the older persons headed households?

2. What is the potential of the cash transfer to mitigate these effects?

    a. How is the cash transfer utilized by the beneficiaries?

    b. What do the non-beneficiaries think about utilization of the cash by the beneficiaries?

    c. In which ways has the cash transfer changed the financial and social assets of the beneficiary households?

    d. What differences are found between the male and female beneficiaries utilization of the funds?

1.11 Definition of Concepts

Older person: According to (WHO, 2012), Most developed world countries have accepted the age of 65 years as a definition of 'elderly' or older person but the UN agrees that an elderly person could be anyone above 60 years of age. For the purpose of this research an older person is considered to be a male or female over the age of 65 years.

AIDS Orphan: An orphan is any child below the age of 17 years who has lost one or both parents due to AIDS or other cause (DGSD, 2010).

Social Protection: Social protection measures are policy interventions that are intended to reduce poverty and vulnerability (including transitory poverty and vulnerability due to economic or other shocks) and to improve human welfare (UNDP,2010).

“Social Protection in Kenya is defined as: policies and actions aimed at enhancing the capacity of the poor and vulnerable to better manage their livelihoods and welfare.”

Kenya – National Social Protection Strategy [draft] (2009)

Cash Transfer: Social cash transfers can be defined as regular non-contributory payments of money provided by government or non-governmental organizations to individuals or households, with the objective of decreasing chronic or shock-induced poverty, addressing social risk and reducing economic vulnerability (Samson, 2009).

Livelihoods (Sustainable): A livelihood comprises the capabilities, assets (including both material and social resources) and activities required for a means of living. A livelihood is sustainable when it can cope with and recover from stresses and shocks, maintain or enhance its capabilities and assets, while not undermining the natural resource base (Chambers and Conway, 1992).

Household: A household is composed of a group of people living in the same dwelling space, *who eat meals together* and acknowledge the authority of a man or woman who is the head of household (Beaman and Dillon, 2009).

Social Welfare: Social Welfare refers to any government program that provides help or support for those in need. Welfare comes in many forms including, but not limited to family cash aid, welfare to work, aid to dependent children, food stamps, unemployment insurance, disability and some form of national health care (eHow,2010).

Chapter 2 – LITERATURE REVIEW

2.1 Impact of HIV/AIDS on older persons

According to the 2009 National Population and Housing Census Report, the population of persons aged 60 years and above was about 1.5 million, representing 4 percent of the total population. While in the year 2011 it was estimated that those over 65year were around 500,000 males and 600,000 female comprising of 2.7% of the population.

For long it was true that older persons in Kenya were taken care of by the community/ extended family, however in recent times most of the support has become elusive as families disintegrate and the younger, stronger, healthier and most productive members move to towns in search of jobs. The community support system has broken down and the older persons are no longer well taken care of and respected as it used to be. This phenomenon has been aggravated by emergence of HIV/AIDS and which continues to decimate the most productive in the society. The deaths of the young and productive population has left 1.8m children orphaned in Kenya and it is estimated that in some areas/ districts in the country, 40%- 50% of them are taken of by the older persons. Considering that the older persons have limited sources of income, this extra burden makes them more vulnerable to poverty, diseases and other ravages. Poverty among the poor elderly in Kenya could partly be attributed to the impact of HIV/AIDS and erosion of traditional safety nets among other causes.

An issue that has not been given attention is that older persons are also prone to HIV infection like other people. They face the risk of infection due to cultural practices including marrying younger girls, widow inheritance, risk of rape and other forms of abuse from younger HIV infected persons. Other persons are also entering old age while already HIV infected.

As a result of this older persons in Kenya face a number of challenges: lack of adequate food, lack of income, poor access to health care, inadequate shelter, among others. Older person's challenges are further compounded by their second parenting roles for HIV/AIDS orphans (Likaka, 2011). Despite the problems facing the older persons most institutions providing insurance and credit do not consider them in their schemes Kenya National Human Rights Commission (KNHCR) in one of its reports states that the right to access health care in Kenya particularly by older persons is characterized by obstacles especially those provided by private insurance companies. Several of them have 60 years as the maximum age of coverage which is clearly discriminatory against older persons (KNHCR,

2011). Further to it, programs related to HIV/AIDS hardly focus on older persons who are erroneously adjudged as sexually inactive.

Older women who are the majority in rural areas are the most disadvantaged as they have little or no control over economic resources and are disempowered by traditional practices. They are however the majority of those caring for AIDS orphan`s/ children. One of the joint reports by UNFPA/UNAIDS/UNIFEM in 2001 concedes that, in many of the hardest-hit nations and increasingly in all countries affected by HIV/AIDS—women and girls take on the major share of care work by nursing the sick and taking of AIDS orphans, while trying to earn an income that is often their family's only means of support. In addition, women may be cultivating crops to feed their families.

The government of Kenya has shown commitment in addressing the situation of the older persons through a number of policies and acts among them the National Social Security Fund Act, Cap 258; National Health Insurance Fund Act, Cap 255; Pensions Act, Cap 199; Widows' and Orphans' Act, Cap 192; and the Provident Fund Act, Cap 191.

Under the welfare programs we have the social protection programs to which cash transfer belongs. As mentioned earlier the cash transfer which is guided by an older persons social protection policy was piloted in three districts in the financial year 2006/07 and expanded to cover 44 districts in 2009.

2.2 Understanding Social Protection and Cash Transfer

Social protection is defined as "policies and actions for the poor and vulnerable which enhances their capacity to cope with poverty, and equips them with skills to better manage risks and shocks" (National Social Protection Strategy, 2008) and cash transfer is just one of its instruments. Social protection schemes have become increasingly important in the developing nations and are now considered as important in achieving of development by most of the African states. The Africa Union Social Policy Framework for Africa (2009) says the purpose of social protection is "to ensure minimum standards of well-being among people in dire situations to live a life with dignity and to enhance human capabilities". It includes strategies and programs aimed at ensuring better standards of livelihood for people in a given country. Many of the initial social protection programs were initially short term in nature and therefore had limited impact. It is as result of this that most of the developing countries including Kenya designed a comprehensive social protection policy which guides implementation of the programs. "Social protection broadly, and cash transfers in particular, are increasingly receiving recognition as an important part of a comprehensive HIV/AIDS response" (UK, 2009).

Other social protection programs in Kenya include; Urban Food Subsidy Cash transfer Program, Hunger Safety Net program (HSNP), Persons with Severe Disabilities and Orphans and Vulnerable Children Cash Transfer Program. Unlike most of other social protection programs which are donor supported, the older person`s cash transfer is wholly sponsored by the government of Kenya.

2.3 OPCT Position in Development Programs

As mentioned earlier, the OPCT was launched by the Department of Gender and Social Development in the financial year 2006/2007 and now covers 44 districts with a total of 36,000 households benefiting currently. The program started as one of the government`s rapid results initiatives (RRI) project. The RRI were supposed to be quick and effective response measures to counter problems faced by Kenyans and by different sectors. The results were expected in 100 days from launch. Effectively, after several RRIs were implemented, it was realized that public service could be prompted to achieve results faster and successfully than previously thought. By the year 2008, three RRI had been implemented since it was launched in 2003 (Obongo, 2008). The RRI moved from being a mere tool for generating results within 100 days to being a robust tool for transforming the public service from process orientation to results based management culture; establishing public service values and providing a mechanism that supports the achievement of Economic Recovery Strategy (ERS), the attainment of Millennium Development Goals (MDGs) and the Vision 2030 – Kenya's flagship strategy for public service renewal (Obongo 2008, Marwa, 2011). The OPCT belongs to the social pillar under vision 2030 which aims at improving livelihoods for vulnerable groups. Under the vision, the government aims at establishing a consolidated social protection fund.

> Currently a Social Protection Secretariat has been established to oversee the programs management while the social protection policy was passed by parliament on 12th June, 2012. Initially the program covered select districts based on population and poverty indexes but it now covers all the constituencies in the country. The program is now in all constituencies in line with the new constitution and government policy where the country development will no longer be district based but constituency based.

DGSD through the cash transfer programs and enterprise programs aims at contributing towards alleviation of poverty and by supporting the poor and vulnerable groups of persons

who include women, disabled and the older persons to possibly reduce susceptibility and vulnerability to HIV/AIDS among them and the communities they live in.

2.4 Department of Gender and Social Development Capacity

Despite the fact that DGSD has representation in all districts in the republic, it faces a number of challenges including inadequate staffing, inadequate office equipment e.g. computers and transport. While a good number of DGSDOs are quite well trained on HIV/AIDS very few have been trained on social protection programs implementation, a factor which may reduce effectiveness of the programs implementation. The social protection programs and especially the cash transfer programs like OPCT require great attention, commitment and initiative on the part of the implementers if they are to be successful. Due to the few numbers of officers, DGSDOs normally use volunteers and District Gender and Social Development committees` members to facilitate their work.

2.5 Livelihood Conceptual Framework

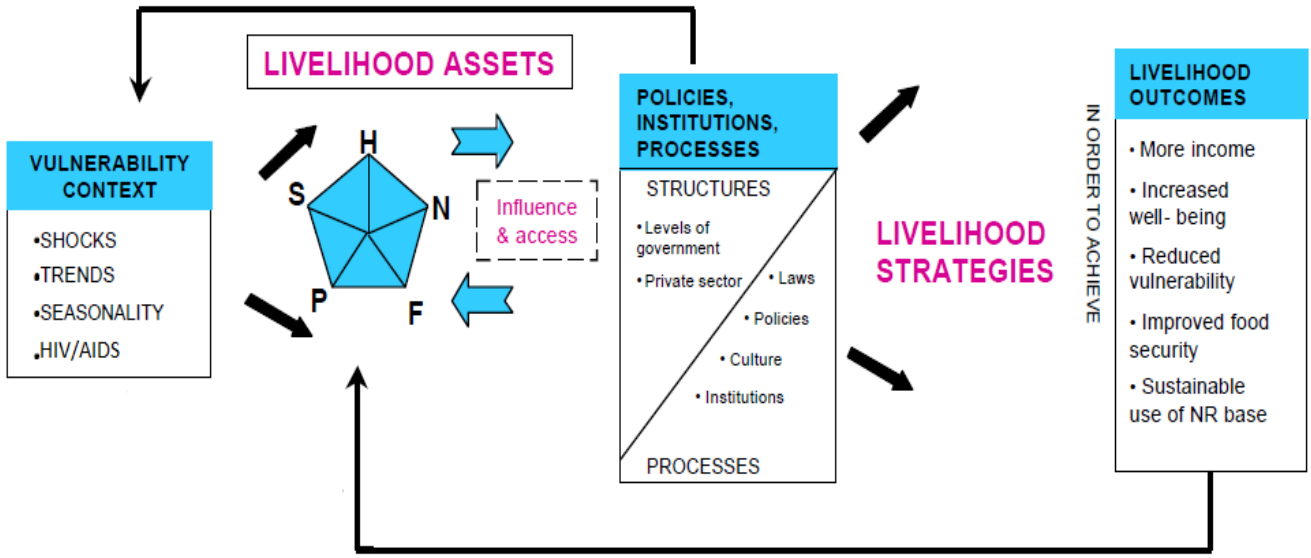
The sustainable livelihood conceptual framework encompasses aspects of vulnerability which impact on people and the five assets which determine the resources available for exploitation. It also indicates structures, institutions and processes that have been created to cater for the capitals and strategies, and which in turn lead to outcomes.

The livelihood framework will be used in this paper to provide a glimpse of how HIV/AIDS affects/relates to the social and financial assets in older persons households and how the assets influence DGSD and policies resulting in livelihood strategies like the CT. Though there are five assets, concentration will however be on two assets, the social and financial assets. The impact of HIV/AIDS which in this regard is the vulnerability context has compounded problems for the older persons who already have limited sources of livelihood and quite commonly extremely poor and vulnerable. Under institutions, structures and processes we have the DGSD which has developed policies for the older persons, gender and even the disabled and its capacity building activities for the gender and social development officers, social development committees and communities. The DGSD CT which is a form of social protection is a livelihood strategy which contributes to enhancing the social and financial assets of which several livelihood outcomes are expected. These include an enhanced purchasing power and increased self-esteem, improved nutrition and health, a possible higher school enrolment among children/ orphans being taken care of by the older persons and their increased participation in social and development activities (DGSD, 2010). Better living conditions in the form of improved dwelling structures and consumables are also expected as well as possible savings and small scale investments. These factors contribute to enhancing resilience and reducing susceptibility and vulnerability

to HIV/AIDS and other vagaries among the older persons' households. As it is, these outcomes would in turn definitely affect the different capitals as shown in the livelihood framework. The cash transfer and HIV/AIDS relationship therefore fits well within the livelihood framework (Fig.1) which will be used in the context of this research.

Though the OPCT covers the poor and vulnerable older persons, available literature confirms that most of these older persons are also impacted by HIV/AIDS. The cash transfers though in early stages in most of the developing countries especially in Africa are initiated with respect to their effectiveness in mitigating the impacts of HIV/AIDS (Adato and Basseti, 2012).

Figure 1 - Livelihood Conceptual Framework



Source: DFID 2001

The livelihood framework has been adapted with minor changes by the author of this paper. On the vulnerability context HIV/AIDS was added.

Chapter 3 - RESEARCH METHODOLOGY

3.1 Research Area

The research was carried out in the larger Thika District which is one of the districts in Central Province of Kenya. See figure 2 for a map, in which The white star and arrow indicate location of Thika in Kenya. With the scrapping of the provinces under the new constitution which is being implemented, Thika District lies within Kiambu County and covers an area of 1,479 km^2. The district had a population of approximately 650,000 people (324,000 males and 326,000 females) according to the 2009 national census report (KNBS, 2012). Thika District had one of the highest HIV prevalence rates in the country in 1998 standing at 34%. This has since dropped to 3.7% (DPHO, 2012). The district borders Nairobi to the north-west and can be regarded as a bedroom district for the fast expanding Nairobi City which is situated only 40kms away. Due to its proximity to Nairobi and currently a super highway which connects with the city, many people have bought properties and settled in the district and its environs while others opt to rent. Thika town is an industrial town and among the fastest growing towns in Kenya but the district is generally agricultural. According to the district development plan for the period 2008-2012, it is estimated that around 36% of the population is absolutely poor translating to approximately 170,000 people.

Figure 2 - Location of Thika District

Source: Atlas of Kenya

Despite having quite a large urban area which comprises of Thika, Juja and Ruiru towns, most of the district still comprise of rural settlement. The main cash crops include coffee and floriculture while the main subsistence crops are maize, beans and bananas. Production of fruits among them mangoes and avocados is also quite high. More importantly, Thika is best known for production of pineapples in farms owned by Del Monte a world renowned company.

According to the 2009 national census, the population of older persons above the age of 65 years in the district was around 16,000 (7,000 male and 9,000 female) (KNBS,2009). The highest concentration of older poor persons was within the rural and urban areas occupied by squatters. As such the DGSD targeted its first OPCT beneficiaries within these areas. Thika was one of the three pilot districts for the implementation of the older persons cash transfer program. The other two districts were Nyando and Busia. During the pilot face only 100 households benefited with monthly transfers of 1,000 KShs per month which was later raised to 1,500 and subsequently to 2,000 KShs per month in the year 2010.

3.2 Research methodology

To effectively undertake this research I carried out a desk study comprising of gathering relevant information on effects/impact of HIV/AIDS on older persons headed households. In addition, information on the impact of cash transfer on older persons headed households was gathered. Subsequently, twenty beneficiary households and ten non-benefiting older person's households were interviewed. Efforts were made to have equal representation between male and female. Among the respondents interviewed were eleven female beneficiaries and 9 male beneficiaries and 5 female and 5 male non-beneficiaries. Purposeful sampling was done and face to face interviews conducted among the older persons caring for AIDS orphans and benefitting from the program. The interviewees were identified by the locational committee members in collaboration with the community leaders and the DGSDOs office.

Information on the older persons social protection (cash transfer) program at the different implementation levels was also sought i.e. information from the national and district program officers on how they view the program.

Face to face interviews were conducted to gather information from the different government officers in the district and at the national offices. Those interviewed included; District Gender and Social Development Officer, an OPCT program officer at the national office, the District Children Officer and the District Public Health Officer (DPHO).

The face to face interviews also included those of 4 locational community leaders who included 2female and 2 male and who are involved in awareness creation, mobilization and recruitment. They also assist during payments, conflicts resolution, and follow-ups of the OPCT beneficiaries.

One focus group discussion for the beneficiaries and one for the non-beneficiaries were also conducted to gather more information. Each of the group comprised of 8 beneficiaries 4 female and 4 male. The respondents in the focus group discussions were different from those who had been interviewed individually, as the aim was to see what other information would be adduced.

The secondary data was collected from literature obtained from various textbooks, the internet, journals and reports from the Ministry of Gender, Children and Social Development and other organizations e.g. the NACC. Data collected contributed in building concepts and guiding the research.

The data was collected by use of checklists and some guiding questions while the analysis was conducted manually, information collected was then categorised and put in matrixes. The tables and charts were generated with the use of excel. Information collected was transcribed every day and most interviews were recorded for ease of reference and clarification during the writing of results and discussion chapters.

3.3 Respondents and Selection Criteria

National Level- An OPCT program officer was interviewed as a key informant to provide an in-depth analysis of how the program operates, how funds are sourced and channelled to the beneficiaries, etc. Discussion also focused on the roles of the national office in the program implementation and challenges faced. The national office is key in determining the direction the program takes (expansion, transmission of funds to the districts and providing policy guidelines for its success.

District Level- At the district level, the DGSDO was interviewed. The DGSDO is the key implementer of the program, and is the District OPCT committee Secretary. He/she keeps records of all beneficiaries and is involved in the day to day running of the program. The District Children Officer is a member of the District OPCT Committee and belongs to a sister department (Children Department) which also implements a CT but for the OVCs. The DCO assists the DGSDO in establishing older persons who could be benefiting from the two programs. The DPHO roles in HIV/AIDS matters in the district is very important and though not directly involved with the cash transfer, also have programs covering the older persons and is a good custodian of HIV/AIDS information in the district.

Committee Level- Two active locational committee members were interviewed. They are in touch with beneficiaries and are the main link between the DGSDO office and beneficiaries

Community/Opinion Leaders- They were involved from the time the program started and helped informing the community members about the program. They are important in relaying information.

3.4 Limitations

One of the main limitations was adhering to time set to start interviews. The DGSDO had provided a government vehicle for facilitation of data collection, but at times she would be using the vehicle which caused delays and at times rescheduling of interviews. Thus the researcher was relying on public transport, which proved quite unreliable to reach the DGSDOs office about 50 kms from where the researcher lived. This could at times lead to delays in starting the interviews on time. We however always kept our contact persons at the ground informed to avoid disenchantment among the interviewees through our mobile phones.

Even though we were aware that Thika is cosmopolitan and has mixed tribes, a good number of the interviewees were only fluent in their mother tongues. This I must say had not been foreseen as I expected everyone to be conversant with Kiswahili which was a wrong assumption. Fortunately most of those who could not converse in Kiswahili could use Kamba and we used one of the community leaders who knew the language as our translator. Using a check list also meant the interviews were quite open and at times the interviewees could digress from the real issues, it meant being alert and cunning to put back discussions on course without offending. I must say at times it needed a lot of self control not to be judged insensitive to the issues which they were raising. At one point I really was not sure whether I had used the correct methodology.

Another limitation was getting appointments from the government officers and having them honoured. We had to reschedule interviews of three of the officers for a number of times. This was inconveniencing as well as frustrating and made us lose some precious time.

Chapter 4 - RESULTS

This chapter covers findings from the interviewed OPCT beneficiaries and non-beneficiaries, the locational committee members, opinion leaders and the key informants who were interviewed through use of checklists. Their responses were further triangulated by use of focus group discussions.

4.1 Characteristics of Respondents

For the purpose of the research, 20 OPCT beneficiaries and 10 non-beneficiaries were interviewed. Of the 20 beneficiaries 11 were female while 9 were male. On the part of non-beneficiaries, 5 were female while 5 were male. The following table illustrates their characteristics;

Table 1. Respondents Age and Level of Education by Category

Characteristic	**Male**		**Female**	
	Beneficiary	**Non-Beneficiary**	**Beneficiary**	**Non-Beneficiary**
Average Age	75.5	75	72.4	71.6
Highest Education Level	Class 8	Class 8	Class 4	Class2

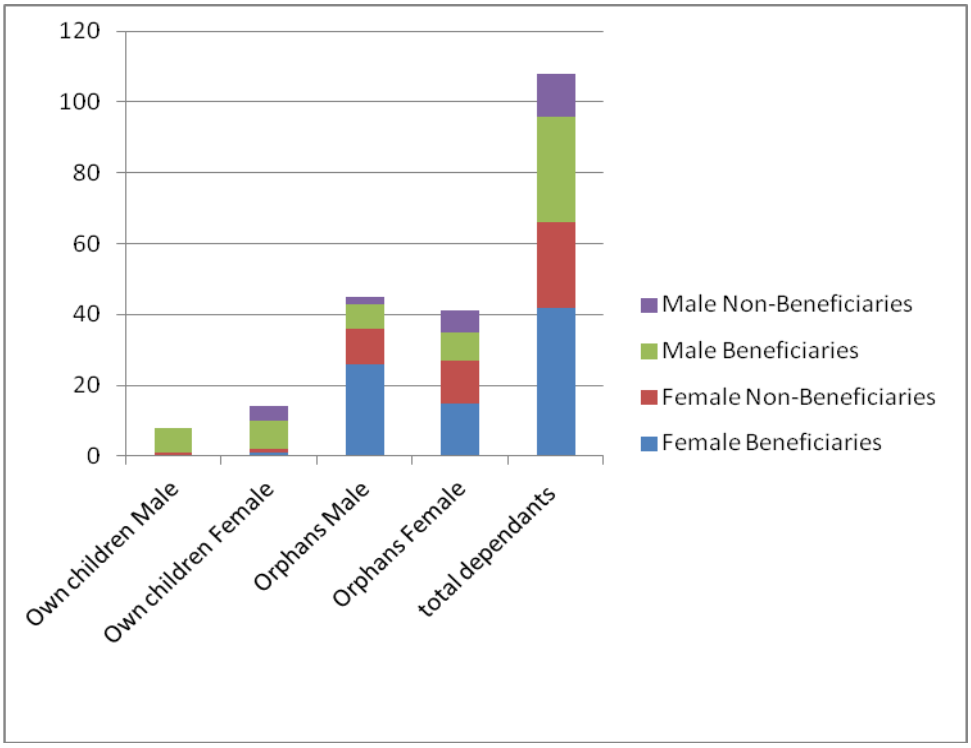
The average age of respondents was 75 years and 72 years for males and females respectively. The beneficiary with the lowest age was a female aged 60 years and the beneficiary with the highest age was a male aged 88 years. The respondent with the highest age interviewed was a 90 years old female belonging to non-beneficiary group.

Our data further revealed that the level of education among the participants was very low. None of the beneficiaries had post primary education. Of the female participants interviewed, only two indicated to have been to school, with the most educated being a beneficiary who had reached class 4 while the other was a non-beneficiary who had reached class two. Compared to the females, out of the 9 male beneficiaries and 5 non-beneficiaries interviewed, 3 had reached class 6, 1 had reached class 7 while 2 completed their primary education.

Furthermore, out of the 16 female respondents, 12 were widows while 4 were separated. On the contrary, for the males out of the 14 interviewed 10 reported being married while only 4 were widowers. This strongly suggests that most men either married again or had younger wives while most women never married after separation or the death of their husbands/partners.

We further investigated the number of orphans and other dependants that were being taken care of by the respondents. Figure 3 below shows the distribution of orphans based on gender and beneficiary status.

Figure 3: Distribution of Orphans/ Dependants Among Respondents



The 16 female respondents had a total of 66 orphans, comprising of 37 male and 29 female children. They also had their own 3 dependent children, one male who was under the care of the oldest interviewee earlier mentioned aged 90 years and 2 female children in the care of others. The 14 male respondents on the other hand had a total of 23 orphaned children under their care (9 male and 14 female). Remarkably, they had a total of 19 who were their own children depending on them (7 male and 12 female), suggesting that most of them married again. The highest number of dependents/orphans that were being taken care of by a single respondent was 7. Only one respondent did not report having any child depending on him.

Though the beneficiaries were more in number (20) than the non-Beneficiaries who were 10, they still had more dependants. The 11 female beneficiaries had 42 dependants and the 9 male beneficiaries had 30 dependants. On the other hand the female non-beneficiaries had 24 dependants while the male non-beneficiaries had only 12. The male beneficiaries thus had the highest number of dependants.

4.2 Land and House Ownership among Beneficiaries

Of the 20 beneficiaries interviewed 17 are squatters living on government land in the three different locations covered. Similarly, (8) of the 10 non-beneficiaries were squatters. The remaining (2) owned their land. Currently a demarcation exercise to allocate them land is at an advanced stage. The portions of land they live in range from one eight to half an acre and most of it has low soil fertility it was observed. Of the beneficiaries only 3 of them live on their own land.

In effect the OPCT beneficiaries covered in the study live in temporary and semi- permanent structures made of either, mud, timber or iron sheet walls and earthen floors. The roofs are however mostly made up of irons sheets or thatched. They own the houses and only two beneficiaries, a male and female, reported to be renting. Almost all the houses visited were one or two roomed and squalid life was evident. In one of the villages three beneficiaries reported that the houses they now live in were constructed for them by an organization called Help Age Kenya. They said they maintain/repair their houses with the little income they raise through manual labour and the CT program. However 2 beneficiaries a male and a female are living in permanent houses. Figure 4 below shows representative samples of the type of housing they live in.

Figure 4. Beneficiaries outside their Houses (photos by the Author)

4.3 Sources of Income and Support among the beneficiaries interviewed

The respondents reported engaging in different activities to eke a living. Out of the 20 beneficiaries 2 female and 2 male are involved in small scale businesses, ranging from selling green grocers to running a small stall. Three reported to own some rental rooms which they rent for around 300KShs per month. Four female beneficiaries said they have no other source of income while it was noted that 2 males were in wage employment and one in skilled work.

Among the 10 non-beneficiaries interviewed, 4 reported to be getting food aid from donors who include relatives, Red Cross, local NGOs and the government to survive, while one is engaged in making and selling of illicit brew.

4.4 Sickness, Food Consumption and Food Source

17 of the beneficiaries and non-beneficiaries reported to be sickly/ or to have been sick in the last six months, the most common diseases mentioned were malaria, chest infection and blood pressure each of which were mentioned by 3 respondents. Arthritis, failing eyesight and lame/weak limbs were also registered, while one female non-beneficiary indicted they were suffering from colon cancer and another from HIV/AIDS. Eight of the respondents were able to estimate their monthly medical bills which ranged from 500Kshs to 5000 Kshs. One non-beneficiary said she relied on herbs as she could not afford the fees charged in the hospitals.

When asked about the type of food they commonly consume, most seemed surprised as they take it to be obvious. The main foods are *ugali* (ground maize flour boiled and stirred to harden) and *githeri* (a mixture of beans and maize boiled till ready and salted). Only one male non-beneficiary mentioned he commonly consumed rice and this he related to having no teeth to chew maize. On average both beneficiaries and the non-beneficiaries take 1-2 meals per day depending on food availability. 3 male and one female beneficiary however said they take 3 meals a day while not a single non-beneficiary was taking 3 meals. All the beneficiaries indicated that they buy most of their food and produce a little from their small *shambas* for consumption, while two of them a (male and female) said they also borrow and rely on donations from neighbours. Among the non-beneficiaries 4 out of 10 said they relied on borrowing/ well-wishers to get food.

4.5 Involvement in Social Activities

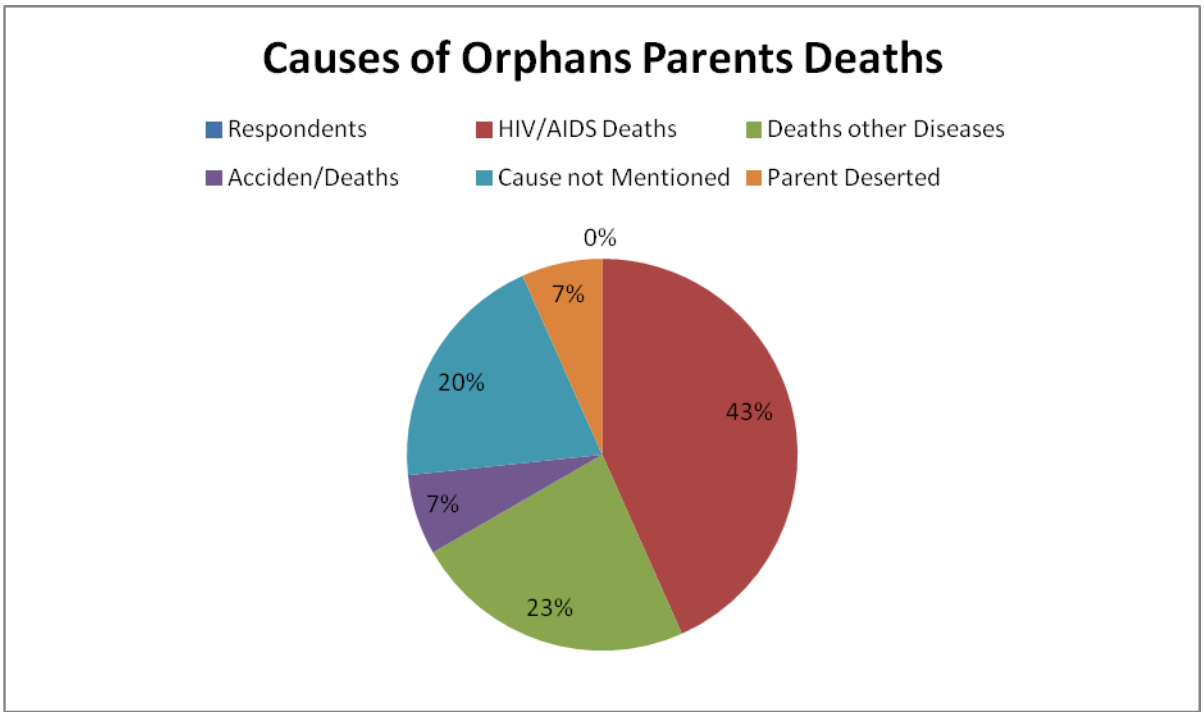
Among the beneficiaries, 11 are members of welfare or self5help groups. Only female beneficiaries are members of savings groups with a total of 3. The average monthly contribution is 100 KShs the highest being 200Kshs and lowest 15 KShs. Those in savings groups indicated that they meet every month while the welfare only meet at times of need,

usually to make arrangements for a burial. Apart from working closely with the other members of the society during burials a good number indicated that they also attend *barazas* while a few said they attend church and family activities. The few who attended the family gatherings away from where they live, owned to the fact that they are sponsored by their relatives to do that. While the beneficiaries related their source of money for these events to cash transfer, the non-beneficiaries mostly indicated that they get it from doing casual labour or borrowing. The non-beneficiaries contribution, similarly range at around 100 KShs per month and they also belong to welfare and savings groups.

4.6 Causes of Death of orphans' parents

The following pie chart is a representation of the stipulated different causes of deaths of parents whose children are being taken care of by the older persons. It therefore represents causes of deaths of the 30 parents whose orphans are being taken care of by the respondents.

Figure 5 - Causes of Deaths of the Orphans Parents



The total 30 respondents have a total of 41 children comprising of 27 female and 14 male but they are taking care of orphans who belong to only 30 of their deceased children. Out of the 30 respondents again, 13 of them (8 female and 5 male) confirmed they had children who had died of HIV/AIDS and another 7 said their children had died of diseases which were not specified leaving them to care for orphans. What was interesting was that out of the reported confirmed deaths due to AIDS, 12 were their daughters and only one was a son.

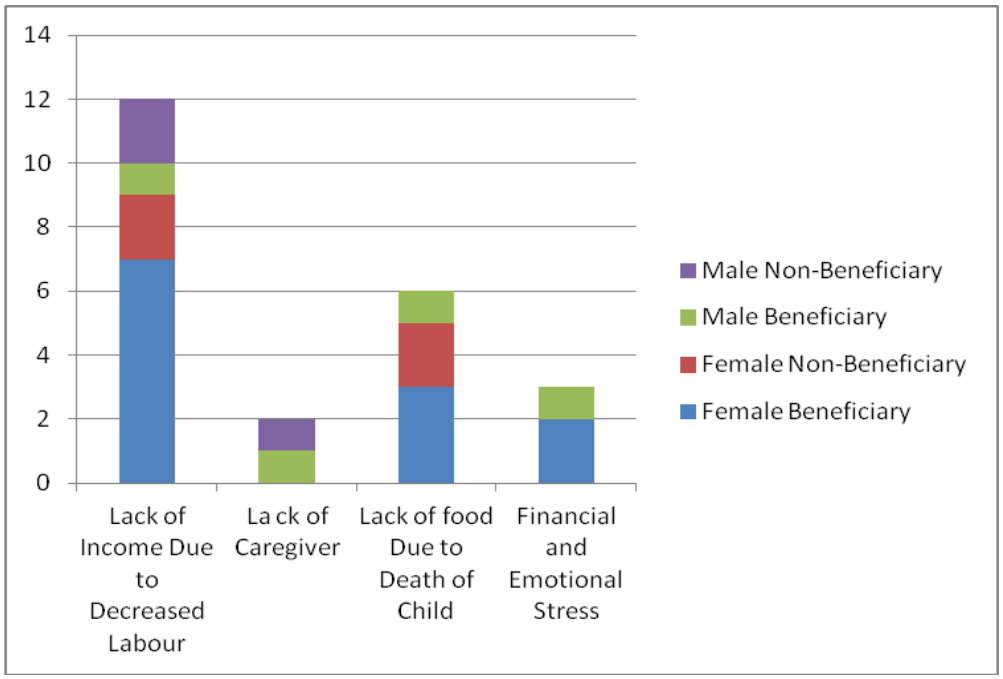
As a result of this, the respondents are taking care of 33 orphans, who comprise of 18 boys and 15 girls making an average of 3 orphans for every older person headed household.

4.7 Effects of HIV/AIDS on Older Persons Households

Of the 30 respondents, 20 on equal numbers between male and female had knowledge on HIV/AIDS transmission, its causes and how it could be avoided. Not all were ready to answer questions in this regard, with one male non-beneficiary saying he had no knowledge on transmission and one female non-beneficiary saying she had only heard about it.

When asked about the effects of HIV/AIDS on their households, the effects mentioned by the respondents were; Lack of income due to low productivity caused by decreased labour and time spent caring for the sick which was mentioned by a total of 12 respondents comprised of 7 female beneficiaries, one male beneficiary, 2 male and 2 female non-beneficiaries. Lack of caregivers to the orphans leading to increased workload was another concern which was mentioned by one male beneficiary and one male non-beneficiary. Lack of food due to loss of their children who were providers was mentioned by 3 female beneficiaries, one male beneficiary and 2 female non-beneficiaries. Financial and emotional stresses among the older persons were mentioned by 2 female beneficiaries and one male beneficiary. The AIDS patients require a lot of attention and nutritious foods. Two male respondents one beneficiary and a non-beneficiary also mentioned that due to problems caused by the disease, some households are forced to sell their assets including animals in order to care for the infected (buy food and drugs).

Figure 6 - Different Effects Caused by HIV/AIDS



The District Public Health Officer (DPHO) as if to confirm effects of HIV/AIDS on older persons said that most of them are usually poor and sickly and a good proportion of them neglected by their children. A good number is also affected by the fact that their sons and daughters have died of AIDS leaving them with the burden of caring for orphans he said. In addition the older persons are weak and their immunity is lower hence they also easily get infected. He then remarked that some of the older persons are already infected and the uninfected are also at a risk of getting infected through caring for their infected children and through rape. He went on to say that some are still sexually active and that this fact should not be ignored.

To assist the affected older persons the Ministry of health has a public health and sanitation program which supports the elderly in the issues of hygiene, food and water safety and home care.

4.8 Most Affected Among Male and Female Households

One female and one male community leader said that the female headed households are worst affected by HIV/AIDS due to the cultural roles of being caregivers and doing a lot of housework, they also said that the infected male are unlikely to socialize and attend counselling, the female respondent said that “the male seem not to want to accept there is a problem and kind of want to prove they are strong”. One male community leader further said that in the male headed households, orphans are usually kind of let loose and are more likely to be truant and start roaming the streets.

Both male and female community leaders again said that the male headed households are worst affected by HIV/AIDS as they do not provide enough care to the orphans while the female are more cautious and offer better care to orphans especially those left by their daughters, this they said was related to the fact that when their sons die it is the daughters in-law who are left to take care of the children. Again by the time of death, most of the daughters have already returned to them they said. One of the male community leader added that the women encounter loss of business as they engage in providing care for the infected persons. He also mentioned that women engage in less labour intensive activities.

4.9 Conclusion of HIV/AIDS Effects on Households Headed by Older Persons

HIV/AIDS affects the older persons headed households in diverse ways but one of the key effects is the sickness and eventual death of their children who then leave them with the burden of caring for the grandchildren. The older persons are basically among the most disadvantaged and poor in most societies and the added burden only complicates

livelihoods in their households. The following is a list of common problems which they mentioned;

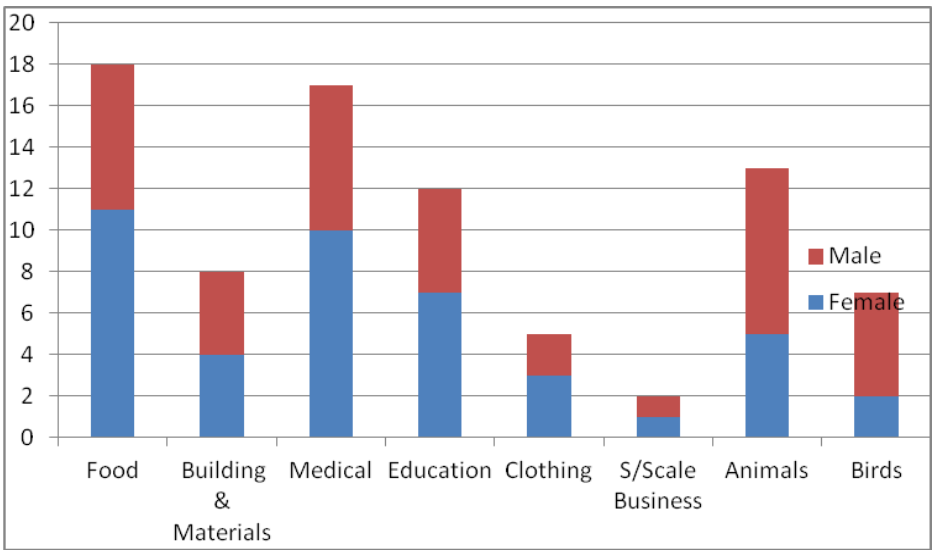
- Inadequate food due to low production occasioned by death of the productive members of the households while yet requiring high nutrient intake among the infected members of their household.
- Increased food requirement due to increased membership of the households occasioned by the joining orphans.
- High medical/ health expenditure due to their failing health related to advanced age and caring for their HIV infected and AIDS suffering sons and daughters and their grandchildren (orphans).
- New/Increased cost on children education, for buying their uniforms and other requirements not covered by the governments free primary education program and much more higher cost implication for those caring for children in secondary school.
- Being tied at home to care for the very young orphans which reduces/ hinders their participation in social and community affairs.
- Mental/ psychological anguish/ pain resulting from the loss of their children

4.10 The Different Uses of Cash Transfer Among Beneficiaries

From the interviews conducted, it was realized that the CT is utilized in many different ways.

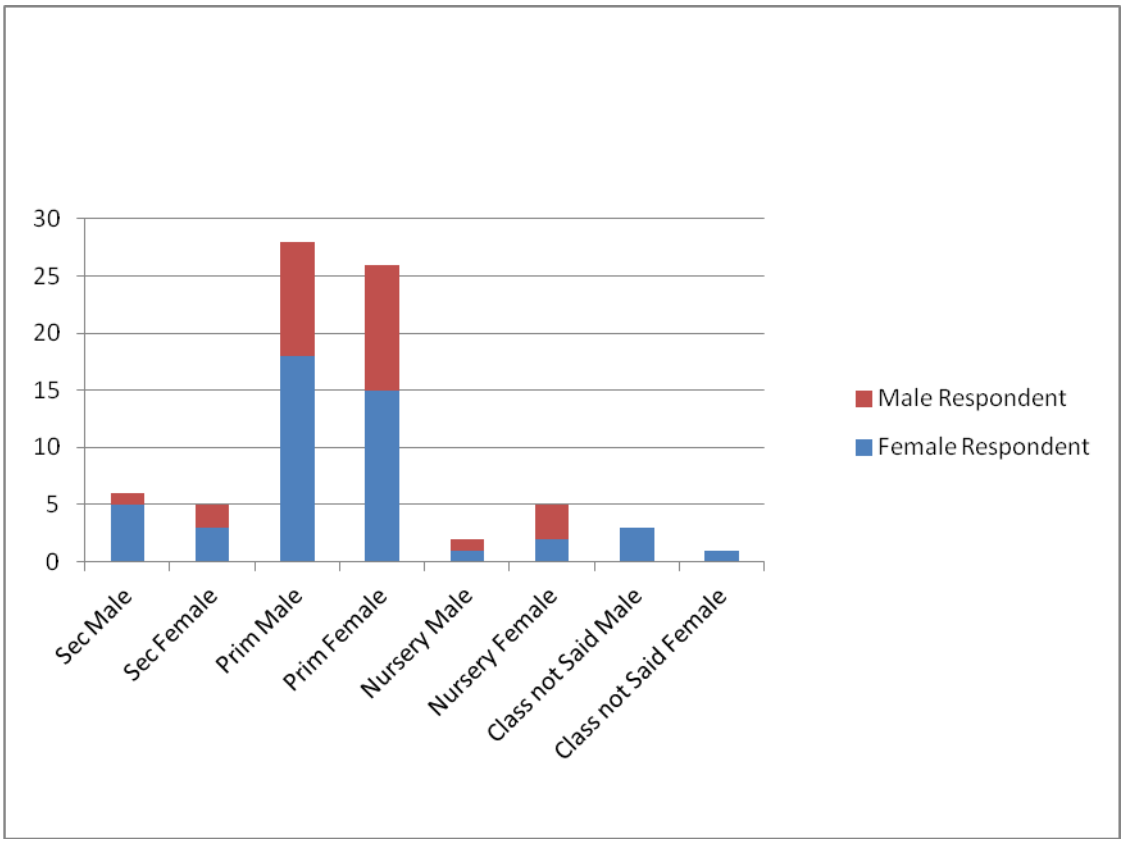
The following bar chart represents the various consumption uses and investments that the CT is put to by the beneficiaries.

Figure 7 - The Different Uses of CT among Respondents



Except 2 male beneficiaries, all the others said they use the CT to buy food, the next most common use was settling medical expenses with all beneficiaries indicating they used the CT for this purpose except 2 male and a female. On education, 7 female and 5 male indicated they used it for paying fees, buying uniforms and other school expenses. In total, the female respondents are maintaining 48 children in school while the male respondents are maintaining only 28. A more comprehensive analysis is attached in annex 16. Three females and 2 males said they had also used the CT money to buy clothing. All the beneficiaries indicated that they had either bought goats or chicken or both while one said he had bought a cow and one male and a female engaged in small scale business. Four female and 4 male beneficiaries said they had used the CT to buy iron sheets and build rental rooms while one female had used it for paying rent. The following bar chart represents the number of children maintained in school by the beneficiaries.

Fig8: Number of Children Maintained in Schools by Respondents



The DGSDO on her part said that she was aware that the beneficiaries were utilising the CT money for buying food, paying school fees, meeting health expenses, starting small-scale businesses and improving living dwellings among others. She further went on to say that there is no restriction to CT usage but beneficiaries are always advised to spend it wisely.

The DCO said that the OVC CT is used by the beneficiaries for similar purposes but unlike the OPCT the money is specifically to meet the children's needs. He further said that for sustainability, the caregivers who receive the money are specifically women, this he informed is because they are culturally considered as the care givers and it is thought unlikely to misuse the money.

4.11 Differences in Use of CT Among Female and Male Beneficiaries

All the 4 community leaders were agreed on one fact, that majority of the beneficiaries were putting the money into good use. They all mentioned that livestock rearing which mostly includes goats and poultry rearing as the most accepted IGA among the beneficiaries. They also mentioned purchase of food for the households, paying for medical expenses, purchase of clothing, improving living shelters paying rent, catering for education expenses, settling debts usually accruing from food expenses, attending social functions and groups contributions, starting small-scale businesses e.g. kiosks, green grocers, charcoal selling (change in clothing evident). Though the community leaders mentioned these activities, when the beneficiaries were interviewed very few mentioned as being in these businesses.

On utilization, one female community leader further said that the elderly women are better planners and spend their money more wisely, worry about tomorrow and are developing faster. She said the male are likely to spend a good amount of their money on leisure. Both the male community leaders seemed to affirm this by saying that the female beneficiaries are more organized and put CT in better usage in their household than the male they described them as better in budgeting and saving. The female community leaders on the other hand said that the women run more s-scale businesses and said they are cautious and calculative in spending than male. One female community leader was quoted as saying "Females are more involved in changing their lives and join savings and credit groups to improve their household livelihoods".

The male community leaders said that the male were more likely than the female to engage in leisure and alcohol consumption while one of them said that he had noted that most of the money went to food and health issues agreeing with what the beneficiaries had said. The female community leaders additionally said that elderly women are better planners and spend their money more wisely, worry about tomorrow and are developing faster

When the community leaders were asked what was the biggest problem caused by HIV/AIDS in the older persons households they all said that it was availability of food as if supporting the beneficiaries.

4.12 Changes Observed

Both male community leaders and one female community leader said that the beneficiaries are participating more in social/community activities including visits to friends and *barazas*. "The families that neglected some of them are now seemingly eager to take care of them" were the words of one of the community leaders. The ability of the older persons to borrow and repay has been enhanced both male community leaders said. All the 4 community leaders were in agreement that the CT had greatly contributed to initiation of small scale businesses/ IGAs among the beneficiaries.

4.13 Reasons for Inclusion and Non-Inclusion

12 of the beneficiaries said they were included in the program due to poverty and 12 due to their old age, two indicated that they were considered as they were also taking care of orphans while one male said his disability was considered (more details in Annex14).

When the non-beneficiaries were asked why they were not included, reasons varied from having been away working, hospitalized, lack of identity card and unawareness of the CT among others. While 5 of them readily commented on the benefits of the CT to those receiving and how it was being utilized, 5 said they did not know how it was being utilized. Again not a single non-beneficiary confirmed as having acquired any valuable asset in the last two years while all beneficiaries mentioned one or two valuables/items which they had bought.

4.14 Challenges for Cash Transfer

One of female community leaders said that due to the high mobility of the beneficiaries who live in rental rooms it is hard to identify them and also make follow-up on what they are doing. All the leaders again concurred that some of the beneficiaries are too old or sickly and have difficulties to reach the post offices where the payments are done and that most of them are illiterate and rely on goodwill of those paying.

One of the male community leader again pointed out that initially during payments there was security risk as the payments used to be conducted in the open while one of the female leader voiced her worry on misuse of the money by a few beneficiaries especially the male (alcoholism) and the likelihood of dependency.

All the leaders also informed that numerous complaints had been raised by non-beneficiaries who qualify for the CT and who have been left out. They also expressed their dissatisfaction for they always have to leave their work to mobilize beneficiaries for payments, meetings, relay information etc. and get very little support if anything from the department.

One of the male leaders also reported that they had received information that the CT payments may be carried out by one of the banks in future. He railed at the idea saying this would only cause more problems as most banks are located quite far from the beneficiaries.

Lastly, one of the female leaders said that most beneficiaries are squatters and may therefore not establish permanent residence which affects their development.

4.15 Focus Group Discussions

Apart from the uses mentioned earlier to which beneficiaries put the cash transfer, the 8 beneficiaries in the focus group discussion concurred that the CT had been of great help and had positively changed their lives. They mentioned for example that a good number of them used to rely on herbal medicine before joining the CT but they are now able to go to hospital/ buy conventional medicine. They also were in agreement that though the cash transfer is meant for the older persons the children/orphans under them benefit more. All the beneficiaries hailed the program and said they saw it as God sent. They expressed their feeling of joy and pride of having money in their pockets. They further went on to say they would not mind if the monthly allocation was added to enable them cover for the orphans education especially. They went on to say that when the money is delayed for two or three months, they receive it in lumpsum at times to a tune of KShs.6,000. Some said they had never received this kind of money at once in their lifetime.

The focus group for non-beneficiaries also comprised of 8 persons, they said they were aware that the beneficiaries were receiving money but they rarely knew how much or when they went to collect it. They however agreed that the persons who benefited were needy and there was nothing wrong with them being recipients. Some gave reasons as to why they were not included but hoped to be included the next period. They came out very clearly to state that they had seen a lot of change among the beneficiaries. Two of the most noticeable changes they said were the increased number of livestock and improvement in housing from thatched roofs to iron sheets roofs. They also mentioned that they indirectly gain from the CT as they can at times borrow food or some little money from the beneficiaries.

Chapter 5 - DISCUSSION

5.1 First impressions on CT in Thika area

The average age for male respondents was around 75 years while that of the female was 72 years. This characteristic is quite common in most of the Kenyan communities where the men tend to marry younger women and the customary laws allow them to marry more than one wife. Strikingly, we found that all the female respondents with the exception of 2 were widows. The 2 non- widows were however separated from their husbands. In contrast, all

male respondents except 3 who were widowers were married, suggesting that most men as opposed to the women married after their wives deaths or had married younger wives. There is also a possibility that some of them could be polygamous. This is likely due to cultural practices, where in most communities in Kenya women especially old ones are not expected to re-marry, while their male counterparts do so without much hindrance. Such a scenario could easily lead to the spread of HIV especially when old men marry younger sexually active wives or older women engaging in sexual activities by multiple partners

The female beneficiaries who participated in this study had very low levels of education. None had gone beyond primary education. More worrisome was the fact that none of the female participants had gone beyond class 4, with only 2 of them reporting to have been to school. Nationally, gender parity in primary school education has almost been achieved but there are disparities which are region based and in the higher levels of education, in 2007 the ratio among boys and girls was 48:52 (World Bank, 2007). In most communities, girls were forced out of school and married off at an early age UNAIDS (n.d), reports that in many countries including several with high rates of HIV infection, girls are married in their teens- often as poverty-reduction strategy. It continues to say more than 100M girls in developing countries will be married before their 18th birthday- mostly to older men and against their will.

Despite the difference in level of education observed among the male and female older persons, both young boys and girls under their care were reported to be enrolled and attending primary schools. Indeed, the majority of the older persons viewed education as the most important means of escaping from poverty. They face an uphill task to educate the children beyond class eight due to the high cost of education in the secondary school.

Female headed households bore the largest burden of orphans. In total female and male respondents were found to be taking care of 66 and 23 orphans, respectively. This is a big mismatch, and considering that these women are widows and poor, the large number of orphans under their care is likely to put great burden on their households compared to their male counterparts headed households. This coincides with Barnett and Whiteside (2006) who write that older women have been found to bear the greatest brunt of caring for the HIV/AIDS orphans compared to men. Furthermore, they noted that the most affected are the older women population living in the rural areas. This may make them highly vulnerable to engage in activities such as sex for food or money. The danger again is that with constrained resources both the older women and the children they are taking care of, especially girls, are likely to engage in prostitution.

Despite the fact that majority of the men were married, they had fewer orphans under their care.This may suggest that the men are not easily entrusted with care of children or due to cultural practices which place the responsibility of taking care of children on women. Only two widowed men reported taking care of orphans. According to a report of WHO (2012) , the number of grandparents caring for AIDS orphans in developing countries has doubled over the last ten years and up to half of the world's 15 million AIDS orphans are being cared by a grandparent, majority of whom are women, who are faced with serious financial, physical and emotional stress due to their belated care giving responsibilities. More striking however, was the fact that the male respondents had 19 children under their care who were their own, compared to their female counterparts who had only 3 children, strongly supporting the observation that most of the older men re-marry or marry younger wives.

The majority of the older persons interviewed were found to live in tiny temporary shelters as squatters, which erodes their privacy as they have to share their tiny houses with children under their care. Barnett and Whiteside (2006) observed that the relative riskiness of an environment could enhance or diminish the ease with which the disease is transmitted. Under such living condition, children under the care of the older persons may be exposed to unwarranted sexual activities.

A majority of the beneficiaries are also squatters and do not own land. The little they have is the land around their houses and which it was observed was low in fertility. This means despite the high requirement for food in the households they can only produce very little. This has a direct impact on the health of the household members and worse still if there is a HIV infected or AIDS suffering person being taken care of. The other aspect in this regard is that as said by the DPHO, the older persons are weak and have a lower immunity compared to the average person and they could therefore very easily get infected while caring for their infected children and grandchildren. Niehof and Rugalema (2010) affirmed that vulnerability cannot exclusively be attributed to HIV/AIDS, but should take into account the land rights and other fundamental linkages.

5.2 Effect of HIV/AIDS on Financial Activities of the Older Persons Headed Households

The majority of the respondents' have very few other sources of income and where available those are quite unreliable. The women are again worst affected with 4 beneficiaries saying they have no other source of income other than the CT and none of them is in wage employment while 2 men are in wage employment and one is a mason. This could be an indicator that men continue being in active employment for longer than women and are thus likely to be living a better life. Among the non-beneficiary respondents, 4 said they were

heavily relying on food donation from the government, NGOs and relatives/well-wishers while one female was brewing and selling illegal liquor. The latter scenario is common among the very poor and the pressure of this kind of life at times forces orphans/children to disappear from home and go to the towns/streets begging where they become vulnerable to sexual abuse. The old women in this category become less resilient and therefore vulnerable and susceptible to HIV/AIDS as they may have no power to negotiate for safe sex.

The older persons have a reduced source of income by the actual death of their children. “When death occurs due to HIV/AIDS, the temporary loss of income becomes a permanent loss. Funeral and mourning costs are incurred and the family may compensate by reducing investments in productive activities, for instance removing children from school to save on expenses and increase household labour” (Chitere and Mutiso, 2011). One of the community leaders did mention that there was always danger of affected households selling their properties to meet the rising costs of medication, food and caring for the orphans as to confirm what had already been said by 2 respondents. One of the female community leaders also said that even the small businesses that the older persons may have started stagnate in the event of HIV/AIDS occurring in their household. The women were said to be worst affected as they have to sacrifice a lot of their time to the care of the ailing child and later of course the orphans to the detriment of any of their undertakings.

A majority of the older persons rely on their children to have their farms tended either by them or by hiring labour and in the event of HIV/AIDS, they lose the capability of maintaining production as they may lack the strength or money to expend on the venture. This is especially so in the rural areas and it is no exception to see tracts of land which used to be under farming which are no longer being utilized. This renders the household poor and poorer and if there is no support from outside, the household continues to wallow in more and more poverty. Among the older persons interviewed 17 of them reported to be sickly and most of whom their failing health could be visually observed.

In the event of a sharp shock for instance the death of a breadwinner, there is an immediate decline in living standards (Barnett and Whiteside, 2006) this is reflected in all aspects of the household affected. Most of those dying and leaving the orphans are the most productive as said earlier and therefore commonly the breadwinners in the older persons households. Their demise calls for immediate adjustment and in the poor older person household reduction in food consumption and other strategies are employed. Among the older persons interviewed the meals taken in their households are either one or a maximum of two per day when things are bright. The type of food is monotonously *ugali* or *githeri*. This is the cheapest food and what they can afford. Two CT beneficiaries however said they give their

families a treat whenever they receive their money by buying meat for them. In this kind of a situation, if the older person or any of the dependants happens to be HIV positive or suffering from AIDS the situation becomes quite grim as the possibility of meeting the required diet becomes a tall order. A malnourished person is more susceptible to parasitic infection and chronic parasitosis which reduces the body immunity making it easier for HIV to invade (Loevinsohn and Gillespie, 2003).To recover from the shock wrought by the death of the breadwinner in such circumstances also becomes extremely difficult.

The level of income and diversified sources of income determine the quantity and quality of assets that an older person possesses, just like any other person. During the research, the OPCT beneficiaries were able to mention one or two valuables they had acquired in the last two years unlike the non-beneficiaries who could not mention anything, to quote one non-beneficiary she said: “what would you expect me to have bought without money? There are many things I would wish to buy but I do not even have enough money for food”.

The beneficiaries and especially men have bought building materials, goats, chicken, duck etc which they dispose of/sell to pay fees for children or buy food when the going gets tough.

5.3 Effect of HIV/AIDS on the Social Activities

The respondents when asked what effect HIV/AIDS had on their social life mostly connected it with finance. With loss of income and new responsibilities most said they rarely participated in social activities. Most of the activities require contribution and travelling and this, most said, they cannot afford. Two respondents said that their relatives supported them whenever there was an activity that they were required to participate in. Most of them said they rarely participated in the social activities e.g. weddings. The majority of the respondents however confirmed that they were members of welfare/self-help groups. All interviewed were members of one or two of these groups which only meet to organize for burial when a person in their village dies. It is like buying insurance in case of their death as failure to participate will mean no one will be concerned when they finally die. Due to the responsibilities facing them, most of the respondents especially the women said they cannot easily join other groups as they cannot afford the monthly contributions required. One female and one male community leaders had also indicated that in a household where there is a member who is ailing from AIDS it becomes very difficult for the responsible female head to engage in social activities as most of her time will be spent in providing care.

While all the community leaders interviewed suggested that the male beneficiaries were more likely to engage in social activities like beer drinking this was seen as quite unlikely to happen among the women. Ellis (2000) says that additional cash income obtained by the

household has quite different effects on the welfare of women and children, depending on whether the recipient of that income is male or female. This thought could be the same used and expressed by the children officer who was quoted as saying that “the Children Department OVC program only considers the women as the caretakers” It is considered that if the recipient is female then the cash or benefit is in safe hands, which was also echoed by the community leaders involved in the OPCT. The other activity that majority of the respondents were involved in were attending of *barazas* (local community meetings). This is most likely as the convener of the meetings is usually the local administration and the older persons do not want to be seen as not supporting the government initiatives, they also require the local administration especially the chiefs if they ever have a problem they want sorted. The meetings are also conducted within the villages where the respondents reside and they therefore accrue no cost.

5.4 Utilization of Cash Transfer

As reported in chapter 4, the CT money is utilized by the beneficiaries on a number of things. Most of the money is used to purchase food which is the leading usage, followed by settling of medical expenses and then education. The older persons understandably spend a lot of the money on food and education for the children/orphans left under their care. MGCSD (2010) report indicates that these are some of the main areas on which the cash is being utilized. This study revealed that more women than men are spending on food, health and education while more men are spending on purchase of livestock and poultry. This could mean that the women are actually spending more on basic necessities. For instance, the female beneficiaries are maintaining 48 children in school while the male though had less children under their care were only maintaining 28 yet they are married. The men on the other hand seem to be spending more on investment. This reflects the common belief that women are good caregivers and concentrate in providing for the family and especially the children, it may also mean that the male headed households are doing better thus they can afford to save and put money in investments. The number of women and men engaging in small scale business and buying of building materials/construction is however similar.

The 5 non-beneficiaries who agreed to answer the questions on CT utilization confirmed that the CT had created some differences on the benefitting households. Among the most evident being improved living structures where the beneficiaries were now roofing with iron sheets and removing the thatched roofs and clothing, where they are seen as wearing better clothes. These sentiments were also echoed by the community leaders and all the key informants interviewed and has similarly been documented by MGCSD. Half of the beneficiaries were not willing to comment on how the beneficiaries were utilising the CT.

Though they explained that they could not comment as they were not part of any of the receiving households it could be observed they were not happy.

Despite these achievements it was however noted that there are no regulations guiding the usage of the CT and this was confirmed by the DGSDO and the program officer at the national office. Both said that the most they do is to advice the beneficiaries to put the money into good use and always to try and spread it to cover for the period until they receive the next transfer. The locational committees and the DGSDOs have however come up with local arrangements on how to keep track of the utilization and the head office has of recent agreed that any beneficiary confirmed to be misusing the money should be discontinued from the program.

The non-beneficiaries did not come up with anything new that they would do with the money if they became recipients, but would mostly utilize the funds on more or less similar activities with the ones being carried out by the beneficiaries.

5.5 Financial and Social Changes Resulting from the Cash transfer

The beneficiaries as already mentioned are now more financially empowered and some have managed to start small scale- businesses and other forms of IGAS like rearing of livestock which provides them with a better financial base. The goats and chicken being reared are investments which contribute in the improvement of their livelihood. This is so evident in one of the villages namely *Kilimambogo* and one of the female and one male community leaders did remark about it, almost all the beneficiaries now own goats. Though the programs intention was not to have the older persons start income generating activities, it is seen as a good way to possibly reduce dependency in the future. The program is however still in its early stages and may not necessarily create financial independence in the so soon. As explained in the literature, the main objective of CT is to cushion the very poor from wallowing in deep poverty where even meeting the basic necessities becomes a problem. Some of the non-beneficiaries mentioned that they also gain from the CT as they can now borrow food or other items from the beneficiaries thus there is some indirect benefit to them.

The CT as mentioned by the beneficiaries and as pronounced by the program officer in Nairobi has contributed in building confidence and participation among the beneficiaries. A good number of them also mentioned that though their relatives had initially detached themselves from them they now treat them better and with caution and respect.

CHAPTER 6-CONCLUSIONS AND RECOMMENDATIONS

6.1 CONCLUSIONS

The OPCT program was initially meant for the poor and especially those affected by HIV/AIDS it was only in its second year of implementation that it was transformed to a cash transfer for the older persons. The issue of HIV/AIDS however remained key, as one of the criteria for inclusion is the number of orphans that an older person is taking care of. Considering that, in this study around half the orphans were orphaned as a result of AIDS, so the program tackles the HIV/AIDS impact albeit indirectly.

The aim of the social protection the world over is to uplift the standards of living among people to an acceptable level where they can meet the basic needs and live without feeling degraded. Adato and Bassett (2012) concede that "while preserving basic levels of comfort and human dignity among the sick, social protection interventions may also be the only means of preventing the destitution of entire households, as well as irreversible health, nutrition, and education deprivation among children—with lifelong consequences".

Though the OPCT is meant for older persons, benefits to the children are enormous and most beneficiaries stated that the real beneficiaries could be the children in most cases. This should however not be construed to mean that it does not benefit the older persons. It does greatly contribute in improving livelihood in their households for there is no worse feeling than to have children whom you cannot feed or clothe. Not only have the beneficiaries gained a new capacity to purchase and own properties but a good number are able to be more active socially.

From the study it is clear that HIV/AIDS has affected the livelihoods of the older persons households by causing deaths and sickness of their breadwinners. Not only that, but the time taken and money spent in caring for orphans and the sick, affects every financial activity that the affected older persons would undertake to improve their status by engaging in small scale businesses/IGAs or even attending to their gardens. HIV/AIDS therefore propagates poverty among the older persons especially the women who already have limited sources of income.

The study also revealed that the older persons are affected so much that they rarely engage in social activities. This is partly due to lack of money which they would rather put in acquiring basic needs like food, purchasing medicine and improving their living shelters. The most common social activity (baraza) is really not just a social activity but actually a meeting to address development issues by the government and other partners. The older persons'

participation in social activities is limited not only because of the finances but also the requirement for care of orphans. The community leaders did allude to the fact that some HIV/AIDS affected/ infected older persons shy off from participation. This however is still a subject that could be investigated.

The study confirmed what is often found in literature, that HIV/AIDS affects the older women more than the men. They were seen to be carrying the burden of care, spending more on food education and education for the orphans/dependants. During the study, a number of respondents especially the community leaders seemed to maintain that the women utilize the CT money better and that they are unlikely to misuse it. They particularly saw them as using most of the money in the care of orphans. This is an area which may require further investigation.

The non-beneficiaries who agreed to respond to the question on usage did confirm that the CT is well utilized. The interviewees were able to observe a number of the things that beneficiaries had done with the money. They said they would use it in similar manner meaning they liked what they saw or what was being done with the money by the beneficiaries. Five of the non-beneficiaries were however unwilling to respond to questions in this regard for reasons we could not establish but they seemed unhappy.

Considering all these, the study can safely conclude that the CT is to a good extent mitigating the effects of HIV/AIDS among the older persons' households. Having lost the most productive persons in their households/ families the older persons are usually left helpless to look after children/orphans without a glimpse of hope. As the beneficiaries said during the focus group discussion, they regard it as God sent. They now have something to look forward to and are able to plan on how to improve their lives. It has changed their financial status and enhanced feeling of worthiness.

6.2 RECOMMENDATIONS

It is clear that the older persons are carrying a heavy burden of caring for their sons and daughters' children (the orphans). The burden is however more on the elderly women who are taking care of majority of the orphans in most cases single-handedly. This is a group that may require special attention in the social protection programs and there should be a deliberate effort by the organizations concerned both government and non-government to urgently address their plight.

The other issue of great importance is for the government to come up with interventions which can address the problems of the orphans /children living with these disadvantaged older persons, this could be by providing free education in both primary and secondary school. This would ease the burden to a good extent and contribute in making their lives even better. The older persons it was established also spend a lot on health related matters and a scheme to cover their medical bills could also go a long way in improving their lives.

Five of the non-beneficiaries were not ready to be asked anything about the beneficiaries and there could be some masked hostility. Considering the gap that has been created, the government/ the implementing department DGSD requires to continuously provide information and updates on the older persons programs to the communities to alleviate any misunderstandings. This can be done with the use of the community leaders and officers who are already trained on the program implementation.

Finally, the community leaders complained of not being appreciated for the work they do and said they require support in form of little finances to be able to continue working for the OPCT, this seriously needs to be looked into as the department really requires them as it has no staff in the locations.

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Annexes

Annex 1: Distribution of Dependants among Respondents

Type of Respondent	Number of Respondents	Own Children		Orphans		Total Dependants
		Male	Female	Male	Female	
Female Beneficiaries	11	-	1	26	15	42
Female Non-Beneficiaries	5	1	1	10	12	24
Male Beneficiaries	9	7	8	7	8	30
Male Non-Beneficiaries	5	-	4	2	6	12
Total	30	8	14	45	41	108

Annex 2: Age, Distribution and Education

Type of Respondent	Highest Age	Lowest Age	Highest Level of Education
Female Beneficiary	80	60	Class 4
Female Non-Beneficiary	90	64	Class 2
Male Beneficiary	88	67	Class 8
Male Non-Beneficiary	82	65	Class 8

Annex 3: Cash Transfer Usage

Beneficiary	Consumption					Investment		
	Food	Building & Materials	Medical	Education	Clothing	S/Scale Business	Animals	Birds
Female	11	4	10	7	3	1	5	2
Male	7	4	7	5	2	1	8	5
Total	**18**	**8**	**17**	**12**	**5**	**2**	**13**	**7**

Annex 4: Causes of Orphans Parents Deaths

Respondents	HIV/AIDS Deaths	Deaths other Diseases	Accident Deaths	Cause not Mentioned	Parent Deserted
30	13	7	2	6	2

Annex 5: Different Effects Due to HIV/AIDS

Respondent	Lack of Income Due to Decreased Labour	Lack of Caregiver	Lack of food Due to Death of Child	Financial and Emotional Stress	Sale of Assets
Female Beneficiary	7	0	3	2	0
Female Non-Beneficiary	2	0	2	0	0
Male Beneficiary	1	1	1	1	1
Male Non-Beneficiary	2	1	0	0	1

ANNEX 6: Demographic data

Name of Beneficiary (Female)	Location/ Village	Sex	Age	Education Level	Own Dependent Children		Orphans		Marital Status
					Male	Female	Male	Female	
M W	Kiangombe	F	73		-	-	3	-	Widow
T M	Kilimambogo	F	68		-	-	5	2	Widow
F N N	Kilimambogo	F	60	Class 4	-	-	3	2	Widow
H N	Kilimambogo	F	79	Non	-	-	3	-	Widow
M N	Gacagi	F	74	Non	-	-	2	1	"
V W	Gacagi	F	80		-	-	-	2	"
W K	"	"	70		-	-	2	2	Separated
E W	Athena	"	67	Non	-	-	1	2	Widow
G W	Athena	"		Non	-	-	2	-	Widow
E WAN	Umoja	"	70		-	1	3	2	Separated
W G	Juja	"	69	Non	-	-	2	2	Separated

Name of Non-Beneficiary (Female)									
L M M	Kianjau	F	64	Non	-	1	1	3	Widow
T W	Kiangombe	F	66	Non	-	-	3	4	Separated
P M N	Kilimambogo	F	72	Non	-	-	2	1	Widow
D M M	Kilimambogo	F	66	Non	-	-	3	2	Widow
H N K	Gatuanyaga	F	90	Class 2	1	-	1	2	Widow

Name of Beneficiary (Male)	Location/ Village	Sex	Age	Education Level	Own Dependent Children		Orphans		Marital Status
					Male	Female	Male	Female	
E O	Kiangombe	M	73	Class 6	-	-	1	2	Widower
G G K	Kiangombe	M	71	Class 6	3	-	-	-	Widower
M W	Gacagi	M	80	Class 8	-	3	1	-	Married
M N	Kilimambogo	M	67	Non	-	-	1	3	Married
T M	Kilimambogo	M	81	Non	1	2	2	2	Married
M M	Kilimambogo	M	73	Non	-	-	-	-	Married
K G	Juja	M	69	Non	3	3	-	1	Married
M K	Juja	M	88	Non	-	-	-	-	Married
P K	Kiangombe	M	78	-	-	-	2	-	Married

Name of Non Beneficiary (M)									
J K	Kiandutu	M	77	Class 6	-	-	-	-	Married
J N	Kiandutu	M	82	Non	-	-	1	1	Married
F K	KIlimambogo	M	80	Non	-	2	-	3	Widower
J K G	Athena	M	71	Class 8	-	1	1	-	Married
P K	Kilimambogo	M	65	Class 7	-	1	-	2	Widower

Annex 7:Beneficiaries and non- beneficiaries who indicated their sons/ daughters had died of HIV/AIDS

Name of Beneficiary	Sex	Son	Daughter	Male orphans	Female Orphans
T M	Male	-	D	2*	2
M W	Male	-	D	1	-
M N M	Female	-	D	2	1
V W C	Female	-	D	2	1
W K	Female	-	D	2	-
D M M	Female	-	D	3	2
G W K	Female	Son	-	2	2
F N N	Female	-	-	3	2
T MM	Female			5	2

Name of Non Beneficiary (Male)					
F K	Male	-	D	-	3
P K	Male	-	D	1	2
J N	Male	-	D	1	1
P M N	Female	-	D	2	1

Annex 8:House and Land Ownership

Name of Beneficiary (Female)	Land Ownership	House Ownership		Monthly Rent	School Going Children	Other Sources of Income
		Own	Rental			
M W	Squatter	Own				Selling vegetables and doughnuts
T M	Squatter	“				None
F N N	“	“				None
H N	“	“				None
M N	“	“				Daughter and Church Donations
V W	Squatter	“				Menial jobs and rental rooms
W K	Squatter	“				Rental rooms
E W	Own Land	“				Borrowing from friends
G W	Squatter	“				Borrowing
E WAN	“		Rental	Not Indicated		Crushing and selling concrete
W G	Own Land	Own				None

Beneficiaries (Male)						
E O	Squatter	Own, Built by Help Age Kenya				Wage Employment
G G K	"	Own, Built by Help Age Kenya				Wage Employment
M W	"	Own				Rental rooms – 400kshs
M N	'	"				-
T M	"	"				Masonry work
M M	"	"				Kiosk
K G	-	-	Rental	600 Kshs		Growing and Selling Vegetables
M K	4 Acres	Own				-
P K	Squatter	Own				

Annex 9: Land and House ownership

Non Beneficiary (Male)	**Land Ownership**	**House Ownership**		**Monthly Rent per Month in Kshs**	**School Going Children**	**Other sources of Income/ Support**
		Own	**Rental**			
J K	Non	-	Rent	300		Relief food from Government and Red Cross, Well wishers
J N	Non	-	Rent	300		Government Relief food, rent paid by daughter
F K	Squatter	-	-	-		Casual Labour
J K G	Own	Own (from son)	-	-		Receives food from daughter
P K	Squatter	Own	-	-		Casual Labour
Female						
L M	Own	Own	-	-		Casual Labour
T W	Squatter	Own	-	-		Selling Illicit brew, goats, ducks
P N	Squatter	Own	-	-		Casual Labour
D M	Squatter	"	-	-		Casual Labour
H N	Own 5 acres	Own	-	-		Tumaini Group, WEHMIS(NGO), Watoto Wenye Nguvu

Annex 10:Sickness and Food Consumption

Name of Beneficiary Female	Sick HH Member	Type of Ailment	Monthly Medical Bill Kshs	Common Foods	Number of Meals	Source of food
M W	Self	Malaria	=2000	Githeri	2	Own Produce and Buying
T M	Self	Malaria	=500	Ugali, Githeri	1-2	Own garden and borrowing
F N N	Self and grandson	HIV/AIDS	-	"	1-2	Buying
H N	-	-	-	-	2	Buying
M N	-	-	=1000		2	Buying
V W	Self	Arthritis, BP,Ulcers	-	Rice, Ugali	2	Buying
W K	Self	Chest pain	=5000	Ugali, Githeri	1-2	Garden, Buying
E W	-	-	-		2	Garden
G W	Self	BP	-		1	Buying
E WAN	Self	Liver	-	Ugali, githeri	3	Garden, buying
W G	-	-	-	Ugali, githeri	1-2	Garden, buying

Githeri- Meal of boiled maize and beans, Ugali – ground maize flour boiled in water and stirred to harden

Male						
E O				Ugali, Githeri	3	Buying, donations from daughters
G G K				Ugali, Githeri	3	Buying
M W	Self and Wife	BP, Chest	=1000		2	Buying, garden
M N	Self	Sick Leg		Ugali, Githeri	1	Buying
T M					2	Buying
M M				Ugali, githeri, rice	1	Farm, IGA
K G					-	Buying
M K	Self	Dementia		Ugali, githeri, rice	3	Farm, Buying
P K	Self	Malaria	=1000		2	Buying

Annex 11:Health and food status

Non Beneficiary (Male)	Sick HH Member	Type of Ailment	Medical Bill	Number of Meals per Day	Common Foods	Sources of Food	
J K	self	Lame leg, arthritis	-	1	-	Well wishers	
J N	-	-	-	2	Ugali, rice, vegetables	Tending small garden	
F K	Self	-	-	1-2	-	Borrowing from friends, buying	
J G	Self	BP, Failing eyesight	-	1	-	A daughter usually buys, donation	
P K	Self, Children	Ailing leg, Malaria	2000-3000	1	-	Buying	
Female							
L M	Self, daughter	-	-	2	-	Buying	
T W	-	-	-	2	-	Buying, donation	
P N	--	-	-	1	Ugali	Buying	
D M	-	-	Herbs	2	Ugali,githeri	Buying	
H N	Self, Son	Cancer, mental	200-500	2	-	Own farm, buying	

BP- Blood Pressure

Annex 12: Cash Transfer Usage

Beneficiary Female	Food	House Repair/ construction	Medical	Education	Clothing	S/Scale Business	Animals	Birds
M W	X	-	X	-	X	Doughnuts	-	-
T M	X	-	X	X	-	-	2 Goats	
F N N	X	Iron Sheets	-	X	-	-	Goat	
H N	X	-	X	X	-	-	-	-
M N	X	-	X	-	-	-	Goats	
V W	X	-	X	X	X	-	Goat	Chicken
W K	X	-	X	-	-	-	-	-
E W	X	Blt 2 Rental rooms	X	X	X	-	Goat	Chicken
G W	X	Blt Rental Rooms	X	X	-	-	-	-

E WAN	X	Paying Rent	X	-	-	-	-	-
W G	X	-	X	X	-	-	-	-

X- Represents usage

Beneficiary Male	Food	House construction	Medical	Education	Clothing	S/Scale Business	Animals	Birds
E O	-	-	X	X	-	-	Goats	-
G G K	X	Iron Sheets	-	X	X	-	3 Goats	5 Ducks
M W	X	Rental rooms	X	-	-	-	2 Sheep, 3 Goats	-
M N	X	Iron Sheets	X	X	X	-	Goats	Chicken
T M	X	Iron Sheets, Furniture	X	X	-	-	Goats, 1 Cow	-
M M	-	-	X	-	-	Shop	Goat	-
K G	X	-	X	X	-	-	Goat	5 Chicken
M K	X	-	-	-	-	-	-	Chicken
P K	X	-	X	-	-	-	Goat	Ducks

Annex 13: Involvement in social activities

Beneficiary Female	Group Membership	Monthly Contribution in Kshs	Meetings	Other Social Activity	Source of
M W	Welfare Group	100	Dictated by need	Burials and barazas	OPCT
T M	-	-	-	Barazas	-
F N N	Savings Group	-	Monthly	Barazas, burials	OPCT
H N	Savings Group	100	Monthly	Group counselling	-
M N	Welfare Group	-	Dictated by need	Barazas, burials	Borrowing, OPCT
V W	Welfare Group	100	Dictated by need	Burials	Borrowing, OPCT
W K	-	-	-	-	-
E W	Welfare Group	15	Dictated by need	-	-
G W	Welfare	100	Dictated by need		OPCT
E WAN	-	-		Burials	-
W G	Savings Group	120	Monthly	-	-

Beneficiary Male	**Group Membership**	**Monthly Contribution in Kshs**	**Meetings**	**Other Social Activity**	**Source of**
E O	SHG	100	Monthly	-	Wages
G G K	-	-	-	-	-
M W	Welfare	65	Dictated by need	Barazas, Funerals	
M N	Wefare	200	Time of need	Church, community	
T M	-	-	-	Visiting Relatives	-
M M	SHG, Wefare	100, 120	Monthly, Time of need	-	Kiosk
K G	SHG	Group is inactive	Non		
M K	-	-	-	-	-
P K	SHG (Chaiman)	100	Monthly	-	His Children, OPCT
Beneficiary Male	**Group Membership**	**Monthly Contribution in Kshs**	**Meetings**	**Other Social Activity**	**Source of**
E O	SHG	100	Monthly	-	Wages

Non Beneficiary (M)	**Group Membership**	**Contribution in Kshs**	**meetings**	**Other Activities**	**Source**
J K	Non	-	-	-	
J	Non (no money)	-	-	-	
F K	Savings group	100		Social meets, funerals	Casual labour
J G	-	50	Time of need	Funerals, socio	Daughter
P K	Savings group	100	Monthly		Casual Labour
Female					
L M	-	20	-	Funerals	Wages
T W	Non	-	-	Funerals	-
P N	Welfare Group	120	Time of need	"	Borrowing, wages
D M	Welfare Group	100	Time of need	"	Menial jobs
H N	Savings, welfare Group	100, 100			Group, NGO

Annex 14: Research Outcome- Reasons for Inclusion

Beneficiary (F)	**Age**	**Poverty**	**Orphans**	**others**	**CT Identification Rating**
M W		X			Fair
T M		X			Fair
F N N		X	X		Fair
H N	X				*
M N	X				Good, benefited most needy
V W	X				Good
W K	X	X			Okay
E W	X	X			Fair, Reg at a comm. Meeting
G W	X	X	X		Fair, Reg at a comm.. meeting
E WAN	X	X			Fair " " "
W G	X	X			" " "

Beneficiary (M)					
E O					
G G K	**X**			**Disability**	
M W					
M N		**X**			**Fair, village elders and SDA**
T M	**X**				**Community leader**
M M		**X**			**Fair**
K G	**X**	**X**			
M K		**X**			
P K	**X**				**Fair**

Annex 15:Reasons for Non-Inclusion

Non-Beneficiary –M	Reason/s for Non- Inclusion	Valuables bought last 2 years	Comments on Usage of CT by Beneficiaries
J K	Did not register, has no identity card	Non	Not Aware
J N	Was away during recruitment	Non	Not Aware
F K	Hospitalized and regards recruitment as fair	Non	Not Aware
J K G	Community elder during recruitment, feels he should have been included as he is needy	Non	Beneficial and if enrolled could start a small business
P K	Was not aware of the program	-	Food, fees, business, could help him the same
Female			
L M M	Age, though feels she should have been considered		No comment, but could start charcoal business if considered
T W	Not aware why and claims to have registered	Non	No comment
P M N	Hospitalized	-	Livestock, better houses
D M M	Was away working, recruitment well done	-	Goats, poultry, fees
H N K	Recruitment Transparent	-	Clothing, family care, would do same and pay fees

Annex 16: Dependants in School

Beneficiary (Female)	Dependants In Secondary School		Dependants in Primary School &		Level not Indicated but in School		Nursery		Dependants out of School	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
M W	-	-	-	-	3	-			-	
T M	3	-	-	2	-	-			-	
F N N			1	1					2	1
H N			3							
M N			1			1 Special class			1	
V W			1	1				1		
W K	1		1							
E W	Not said									
G W			2	1						1
E WAN			2	2						
W G		1	2	1						

Beneficiary (male)	Dependants In Secondary School		Dependants in Primary School &		Nursery		Level not Indicated but in School		Dependants out of School	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
E O			1	1		1				
G G K	Not Said									
M W			1							3

M N				2	1	1				
T M			3	4						
M M	Non									
K G			2			1			1	3
M K	Non									
P K			2							

Non Beneficiary (M)	**Secondary Level**		**Primary Level**		**Not said but in School**		**Nursery**			
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
J K										
J N			1	1						
F K		2		1						2
J G										
P K	1			2						
Female										
L M			1	1						
T W			1	3				1	1	
P N			1	1					1	
D M	1		1	2			1			
H N		2							1	

Children Supported by Respondents to be in School

Respondents	**Sec Male**	**Sec Female**	**Prim Male**	**Prim Female**	**Nursery Male**	**Nursery Female**	**Class not Said Male**	**Class not Said Female**
Female	5	3	18	15	1	2	3	1
Male	1	2	10	11	1	3	0	0
Total	**6**	**5**	**28**	**26**	**2**	**5**	**3**	**1**