01

VOLUME

Evaluation of FCDO's COVID-19 Cash Transfer in Kenya

Report produced as part of the Evaluation of the Hunger Safety Net Programme Phase 3

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Cover photo caption
Community member in Mathare slum, Nairobi, Kenya during COVID-19 - May 2020.
Photo: @UN-Habitat/Kirsten Milhahn

Preface

Oxford Policy Management (OPM) has been engaged by the UK Foreign, Commonwealth and Development Office (FCDO) as the monitoring, evaluation, and knowledge (MEK) partner for the Hunger Safety Net Programme (HSNP) Phase 3. The HSNP has been delivering unconditional cash transfers (CTs) to approximately 100,000 poor and vulnerable households in Turkana, Marsabit, Mandera, and Wajir counties since 2009. In addition, mass registration efforts across the four counties mean that, during times of shock, mostly defined by drought conditions, the HSNP is able to rapidly scale up and reach up to a further 250,000 households. The third phase of the programme will transition the HSNP to full Government of Kenya (GoK) ownership and financing, while continuing to support vulnerable households with regular CTs and during shocks. The primary aim of the United Kingdom's support to the HSNP Phase 3 is to build capacity within GoK to fully take over the management, leadership, and coordination functions required to deliver the HSNP, and to invest in disaster risk financing and approaches to economic inclusion.

The payment of CTs and the management of HSNP Phase 3 will be delivered through an FCDO-World Bank Trust Fund. This trust fund is part of the World Bank's Kenya Social and Economic Inclusion Programme (KSEIP), an IDA loan programme to the value of US$ 250 million (November 2018 to December 2023) to support Kenya's social protection sector. KSEIP will contribute to the delivery and expansion of HSNP into additional counties and will finance pilot economic inclusion interventions in five counties: Kisumu, Makueni, Marsabit, Muranga, and Taita-Taveta.

The MEK component is structured around four workstreams to achieve the following objectives:

- to assess the quality of HSNP delivery throughout the transition of programme implementation to GoK;
- to assess the capacity needs of GoK to manage the HSNP and to inform capacity building and transition plans and processes;
- to assess the progress made in building capacity within GoK to successfully manage and finance the HSNP;
- to assess the effectiveness and efficiency of the economic inclusion implementation process under KSEIP, with a focus on operational lessons and recommendations for scale-up; and
- to assess the impact of the KSEIP economic inclusion interventions on household poverty and wellbeing.

Beyond these objectives, the MEK component is designed to provide useful, relevant, and timely outputs to FCDO, the World Bank, and government stakeholders, which can then be used to inform programme design and implementation and ultimately improve service delivery for beneficiary households. For this purpose, the MEK component has budget for several 'deep dive' studies to provide bespoke knowledge outputs to address evidence gaps or to answer new questions as they emerge. These have not been specified in advance because the aim is to respond to emerging findings from the four workstreams and to relevant new demands from MEK stakeholders, should those arise during the project period.

Drawing from these 'deep dive' resources, FCDO has requested OPM to provide monitoring and evaluation (M&E) of the COVID-19 CT to assess the impact of the cash on vulnerable people residing in urban informal settlements and to learn lessons for future shock-responsive CTs.

Acknowledgements

The authors would like to thank all the individuals who have contributed to the undertaking of the evaluation of the COVID-19 cash transfer, as well as to producing this report. These include the GiveDirectly implementation team, with special thanks to Stephen Kalungu for his continued support and cooperation throughout the life of the evaluation, and to the NGO partners for their engagement; FCDO Kenya (Anthony Njage, Josephine Gitonga, Dorothy Shihemi, and Mercy Odour) for funding the intervention and this evaluation, as well as for their engagement throughout the process; the Ministry of Labour and Social Protection (including the Social Protection Secretariat and the Social Assistance Unit) for their valuable insights provided during the implementation review; and Research Guide Africa (in particular John Chege, for his tireless efforts in managing the fieldwork), as well as the qualitative and quantitative field teams for their rigour and diligence. Last, but definitely not least, a special thank you to all the respondents who generously gave their time and opinions for the interviews for this evaluation.

The Study Lead for this deep dive study is Michele Binci, the Project Manager is Alexandra Doyle and the evaluation Team Leader is Fred Merttens.

This report was co-authored by Michele Binci, Alexandra Doyle, Clare Gardner, Martina Garcia Aisa, Shafique Arif, Lucy Scott and Fred Merttens. All opinions expressed, and any mistakes, remain the responsibility of the authors.

Disclaimer

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Executive summary

Oxford Policy Management (OPM) has been engaged by the UK Foreign, Commonwealth and Development Office (FCDO) as the monitoring, evaluation and learning (MEK) partner for the Hunger Safety Net Programme (HSNP) Phase 3. The MEK component has budget for several 'deep dive' studies to provide bespoke knowledge outputs to address evidence gaps or answer new questions as they emerge. Drawing from these 'deep dive' resources, FCDO has requested OPM to provide monitoring and evaluation (M&E) of the COVID-19 Cash Transfer (CT) to assess the impact of the cash on vulnerable people residing in urban informal settlements, as well as to learn lessons for future shock-responsive CTs.

The COVID-19 CT

The first case of COVID-19 in Kenya was confirmed on 13 March 2020. In response to the outbreak, on 15 March 2020, the Government of Kenya (GoK) declared a state of emergency and implemented a range of strict containment measures. The measures imposed to contain COVID-19, coupled with the global recession, have severely impacted the Kenyan economy and the livelihoods of poor Kenyans, particularly in urban areas, with approximately 2 million people expected to fall into poverty (World Bank, 2020).

To support the urban poor during the COVID-19 crisis, the UK government provided a monthly CT of 4,000 Kenyan Shillings (KSH) (or £27) to approximately 50,000 vulnerable people living in informal settlements in Nairobi and Mombasa over a period of three months. The COVID-19 CT was implemented by a consortium led by GiveDirectly, and the monthly stipend was paid using mobile money transfers from October 2020. The CT was designed to support beneficiaries to buy food or meet other high-priority needs—such as purchasing water, paying for medical care, or making rent payments—as well as to reduce the use of negative coping strategies (e.g. selling assets; borrowing money).

Evaluation design and methods

The main objective of this evaluation is to determine whether, and to what extent, the emergency COVID-19 CT has had a positive effect on its target population in informal urban settlements in Kenya. The evaluation also provides an assessment of the implementation parameters and mechanisms adopted as part of the design and delivery of the COVID-19 CT. Finally, we have collected a set of indicators directly related to COVID-19 to contextualise our findings and to provide timely evidence on any behavioural change prompted by knowledge and awareness around the COVID-19 epidemic.

In order to fulfil these aims, the evaluation has been structured around two separate components—an impact evaluation and a process review—and draws on multiple research methods through a mixed methods research framework, as follows.

- **A quantitative research study** has been used to respond to questions of impact and to support answers to questions of relevance and effectiveness. This study is based on a panel design and a remote quantitative survey implemented at three points in time.
- **A qualitative research study** has been used to respond to questions of relevance and to support answers on questions of impact, effectiveness, and efficiency. This study is based on in-depth interviews with beneficiaries carried out by mobile phone at midline and endline.

- **A process review** has been used to respond to questions regarding the effectiveness, efficiency, and coherence of the project. This study is based on interviews with national-level and county-level stakeholders, including GoK, FCDO, and the implementing agent (GiveDirectly) and their non-governmental organisation (NGO) partners, as well as on a short self-administered survey with NGO partners.

COVID-19 knowledge and behaviour

We sought to understand household knowledge about COVID-19 and the risk-mitigating behaviours in which they engaged. Overall, we found that beneficiaries had good knowledge of measures to reduce the risk of contracting COVID-19, with the majority of beneficiaries citing the use of mask and gloves (93%), handwashing with soap and water (86%), maintaining social distance (80%), and handwashing with hand sanitiser (60%).

We also found that beneficiaries adapted their behaviour to reduce the risk of contracting COVID-19. At baseline, almost 90% of beneficiaries reported avoiding handshakes and physical greetings, while around 80% mentioned staying at home more than usual, engaging in more frequent handwashing with soap and water, and avoiding large groups. However, it was more common for beneficiaries to stay at home more often than usual in Mombasa and among female beneficiaries (both by 10 percentage points). These findings were consistent throughout the implementation period of the COVID-19 CT (i.e. November 2020 to February 2021), with the exception of staying at home more frequently, which significantly dropped from 78% of beneficiaries at baseline to 57% at endline. This is likely due to the reduction in COVID-19 cases between December 2020 and March 2021.

Main findings and conclusions

Relevance

Overall, the evaluation found that the COVID-19 CT was relevant for the target population of individuals living in informal urban settlements in Nairobi and Mombasa. The amount and timing of the COVID-19 CT were also appropriate, although the delay to the COVID-19 CT implementation may have weakened some of its effectiveness.

Our quantitative and qualitative findings also show that the COVID-19 pandemic has had a noticeable negative impact on individuals' employment and income sources, as well as on their food security and use of coping strategies to deal with the economic downturn. CT beneficiaries reported their employment had become less secure due to the crisis, with less than two-thirds of beneficiaries still working in the same job in November 2020 (at the time of our baseline survey) as they had before the COVID-19 pandemic. Most of them (86%) said their employment-related income had reduced since the start of the pandemic.

Further, households' reduced income and employment affected both the quantity and quality of food they bought and severely impacted their food security. Prior to the pandemic, respondents described having sufficient food stocks, but were now only able to buy small quantities of food when they earned money. The quantitative measure of food security suggests considerable insecurity in terms of access to food before the start of the COVID-19 CT. Further, at baseline, three-quarters of beneficiaries reported having experienced at least one food deprivation situation in the four weeks prior to the survey.

Finally, coping strategies, including negative strategies, were widely used by CT beneficiaries to deal with the economic downturn, especially due to the reduced income and employment

opportunities. Qualitative and quantitative findings both highlighted that beneficiaries had most commonly borrowed money, especially from family and friends, to cope with the pandemic, although some respondents perceived that they had limited access to coping strategies that offered them credit further into the pandemic. Other common coping strategies included reducing or stopping to pay rent, and using savings.

Efficiency

The targeting approach used for the CT was appropriate in the context of the COVID-19 crisis, given the need to achieve rapid and remote enrolment of beneficiaries, as well as scale, while keeping costs low. However, the loosely defined targeting criteria, focusing on vulnerable groups in urban informal settlements, led to confusion among partners. Further, the provision of low-quality data (i.e. old databases with beneficiary names that did not match the mobile money registered name) to GiveDirectly by partner NGOs led to high levels of rejection from the programme. These issues negatively affected the equity of the targeting, as the same vulnerable groups were either included or excluded depending on the local partner NGO used in a particular area. While the emergency nature of this COVID-19 CT intervention prevented the adoption of a more equitable targeting approach, simpler, clearer, and more transparent targeting criteria that were better aligned to the populations most in need could have been implemented.

The choice of cash (rather than in-kind transfers) and the transfer amount of KSH 4,000 was in line with other COVID-19 responses and can be considered appropriate as an individual entitlement. However, the findings indicated that it has generally been used to contribute to household needs rather than just covering those of an individual. For this reason, only around half of partner NGOs and beneficiaries felt the amount was entirely adequate.

Finally, while the timing of the transfer was delayed, it was still relevant in the context of the pandemic, especially as it happened to coincide with a second spike in infections in Nairobi and Mombasa. The three-month duration is in line with global and national norms for COVID-19 CTs. However, a shorter delay in implementation—starting the disbursement of the COVID-19 CT only a few months after the onset of the crisis—could have achieved even better outcomes. Specifically, receiving the support during the first phase of the crisis might have prevented the adoption of some of the more detrimental coping strategies and built household resilience. Nonetheless, the CT was delivered at a time when other support mechanisms had been exhausted and therefore played an important role.

Effectiveness

The effectiveness of the targeting approach was mixed. While it was able to reach residents of urban informal settlements (arguably some of the poorest urban residents and most affected by the economic impacts of COVID-19), as discussed above the targeting approach was not sophisticated enough to ensure that only the most vulnerable within these locations were reached. This was exacerbated by the lack of opportunities for partner NGOs to collect new data on individuals known to be most in need of assistance.

The payment mechanism based on mobile money transfers was effective in delivering cash relatively easily, cheaply, quickly, and directly to those in need, while minimising opportunities for corruption. This was facilitated by the high coverage of mobile money provider Safaricom in urban areas. However, the use of M-PESA was also the main reason (in 80% of cases) many were found ineligible for the programme, as poor-quality data from NGO partners led to

mismatches between beneficiary lists and the names registered with M-PESA.

The communication and complaints response mechanism (CRM) processes established by GiveDirectly were broadly effective. Both partner NGOs and beneficiaries were aware of, and using, the CRM system, which seemed to be functioning well and led to the timely resolution of most issues raised. The communication from GiveDirectly to the beneficiaries, mainly delivered through SMS, was also generally reported to be clear and direct.

Finally, GiveDirectly set up effective internal monitoring processes and metrics for different stages of the project. Monitoring data were collected by GiveDirectly themselves through SMS and call surveys, and GiveDirectly submitted monthly progress reports to FCDO, which provided regular and useful updates on implementation.

Coherence

GiveDirectly sought to engage in coordination mechanisms with both NGOs and government stakeholders providing other COVID-19-related cash. In particular, GiveDirectly participated in the Kenya Cash Working Group (KCWG), a mechanism for coordinating with other cash stakeholders, and proactively shared information on its CT implementation with the COVID-19 Secretariat. GiveDirectly also shared information with the European Union (EU) consortium and the World Food Programme (WFP), which are also running large COVID-19 cash programmes, in order to de-duplicate the beneficiary lists.

Coordination on specific aspects of CT implementation remains weak, however, and there is no requirement to comply with agreed good practices. For instance, coordination on targeting lacks clear government direction and only relies on the goodwill of individual agencies. Similarly, it is not easy for NGOs to access data in the Single Registry, which leads to frustration and duplication; each separate COVID-19 response intervention established its own CRM, with no clear mechanisms to ensure coordination between them.

Impact

The COVID-19 CT had a discernible impact on food security and the use of coping strategies. Beneficiaries' employment status and related income sources also improved, and some of these improvements appear to be associated with the CT.

The employment opportunities of CT beneficiaries increased between baseline and endline, which led to an increase in weekly income obtained from employment. Although these trends may be partially due to changes in COVID-19-related restrictions, CT beneficiaries did link the transfer to starting or expanding small businesses or paying for transport to look for work. This seems to be confirmed by our quantitative findings, which showed that receiving the COVID-19 CT increases the chances of undertaking an economic activity.

The positive effect of the CT on food security levels was clear: our quantitative analysis estimated that receiving the COVID-19 CT reduced the probability of experiencing severe food deprivation by 32% on average. The quantitative analysis also showed a cumulative effect of the CT over time, with the food security improvements increasing between midline and endline. Our qualitative interviews showed almost all respondents used part of the money to buy food; many stocked up on staple items, which meant they no longer had to worry about providing food to their families on a daily basis.

The use of coping strategies decreased significantly, from an average of five strategies reported at baseline to an average of three coping strategies reported at endline. This decrease was consistent across counties and the gender of beneficiaries. While the most commonly reported coping strategy at endline was still borrowing money, this was only used by 67% of CT beneficiaries, compared to 82% of beneficiaries borrowing at baseline. Similarly, the qualitative research also found that many respondents no longer had to ask family or friends for money or support and did not need to buy food on credit.

Implications for policy

A number of policy implications follow these conclusions, which can be useful for all stakeholders involved in the COVID-19 CT—including GoK, FCDO and other development partners, and GiveDirectly and their partners or other NGOs—to improve the design and implementation of shock-responsive CTs within the context of Kenya's social protection system.

The use of an emergency CT is an appropriate tool to deal with the most severe consequences of large, sudden, and long-lasting shocks, such as the COVID-19 pandemic. It is advisable to continue employing this type of unconditional CT in similar contexts of crisis, especially when systems and mechanisms for the development, implementation, and coordination of shock response interventions are not in place or are not fully operational.

However, an effective use of social protection to respond to shocks requires *ex ante* preparation in order to facilitate swift and efficient action at the onset of a crisis. Government guidance and strategy is required for responses to different kinds of shock, with institutional mechanisms for strategic collaboration across sectors established in advance. Guidance for emergency cash-based programming should stipulate the relevant target populations and the methods for identifying them, as well as appropriate transfer values and durations, payment modalities, use of existing delivery systems, and M&E frameworks.

- → Identification of appropriate target populations: criteria ought to be transparent and implemented equitably, with all those meeting the criteria included in the programme.
- → Setting transfer values: if interventions aim to support household needs, the amount provided to individual beneficiaries should be calibrated accordingly, using verification and de-duplication processes to mitigate the risk of households 'double dipping'.
- → Pre-shock agreements: these include agreements between data owners on protocols for sharing data for verification and coordination of targeting during shocks. Additional agreements on exemptions for automatic debt repayment or temporary fee waivers may also be necessary, if mobile money is to be used.

Non-government actors need government support and coordination. In the case of cash programming, KCWG provides a platform that GoK could leverage to organise and provide support and coordination of non-government actors.

- → Support is needed to improve data quality. GoK should provide support to NGOs delivering emergency cash programming to help build their capacity to gather and maintain high-quality data, as well as to link it to the Single Registry.
- → For links to the Single Registry to be possible, it must be properly functioning and protocols for accessing data need to be strengthened.

- → NGOs could also be encouraged to use, or at least align registration tools with the Harmonised Targeting Tool (HTT) to enable compatibility of datasets within the Single Registry. Training on the use of the HTT could be provided to NGOs.
- → The quality of existing data underpinning the Single Registry itself needs improving to be useful in coordinating and facilitating sector-wide shock response. This will require building capacity within GoK to gather and maintain high-quality data.

GoK should build its capacity to utilise mobile technology. The COVID-19 CT has demonstrated the value and efficiency of mobile technology, for example SMS platforms, as a core element across the CT delivery systems chain, from registration and enrolment to payments, grievances and case management (G&CM), communications, and M&E.

- → Capacity to use this technology should be embedded in the delivery chains of Kenya's routine social protection programming such that it can easily be deployed in the context of shocks, with additional actors able to piggy-back on a functional existing system.
- → Including mobile money providers as a payment service provider option offered to routine social protection beneficiaries has the potential to vastly improve the quality of the Single Registry data (especially in terms of currency and accuracy).
- → Developing the existing routine social protection payments system to include mobile money service providers would also build government capacity to manage contracts with these providers, while acting as a model for contractual arrangements between emergency response actors and mobile money service providers in the event of a shock.

However, it is important to recognise that the exclusive use of mobile money (and technology more broadly) may exclude an especially vulnerable portion of any target population. If mobile money is to be used in routine social protection or for future shock responses, this implies the need for the following:

- → strategies to support the registration of especially vulnerable groups to mobile payment mechanisms;
- → partnering with multiple mobile providers; and
- → including alternative payment modalities to serve those who cannot or choose not to use mobile money as a payment option.

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List of abbreviations

CATI	Computer-Assisted Telephone Interview
CRM	Complaints Response Mechanism
CT	Cash Transfer
DAC	Development Assistance Committee
DFID	UK Department for International Development
ESR	Enhanced Single Registry
EU	European Union
FANTA	Food and Nutrition Technical Assistance
FCDO	UK Foreign, Commonwealth and Development Office
G&CM	Grievance and Case Management
GDPR	General Data Protection Regulation
GoK	Government of Kenya
HFIAS	Household Food Insecurity Access Scale
HFPS	High Frequency Mobile Phone Surveys
HSNP	Hunger Safety Net Programme
HTT	Harmonised Targeting Tool
KCWG	Kenya Cash Working Group
KNBS	Kenya National Bureau of Statistics
KSEIP	Kenya Social and Economic Inclusion Programme
KSH	Kenyan Shillings
M&E	Monitoring and Evaluation
MEB	Minimum Expenditure Basket
MEK	Monitoring, Evaluation, and Knowledge
MLSP	Ministry of Labour and Social Protection
MoI	Ministry of the Interior
MoU	Memorandum of Understanding
NCPWD	National Committee on Persons with Disabilities
NDMA	National Drought Management Authority
NGO	Non-Governmental Organisation
OPM	Oxford Policy Management
OVC	Orphans and Vulnerable Children
PWD	People With Disabilities
SPS	Social Protection Secretariat
UNICEF	United Nations Children's Fund
WFP	World Food Programme

01 Introduction

CHAPTER

Caption: Market seller, Nairobi, Kenya
Photo: Pixabay

OPM has been engaged by FCDO as the MEK partner for the HSNP Phase 3. The MEK component has budget for several 'deep dive' studies to provide bespoke knowledge outputs to address evidence gaps and to answer new questions as they emerge. Drawing from these 'deep dive' resources, FCDO has requested OPM to provide M&E of the COVID-19 CT to assess the impact of the cash on vulnerable people residing in urban informal settlements and to learn lessons for future shock-responsive CTs.

This report presents the findings from the 'deep dive' study of the COVID-19 CT. Although the purpose of the study is to provide an evaluative judgment about the COVID-19 CT, it should not be considered as a comprehensive and standalone evaluation, such as the upcoming evaluation of the economic inclusion pilots under KSEIP. Features typical of an evaluation, including for instance an evaluation governance structure or an evaluation results dissemination strategy, are not relevant and specific to this study, which is to be placed and considered in the broader context of the MEK HSNP Phase 3 framework.

1.1 COVID-19 in Kenya

The first case of COVID-19 in Kenya was confirmed on 13 March 2020. In response to the outbreak, on 15 March 2020, GoK declared a state of emergency and implemented a range of containment measures, including instructing non-essential personnel to work from home, banning large social gatherings, and imposing a nationwide curfew. Following this, all schools and learning institutions were closed until January 2021, with only candidate years returning to school in October 2020. A ban on international passenger flights was introduced until August 2020. Furthermore, movement in and out of the five counties most affected by the 'first wave', known as the lockdown counties, was curtailed between April and June (for Kilifi and Kwale) and April and July (for Nairobi Metropolitan Area, Mombasa, and Mandera).[1] While the 'first wave' of COVID-19 peaked in July 2020, a 'second wave' began in early October, peaking in early November and subsiding in December 2020. Cases began to rise again in March 2021, in what has been described as a 'third wave'.

The measures imposed to contain COVID-19, coupled with the global recession, have severely impacted the Kenyan economy and the livelihoods of poor Kenyans, particularly in urban areas. Kenya's economy contracted by 0.4% between January and June 2020, compared to a growth of 5.4% between the same months in 2019. By November 2020, the unemployment rate had almost doubled compared to its pre-COVID-19 level and the labour force participation rate had decreased. Among wage workers, between February and June 2020, average hours worked fell by 18% for men and 30% for women. In addition, one in three household-run businesses closed. Overall, this has resulted in a significant decrease in earnings for wage earners (especially those in the informal sector),[2] with a greater decrease for women, who saw a 46% decline in earnings between February and June (compared to approximately 14% for men). Remittance earnings were also found to have significantly decreased (KNBS, 2020; World Bank, 2020).

COVID-19 is estimated to have increased poverty in Kenya by about 4 percentage points, resulting in 2 million 'newly' poor Kenyans. These newly vulnerable households are

1 See www.kenyacovidtracker.org/.

2 The Kenya National Bureau of Statistics (KNBS) (2019) found that 83.6% of total employment in Kenya is in the informal sector.

different from the majority of households traditionally living in poverty in Kenya in that they predominantly reside in urban areas and have younger, better-educated household heads. They also tend to live in smaller households, with more working-age household members (World Bank, 2020). This increase in poverty has been linked to a deterioration in food security in urban informal settlements. A food security assessment conducted in July 2020 showed that 99% of households in 10 of Nairobi's informal settlements were food insecure (Oxfam, 2020). Extrapolated to the 2.6 million residents of Nairobi's informal settlements, this implies an estimated 1.45 million people were unable to meet their food needs in that month.

1.2 The COVID-19 CT

To support the urban poor during the COVID-19 crisis, the UK government provided a monthly CT of KSH 4,000 (or £27) to approximately 50,000 vulnerable people living in informal settlements in Nairobi and Mombasa over a period of three months. The COVID-19 CT was implemented by GiveDirectly, and the monthly stipend was paid using mobile money transfers from October 2020.

The purpose of the CT was to help beneficiaries cope with the immediate negative effects of COVID-19 that have severely impacted the informal economy where most of the urban poor make a living. The CT was designed to support beneficiaries to buy food or to meet other high-priority needs, such as purchasing water, paying for medical care, or making rent payments, as well as to reduce the use of negative coping strategies (e.g. selling assets; borrowing money).

1.3 Overview of the social protection landscape in response to COVID-19

Table 1 provides an overview of the cash-based responses implemented by GoK and non-state actors to mitigate the negative impacts of the pandemic. It is clear that a large number of responses have been implemented, covering an impressive number of individuals and households, with some responses having a national coverage and others focusing on specific areas. Although many agencies are working in the informal settlements of Nairobi and Mombasa, their responses have not been fully aligned, resulting in variations in terms of the level and duration of support provided.

Table 1: Overview of cash-based responses to COVID-19

Response	Caseload	Geographic coverage	Eligibility[1]	Transfer value	Implementing agency
Multi-agency COVID-19 CT	669,000 households	National	Poor, vulnerable households affected by the pandemic	KSH 1,000 per week for four months	State Department for the Interior
National Committee on Persons with Disabilities (NCPWD) CT	33,333 households	National	Vulnerable people with disabilities (PWD)	KSH 6,000 (lump sum)	NCPWD
Kazi Mtaani	296,000 youths	34 counties	Youths (aged 18 to 34) residing in urban informal settlements	KSH 600 for 22 days, or KSH 455 for 11 days	State Department for Housing and Urban Development
United Nations Children's Fund (UNICEF) top-up	9,700 households	Garissa, Kajiado, Kilifi, Kakamega, Migori	*Inua Jamii* beneficiaries with children under the age of 10	KSH 2,000 per month for two months	UNICEF
EU-funded consortium	~30,000 households and 10,400 women and girls	Nairobi, Mombasa	Vulnerable households in urban informal settlements in Nairobi and Mombasa	KSH 7,668 per month for three months	Consortium led by Oxfam
WFP	94,500 households	Nairobi, Mombasa	Vulnerable households in urban informal settlements	KSH 4,000 per month for three months	WFP
UNICEF	2,000 households	Kilifi, Kajiado	Households with children with severe acute malnutrition	KSH 2,000 per month for two months	UNICEF
FCDO	52,700 individuals	Nairobi, Mombasa	Individuals in urban informal settlements	KSH 4,000 per month for three months	GiveDirectly
Shikilia	50,000 individuals	Nairobi, Mombasa, Kisumu	Individuals in urban informal settlements	KSH 3,000 per month for three months	GiveDirectly (with private sector and NGO partners)
TED	120,000 youth	Nairobi, Mombasa	Reside in urban informal settlements	KSH 3,000 per month for four months	GiveDirectly

Source: adapted from Doyle and Ikutwa (2021). Note: this table covers a subset of cash-based responses implemented in Kenya. A more comprehensive mapping has been conducted by the Kenya Red Cross Society and is available here.

1.4 Structure of this report

This evaluation report is presented in two volumes. The present Volume I sets out the endline evaluation findings, conclusions, and implications for policy, drawing on all research activities conducted as part of the evaluation activities. Volume II contains the technical annexes to the endline evaluation report, including further details regarding the methodological approach and full statistical tables for the baseline, midline, and endline quantitative household surveys.

The remainder of Volume I is structured as follows. Section 2 describes the evaluation methodology and approach to each research activity. Section 3 presents descriptive statistics about beneficiaries' COVID-19 knowledge and behaviour to situate the findings. Section 4 presents the findings from the process review component of the evaluation. Section 5 presents the findings from the mixed methods impact evaluation component. Finally, Section 6 provides conclusions and presents the implications for policy.

02 CHAPTER

Evaluation approach and methodology

Caption: Crowded street, Nairobi, Kenya
Photo: Pixabay

2.1 Objective of the evaluation

The main objective of this evaluation is to determine whether and to what extent the emergency COVID-19 CT has had a positive effect on its target population in informal urban settlements in Kenya. This represents an assessment of the immediate impact of the COVID-19 CT, as it is focused on the short timeframe of the COVID-19 CT three-month implementation. In addition, the evaluation investigated whether the COVID-19 CT had any unintended effects for individuals who received the transfer, their household, and the community. The evaluation also provides an assessment of the implementation parameters and mechanisms adopted as part of the design and delivery of the COVID-19 CT. Finally, we have collected a set of indicators directly related to COVID-19 to contextualise our findings and to provide timely evidence on any behavioural change prompted by knowledge and awareness around the COVID-19 epidemic.

In order to fulfil these aims, the evaluation has been structured around two separate components: an impact evaluation (Section 2.3) and a process review (Section 2.4). The specific objectives of these components can be categorised into five of the six Development Assistance Committee (DAC) evaluation criteria.[3]

- Relevance: Our assessment of relevance focuses on the extent to which the goals of the COVID-19 CT have responded to the needs of the target population and whether the transfer characteristics are consistent with these goals. This includes considerations related to the suitability of the COVID-19 CT to the local urban context and to the local effects of the crisis.
- Impact: Our assessment focuses on the impact (positive or negative; direct or indirect; intended or unintended) of the CT on food security and the coping strategies employed by beneficiaries to deal with the effects the crisis. We also conduct a trend analysis on employment and income over time.
- Effectiveness: We focus on the effectiveness of the COVID-19 CT project design and delivery systems. This includes an assessment of the effectiveness of implementation processes, including the programme's reach, approaches to beneficiary registration, targeting and enrolment, payments, G&CM, and monitoring.
- Efficiency: Our assessment of efficiency focuses on programme processes, including targeting and the CT payment mechanism. Specifically, we assess the appropriateness of targeting decisions, and whether and how innovations have been used to improve approaches to rapid targeting. Emphasis is placed on understanding what learning may be transferable and relevant to the National Safety Net Programme, the development of shock-responsive social protection systems in Kenya, and the development of the Enhanced Single Registry (ESR).
- Coherence: We assess the coherence of the COVID-19 CT in relation to wider efforts (government, NGO, and other support) to mitigate the negative impacts of the crisis. In addition, coherence is considered in terms of how the intervention has interacted with existing social protection programmes and delivery systems.

The key research questions addressed by the two components of the evaluation focus on

3 Given the short timeframe and emergency nature of the COVID-19 CT, we did not address questions relating to the DAC criterion of the intervention's sustainability.

the effects of the COVID-19 CT on beneficiary households living in Kenya's informal urban settlements during the COVID-19 crisis on the one hand, and on the mechanisms that the COVID-19 CT employs to target and reach vulnerable households and deliver assistance on the other. Table 2 lists the high-level research questions for each of the DAC criteria. A full set of detailed research questions are presented in Volume II.

Table 2: High-level research questions

Evaluation criteria	Research questions
Relevance	• To what extent are the COVID-19 CT amount, duration, and timing appropriate, given the COVID-19 situation in the county and in urban settlements in particular? • To what extent does the emergency COVID-19 CT address the immediate needs and priorities, as well as the vulnerabilities, of the targeted households?
Impact	• What is the impact of the COVID-19 CT on individual and household-level food consumption, livelihoods, coping strategies, and general wellbeing? • Have there been any unintended impacts, either positive or negative? If so, what?
Effectiveness	• What are the chosen delivery mechanisms and how effective are they in reaching the selected beneficiaries? • What lessons in terms of delivery mechanisms are relevant for GoK in normal times and in response to shocks?
Efficiency	• How appropriate are the targeting criteria and approach in the context? What are the targeting innovations being used and how are they performing? • How efficiently have delivery mechanisms performed in the context of the COVID-19 pandemic?
Coherence	• Why is the COVID-19 CT being implemented in parallel to GoK's response and systems? Is this appropriate in the context? • Is the COVID-19 CT aligned with other cash-based responses to the impact of COVID-19 in Kenya? • Is the implementing consortium coordinating effectively with others?

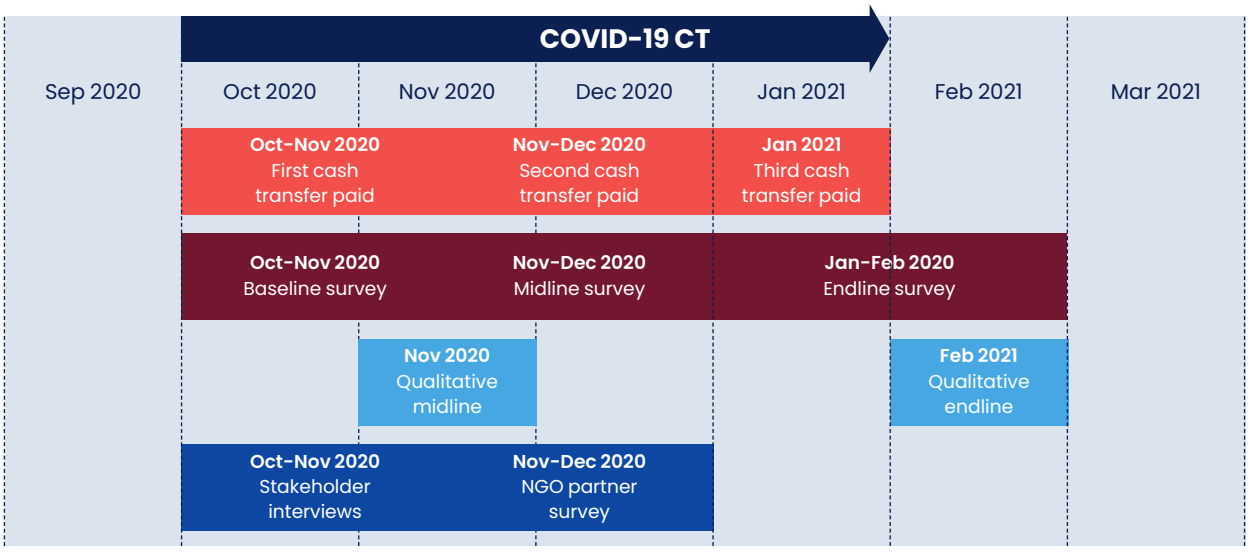
2.2 Mixed methods evaluation approach

A mixed methods research framework has been designed to answer the research questions using three methodologies.

- A quantitative research study is used to respond to questions of impact and to support answers on questions of relevance and effectiveness. This study is based on a panel design and a quantitative survey implemented using a mobile phone application at three points in time (Section 2.3.1).
- A qualitative research study is used to respond to questions of relevance and support answers on questions of impact, effectiveness, and efficiency. This study is based on in-depth interviews with beneficiaries, carried out by mobile phone at midline and endline (Section 2.3.2).
- A process review is used to respond to questions regarding the effectiveness, efficiency, and coherence of the project. This study is based on interviews with national-level and county-level stakeholders, including GoK, FCDO, and the implementing consortium (GiveDirectly and NGO partners), as well as on a short self-administered survey with NGO partners (Section 2.4).

Figure 1 provides a summary of how data collection has been sequenced for each of these studies in relation to the implementation of the CT.

Figure 1: Sequencing of data collection



2.2.1 Analysing mixed data across studies

Throughout the evaluation, we have sought to ensure that the emergent evidence from each research study has been used to shape the research and considered alongside the findings from other studies. Initially, evidence from each research study was analysed by the study lead and their team in order to draw draft findings. These were then shared and discussed with the wider evaluation team. Given that data collection and analysis was staggered between October 2020 and February 2021, the team met several times to keep abreast of the evidence as it developed. While each section of this report had a lead author and a

supporting author, based on the relevant methods used to answer the evaluation questions, the findings from the three research activities (quantitative survey, qualitative study, and process review) are mixed in each chapter. This approach culminated in a mixed methods workshop, during which overall conclusions and implications for policy were discussed with the full evaluation team based on this mixed methods analysis.

2.3 Approach to the impact evaluation component

The impact evaluation component is built on a mixed methods framework, including quantitative and qualitative research methods. Since quantitative and qualitative methods both have specific strengths and weaknesses, deploying a mixed methods framework is crucial to ensure that the approaches complement one another and build on each other's strengths. Throughout the impact evaluation, we have sought to exploit the strengths of the quantitative and qualitative research methods to comprehensively answer our research questions. While the quantitative estimation of impact provides a robust measure of the effects of the CT on individual recipients and their households, qualitative information has been used to add a more nuanced and in-depth understanding of how the transfer has affected people's lives and wellbeing, including a focus on unintended consequences of the intervention.

The mixed methods impact evaluation is based on three rounds of quantitative data collection (Section 2.3.1) and two rounds of qualitative data collection (Section 2.3.2).[4] Baseline (shortly before the first payment was delivered), midline, and endline (after all three payments were made) quantitative household surveys were administered to programme recipients at one-month intervals. Qualitative research was undertaken at both midline and endline. The timing of the baseline (and subsequent surveys) was sequenced to follow the timeline of the registration and enrolment of beneficiaries in Nairobi and Mombasa, and therefore took place in three batches.

The objective of the quantitative component was to answer questions related to immediate impact of the programme over the three-month implementation period, while the objective of the qualitative research was to assess the relevance of the programme in relation to individual and household needs during the crisis. However, this assessment of relevance was complemented by descriptive quantitative analysis using the baseline data, while the qualitative findings complemented the quantitative impact measurement to provide a more complete assessment of the impact of COVID-19 on individual and household wellbeing. In this regard, the qualitative research has been designed to be responsive to the findings of the quantitative surveys, with the focus determined by the baseline, midline, and endline quantitative survey findings.

4 In order to mitigate bias in responses (in particular desirability bias), we ensured that our informed consent procedure clearly stated our role as evaluators, and how these data would be used. We reminded respondents of this throughout the survey, in particular when asking questions where respondents might have been incentivised to answer the question in a way they thought might entitle them to support.

2.3.1 Quantitative approach

The objective of the quantitative impact evaluation was to assess whether the COVID-19 CT has had an impact on its beneficiaries, and to quantify the scale of any effect detected. This estimation of impact was based on **a longitudinal non-experimental design, focusing on a panel of beneficiaries interviewed three times** (baseline, midline, and endline) over the course of the implementation period. All quantitative data collection took place remotely through the use of Computer-Assisted Telephone Interview (CATI) software. Full details on the data collection instrument and survey methodology can be found in Volume II.

The quantitative impact evaluation combined different analytical approaches to provide comprehensive answers to the evaluation questions of interest. In particular, the quantitative analysis had the following objectives:

- to provide a descriptive picture of the socioeconomic status of beneficiaries and their households prior to receiving any CT support from GiveDirectly, and to assess whether this situation was affected by the economic downturn induced by the COVID-19 crisis;
- to provide descriptive trends of changes in outcome indicators of interest among the CT beneficiaries between baseline, midline, and endline; and
- to provide a measure of impact on those indicators at the beneficiary level that can be more directly linked to the COVID-19 CT when controlling for confounding factors.

In line with the first objective, we present cross-sectional descriptive findings on the outcomes of interest (i.e. employment and other income sources; food security; and the use of coping strategies) at baseline in Section 5.1. Section 5.2 then describes the uses of the COVID-19 CT by the beneficiaries interviewed at midline and endline respectively.

Finally, Section 5.3 responds to the second and third objectives of the quantitative analysis. For each of the outcome indicators of interest, we first present descriptive trend graphs to show how the key variables have changed between baseline, midline, and endline among the panelled group of CT beneficiaries. Once time trends on the outcomes of interest have been presented, this section also shows the results of a more sophisticated econometric approach, which aims to measure the impact of the COVID-19 CT on each of the outcomes of interest. The econometric approach consists of a panel estimation strategy based on a fixed-effects model, which allows us to isolate the impact of the CT and of other factors affecting the outcomes of interest, while controlling for the effect of all observable and unobservable time-invariant confounders, as well as the effect of some time-variant confounders. Full technical details on the econometric impact analysis are provided in Volume II.

Given that we were not able to construct a counterfactual to estimate impact, Section 5.3 also includes, where appropriate, coefficient comparisons with national estimates obtained from the World Bank's 'High Frequency Mobile Phone Surveys (HFPS) of Households to Assess the Impacts of COVID-19' initiative[6], which focuses on similar variables to this study during the period of interest. However, we caution against making direct comparisons across surveys given the differences in target population and indicator definition. We nonetheless present these findings as they are informative of the general context within which our own findings are placed.

6 https://www.worldbank.org/en/country/kenya/brief/monitoring-covid-19-impact-on-households-and-firms-in-kenya

Box 1: How quantitative results are presented in this report

All quantitative descriptive findings in this report are presented graphically for the overall sample of beneficiaries, as well as disaggregated across two categories of interest: the gender and location (i.e. county) of the beneficiary. The sample size for different indicators varies depending on the analysis target subsample, which is specified in the subtitle of each graph. The size of the sample upon which the analysis is conducted is reported in the notes at the bottom of each graph.

In particular, trend graphs display disaggregated results over time, with 95% confidence intervals showing where differences between time estimates are statistically significant. Differences are considered highly statistically significant when the confidence intervals do not overlap.

Sampling strategy and sample characteristics

A stratified one-stage probability sampling strategy was implemented for the selection of survey respondents from the individuals included in the lists covered by GiveDirectly for the COVID-19 CT.

The sampling strategy applied explicit stratification based on the geographical location of the COVID-19 CT recipient, and an equal number of individuals were sampled in the two locations of interest: Nairobi and Mombasa. In order to enhance the representativeness of the sample with respect to the target population (i.e. the complete list of beneficiaries of the COVID-19 CT), implicit stratification was also applied based on the following two categorical variables: the local partner from which the eligible beneficiary was selected, and the gender of the COVID-19 CT recipient. Finally, post-stratification weights were used to adjust the distribution of the sample between Nairobi and Mombasa to the frequency distribution between the two counties in the target population.

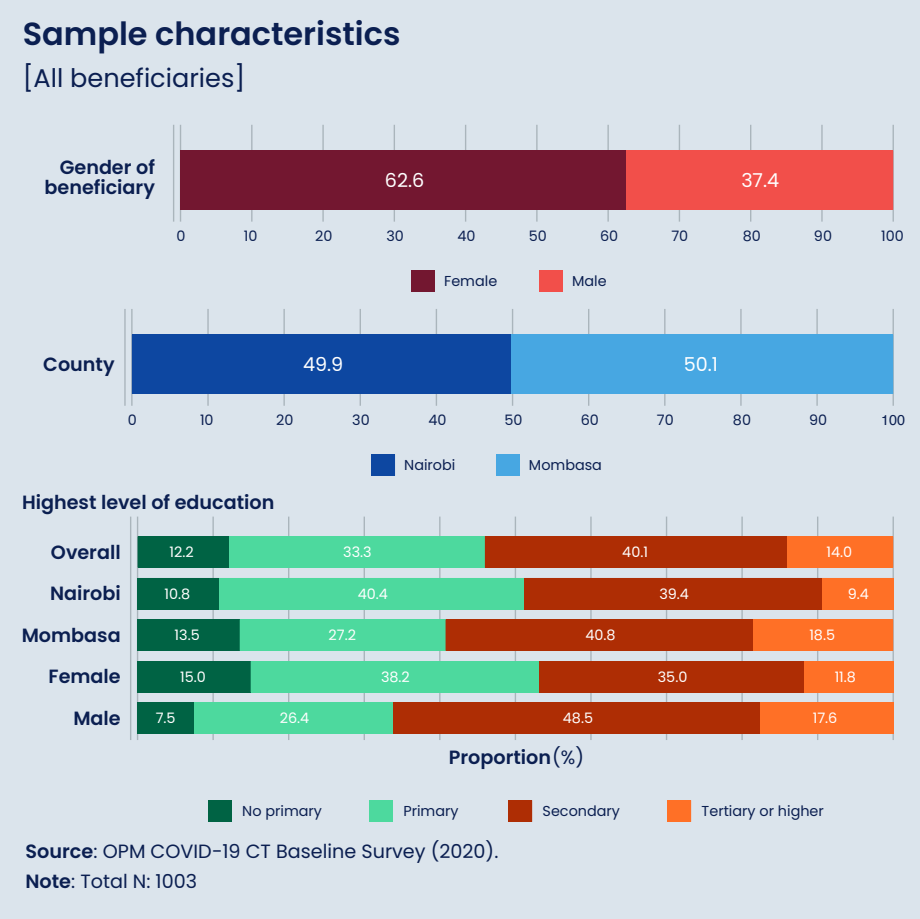
As shown in Table 3, the attrition across the three survey rounds was kept very low, with well over 90% of the baseline respondents traced and re-interviewed at midline and endline.

Table 3: Sample achievement

County	Baseline survey	Midline survey	Endline survey
Nairobi	500	483 (96.6%)	463 (92.6%)
Mombasa	500	489 (97.8%)	478 (95.6%)
Total	1,000	972 (97.2%)	941 (94.1%)

Figure 2 provides an overview of the main characteristics of the COVID-19 CT beneficiaries in the evaluation sample at baseline in terms of location, gender, and educational attainment.

Figure 2: Sample characteristics



Source: OPM COVID-19 CT Baseline Survey (2020).
Note: Total N: 1003

2.3.2 Qualitative approach

While the qualitative research focused primarily on answering research questions of relevance and impact, following the impact evaluation design, there was also a focus on answering questions of effectiveness and efficiency (related to the process review: see Section 2.4), in particular to understand the perceptions of beneficiaries in relation to the intervention's service delivery.

Qualitative sampling and tools

The qualitative research took place remotely in two rounds, in November 2020 (after the first CT payments had been received) and in February 2021 (after all three payments had been received). In total, we conducted semi-structured in-depth interviews with 30 programme beneficiaries per round: 15 in Nairobi and 15 in Mombasa. This sample size was selected to ensure that we were able to introduce sufficient demographic variation into our sample in each county (e.g. gender; disability status; age) and to include respondents from across NGO partner organisations.

The midline research was conducted after the baseline quantitative survey was completed

(Figure 1). The qualitative component took a purposive approach to sampling respondents and, therefore, by design, the qualitative sample is not representative of the population of beneficiaries who received the COVID-19 CT. The objective of sampling in qualitative research is to explore a sub-set of issues from a range of perspectives in-depth rather than statistical representation.

The midline qualitative sample was drawn from the quantitative baseline survey, which was conducted with beneficiaries of the COVID-19 CT. This approach enables us to select purposive cases, in addition to presenting a generalisation about the larger population from the quantitative survey. As part of the baseline survey, we asked respondents whether they would be willing to participate in further research, and only those who were willing to take part were included in the potential qualitative sample. In the first round of qualitative research, the objective of the sampling approach was to identify the most vulnerable beneficiaries (in terms of food security and the coping strategies used) within the target population in order to understand their needs during the crisis and prior to receiving the CT.

In order to minimise the research burden on respondents, we interviewed different respondents in each round of the qualitative research. The focus of the endline was to understand whether and how the CT had impacted the wellbeing of beneficiaries in terms of food security and the use of coping strategies, as well as to understand any unintended consequences of the CT. In line with this focus, the endline qualitative sample was drawn considering the endline quantitative survey results and purposively selected respondents who had experienced the most change (positive or negative) between baseline and endline in terms of food security and the coping strategies used.

Further details about the qualitative approach can be found in Volume II.

2.4 Approach to the process review

The process review focuses on the DAC criteria regarding the effectiveness, efficiency, and coherence of the chosen targeting and delivery mechanisms (communication and outreach; registration; payment; G&CM; and monitoring mechanisms). It explores some of the key programme delivery systems in depth, such as the targeting approach and payment mechanism, and analyses how they performed. In view of FCDO's long-term engagement in the social protection sector in Kenya and heavy investment in strengthening GoK's social protection systems, including innovations in shock-responsive social protection, the review also aims to draw out lessons that are of value to strengthening GoK social protection systems.

The process review has drawn upon several different methods to collect both primary and secondary data.

- **Literature review:** This included literature on other social protection responses to COVID-19 in Kenya; literature on the COVID-19 shock and its impact in Kenya, especially in urban areas; and project documentation, including GiveDirectly's project documentation (proposal, workplan, procedures and manuals, reports).
- **Primary quantitative data analysis:** This involved the following.
  - Process-related questions were included in the quantitative baseline, midline, and endline surveys to collect data on service delivery at the beneficiary level (Section 2.3.1).

- A self-administered survey was held with up to three staff at each partner NGO in Nairobi and Mombasa (limited to partners on board by late 2020: see Volume II for a full list of respondents).

→ **Secondary quantitative data analysis:** This involved analysis of monitoring data collected by the implementing consortium, including data from GiveDirectly's CRM.

→ **In-depth interviews with beneficiaries:** Questions on perceptions of implementation at the beneficiary level were included in the qualitative research (Section 2.3.2).

→ **Key informant interviews:** These were held with the following:

- at FCDO, the Senior Responsible Officer and other key staff;
- GiveDirectly's partner NGOs;
- agencies implementing COVID-19 CTs in urban informal settlements;
- KCWG;
- local administration in implementation areas, including chiefs, assistant county commissioners, and deputy county commissioners; and
- GoK stakeholders at the Ministry of Labour and Social Protection (MLSP) and the COVID-19 Secretariat.

→ **Regular discussions with GiveDirectly:** Monthly meetings were held with key GiveDirectly staff, as well as regular bilateral meetings with the programme manager, to source and verify information, ask questions, and share findings as they emerged.

2.5 Strengths and limitations

2.5.1 Strengths of this study

This study was implemented during the COVID-19 pandemic and, although this limited the way in which data was collected (see Section 2.5.2), there are also several strengths to this study that emerged from the adaptation of the study approach to this context, which we highlight below.

The use of telephone-based interviewing, using a bespoke computer-assisted telephone interviewing (CATI) software, provided several advantages to the data collection process while adhering to social distancing requirements. The VOXCO software has an in-build call management platform, which allows interviews to be assigned to enumerators based on language or experience in the case of reluctant respondents. Further, the software manages call-backs and, based on a set of rules, is able to optimise the time at which call-backs take place in order to minimise attrition from the survey. The CATI software also allows survey managers to provide live quality assurance to enumerators. Since the operationalisation of the COVID-19 CT was based on mobile money transfers, this convergence between implementation and evaluation survey modes was conducive to a robust evaluation and the collection of high quality data.

We were thus able to implement a thorough and comprehensive evaluation entirely remotely. This allowed us to learn about the design and implementation of a CT in an emergency situation and provide timely feedback to both GiveDirectly and FCDO to improve programme

implementation, in real-time, and to learn lessons for future social protection responses to shocks.

2.5.2 Limitations of this study

The main limitation affecting this evaluation has been the inability to include non-beneficiaries who met the programme's eligibility criteria. This has several implications.

- In relation to the quantitative component of this study, this has meant that a counterfactual could not be constructed for the estimation of impact. As explained in detail in the study design note, it was agreed among all stakeholders that it not possible to identify or construct an experimental or quasi-experimental control group due to the saturation of the lists of all possible eligible beneficiaries of the COVID-19 CT. The lack of a counterfactual means the quantitative estimates of impact obtained with the econometric techniques adopted (i.e. panel regression model with time-invariant fixed individual and cluster effects, and time-variant covariates) cannot be directly or fully attributed to the CT. Rather, they represent estimates of the effect of receiving the CT over time, when also controlling for the simultaneous effect of other influencing factors and confounders. This still represents a valuable indication of the causal effect of the CT, but does not amount to attributable impact.

  To partially mitigate this, and as already mentioned, Section 5.3 includes some coefficient comparisons with national estimates obtained from the World Bank's HFPS on the impacts of COVID-19, which focuses on the analysis of similar variables to this study during the period of interest. Although interesting to contextualise our findings, these comparisons should be taken with caution given the existence of differences between our survey and the World Bank's surveys in terms of reference populations and indicators definition.

- The qualitative component of the evaluation also only interviewed beneficiaries of the COVID-19 CT; we were unable to explore how food security and the use of coping strategies changed for the group of non-beneficiaries between November 2020 and February 2021, which coincided with the 'second wave' of COVID-19 infections and the subsequent opening of the economy.

- Finally, as data were not available on the full eligible population (i.e. those who met the programme's targeting criteria), an assessment of exclusion errors, the appropriateness of the eligibility criteria, and the targeting effectiveness was not possible as part of this study.

Another limitation affecting the quantitative analysis is the relatively limited range of indicators and data that could be collected, given the remote nature of the data collection exercise. Although the use of CATI ensured high data quality and a very low attrition rate between survey rounds, the remote survey mode meant that the length and scope of the survey tools were limited when compared to the information that could be collected in person.

The final limitation associated with the quantitative analysis concerns the sample used for the quantitative survey. Although the survey sample is representative of the sampling frame from which it was drawn, which was provided by GiveDirectly before baseline, GiveDirectly subsequently enrolled more individuals into the CT from different partner NGOs, which were not included in the original sampling frame. These additional individuals represent a small minority of the overall CT target population, and the sampling frame from which the

quantitative sample was drawn contains the great majority of CT beneficiaries, of which the sample is thus representative. It is, however, important to highlight that this does not represent the entire final target population of all CT beneficiaries. The same limitation applies to the qualitative sample, which was derived from the quantitative sample.

Similarly, the in-depth interviews conducted as part of the qualitative study were also conducted remotely. This meant that interviews were limited to 30 minutes. In order to cover the breadth of topics of interest, all respondents were asked a core set of questions, as well as one of three secondary modules, and this limited the depth of the data collected for the secondary modules. Further, using remote interviewing meant interviewers were not able to interpret visual cues and did not have access to non-verbal data, which is usually gathered as part of face-to-face research.

Finally, while the process review sought to be comprehensive in consulting stakeholders, the staggered approach to engaging partner NGOs in the programme has limited our engagement to those partners brought on board by November 2020. This meant we were not able to include all partners in the self-administered survey, although this limitation was partially overcome by engaging a subset of partners that came on board later bilaterally. Further, it was difficult to engage assistant county commissioners and area deputy county commissioners, and several were not aware of the project. This was because most of the district commissioners for Nairobi were changed just before the launch of the project and therefore had not been involved in initial engagement by GiveDirectly. Where this happened, attempts were made to contact other members of the administration from the same sub-counties or to replace the sub-county with another similar location.

03 CHAPTER

COVID-19 knowledge and behaviour

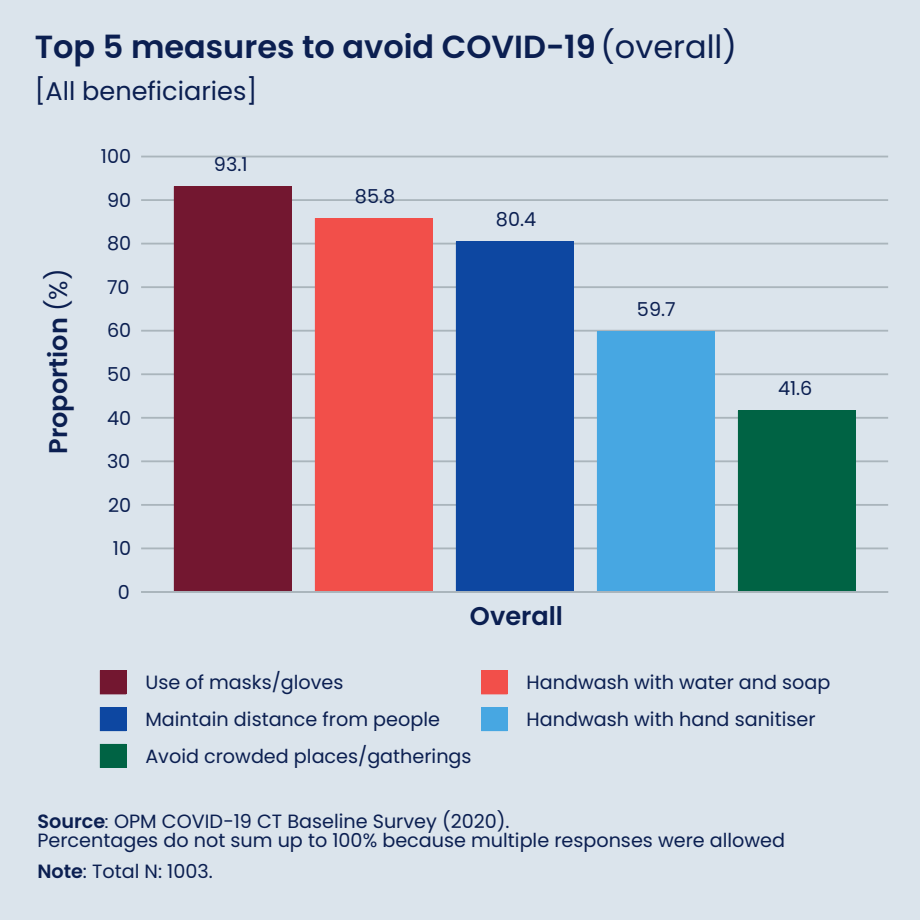
Informing and Inspiring the Youth through Shujaaz Comic in Nairobi County
Photo: Geoffrey Mwangi/USAID

To contextualise the findings presented in this report, this chapter briefly presents a description of households' knowledge about COVID-19 and the risk-mitigating behaviours that can reduce the spread or likelihood of contracting the virus.

At baseline the most commonly known measures to avoid COVID-19 (Figure 3) included using mask and gloves (93%), handwashing with soap and water (86%), maintaining social distance (80%), handwashing with hand sanitiser (60%), and avoiding crowded places or gatherings (42%).

These results were consistent across genders and locations, although significant differences were observed in the magnitude of some mitigating measures. For example, despite being the third most mentioned measure in both counties, the proportion of beneficiaries who reported maintaining distance from people was 6 percentage points higher in Nairobi than in Mombasa. Similarly, the proportion of beneficiaries who mentioned handwashing with soap and water was 8 percentage points higher among the female group than among their male counterparts.

Figure 3: Top five measures for avoiding COVID-19 known by beneficiaries



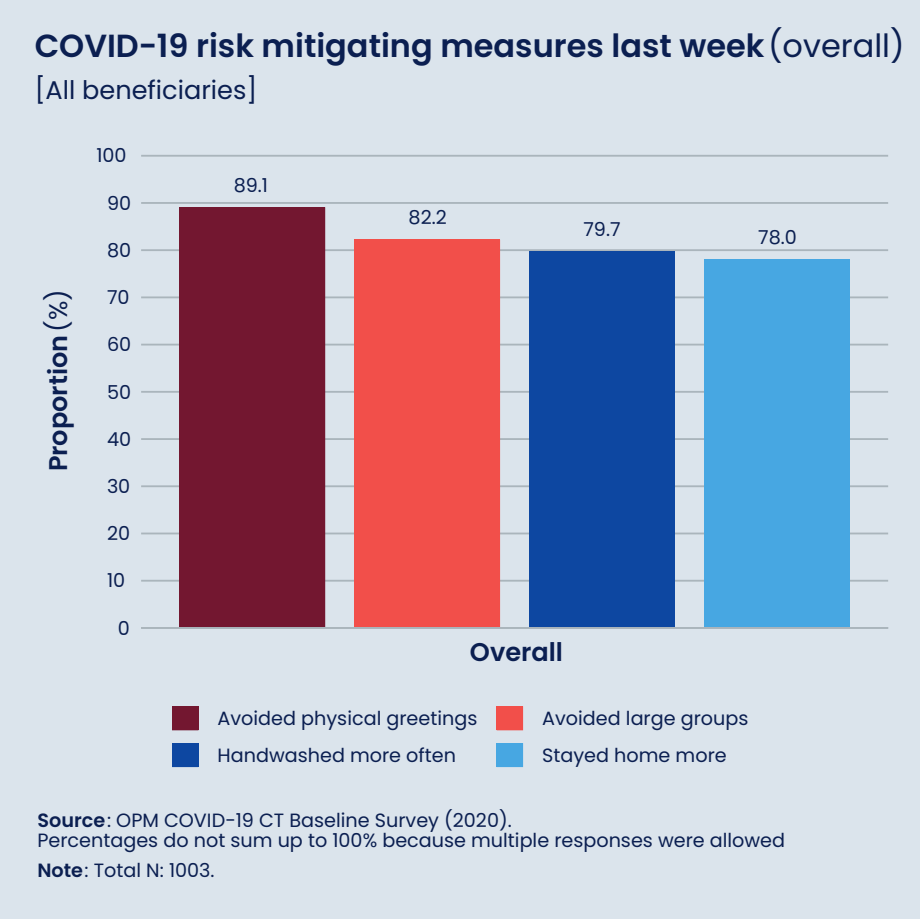
Source: OPM COVID-19 CT Baseline Survey (2020).
Percentages do not sum up to 100% because multiple responses were allowed

Note: Total N: 1003.

We also asked beneficiaries whether they had adapted their behaviour to reduce the risk of contracting COVID-19 in the seven days preceding the survey. At baseline, almost 90% of beneficiaries reported avoiding handshakes and physical greetings, while around 80% mentioned staying at home more than usual, engaging in more frequent handwashing with soap and water, and avoiding large groups (Figure 4).

These results were also highly consistent across locations and genders for all but a few categories. For example, the percentage of beneficiaries who stayed home more often than usual and who washed their hands with water and soap more frequently was 12 percentage points and 10 percentage points lower in Nairobi than in Mombasa respectively. Similarly, the proportion of female beneficiaries who reported staying home more than usual was 10 percentage points higher than that of male beneficiaries.

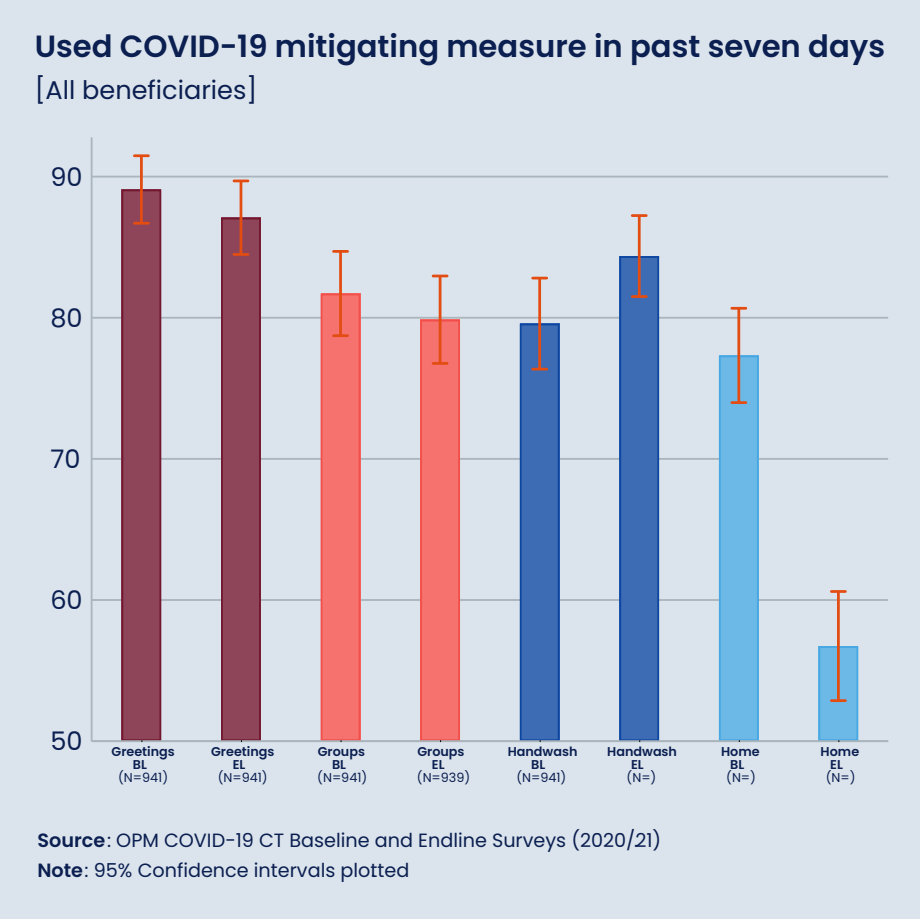
Figure 4: Proportion of beneficiaries who took risk-mitigating measures in the seven days prior to the survey



Source: OPM COVID-19 CT Baseline Survey (2020).
Percentages do not sum up to 100% because multiple responses were allowed
Note: Total N: 1003.

Finally, it is important to mention that the use of these risk-mitigating behaviours stayed considerably constant throughout the implementation period of the COVID-19 CT (i.e. November 2020 to February 2021), except for the proportion of beneficiaries who mentioned staying at home more frequently, which significantly dropped from 78% at baseline to 57% at endline. This is likely due to the reduction in COVID-19 cases between December 2020 and March 2021.

Figure 5: Proportion of beneficiaries who took risk-mitigating measures in the seven days prior to the survey, over time



04 Process review findings

CHAPTER

CT beneficiary going through her phone message record of KSH 4,000 received through mobile money transfer.
Photo: Geoffrey Mwangi/USAID

This chapter presents the findings from the process review component. We first describe and discuss the overall programme design of the COVID-19 CT (Section 4.1). In Section 4.2, we present findings related to the delivery of the programme along the delivery chain, including outreach and communications, registration, verification and enrolment, payments, G&CM, and programme monitoring (Sections 4.2 to 4.6). Finally, in Section 4.7.3, we provide a cross-cutting assessment of the response.

4.1 Programme design

This section assesses whether the programme design—in terms of the transfer modality (Section 4.1.1), targeting approach (Section 4.1.2), timing (Section 4.1.3), and transfer level and duration (Section 4.1.4)—was appropriate in the context, including in comparison to other COVID-19 CT programmes.

4.1.1 Transfer modality

Across the board, stakeholders supported the choice of a cash-based social protection response to COVID-19. FCDO had a strong preference to provide cash, based on evidence of the efficacy of using cash to respond to shocks in contexts with functioning markets, and emerging lessons on aligning with, and using, existing social protection delivery systems to provide cash-based responses to COVID-19 (Gentilini *et al.*, 2020). Further, GiveDirectly's model of operation is also based on giving cash, and they had already established a cash-based COVID-19 response programme in Nairobi, which could be adapted for the FCDO programme.

Similarly, almost all partners interviewed through the self-administered survey (97% in Nairobi and 100% in Mombasa) agreed that cash was the most appropriate choice of response. Partners cited a number of reasons for this preference, including that cash provided beneficiaries with a choice in how they used the support provided. One Nairobi partner explained: *'Cash enabled households to meet their unique needs, for example to choose the amount they spent on food and [to] cover rent deficits.'* While food was generally the primary need, some communities and programme beneficiaries had received sporadic food assistance from other sources and so could use a portion of the CT to cover other high-priority needs, including rent, medical costs, toiletries, and costs associated with returning to school (Section 5.2.1). Further, partners noted that cash (delivered via a mobile money platform, in this case M-PESA) was perceived to be more COVID-19 safe, avoiding large gatherings of people that come with distributions of food or non-food items.

Finally, key informants also reported the benefits of injecting cash into the local economy of informal settlements, as opposed to food. A district county commissioner in Nairobi put it in the following way:

> *'Cash is best as it goes directly to beneficiaries. With relief food, there can be embezzlement and corruption and assistance often doesn't reach the beneficiaries. Cash is also really positive for the wider economy of the area as it benefits neighbouring shops and the local market when beneficiaries make their purchases locally.'*

4.1.2 The overall targeting approach

During the programme design phase, a number of approaches to targeting were considered (Box 2).

Box 2: Alternative targeting approaches considered

GiveDirectly initially intended to incorporate innovative approaches to remote targeting, as adopted in other contexts. Two examples follow.

- To verify that individuals are resident in a given location, cell towers provide geolocation data through the GPS of smart phones. The location is triangulated, revealing the most frequently used cell tower is generally 50 metres to 100 metres from where a given beneficiary lives. While this provides data on an individual's location, it risks excluding the most vulnerable, who may not have smart phones.
- To include proxy indicators for poverty targeting, call data are analysed from Mobile Network Operators, using the duration and frequency of calls, how much people top up by, and/or M-PESA usage as proxies for poverty status. This method is being used in Uganda and Togo, allowing better poverty-based targeting and a more accurate focus on the most vulnerable.

However, GiveDirectly had been unable to implement these methods, at the time of writing, as Safaricom had not yet allowed them access to the necessary data. By adopting the Data Protection Act, Kenya is now in line with General Data Protection Regulation (GDPR) legislation used in Europe, and Safaricom is not willing to share data without consent.

The programme's eventual approach to targeting followed a two-tier process, applying geographic and individual targeting criteria. First, eligible individuals had to be resident in a vulnerable location, which included selected urban informal settlements in Nairobi and Mombasa.[7] The focus on urban areas was based on the evidence that COVID-19 had greater impacts in urban areas, particularly for those living in urban informal settlements and working in the informal sector (Section 1.1 and Section 5.1), while decisions around geographical focus appear to have been driven by FCDO. Nairobi was the highest priority as it is Kenya's largest urban settlement, followed by Mombasa which is a strategic priority for FCDO with other programming there.

This justification is supported by insights from the qualitative research. A male respondent in Mombasa explained the difficulties in selling products:

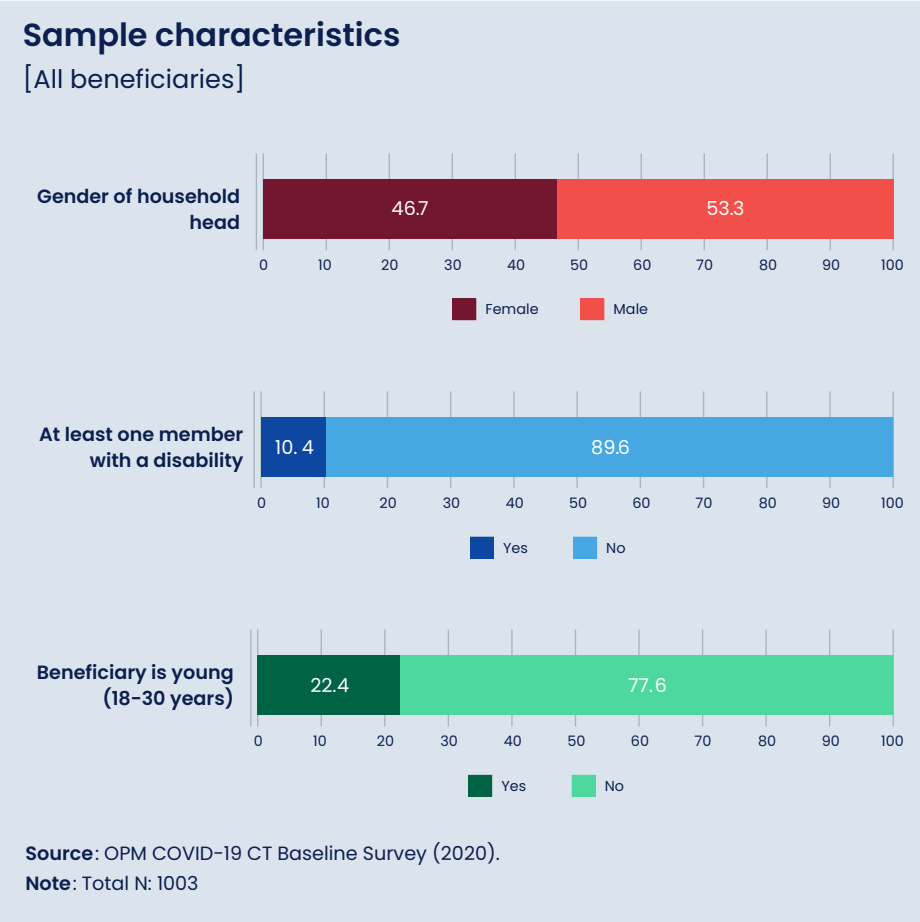
> *'In the past, people used to gather together, but right now people can't gather around because of Corona. There is no interaction with people; people are minding their own business. Even if you meet them on the way they are wearing masks. Even calling someone to buy something is a problem, so those small things are really affecting our businesses. You know, in the past you could walk where people were gathered and you could even go to clubs and sell to people, but now you can't.'*

7 The original programme intention was to target 150,000 individuals in three cities (Nairobi, Mombasa, and Kisumu), but this was reduced to Nairobi and Mombasa only and 52,700 people due to budget revisions.

Second, the programme aimed to target 52,700 vulnerable individuals. Individuals were identified on the basis of already being registered with a local NGO, with local organisations given scope to apply their own vulnerability criteria in the context of their programmes. This meant that beneficiaries were included in the programme on the basis of a range of different types of vulnerabilities. For instance, several NGO partners focused on women and single mothers, orphans and vulnerable children (OVCs), and in some cases PWD. Meanwhile, NGOs with health programmes may have been prioritised because vulnerable people registered with them may have a terminal illness, live with HIV/Aids, and/or live in households with malnourished children under the age of five. However, other partners have a much broader and potentially less inherently vulnerable membership base, such as youth. That said, considering the wide-reaching effects of crisis on all types of people living in informal settlements, this approach is justified in relation to the programme's objectives of helping people cope with the immediate negative effects of COVID-19. Ultimately, the programme was able to exceed its target and enrol 52,834 beneficiaries.

Figure 6 provides an overview of the characteristics of programme beneficiaries (sampled for the quantitative survey).[8] While only slightly more households are male-headed, most programme beneficiaries (62%) were female (Figure 2). Further, although not stated explicitly in the targeting criteria, if we consider PWD to be a key vulnerable group, we find that 10% of households had at least one member with a disability.

Figure 6: Beneficiary characteristics



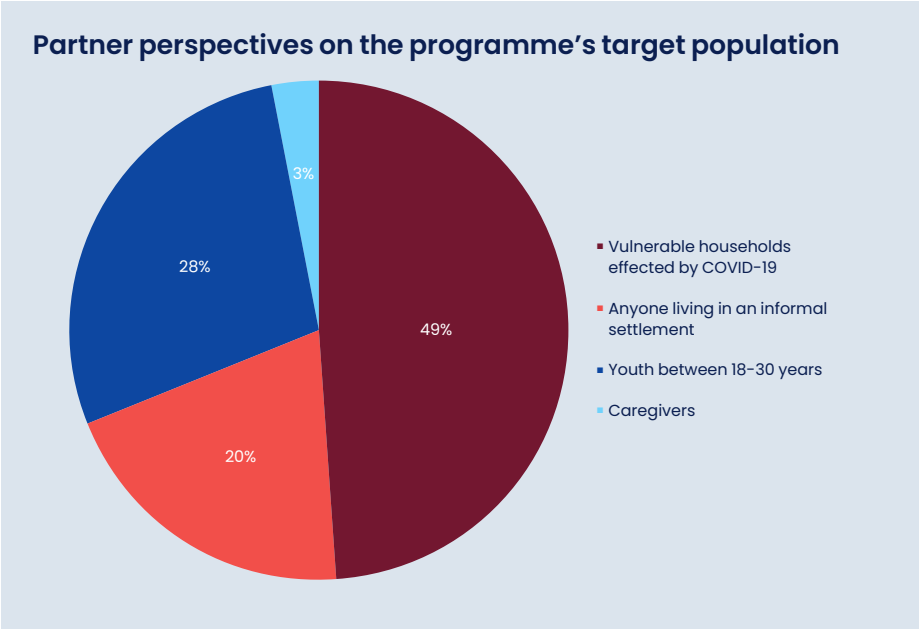
Source: OPM COVID-19 CT Baseline Survey (2020).
Note: Total N: 1003

8 Data gathered by GiveDirectly on the characteristics of people enrolled in the FCDO-funded transfer is limited, as the process was intentionally rapid and remote.

Partners' perspectives on the targeting criteria

Findings from the partner survey indicate that partners had a broad understanding of the programme's target population. In line with the programme's targeting criteria, Figure 7 shows that most partners (49% and 20% respectively) understood the target population to be either vulnerable households affected by COVID-19 or as anyone living in an informal settlement. However, a large proportion of respondents (28%) thought the programme's target was youths between the ages of 18 and 30.[9]

Figure 7: Partners' understanding of programme targeting criteria



Source: Partner survey (2020) Note: N = 39

Despite different understandings of the targeting criteria by partner organisations, 77% felt the criteria were appropriate in reaching the most vulnerable. However, some of those who disagreed highlighted issues around coverage of their databases compared to the extent of need. Further, as partner organisations were not allowed to conduct fresh registration exercises, some partners highlighted that this inevitably led to the exclusion of needy households and cohorts they did not specifically cover.[10] Others stated that those who were vulnerable in the pandemic were perhaps not the people NGOs normally worked with. One Nairobi NGO partner staff member explained:

> *'By excluding non-members, many people were left out and thus [we were] not being able to help fully, while at the same time having members of the community calling in to the organisation, but they were unable to help them.'*

9 The focus on youth is an incorrect understanding of the FCDO funding and relates to other GiveDirectly funding sources focused specifically on a youth cohort. For example, concurrently with the FCDO project, GiveDirectly has been running a COVID-19 CT programme with funding from TEDX, specifically targeting youths aged between 18 and 30.

10 GiveDirectly chose not to allow this as safeguarding risks were found to be exacerbated when partners conducted fresh listing.

Another partner stated:

> *'GiveDirectly selection criteria was not considerate of who was more vulnerable. The assumption was that every name submitted was the same regardless of the needy or vulnerable. … It meant that even if you knew those that are really suffering and much more vulnerable, you can't help out as they don't belong in your database, which is quite unfortunate.'*

The view that the vulnerable during the pandemic might differ from people who are normally vulnerable was supported by beneficiary interviews (see also Section 5.1). As explained by a male respondent in Mombasa:

> *'I have seen people shifting from what they used to do before Corona to doing something else. For example, I have seen teachers joining me in the construction sites. I have seen teachers opening small businesses to make ends meet, especially those teachers who used to work in private schools because during Corona they didn't have any pay. So I have seen that happening in the larger community in which I live.'*

4.1.3 Timing of the CT

Implementation of the COVID-19 CT was significantly delayed from the original envisaged timeframe for a number of reasons. FCDO initially envisaged that the programme would be implemented soon after GoK announced the start of COVID-19-related restrictions, with the first payments planned to take place in July 2020. However, delays in, first, the UK Department for International Development (DFID) and then, second, in obtaining FCDO approval during the period when DFID merged into the FCDO meant payments did not commence until October 2020, and then only in Nairobi. By the end of January 2021, GiveDirectly reported that they had enrolled the full target of 52,326 individuals, with 99% of these receiving their first transfer, 69% receiving their first and second transfers, and 48% receiving all three transfers.

Additionally, due to concerns about raising partners' expectations, GiveDirectly did not want to scale up their partnerships significantly or sign Memoranda of Understanding (MoUs) with new partners prior to signing the grant agreement with FCDO. Once the contract was signed, GiveDirectly gradually took on new partners and received their data on vulnerable individuals as the programme unfolded. However, GiveDirectly found these data to contain errors and gaps, resulting in delays to beneficiary enrolment.[11] While at the outset GiveDirectly had a sense of the reach of a given partner, they did not know the quality of their data and therefore the proportion of individuals that could be enrolled. As GiveDirectly realised their partners had insufficient (clean) data on vulnerable individuals, they had to reach out and form new partnerships in order to reach the target of 52,700 individuals. The process of establishing new partnerships, from the start of the due diligence process to making the first payments, took between six weeks and two months among the four partners with the fastest delivery times.[12,13]

11 Data errors and gaps caused high rates of ineligibility for the programme. This required the data to be cleaned and partners to return to their beneficiaries to improve the quality of their data before they could be used. Data cleaning included correcting names, ID numbers, and phone numbers. This process was complicated by the volume of partnerships and datasets GiveDirectly were dealing with.

12 This analysis is based on data related to on-boarding that we were initially provided by GiveDirectly, which covered four partner NGOs. Subsequent interviews with GiveDirectly indicate that there were some cases where this process took only two weeks.

13 The beneficiary numbers for these partners range from 293 (HATUA) to 5,242 (Caritas Mombasa). There does not appear to be a correlation between the size of a dataset and the time taken for enrolment processes to be carried out.

Assessing the timing of the CT

Despite these delays, most stakeholders interviewed—including GoK, Development Partners, NGO partners, and the beneficiaries themselves—stated that the timing of the CT was appropriate. However given its design as an emergency response to the crisis, there was some preference for it to have commenced earlier, at the height of the lockdown between April and June 2020.

The timing of the transfer remained relevant for the target population, due to the protracted nature of the crisis. Some interviewees also stated that, at the initial stage of the pandemic, needs were not so great due to household ability to draw on savings or access in-kind support from other sources. By October, however, these coping strategies had been exhausted, making it an appropriate time for them to receive assistance (Section 5.1.5). That said, receiving the support earlier during the first phase of the COVID-19 crisis might have prevented the adoption of some of the more detrimental coping strategies.

By chance, the programme also coincided with the second wave of the pandemic in Kenya, with cases of the virus rising in October 2020. Some beneficiaries who had reported returning to work were now forced to return home (Section 5.1.2). As one male beneficiary (30) in Mombasa stated:

> *'I can say now is the right time because now [November 2020] is when Corona has really affected a lot of things. When Corona started, we still had some savings that we were able to use … and there was at least a bit of freedom and the laws were not too strict, but now things have really become hard and now is the right time to get support.'*

Additionally, the return of some children to school in October 2020 (exam year students) and the full return for all children in January 2021 meant beneficiaries were able to use transfers to contribute to related costs (Section 5.2.1).

4.1.4 Transfer level and duration

The project provided KSH 4,000 per individual per month over a period of three months. This amount was chosen to align roughly with the urban food poverty line[14] and with GoK's COVID-19 CT, implemented by the Ministry of the Interior (MoI) (Table 1).[15] However, unlike GoK's response, which targeted households, the FCDO-funded programme was designed as an individual benefit. Affordability was also a factor in determining the level of the transfer, with the need to balance coverage and transfer value within the programme budget.

The three-month duration was chosen to align with the norm of global COVID-19 responses at the time the programme was designed.[16] It was initially estimated that two to three months of restrictions on movement would be sufficient to control the spread of the virus. This duration is also consistent with recommendations from KCWG (2020), which stipulate: *'Bearing in mind the current situation, it is recommended that agencies consider providing a three-month cash transfer to the most vulnerable population in urban settings, such as those who are living in informal settlements relying on daily wages, and those whose occupational activities are highly affected by the COVID-19 public health measures'*.

14 The urban food poverty line in monthly adult equivalent terms is KSH 2,551, according to the Kenya Integrated Household Budget Survey (2015/16). When updated for inflation (28.1% cumulative between 2015 and 2019), this is KSH 3,268. Therefore, a transfer of KSH 4,000 was seen as allowing KSH 700 for essential non-food items such as soap, water, and contribution to rent.

15 While KCWG developed guidelines for setting transfer values using the urban minimum expenditure basket (MEB), these were still being developed when this programme was first designed.

16 Globally, the average length of similar COVID-19 cash support was 3.3 months (World Bank, 2021).

Perspectives on transfer level and duration

In key informant interviews, there were some calls for the duration of the CT to be increased due to the protracted nature of the crisis, which perhaps had not initially been envisaged. Similarly, the KCWG (2020) guidelines also referred to the need to review duration depending how the situation unfolds: *'Agencies should continue to assess the situation and … if there is a need to continue cash transfer support beyond three months.'*

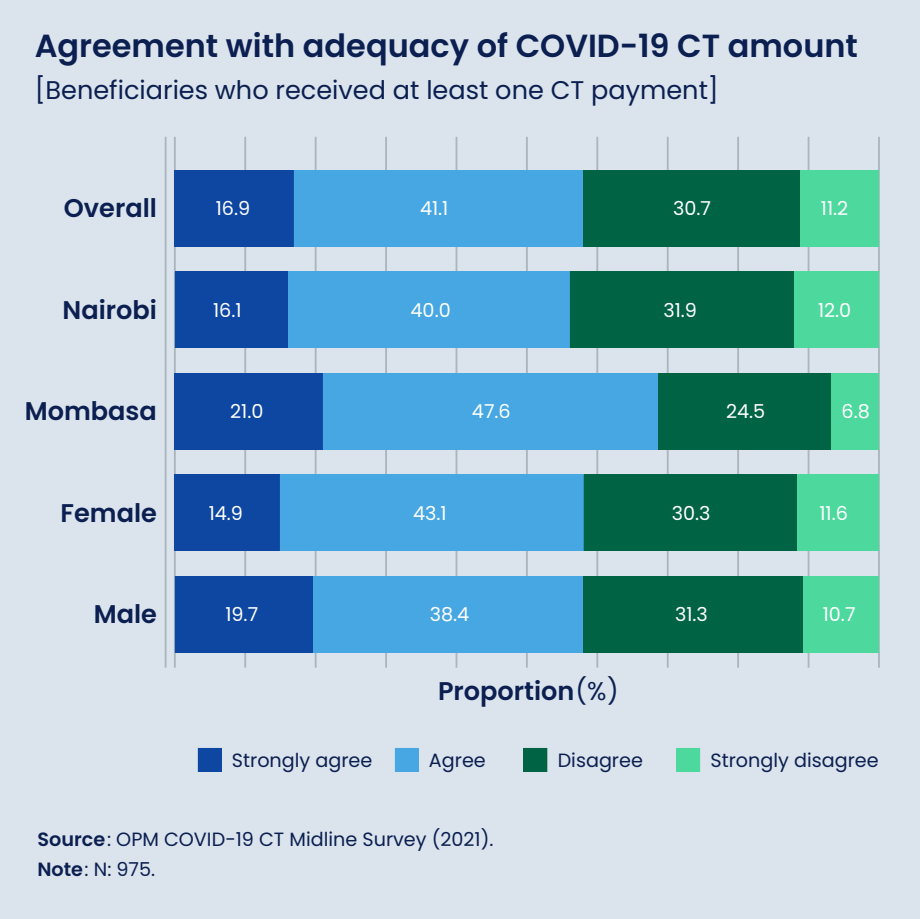
Similarly, slightly over half of all partner respondents (54%) felt the level of support was adequate to meet the needs of beneficiaries. Some of those who felt it was insufficient flagged that, while it was calculated on the basis of an individual's food needs, it was generally used to cater for a family's needs, so its adequacy also depended on the number of household members. This finding was echoed in the qualitative research, where several beneficiaries stated they were using the CT to contribute to household and not just individual needs (see Section 5.2.1 for a full discussion on use of the CT). One GoK interviewee echoed this sentiment, stating that *most of the members of the community had to change their lifestyles after losing their jobs and this [KSH 4,000] is not sufficient for them to meet their needs.*

On the other hand, some partners felt the support was adequate:

> *'Yes, it is adequate. For some this is the closest they have come to having a cash flow in the family as most of them lost their jobs or closed down their businesses due to COVID-19. While for others this is an extra source of income which has enabled them to meet other needs that could not be met with their current budget.'*

While all beneficiaries interviewed as part of the quantitative survey welcomed the transfer, 58% agreed, or strongly agreed, that the transfer value was enough to help meet monthly needs at midline (Figure 8). Significantly more beneficiaries agreed with this statement in Mombasa than in Nairobi, while there were no significant differences across genders.

Figure 8: Beneficiary opinions of the adequacy of CT amount



Source: OPM COVID-19 CT Midline Survey (2021).
Note: N: 975.

A male beneficiary from Mombasa summarised his views on the adequacy of the CT support thus: *'Before I got that money … we used to pass through hardship because [of] the little money that we are getting.'* He described how it used to be hard to budget for *'rent, water, food, and everything.' With the help from the FCDO-funded programme, 'even though it could not cater for every need … it has given me relief compared to the past.'* In particular, he was able to add things to the household budget, including increasing food (sometimes eating food in the afternoon) and being able to buy enough water and electricity, as well as some soap. The family had also been enabled to pay the rent on two rooms in the last month, though this was not the full amount due given his household resided in more than two rooms.

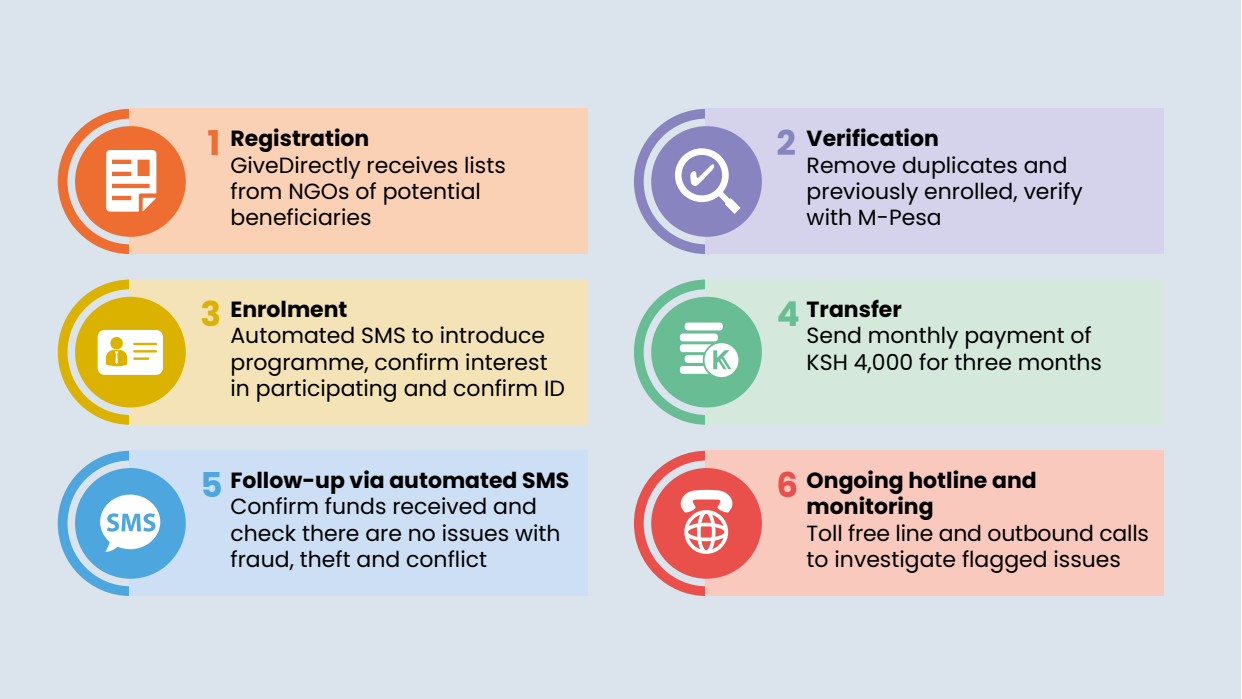
Box 3: Lessons on programme design

- Cash is the best form of support, allowing choice in spending to meet the differing needs of beneficiaries and providing knock-on benefits as a stimulus to local markets.
- Targeting criteria are loosely defined, focusing on vulnerable groups in urban informal settlements. This has been broadly appropriate in the context of COVID-19 to enable fairly rapid and remote beneficiary enrolment. However, the lack of clear criteria has created some confusion among partners.
- A more sophisticated poverty-based targeting approach is not feasible without much more extensive data collection and would have slowed the process or required smart targeting tools that were not feasible according to Kenya's data protection laws. To improve preparedness, there is a need to explore what is and what is not possible, while remaining within the data protection laws for future innovative targeting.
- Although the programme was delayed, the timing has still been relevant in the context of the impact of the pandemic on people living in informal settlements in Nairobi and Mombasa, by chance coinciding with a second wave of infections.
- The three-month duration is in line with global and national norms for COVID-19 CTs, although many partners have recognised the need for longer support given the protracted nature of the crisis.
- The transfer level of KSH 4,000 is in line with other COVID-19 responses implemented in Kenya and is appropriate as an individual entitlement. However, it has generally been used to contribute to a household's needs, rather than just covering the needs of an individual. Only around half of partners felt it was adequate in this regard. Similarly, only 58% of beneficiaries at midline felt it was adequate.

4.2 Outreach and communication

Both GiveDirectly and the partner NGOs played a role in communicating with beneficiaries at different stages in the process (Figure 9). The first line of communication with beneficiaries came from the NGO partner, which contacted individuals already on their lists to gain consent for sharing their data with GiveDirectly. Once consent was obtained, the lists of potential beneficiaries were passed on to GiveDirectly, who cleaned the data and verified it against Safaricom's M-PESA database. At this point, GiveDirectly commenced direct communications with potential beneficiaries through SMS and phone calls (depicted as Steps 3 to 6).

Figure 9: Communication process



Source: authors' own based on operational manual and key informant interviews with GiveDirectly.

Our research found that the roles and responsibilities of NGO partners in relation to communications were not clearly understood by the NGOs themselves, nor were they clearly laid out in the MoU between GiveDirectly and the partner NGOs.[17] GiveDirectly documentation (GiveDirectly, 2020) states that one of the reasons for partnering with local NGOs is to manage community messaging where there is resistance. However, this requirement was not clearly laid out in the MoU and several partners did not seem clear on their role in communicating with beneficiaries.

Despite GiveDirectly having resources on which partners could draw for communications and mobilisation,[18] some NGO partners stated they did not have the funds to follow up with beneficiaries on enrolment processes, to find out if people had received their transfers, or to explain why they had not been successfully enrolled. The NGO partners with larger datasets and access to SMS platforms for engaging beneficiaries drew most heavily on GiveDirectly's communications resources. However, this did not necessarily translate into improved response rates, and we found that large partners with large datasets and SMS platforms often had poor response rates. In most cases, this was due to outdated contact details in the dataset, which undermined the effectiveness of engaging beneficiaries through the SMS platform.[19]

17 GiveDirectly issued an Addendum to the MoU in August 2020 to provide more clarity on the roles of partners in terms of communications. However, interviews with partners suggested that there remained confusion in terms of their role and the possibility of reimbursement for these activities.

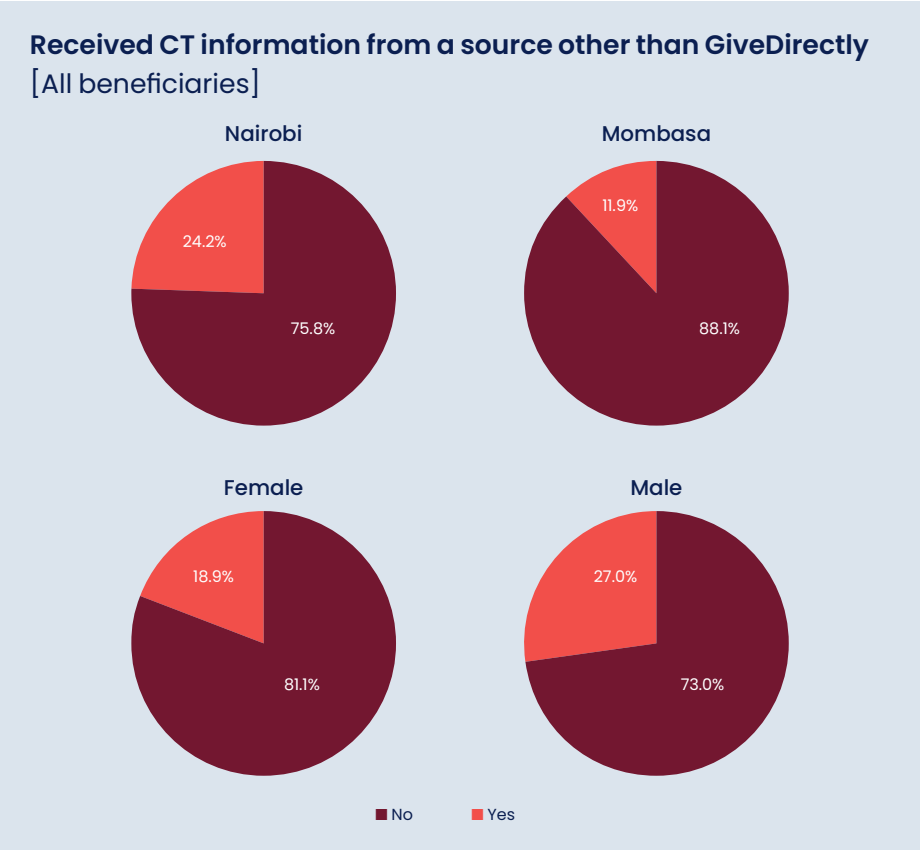
18 GiveDirectly use their own resources for reimbursing partners for their spending on communications and mobilisation, as communications costs are not funded by FCDO.

19 For example, one partner with information on 60,000 vulnerable individuals only received 3,884 responses to the initial SMS asking about interest in participating (6%). Similarly, another with 70,000 only got a response from 7,664 (11%).

Beneficiary perspectives on NGO outreach and communications

Despite the expected role of NGO partners in the communications process, the quantitative endline survey findings shown in Figure 10 indicate that only 22% of beneficiaries mentioned having received information from organisations and/or individuals other than GiveDirectly about the COVID-19 CT.[20] This proportion was significantly higher in Nairobi than in Mombasa (24% compared to 12% respectively), and among male beneficiaries (27% compared to 19% among female beneficiaries). In other words, even by the endline, some 75% of beneficiaries had still not received information on the programme from a partner organisation.

Figure 10: Sources of information about the CT



Source: OPM COVID-19 CT Endline Survey (2021)
Note: Nairobi N; 463, Mombasa N: 478; Female N: 596; Male N: 345.

Qualitative beneficiary interviews also revealed confusion regarding how and why beneficiaries were selected for the CT programme, indicating that initial outreach and communications by the partner NGOs had not been sufficient. Several beneficiaries highlighted they were not aware of the NGO that had put forward their names, and were often not clear about how their names had appeared on the prospective beneficiary list in the first place. This may be explained by people submitting their names for possible COVID-19-related support through several channels and not knowing which led to the registration text from GiveDirectly, as described through some of the qualitative beneficiary interviews. For example, a female respondent in Nairobi noted that she replied to an SMS with the names

20 This could include information about the registration process, reasons for inclusion in the CT programme, timing of the payments, etc.

of household members and national identification numbers, but there was also a time when some community leaders, sent by the chief, came around and wrote their names on a piece of paper. As she explained: *'I'm not sure whether I got selected through them or through the details that I sent through the text message.'*

A woman in Mombasa described her confusion about how she was registered with the programme. She began by explaining that, *'The first time I heard about GiveDirectly, I was told about it by a lady who is my friend,'* a local businesswoman who described the scheme as being there to help Kenyans affected by the pandemic. She, in turn, had heard about it from attending a meeting of one of the partner NGOs, where she was also registered. The female respondent then *'went to the female village elder. She asked me for my number and my Identity Card number, which I gave her. I don't really know whether she is the one who submitted it.'* The respondent noted that the village elder told her that she'd known about the scheme long ago but had forgotten about her. Another female beneficiary in Mombasa further explained how people who normally registered orphans for healthcare came to her home, told her about the programme, and took her national identification number and phone number. They explained to her that they *'saw and knew about my home situation so he said he would register me so that I could get aid and be helped.'* She noted that youths are often used by health organisations to go around the neighbourhood and register people for different initiatives.

Some of the confusion by beneficiaries how, and why, they had been included in the programme could also be explained by the organisation being known by the name of its project and not the NGO that the interviewee referred to. One such example is Hope Worldwide, which shared beneficiary lists from its DREAMS project. Beneficiaries appear to understand DREAMS to be the organisation name.

However, other beneficiaries said the first time they heard about the CT programme was when GiveDirectly took over direct communications and they received an SMS or a phone call. As explained by a female respondent in Nairobi, *'They called me and told me that I had qualified as one of the people who would receive the support from them. … I really don't know how you got my number or knew about me. … It was like a miracle to me because, after answering the questions, I received the money.'* A female beneficiary in Nairobi distantly remembered being informed about the programme by a friend, but stated; *'I just heard of it from you people. They sent me a message. No one told me about at all. I cannot tell you how I came to be one of them.'* Another respondent echoed this: *'Actually, the first time I heard about it [was] when they sent me a message on my phone.'* She thought the programme was for families with children under the age of two.

GiveDirectly communications

Prior to and following enrolment (Step 3 in Figure 9), GiveDirectly communicated directly with individuals through a series of standardised SMS. The first was an introductory message, followed by an SMS for enrolment asking for personal details such as name, age, gender, and identification number, as well as for consent to participate and share data, informing the recipient that the CT is to be used as they wish. Of the potential beneficiaries, 1% were randomly sampled and subject to a longer registration survey carried out through the call centre. If an individual responded by SMS to say they did not want to participate in the programme, GiveDirectly did not follow up. If this refusal was expressed during a telephone call with the call centre, the decisions were interrogated and GiveDirectly had a conversation

to understand the reason for the refusal. In cases where there were a very large number of refusals, GiveDirectly flagged the issue to the partner, but did not do this for individual cases. If a respondent felt they had mistakenly said no, they were able to contact the call centre and would be facilitated to return to the SMS stage for a second opportunity to enrol.

In general, 99% of beneficiaries were invited to be enrolled through the SMS survey and only 1% through the long survey by the call centre. Normally, 60% to 75% of these 99% responded easily by SMS, and the remaining 25%+ had issues that required call centre engagement. However, in Mombasa, the SMS survey had a very low response rate.[21]

To qualify for the second payment, recipients were asked further questions via SMS to verify they had received the first payment and to check no money had been stolen or lost through corruption (Step 5 in Figure 9). A 1% random sample of beneficiaries received follow-up through more in-depth qualitative calls. As of the end of January 2021, GiveDirectly reported 120 'stragglers', i.e. those who failed to respond to the follow-up survey following receipt of the first payment despite chasing, and who were thus classified as 'hard to reach'.

Partner perspectives on GiveDirectly communication with beneficiaries

Partners were generally very positive about GiveDirectly's communication with beneficiaries during and after enrolment. All partners reported that beneficiaries received accurate information on the amount and number of transfers they would receive; 88% reported that individuals received information on the reason for their inclusion in the programme, and 79% reported that beneficiaries received information on when they would get money. The biggest weakness in the communications strategy was seen to be in relation to exclusion from the programme, with only 32% of partners reporting that individuals had received information on the reason for their exclusion. One Nairobi partner explained:

> *'There was no clear answer why some of the people were excluded. It was confusing how the selection was made. For example, people in the same list: some will benefit, and others don't, and they had all provided the same information.'*

Confusion around the data-sharing questions was also an issue that arose frequently in discussions with partners. If a potential beneficiary answered 'no' to sharing their data with the government in answer to the following question as part of the programme-specific consent, they were excluded from the programme:

> *'Although we are not affiliated with the government, by enrolling in this programme, we may have to share your identifying information with government bodies who monitor our work. We cannot guarantee that they will not remove you from being eligible for other government enacted programmes. Given this, do you wish to be a GiveDirectly recipient and give your consent for us to continue the enrolment process?'*

Several partners felt some potential beneficiaries lacked trust or misunderstood this question due to how it was worded, as well as due to low levels of literacy.

21 The average SMS response rate was 54% in Mombasa and 73% in Nairobi.

Beneficiaries' perspectives on SMS communication

At midline, almost all beneficiaries (99%) confirmed receipt of an SMS from GiveDirectly informing them that they would get an SMS-format survey in the coming days to confirm their eligibility for the COVID-19 CT programme. The same proportion of beneficiaries also confirmed receipt of such an SMS survey some days later. Of these, 94% completed the survey independently. These results were consistent regardless of the informal settlement and gender of the beneficiary.

Several beneficiaries reported that they appreciated and preferred direct communication between themselves and GiveDirectly, whether by phone or by SMS. As a male respondent in Nairobi noted, *'If you begin talking to everyone, you will find someone who will tell you to even give them 100 shillings.'* Further, a female beneficiary in Nairobi explained that she preferred direct communication as opposed to going through an intermediary (such as community leaders) because, in the case of the latter, *'You are not sure whether your details would reach the destination or [if] they would decide and tear [up] the papers on the way, or even delete your details, and put [instead] any of their choice.'*

Illustrating the concerns of partner organisations about how potential beneficiaries might react to receiving the initial SMS and the awareness needed to understand it, a female respondent in Mombasa explained her situation when she received the SMS: *'I remember I got a message where I was trying to answer but I didn't understand what type of messages those were because I had a lot of stress in my head. So I didn't follow up; I was just filling them up. I didn't follow up, I don't know if I replied or not, maybe I [sat] down [to] think later, I am not sure.'* A male respondent in Mombasa introduced a concern about conmen when responding to an SMS to provide personal information: *'At first I had been sent a message and read it, and I left it for a while; I didn't delete it.'* This first message informed him about the COVID-19 CT programme. He then received a second message asking him to provide personal information. However, it was not until a lady called him to explain the programme that he accepted it as genuine and provided his personal details over SMS.

Box 4: Lessons on communications

- The role of partners in communication was not clear, with a lack of clarity regarding their role. More than 75% of beneficiaries did not receive any information from the partner organisation.
- Communication from GiveDirectly was generally reported to be clear and direct, and was appreciated by those successfully enrolled.
- There was a lack of communication regarding why some individuals whose data were shared with GiveDirectly did not successfully receive transfers. While data on who was (in)eligible was initially shared with partner NGOs, for safeguarding reasons, this did not take place under the FCDO-funded programme. However, there is a need to feed this information back to potential beneficiaries who were not enrolled in the programme, without compromising safeguarding.
- The SMS enrolment survey had better take-up in Nairobi where greater sensitisation efforts had taken place prior to the enrolment survey. This points to the importance of sensitisation and outreach to reduce exclusion from shock-responsive and routine programming.
- The use of SMS for communication and as a key tool in enrolment processes was useful in lowering costs and enabling scale. Greater use of SMS by GoK in its social protection interventions could be considered for enrolment and ongoing G&CM redressal.

4.3 Targeting

There were two stages to GiveDirectly's targeting process. The first was selecting NGO partners with datasets of vulnerable individuals based in informal settlements in Nairobi and Mombasa. Developing these partnerships in different informal settlements was crucial for the programme's geographic coverage. The second stage was selecting individuals from these datasets who are eligible to receive the CT.

4.3.1 Stage 1: partnering with NGOs and ensuring geographical coverage

The programme required GiveDirectly to partner with NGOs as a route to obtain pre-verified lists of potential beneficiaries. The programme aimed to identify, register, verify, enrol, and pay beneficiaries through a purely remote approach. This was primarily to ensure that the programme was COVID-19 safe, but also to minimise costs and to enable implementation at scale in a timely manner. The latter two objectives provide useful lessons for responding to a range of different shocks. This section builds on Section 4.1.2 to describe the process of targeting.

Prior to the COVID-19 pandemic, GiveDirectly had only worked with two partners, SHOFCO and Ghetto foundation, in only one of Nairobi's urban informal settlements, Mathare. Therefore, the scale-up to the 29 partners[22] that became part of the FCDO-funded programme in Nairobi and Mombasa was significant and relatively rapid (carried out within the space

22 As of January 2021; conversations with GiveDirectly.

of eight months). GiveDirectly's initial COVID-19 response work (prior to the FCDO-funded programme) focussed on five informal settlements in Nairobi where they had existing permission, partners, and data (Mukuru, Mathare, Kibera, Kawangare, and Korogocho). The first three of these also dominated as a source of beneficiaries for the FCDO-funded programme. With permission subsequently granted to work in all informal settlements, GiveDirectly on-boarded new partners as more funding came on-stream.

The process of identifying these partners was largely carried out through desktop research of organisations operating in the informal settlements and through referrals from current partners. Key criteria for selecting new partners included:

- → partners with 1,000 or more members/beneficiaries;[23]
- → partners with beneficiaries located in urban informal settlements in Nairobi and Mombasa;
- → partners with an existing database of their project(s)' beneficiaries (accurate records of names and the phone numbers of their beneficiaries/members); and
- → partners that passed a due diligence process.

Despite these criteria, GiveDirectly found significant problems with partner data during verification. This resulted in high levels of data failure when uploaded against M-PESA due to errors in names or phone numbers, lack of a match between the names used for M-PESA and the names provided by partners, and duplicated or inaccurate identification details. Due to differing timelines and poorer quality datasets than initially envisaged, several more partners than originally planned were involved to try to reach sufficient numbers of beneficiaries,[24] which contributed to delays in implementation (see also Section 4.1.3 on timing). In Mombasa in particular, GiveDirectly faced challenges in obtaining quality data. Despite several attempts to form new partnerships and improve data quality, Mombasa enrolment closed at 7,368 individuals against a target of 10,000.

GiveDirectly have a due diligence process for any new partner. This due diligence process helps to ensure that partners are genuine, have a good reputation, and work with vulnerable beneficiaries in informal settlements. This follows a series of steps laid out below and explained in further detail in Volume II:

1. **due diligence assessment** looking at governance, financial management, human resources and safeguarding policies, experience, and reputation;
2. **internal evaluation of each potential new partner for the following**: risk, reputation, reliability, data quality, potential for scale, and whether the partner targets vulnerable people;
3. signing **standard MoU and non-disclosure agreements**, triggering data cleaning: the MoU states that the roles and responsibilities of each partner are largely based on a data-sharing relationship;
4. an **audit check** to verify the proposed partner's track record through discussions with existing partners, with 10% to 30% of beneficiaries contacted by the internal audit team;[25] and

23 This requirement was later relaxed as GiveDirectly identified smaller organisations that worked with certain groups of vulnerable people who risked exclusion due to this requirement. For example, GiveDirectly partnered with Action Foundation who work with children living with disabilities.

24 Several of these partners came on board late in the process and were therefore not sampled for the interviews or the partner survey.

25 Initial checks covered 10% of the data. This was increased to 30% if there were flags from the initial set.

5. **data cleaning** to correct typos in the shared data, de-duplicate with the EU consortium, WFP, and other GiveDirectly lists, and to check against Safaricom's M-PESA platform.

GiveDirectly does not use local government as a route to verify lists. Some GoK stakeholders interviewed were critical of the lack of GoK involvement in beneficiary selection processes. In some cases, interviewed GoK stakeholders said they had put forward names of vulnerable households and shared data on GoK coverage to ensure there was no overlap. GiveDirectly also picked up some beneficiaries through Ministry of Health and MLSP referrals in the latter stages of the programme.

Interviews with GoK stakeholders indicated that they would have preferred for the programme to follow a more traditional approach to targeting, i.e. through engaging chiefs, elders, and the *Nyumba Kumi* (neighbourhood watch) system. This approach has been used by some other COVID-19-related CT programmes, for example the Kenya Red Cross (including the EU consortium) and WFP, and by GoK itself as part of the multi-agency CT. While the approach adopted by GiveDirectly was seen as more appropriate in terms of being COVID-19 safe (remote) and potentially more rapid[26] (while also protecting against political influence in targeting), there could be room for more GoK engagement to ensure their support. Similarly, local welfare groups[27] have strong local knowledge and links with some of the most vulnerable, and could therefore have played a role in the data verification process, e.g. confirming vulnerability status and helping to prioritise beneficiaries.

GiveDirectly reached informal settlements in all 10 sub-counties in Nairobi and in four of the six sub-counties in Mombasa.[28] However, coverage of the smaller, newer settlements was less apparent due to limited partner presence in these areas, GiveDirectly's only source of beneficiary data when targeting remotely. GiveDirectly staff recognise this as a weakness but struggle to see how to overcome it without directly enrolling beneficiaries themselves, which would go against the remote COVID-19 safe approach. To try and overcome this challenge and to ensure these communities are not overlooked, GiveDirectly has tried to work with other CT actors that are registering households directly, such as the EU consortium and WFP.

4.3.2 Stage 2: targeting vulnerable individuals

As described in Section 4.1.2, the programme's targeting criteria were broad and based on the assumption that if a prospective beneficiary resides in an urban informal settlement they are likely to be vulnerable. NGO partners working in these areas were thus assumed to be already working with vulnerable groups. This assumption was corroborated through discussions with the local leadership, who mostly voiced their satisfaction that the NGO partners had good coverage of the most vulnerable in the urban informal settlements in which they work. In addition, several partner NGOs focused on specific cohorts of beneficiaries, such as adolescent girls, PWD, and OVCs (Volume II).

26 While the GoK multi-agency CT was unrolled relatively rapidly, there has been little transparency in targeting and reports of high levels of data failure. While GiveDirectly has met with challenges relating to the quality of data, the process of registration through their digital remote processes is faster than the traditional targeting approaches used by WFP and the EU consortium. This was particularly evident through the performance of the approach in the early stages of the pandemic, before FCDO funding commenced.

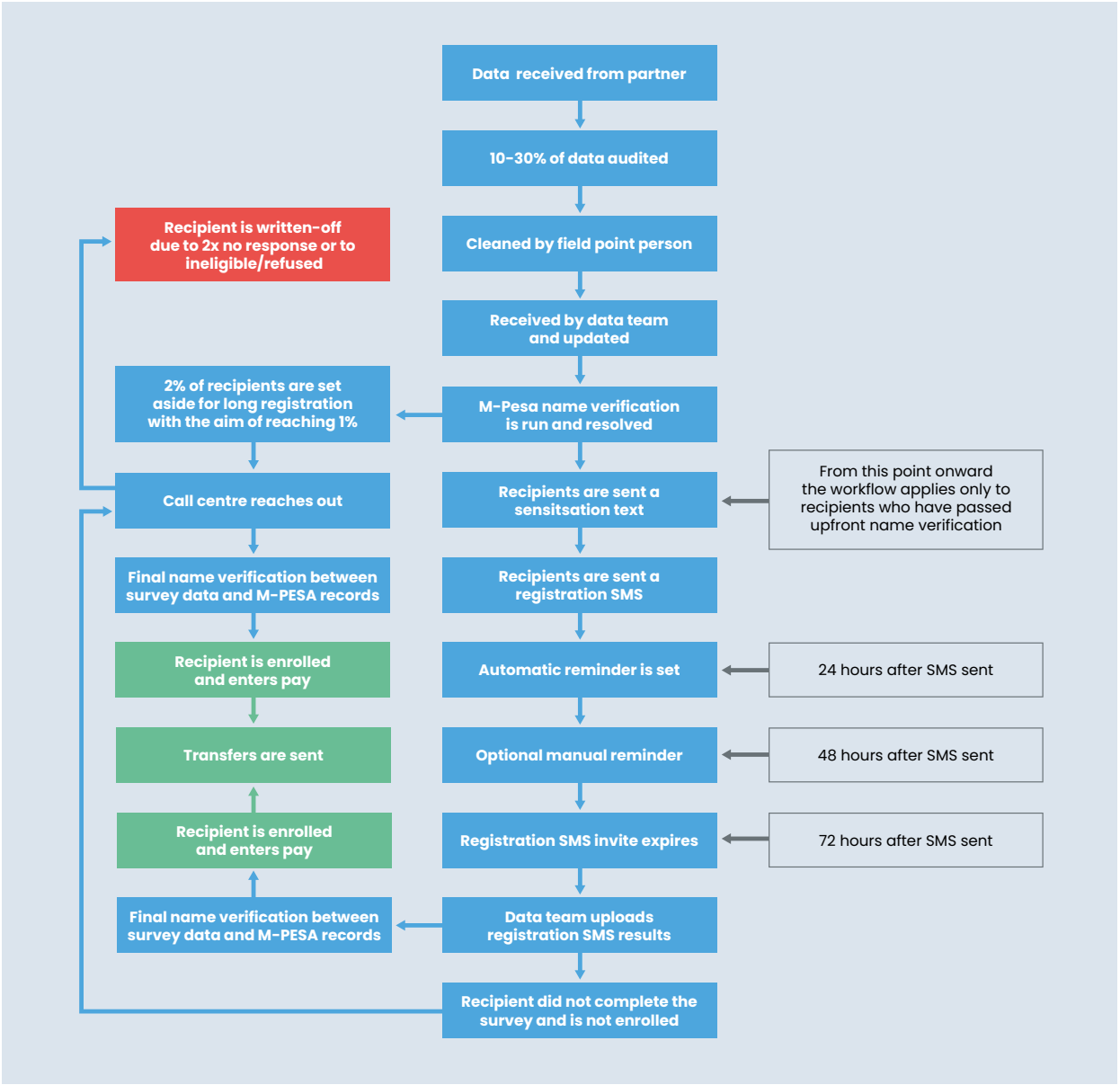
27 These are NGOs that register with MLSP at a local level, which are often much smaller than the type of organisation GiveDirectly has partnered with.

28 Volume II gives an overview of the 29 partners in Nairobi and Mombasa, the type of communities they work with, and the number of beneficiaries included in the programme.

This approach obviously limited the reach of the beneficiary lists drawn on by the programme. It was not clear whether there were deliberate attempts by GiveDirectly to ensure they recruited a range of NGO partners in each informal settlement to ensure reach across different vulnerable groups. Instead, as indicated in Volume II, the focus was on size of dataset, location, and coverage of key informal settlements.

To generate beneficiary lists, partners shared data on vulnerable individuals with GiveDirectly. GiveDirectly cleaned these data and then ran a bulk upload against Safaricom's M-PESA database. If a beneficiary was not M-PESA registered and there was no match in one of three names, they were rejected. Where there was a match, the beneficiary proceeded to the next level of verification, where their ID was checked and an SMS sent to the prospective beneficiary to obtain their consent to participate. If consent was given, they moved to the pay stage. If the individual did not respond, a follow-up SMS was sent and their number was subsequently referred to the call centre. If there was still no response, the prospective beneficiary was rejected. This flow is illustrated in the process diagram in Figure 11.

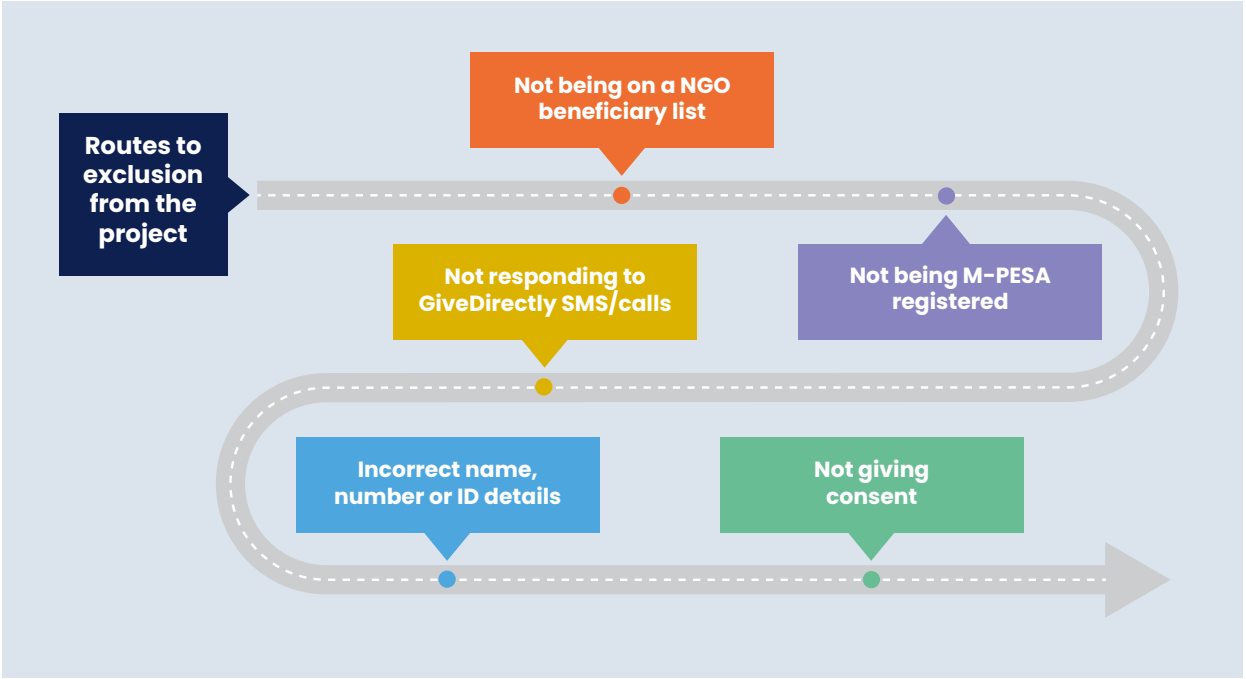
Figure 11: Recipient workflow



Source: adapted from GiveDirectly's operations manual

Figure 11 highlights the process or journey map for GiveDirectly enrolment of a beneficiary and the steps involved following the acceptance of datasets from the partner. The delivery mechanisms performed relatively efficiently, as exemplified by the project's ability to reach scale in a reasonably short time. For example, using their regular, more extensive door-to-door approach to registration, GiveDirectly usually reach around 4,000 people in six months. By contrast, using their COVID-19 remote approach through partner NGOs (and in programmes beyond this FCDO-funded CT), they were able to reach 60,000 people in the first six months of using this approach (April–September 2020) and a further 172,700[29] in the next six months (September 2020–February 2021) as the new approach gained momentum and funding came on board. While there may not have been a need to reach this scale with its prior registration process, it still highlights a good measure of success. Similarly, the approach represents good value for money, costing approximately 10 cents on a dollar to run, which reduces further with scale. By the end of February, GiveDirectly reported a 92.8% efficiency rate.[30]

Figure 12: Routes to exclusion



Source: authors' own

While the targeting approach was able to reach a large number of vulnerable people in a short time, the need for speed and scale may have come at the cost of excluding some of the most vulnerable in these contexts. This was a perspective shared by some interviewed partners and GoK counterparts. Some of these routes to exclusion are illustrated in Figure 12. Clearly, the key factor was not being on a partner's beneficiary list,[31] but even if a name did appear on a list the four other routes seemed to be key fallout pathways.

29 52,700 from FCDO funding and 120,000 through youth-focused TEDX funding.

30 GiveDirectly reports to FCDO. Efficiency is calculated by taking the transfer value and dividing it by the total programme cost.

31 This may be because the community member is newly vulnerable, linked to the impact of COVID-19, or because the NGO providing data works with a specific cohort of vulnerable individuals (such as women, youths, or PWD).

Regarding ineligibility (and exclusion), 80% stemmed from incorrect names and the lack of a match between the names on partner lists and the names registered with M-PESA and there is a clear need to increase emphasis among NGOs and GoK on improving data quality. Generally, GiveDirectly found partners to have poor data, resulting in several potential partners being rejected. GiveDirectly further highlights that organisations with data that looked perfect were the least likely to be genuine. They found that genuine grassroots organisations were often chaotically organised and less methodical in their data gathering, but with greater outreach among the most vulnerable members of the community. For instance, several partners knew their target group personally and were very grassroots-focused but did not keep good records of who their beneficiaries were or of their identification details. Some work with children and had limited details on caregivers and other household members (who might receive the CT on a child's behalf). This enhances the need to improve data quality among genuine grassroots NGOs if the most vulnerable are to be reached through such approaches to targeting.

Another prominent reason for not being enrolled in the programme relates to the lack of response to the SMS enrolment survey. NGOs with greater capacity and reach into the community engaged with their beneficiaries and sensitised them to expect the SMS messages. Some did this through their own SMS platforms (if they have them) (Section 4.2), but others provided this messaging through field staff or community health workers, volunteers, village elders, etc. Those with technical capacity also seem to have had better response rates, perhaps a sign of better data or communication capacity. In new locations, GiveDirectly generally found they received low response rates.

A female respondent in Mombasa explained the important role that contacts in the partner NGO played in her decision to respond to the enrolment SMS:

> *'We asked our mentors when we received the messages … because we had never heard about them and you never know, that's why we had to call and confirm whether it was true Generation Kenya had partnered with them. After confirming and getting the truth from our mentors, we went ahead to answer their questions. … [She further explained:] You know, we are in Kenya, you might find somebody just asking you questions and at the end of the day you find yourself in a tricky situation, so that's why I had to confirm first [before replying to the SMS].'*

While a full assessment of exclusion is beyond the scope of this study, these routes to exclusion indicate that the most vulnerable, especially women and PWD, are more likely to face exclusion due to higher levels of illiteracy and the greater likelihood of lacking ID, phones, or SIM cards registered in their names (see Section 4.7.1). This issue requires greater attention if this list-based and remote approach to targeting is to be used in future.

Operationalising remote targeting

A key objective of the targeting approach was to ensure that it could be done remotely and rapidly in order to reach scale. As discussed, this was achieved through making use of the existing beneficiary lists of implementing partners. These lists could not be adjusted (i.e. added to) once the MoU between GiveDirectly and the partner NGO was signed, as GiveDirectly believed this would create a safeguarding and corruption risk. However, an ID or telephone number could be changed or the spelling of a name corrected, but names could not be changed or added except in the case of an OVC, where a caregiver was incorporated to receive money on the OVC's behalf.

Our research found a mixed picture in terms of adherence to this process of remote beneficiary list generation. In some cases, partners stated that they conducted fresh registration exercises, recruiting new beneficiaries where they did not have coverage of certain cohorts of vulnerable people (such as people with mental or physical disabilities, or survivors of gender-based violence) or informal settlements. Further, interviews with beneficiaries suggest that fresh registration activities and, in some cases, in-person registration activities may have taken place. A male respondent in Nairobi explained how he believed he had registered for the programme: *'From people in my street; they were passing with forms.'* Some of these people lived in the area and others were guests. They described the programme and he registered with them, providing information on his family, children, and where he lived. A female beneficiary in Nairobi explained how a youth leader, who they did not know well, took their names. She had attended a meeting she had heard about that *'was looking for the people who had problems,'* and she believed she had registered there. A male respondent in Mombasa described that he first heard about the programme from church, where *'there were forms that were brought and people filled them up.'*

In specific cases, GiveDirectly allowed fresh registration to take place (e.g. where NGOs worked with victims of gender based violence). However, widespread accounts of beneficiaries experiencing fresh registration suggests that the integrity of the targeting approach as laid out by GiveDirectly was compromised in some instances and GiveDirectly stopped working with partners when they have found confirmed cases of fresh registration. However, the confusion from beneficiaries about how they came to be included in the programme (Section 4.2) made it difficult to understand the extent to which fresh registration may have taken place or whether it also may be explained by NGOs with poor data who were reaching out into the community to fill existing data gaps.

Box 5: Lessons on targeting

- Geographic coverage: the project achieved good coverage of established informal settlements in Nairobi and Mombasa through a broad network of partners. However, the NGO entry mode was not so effective in reaching less established informal settlements.
- Remote end-to-end digital targeting process is feasible and rapid: GiveDirectly were able to identify, verify, enrol, and pay beneficiaries using purely remote means through existing data.
- The targeting process is time-consuming and necessitated GiveDirectly partnering with several NGOs to obtain sufficient data: this required significant due diligence to be undertaken with partners, followed by data cleaning, which also takes time and included high rates of data failure.
- Beneficiary lists did not necessarily equate with those most in need of assistance in the context of COVID-19: some partners were frustrated by the lack of opportunities to collect new data, believing their lists did not include those newly vulnerable due to the impacts of COVID-19.
- Data quality needs to be improved: the data provided were generally of poor quality and led to high levels of rejection due to mismatches with M-PESA, especially in the initial stages of application of the approach. There are concerns that this could disproportionately affect the most vulnerable, who are most likely to lack phones, M-PESA registration in their own names, or ID cards, as well as to be illiterate and to be women.
- There were some reports of fresh data collection, even though partner organisations were not meant to collect new data due to risks regarding corruption and safeguarding. Reports of fresh data collection were especially linked to identifying people with specific vulnerabilities.
- The approach to targeting was relatively efficient, allowing scale while keeping costs low and providing good value for money.
- The effectiveness of the targeting approach was mixed: while it was able to reach residents of urban informal settlements, the approach was not sophisticated enough to ensure reaching the most vulnerable within these locations. There is a risk that existing inequities have been perpetuated by the approach, given that individuals could only be included based on their pre-existing registration with an NGO partnering with GiveDirectly.
- To enable rapid and cost-effective operationalisation of the ESR, the ESR should make use of the datasets that have been curated by GiveDirectly. However, the limited data collected by GiveDirectly will need to be built upon and further developed if it is to be of use for the development of shock-responsive social protection systems.

4.4 Payments

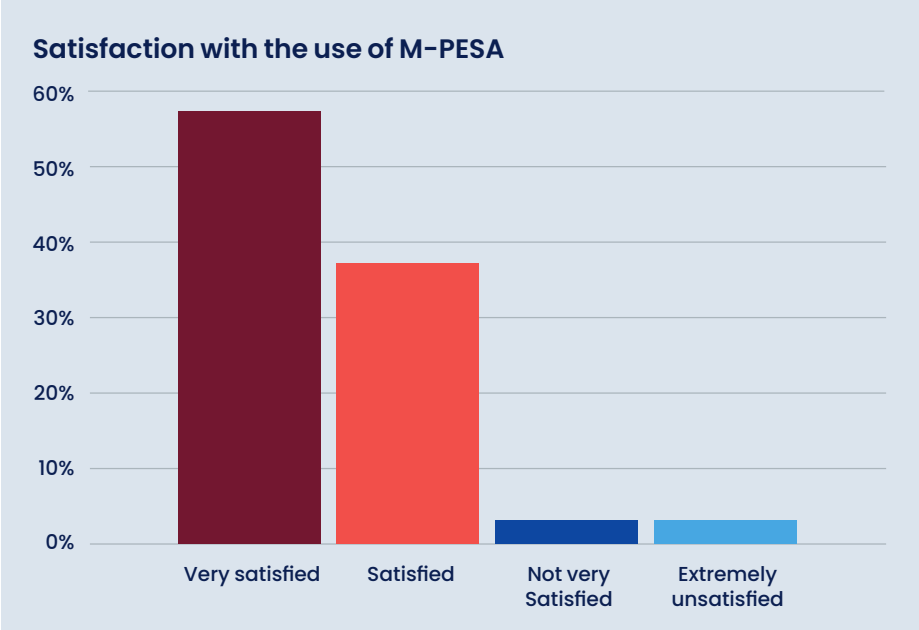
Safaricom's M-PESA was used to transfer cash to all beneficiaries, with no alternative option for payment. M-PESA has wide reach in Kenya, serving over 42 million people[32] with 41.5 billion transactions taking place in the financial year ending 31 March 2020 (Statista, 2020).

Almost all respondents from partner NGOs in Nairobi and Mombasa were either very satisfied (57%) or satisfied (37%) with the use of M-PESA (Figure 13). Those that were happy with the

32 See https://www.vodafone.com/what-we-do/services/m-pesa for more details.

choice of M-PESA felt it allowed money to go directly to beneficiaries without any portion of the transfer lost to corruption or used for partner administration fees. Similarly, 79% of partner respondents in Nairobi and Mombasa said they had encountered no challenges in the use of M-PESA, reiterating its efficiency in getting money directly to the intended beneficiaries and the wide coverage of Safaricom/M-PESA.

Figure 13: Partner organisation satisfaction with the performance of M-PESA



Source: Partner survey (2020). Note: N = 35

However, respondents also noted that there were some limitations to the sole use of M-PESA, with results from the NGO partner survey indicating that 65% of respondents believed the use of M-PESA led to exclusion of vulnerable groups. Reasons for this included the following.

- Most cases of ineligibility were due to a mismatch between beneficiary lists and the names registered with M-PESA. While the majority of these people had a chance to correct these errors by updating their name, number, or ID, by replacing caregiver details, or by opting to send their money to a trusted member of their household instead, some were excluded permanently.
- Some beneficiaries were rejected as they had registered their SIM cards with their guardian or husband's ID card/name. Youths and women were particularly highlighted here.
- Not everyone had access to a phone, especially the most vulnerable, and some did not have a Safaricom line or M-PESA registration.
- Existing debts through Safaricom's FULIZA[33] were also highlighted as a barrier, where transfers were automatically deducted to make loan repayments.[34]
- Some potential beneficiaries lacked an ID card. One respondent stated that 500 of their members were not enrolled due to a lack of ID which meant they were unable to register with Safaricom/M-PESA.

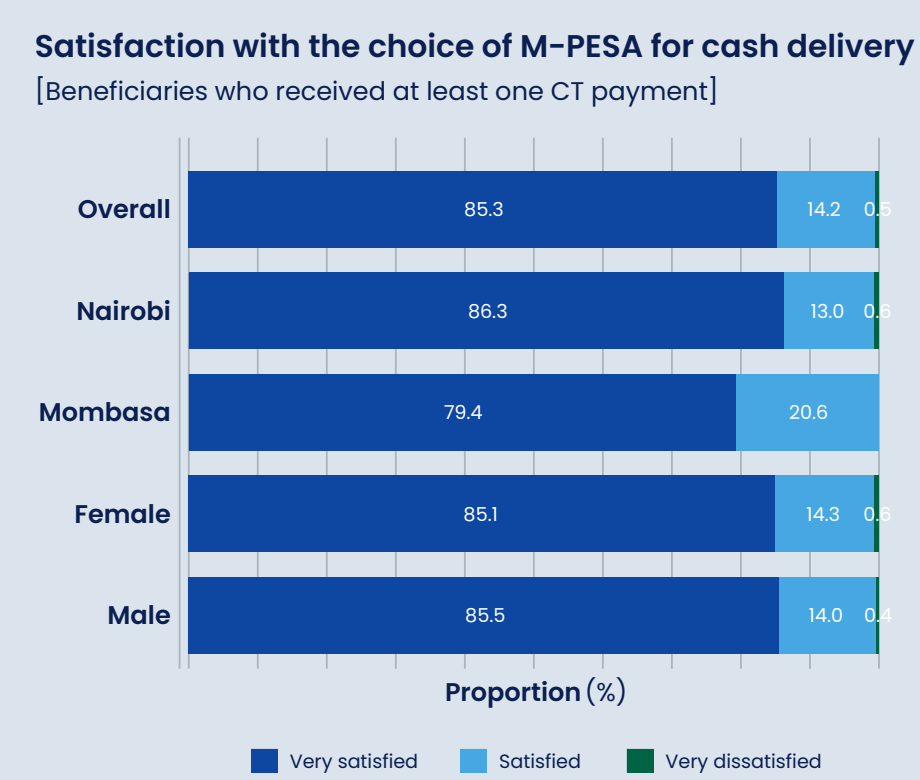
33 FULIZA is Safaricom's overdraft facility on M-PESA.

34 This was only for recipients of GoK's initial KSH 1,000 per week COVID-19 transfers that were exempt from Safaricom deducting loans. Other CT actors lobbied for this exemption to cover other programmes, but without success.

- In some cases, respondents referred to relatives operating their phone and accessing the transfer.
- Relying on the phone for the whole registration process may have led to some exclusions due to literacy levels, misunderstanding of registration messages, or a potential beneficiary not having their phone on. One partner said, *'For a few who do not have a phone, or who charge their phone at a neighbour's place, they were late in answering questions or when called were not available.'*

This evaluation was limited to discussions with beneficiaries, partner organisations, and government representatives, so did not talk to those who had been directly excluded because they lacked M-PESA registration/ID cards etc. However, the potential for exclusion should be explored in more depth and strategies found to expand registration and ensure inclusion if M-PESA is to be used more extensively by, for example, GoK.

Figure 14: Beneficiary satisfaction with M-PESA



Source: OPM COVID-19 CT Midline Survey (2021).
Note: N: 975.

At midline, over 99% of beneficiaries reported being either 'satisfied' or 'very satisfied' with the choice of M-PESA as a delivery mode (Figure 14). This estimate was 7 percentage points larger in Nairobi than in Mombasa, while it did not present significant differences across genders. Only a negligible proportion of beneficiaries (less than 1%) reported being at all dissatisfied.

Beneficiaries gave several reasons for their satisfaction with M-PESA. One was ease of access: for example, a male respondent in Nairobi noted that he felt M-PESA was the easiest way to receive money *'Because when I receive the money wherever I am, there are M-PESA agents*

around and I can withdraw the money any time I want.' As further described by a female respondent in Mombasa, *'M-PESA is faster compared to any other way, rather than use any other way, like say [a] bank, as I am not connected to mobile banking, so it will force me to go to the bank or the banking agents, and maybe they are not close.'* The convenience of M-PESA also compared favourably with hard cash, where *'Physically you will take a lot of time because you will have to queue. You will waste a lot of time there. But for M-PESA you just withdraw money immediately and then there will be congestion of people, because you are not the only one going to receive.'*

A second reason was security: *'It is not easy to misplace your money, or even it being stolen,'* as a male respondent in Nairobi put it. M-PESA was also perceived to reduce the scope for leakage when compared to delivery of hard cash: *'I was satisfied with [M-PESA] because actually nobody asked for a bribe. I got the full [amount of] money that I was told [I would get].'* However, several beneficiaries did note a potential security concern for the elderly, or PWD, who may have to ask for assistance from mobile agents and, in so doing, open themselves up to potential fraud, for example by letting others know their PIN.

Respondents also noted further benefits specifically related to COVID-19. An elderly female beneficiary in Nairobi stated that M-PESA was safer than receiving cash in this regard: *'Like now there was Corona, you won't have to go to crowded places, so you avoid Corona and you won't handle hard cash because you know money is handled by many people.'* Hers was not an isolated concern. One male respondent in Mombasa explained: *'I don't know the method of receiving the cash in hand. There are so many risks that are involved in it, especially [at] this time of Corona. There will be direct transmission of the virus, maybe, due to a lot of travelling. Even at the meeting place, and because it is a crowd, you never know how your fellow beneficiary is.'*

At midline, 9% of beneficiaries mentioned having incurred costs in accessing their transfers. This estimate was significantly larger in Nairobi (10%) than in Mombasa (4%), although we did not observe differences across genders. All beneficiaries who reported incurring some sort of cost specified that it related to converting M-PESA to cash. Some beneficiaries were able to use the money while still on their phone. However, the viability of this depended on what they purchased. As explained by one female beneficiary in Mombasa: *'There is some part that I used [to] pay bill[s] and the other I withdrew. … Another I paid through [the] till number in the supermarket.'*

Box 6: Lessons on payments

- Mobile money transfers provide a viable option for delivering cash quickly, cheaply, and directly to those who need it, minimising opportunities for corruption. The coverage of mobile money providers such as Safaricom in urban areas is high.
- The use of M-PESA requires very limited data collection but correct names, telephone numbers, and IDs for verification.
- Beneficiaries and partners had high levels of satisfaction with M-PESA.
- Greater efforts are needed to ensure the most vulnerable have identification, access to a phone and are accurately M-PESA registered (including in their own name).
- Alternative payment methods could have been offered to maximise inclusion, although this would have increased costs and might have slowed implementation, while potentially compromising COVID-19 safety protocols (if physical cash were to be offered).

4.5 CRM

GiveDirectly established a toll-free line for beneficiaries (and non-beneficiaries) to make complaints, seek information, or raise other concerns. The number was provided to all beneficiaries via SMS as part of the enrolment process and subsequently as part of each communication. GiveDirectly keeps good records of call volumes, issues raised, and how they are resolved. This review has looked at how both partners and beneficiaries can raise grievances and access case management.

The CRM system is well used. A sample of the call centre data gathered by GiveDirectly (drawn from data recorded between 28 October 2020 and 29 January 2021) shows that the dominant reason for calls (53%) appear to be data errors relating to registration with mobile money (name mismatches; duplicates; updates to trustee details; etc.). A further 32% of calls related to transfers sent but not received, 3% to community issues, and 2% to non-registration with mobile money. Of all cases in the sample, 57% were resolved within three days.

4.5.1 Partner access to CRM

Most partners highlighted that GiveDirectly staff were accessible to them and receptive to their calls and emails, and were generally quick to respond and address issues where they could. 91% of respondents to the partner survey said there were systems in place for them to raise issues with GiveDirectly. However, in conversations with partners, it was clear this was very dependent on one individual (the programme manager) rather than a systematic approach to receiving and addressing partner complaints/issues. Partners were overwhelmingly positive about their relationship with GiveDirectly, and several GoK stakeholders were complimentary about their work.

The vast majority (88%) of partner respondents in Nairobi and Mombasa were aware of the GiveDirectly CRM systems. Of these, 96% reported that the CRM was accessible to all beneficiaries and 70% said it was functioning and leading to the resolution of complaints. However, when asked about the CRM for the project, a few partners referred to their own systems and use of the local administration as the route for making complaints, rather than to GiveDirectly's toll-free line.

4.5.2 Beneficiary access to CRM

Beneficiaries showed high levels of awareness of the toll-free line. At midline, almost all beneficiaries (96%) stated they knew how to register a complaint relating to the programme. This proportion was consistent across genders and slightly larger in Mombasa (98%) than in Nairobi (96%). As noted by a male beneficiary in Mombasa regarding the contact number he was given, *'I have saved it in my phone; that is the number that I would call'* if he wanted to raise an issue.

A very low proportion of beneficiaries (1%) registered a concern or complaint about the programme either at midline or at endline. Of these, 100% confirmed their complaint was answered and solved at midline, while this proportion reduced to 69% at endline. Beneficiary responses suggested that the low rate of complaints was due to them feeling the programme was running as communicated, but also because they were grateful for the support they were receiving, which they had not expected. As explained by a female beneficiary in Nairobi: *'I have never had any issue because when they told me about the project and what they told*

me about it was true. The only thing that I would want to tell them is [to] thank them so much for the support.'

As outlined by a male respondent in Nairobi: *'I think if someone tells you "write your name; you will receive something" and you actually receive it, even if it comes [to] more than what you were told, you cannot complain, since you received something. … You yourself did not know there was going to be any help.'* This sentiment was further echoed by a male beneficiary in Mombasa:

> *'Because it is something that someone has given you voluntarily, and not my salary that I would start complaining about. It is only your salary that you would start complaining about when you have not received it by the fifth of the other month because you have worked for it. … because before the job, you had an agreement with your boss. But this one is different and anytime you receive it, you must be grateful.'*

Box 7: Lessons on CRM

- GiveDirectly established a functional and accessible CRM system that partners and beneficiaries are aware of and utilising. The system is broadly effective and leading to timely resolution of most issues.

4.6 Internal programme monitoring

GiveDirectly have different monitoring processes and metrics for different stages of the project. These are summarised in Table 4.

Table 4: Monitoring processes

Stage	Tools	Metrics
Enrolment	Phone enrolment survey (long)	Demographic data (as per enrolment SMS) plus recipient comprehension of the programme, outcomes, and impact data
	SMS enrolment survey	Number and percentage of recipients successfully enrolled; demographics (age and gender)
	Phone enrolment survey (short)	Demographic data (as per enrolment SMS)
Follow-up (post-payment)	Long phone survey	Demographic data (as per enrolment SMS) plus recipient comprehension, transfer spending, outcomes, and impact data
	SMS follow-up survey	Successful receipt of transfer; rates of adverse events/fraud
Internal audit case management	Adverse event case tracking and outbound calling	Detailed follow-up of adverse events reported through SMS survey or to the call centre

The main modality for monitoring the programme is using mobile phones, by engaging beneficiaries through SMS or through calls (see Section 4.3 on targeting for an example of SMS response rates). A key strategy for ensuring good response rates to SMS once the CTs have commenced is tying transfers to SMS response (i.e. payments to beneficiaries who did not respond to the post-transfer survey were gated). Beneficiaries did not need to use smart phones or apps to provide registration or monitoring data. This is appropriate in the context of the profile of the beneficiaries targeted and the potential lack of smart phone ownership and internet access.

The data collected through SMS (which is limited by characters) and phone calls are complemented by longer surveys, which are administered to 1% of beneficiaries. The question format for these interviews is extensive and provides rich data on beneficiaries and on how COVID-19 is impacting them, as well as data on how they are using the transfers. Monitoring data are only collected by GiveDirectly. Quarterly roundtable meetings with partners have been replaced with monthly update emails as the number of partners has grown and the issues to discuss invariably relate to following up on individual cases. Partners also have regular bilateral calls with the GiveDirectly team.

GiveDirectly have submitted monthly progress reports to FCDO. These reports are brief but provide regular and useful updates on implementation. They provide a summary of feedback on the metrics listed in Table 4 and cumulative analysis of the findings from the more in-depth surveys, which 1% of beneficiaries will be asked to complete after the end of the project.

There are several examples of how monitoring data are being used to inform programme implementation, as follows.

- → Cases reported through the follow-up survey of beneficiaries not receiving their transfers have been followed up and addressed.
- → When cases of bribery and coercion were reported prior to the start of the FCDO project, GiveDirectly decided to try to ensure this would not happen with on-boarded partners by stepping up safeguarding. This effort included increasing the engagement with partners' beneficiaries through sampling 30% of them to vet the partner prior to commencing use of their data. It also included shifting this role to the independent auditing team.
- → Where monitoring processes revealed concerns around fresh beneficiary recruitment, these partners were dropped.
- → In the context of a disability-focused partner in Mombasa, low response to the SMS survey was not accepted and follow-up revealed that many of those who had failed to respond were blind. The process was adapted so that blind beneficiaries could only be contacted through calls.

Box 8: Lessons on programme monitoring

- GoK could leverage the experience of this programme to increase the use of SMS technology and remote data collection for both routine and shock-responsive social protection services. GoK could consider tying transfers to response to SMS monitoring tools.

4.7 Assessment of the response

This section provides an assessment of the programme's design and implementation, focusing on cross-cutting issues such as gender and inclusion, the coherence of the programme with government systems, and the way in which GiveDirectly has sought to coordinate with other COVID-19 social protection actors in Kenya.

4.7.1 Gender and inclusion implications

The FCDO-funded programme has reached 52,834 beneficiaries, of whom 32,631 were women (62% of total beneficiaries). However, we find mixed evidence in terms of how intentional this outcome was. This achievement is likely to be linked to the programme's focus on vulnerable groups (though it has not focused deliberately on women), and also the process of targeting beneficiaries through NGOs. Many NGOs have higher numbers of women beneficiaries than men, and this is especially the case with NGOs that enrol caregivers (for example), as they are invariably women. Additionally, in the latter stages of the programme there appears to have been a shift, with GiveDirectly making more deliberate attempts to increase its focus on partnering with NGOs targeting specific cohorts of vulnerability, such as PWD and women affected by violence.

However, it seems that, while the approach ensured good coverage of women and other vulnerable groups, partners highlighted that there was no clear emphasis on gender in the eligibility criteria (see Section 4.1.2). Rather, the programme relied on partner organisations having existing strategies in place to ensure their beneficiary lists were inclusive. *'We were serving everyone equally,'* one partner stated. Another explained: *'We strive to ensure balance in gender when recruiting for our programmes. This may have contributed to gender balance.'* Some partners established criteria to ensure equal inclusion of men and women, or slightly higher coverage of women; this has led to more women beneficiaries than men, but does not appear deliberate from the perspective of the programme design. Rather, it was an effect of autonomous decisions taken by individual partners. One partner stated, *'Gender was not highlighted in the criteria, so I don't think the issue of gender equality was well covered.'* Other aspects of inclusion were covered to some extent through a focus on vulnerability criteria such as poverty, malnutrition, OVCs, people living with HIV/Aids, and PWD.

Despite the more deliberate steps in the latter part of the programme to bring partners with a focus on particular vulnerable groups on board, there are still concerns about the barriers to participation that particularly vulnerable groups may face. This is due to the several stages individuals have to go through before they are able to enrol successfully. First, the targeting approach is based on the assumption that the partner NGOs have good coverage of the most vulnerable. However, while NGOs clearly have coverage of vulnerable groups, the extent of this coverage has not been assessed, nor has the degree to which the vulnerable populations they routinely target overlap with those made newly vulnerable as a result of COVID-19. Indeed, the partners raised specific concerns relating to this issue, but were unable to address it given the restrictions on conducting fresh registration.

Furthermore, it is probably that some of the most vulnerable are less likely to have ID cards, a phone, or a SIM card registered in their name, or to be M-PESA registered. As one partner stated: *'Women are less likely to have IDs and to be M-PESA registered in their own names. These proposed beneficiaries get ejected from lists when there is no match—GiveDirectly can't seem to flex on this issue. This is a big challenge. For example, on Friday, five women*

came to me who don't have anyone they can trust to receive money on their behalf in Kibera and cannot nominate someone outside Kibera. Similarly, child-headed households that lack a trusted caregiver over 18 are excluded.' Other partners highlighted that street children were excluded from the programme and that illiteracy may have been a barrier to inclusion in the initial stages, resulting in misspelling of names or in failure to respond to the SMS enrolment survey.[35]

Another issue of inclusion that arose links to geographic location. The programme has focused on recognised informal settlements, whereas there are several newer settlements that house vulnerable communities. Some partners gathered fresh data on vulnerable people in these locations but then found they were ineligible due to the fresh listing exercise. One partner stated, *'The project is restricted to informal settlements, but there are many newer settlements where people are just as vulnerable or more so. There are over 12 of these in Nairobi that should have been included.'*

4.7.2 Appropriateness of implementing through a parallel system to GoK

There appear to have been several factors influencing FCDO's decision not to work through GoK in delivering its CT response to COVID-19, but rather through GiveDirectly.

- First, the GoK's flagship social protection response to COVID-19, the multi-agency CT, was implemented outside the social protection sector by the MoI.[36] However, several development partners (including FCDO) questioned this decision as there were concerns regarding MoI's experience and capacity to lead the response.[37]
- Second, FCDO recognised that current coverage of the urban poor under the Inua Jamii was limited (for example, only 2.6% of the caseload is in Nairobi).[38] Therefore, there was not sufficient data on existing beneficiaries to enable a quick scale-up of the programme in urban areas.
- Third, FCDO lacked confidence in MLSP's ability to conduct a rapid and remote targeting exercise, which was needed due to the lack of data on the urban poor. Further, it did not seem that MLSP had the interest to attempt to establish a remote targeting system rapidly.
- Finally, by August 2020, GiveDirectly had demonstrated their ability to deliver cash transfers within the COVID-19 context, including conducting remote outreach, registration, targeting, enrolment, provision of benefits, a complaints and grievance system, and monitoring. Further, they had demonstrated their ability to reach scale.

35 In non-remote programmes, GiveDirectly usually allows such beneficiaries to nominate a Trustee of their choice who GiveDirectly will then assess for recipient safety. As the FCDO-funded programme was implemented remotely, GiveDirectly saw this as a safeguarding risk and removed the Trustee approach.

36 The MLSP was expected to lead the social protection response, as the core ministry involved in the provision of routine social protection in Kenya. However, from GoK's perspective, MLSP was focussed on making routine social assistance payments in arrears under the Inua Jamii during April and May 2020. Therefore, MoI was tasked with delivering the COVID-19 response.

37 Other major donors, such as the EU, Denmark and WFP also worked in parallel to GoK systems.

38 The 2019 Kenya Population and Housing Census indicates that 12.4% of households are in Nairobi City.

GiveDirectly's ways of working

Historically, GiveDirectly have worked in parallel to GoK systems in both rural and urban areas. As part of their rural programming, GiveDirectly work with chiefs and village elders only as gatekeepers to communities, with targeting the sole responsibility of GiveDirectly. Similarly, they have not involved GoK systems and stakeholders in targeting as part of their urban COVID-19 work. This appears partly due to working through a partner in their previous urban engagement. However, they are cognisant of GoK's social protection programming, making several attempts to reach out to Social Protection Secretariat (SPS) to share information about their work and to gain access to Single Registry data, initially with a view to using this in their targeting and then to check for duplication. However, these conversations have not yet led to an MoU or to access to the Single Registry. This has meant that GiveDirectly have not been able to check their data against the Single Registry for duplication. Other cash actors, such as the EU consortium (through the Red Cross) and WFP, have been able to do this, and GiveDirectly has checked against these organisations for overlap.

GiveDirectly remains willing to share data from this project with MLSP for inclusion in the Single Registry, as MLSP is embarking on a process of expanding it and of creating a social registry. In particular, while GiveDirectly have not collected detailed data on all beneficiaries, they still believe they have a rich dataset of value to future humanitarian response. By the end of their COVID-19 responses they expect to have data on 250,000 people, 1% of whom will have been subject to the long survey, providing rich data on demographics, food security, impacts of COVID-19, and what beneficiaries used their CTs for.

GiveDirectly has liaised with the COVID-19 Secretariat[39] and has actively shared information on its programme and coverage, providing regular reports, which are appreciated by the Secretariat. The Secretariat has stated that they are very satisfied with GiveDirectly's performance and information-sharing.

While GiveDirectly has not used GoK structures on the ground to target their response, they have engaged Deputy County Commissioners and Assistant County Commissioners and have informed them about their activities. Several of these were interviewed in Nairobi and Mombasa as part of this process review, and their views have been reflected throughout the analysis.

4.7.3 Coherence of the response with the wider CT and COVID-19 response

At the onset of the pandemic, there were no guidelines in place that could be used to align the design of cash-based responses to COVID-19. While KCWG took the lead on developing the urban MEB guidelines, which were designed to align the level and duration of support between cash actors, these were only finalised in July 2020 by which time a number of responses (including by GoK) had already been implemented.

Despite this, the design of this programme is aligned with other cash-based responses to COVID-19 in Kenya in the following ways.

39 The COVID-19 Secretariat in the President's Special Delivery Unit was established to coordinate response and to ensure fair distribution of any donations, monitor how much is given, ensure safety and appropriate targeting, and monitor distribution.

- **The transfer value was broadly aligned** with several of the other cash responses, including GoK's multi-agency CT (see Table 1).
- The **three-month duration** was consistent with several other COVID-19-related responses, especially those implemented by the EU consortium and WFP, and in line with guidelines developed by the KCWG. However, GoK responses differed in duration, including the multi-agency CT which provided support for four months.
- **The use of mobile money** (M-PESA) was in line with all other COVID-19 CTs. The use of M-PESA was encouraged to reduce the spread of infection by minimising the circulation of physical cash and preventing people gathering to receive transfers.
- Almost all the non-government social protection responses to COVID-19 have sought to target **vulnerable households or individuals residing in urban informal settlements, with a focus on Nairobi and Mombasa**. This is because they are considered to have been most impacted by the COVID-19 lockdown measures in terms of reduced access to employment and income earning opportunities, restrictions in movement, and reduced access to food.

Coordination on targeting

GiveDirectly made attempts to coordinate with both government and non-government stakeholders providing COVID-19-related CTs to ensure alignment and limit duplication.

GiveDirectly has tried to coordinate with GoK at several levels. As explained in Section 4.7.2, at the national level, GiveDirectly reached out to SPS in the early stages of the pandemic. While neither an MoU nor access to the Single Registry has materialised, SPS are broadly aware of and supportive of the work GiveDirectly have been doing. Further, GiveDirectly have proactively shared information with the COVID-19 Secretariat, who were pleased with GiveDirectly's coordination efforts with local administrations and communication with GoK, in general.

Coordination has been most successful between GiveDirectly and NGOs and multilaterals. GiveDirectly participates in KCWG[40] as a mechanism for coordinating with other cash stakeholders. GiveDirectly states that the working group in Nairobi and Mombasa helped strengthen partnerships and understanding of each other's targeting approaches. However, it has been noted that these coordination forums are time-consuming to participate in and have no mechanism in place to ensure members comply with good practice.

GiveDirectly has also linked on a bilateral basis with actors involved in implementing other large COVID-19 CT programmes to attempt to coordinate targeting and de-duplicate beneficiary data.[41] Initially, all stakeholders had hoped to upload their data to the Single Registry as a tool for avoiding duplication, but the need to move quickly forced them to work outside government systems and develop their own protocols for de-duplication, as they were unable to access the Single Registry efficiently. To this end, GiveDirectly shared anonymised data with Oxfam (the EU consortium lead) and WFP. Unique (and anonymous) identifiers were created for each beneficiary by combining the last four digits of their ID and phone numbers and these identifiers could be used to check for duplication between

40 KCWG is chaired by the NDMA and co-chaired by the Kenya Red Cross. SPS also participates in this at times. KCWG provides a regular forum where cash actors can share information on their interventions. The KCWG formed a working group that has led on the development of an urban MEB to provide guidance on setting benefit levels.

41 As shown in Table 1, other large non-governmental COVID-19 cash programmes include WFP and the EU consortium (Oxfam in Kenya; the Kenyan Red Cross; Concern Worldwide; ACTED; IMPACT; the Centre for Rights, Education, and Awareness; and the Wangu Kanja Foundation).

lists.[42] While this goes some way to reduce the chance of duplication between programmes, WFP and the EU consortium are both targeting households rather than individuals, and effective de-duplication relies on having the same household member registered for each programme.

While this process for coordination has been established relatively rapidly, adherence to it is purely based on the goodwill of the different stakeholders. Ideally requirements and protocols for systematic coordination should be institutionalised.

In summary, there were a number of challenges to coordination and alignment, including:

- the willingness of cash actors to share data in a timely manner;
- lack of access to government data through the Single Registry;
- lack of information on whom MoI has targeted for the multi-agency COVID-19 response;
- challenges involved in straddling the social protection and humanitarian world and clarity on who is responsible for what; and
- lack of a guiding framework on amounts, duration, and targeting methods, leading to a divergence in approaches.

42 WFP has not shared their data so openly, but states it de-duplicate its lists against those of GiveDirectly and the EU consortium.

Box 9: Lessons for GoK shock-responsive social protection

- A clear overarching national structure to guide shock-responsive social protection is needed that can encompass humanitarian response actors. This should be national, but should also have the potential for substructures that work at the county level. It will require legislation to institutionalise this. Ideally all stakeholders should report to these structures.
- Coordination on targeting remains weak and lacks clear government direction or a coherent framework. Instead, coordination on targeting relies on the goodwill of individual agencies, which is not sustainable and creates divergence.
- Guidelines are needed for cash actors to coordinate programme design and delivery, including defining and implementing equitable approaches to targeting for different types of shock, determining appropriate transfer amounts and durations of support for different types of shock, and making use of existing delivery systems. These should eventually become benchmarks against which CT actors are monitored.
- The COVID-19 pandemic experience highlights the potential value of a social registry (e.g. the ESR), but also emphasises the need for this to be high-quality in terms of containing comprehensive, current, relevant, and accessible data to enable a coherent and coordinated response to a range of shocks. To date, much of Kenya's shock-responsive architecture has been oriented towards drought response and (to some extent) floods, but has not included extensive up-to-date coverage of urban areas. The data collected through COVID-19 responses could be incorporated into the ESR. The HTT has unfortunately not been widely used and is not feasible in the context of rapid and remote data collection. Compromises may need to be made on the extent of data capture if such systems are to have wide coverage and to be kept up-to-date. Digital data collection should be prioritised.
- Once the ESR has been created, mechanisms need to be put in place to ensure easy, remote, and regular access to the system. At present, it is not easy for NGOs to access or upload data to the Single Registry, which leads to frustration and duplication. While GoK need to ensure the integrity of data and that they are used correctly, access needs to be improved if the ESR is to be a viable system for shock response.
- More understanding and agreement is needed on how to better use existing data sources and what scope there is for this within Kenya's data protection laws. There is a need for agreements to be in place before shocks across all relevant stakeholders regarding access requirements and guidance for data-sharing.
- National registrations systems (including for national IDs, but also registration of births and deaths) should be strengthened. This would limit exclusion and strength the ability for GoK to coordinate public services in normal times, as well as in times of shock. A strong national

05 CHAPTER

Impact evaluation findings

Ann, a 20 year old single mother, is purchasing eggs, milk and diapers for her child using the KSH 4,000 received through mobile money transfer in Mukuru Kwa Reuben Urban Settlement, Kenya.
Photo: Geoffrey Mwangi/USAID

This chapter presents the quantitative and qualitative findings from the impact evaluation component. We first describe the socioeconomic status of the COVID-19 CT beneficiaries and their households prior to receiving any support from GiveDirectly, assessing whether and how their situation was affected by the economic downturn induced by the COVID-19 pandemic prior to receiving the CT (Section 5.1). In Section 5.2, we provide a descriptive picture of the main uses of the three COVID-19 CT payments. Finally, in Section 5.3, we evaluate the likely impact of the CT payments on beneficiaries across variables of interest, mainly related to food security and the use of coping strategies as a response to the economic effects of the COVID-19 crisis.

5.1 The effects of COVID-19 on the target population

This section describes the socioeconomic status of beneficiaries and their households prior to receiving any CT from GiveDirectly, and provides an assessment of how their situations have been affected by the COVID-19-induced economic downturn. In particular, interviews from the qualitative research provide a description of how respondents' lives were before the pandemic and how this has changed between March—when the initial, most stringent lockdown measures were in place—and November 2020, when the economy was reopening (Section 5.1.1). Drawing on the qualitative research, we provide a more detailed assessment of how employment opportunities, food security, and the use of coping strategies have changed throughout the crisis. These findings are complemented by the quantitative findings from the baseline survey, which provide a snapshot of the situation in November 2020, eight months into the crisis (Sections 5.1.2 to 5.1.5).

It is important to highlight that food security and the use of coping strategies among beneficiary households are the focus of this impact evaluation, as they are the principal outcome indicators on which we expect the COVID-19 CT to have an effect. However, additional variables such as employment and other income sources can also influence food security and the use of coping strategies themselves. That is why we first analyse how employment levels and access to other income sources have changed over time (Sections 5.1.2 and 5.1.3), before assessing the Household Food Insecurity Access Scale (HFIAS) (Section 5.1.4) and the use of coping strategies (Section 5.1.5).

5.1.1 Setting the scene

Before presenting the main findings, we begin by setting the scene through two case studies from the qualitative midline interviews that illustrate the experience during the pandemic of a male respondent in Mombasa and a female respondent in Nairobi.[43]

43 Names of respondents have been changed for anonymity.

Jacob's experience in Mombasa during COVID-19

Jacob (30) lives in Mombasa with his wife and child. Prior to the pandemic, he was employed in a store, packing goods for clients, but was let go when COVID-19 broke out in Kenya. Jacob was forced to look for other work to support his family and began to take up casual jobs, including working on construction sites and selling water. Before COVID-19, 'life wasn't bad' and Jacob earned KSH 1,000 to KSH 1,500 per day, depending on whether he could find 'side hustles'. This allowed him to buy food and other household goods for his family, pay off any debts, and save between KSH 500 and KSH 700 each day. However, when he lost his job, he had to start using his savings to feed his family, stopped paying rent, and had to ask his parents for food. Finding casual jobs was difficult and sometimes more than a week would pass without a job. The family also changed their diet, reducing the quantity and diversity of food (i.e. eating *omena*, kale, and porridge every day) and, on some days, eating only once. Surplus food and luxuries, including milk and sugar, were kept aside for his child. During the crisis, Jacob felt fearful of catching the virus and spreading it to his family and stressed he might not be able to meet his family's needs and pay for his child's education once the schools reopened.

Jacob used KSH 2,000 from the first CT to start a business for his wife selling groceries, so that she could also support the family by earning a daily income. He also used KSH 1,000 to buy food (allowing the family to return to eating three meals per day), reduced the debt with his landlord (to show he is hardworking and creditworthy), and saved a portion of the money.

Patricia's experience in Nairobi during COVID-19

Patricia (42) lives in Nairobi with her two children, who are in secondary school, and worked as a self-employed tailor earning KSH 12,000 per month before the onset of COVID-19. However, she stopped tailoring and now engages in casual work, such as washing clothes (earning ~KSH 300 per day), when she is called. Patricia describes how her life has changed:

> *'Life is difficult now, because even paying for rent is a problem and before I could pay without any problem. Feeding also is a problem, but before I did not have any problem. Right now, I'm thinking of where to get school fees when schools reopen, because January is [almost] here and I am alone.'*

The biggest problem has been getting food for the family, as Patricia is only able to buy a couple of days' worth of food on the days she engages in casual work; otherwise they sleep hungry. The family often skip at least one meal and eat a reduced variety of foods. She has also been unable to pay her rent. While her children are at home from school, they engage in homework by themselves, as she cannot afford to pay for local tuition, and she worries about being able to afford school fees in January 2021.

Patricia used all the money from GiveDirectly (the first and second transfer) to pay her landlord, as she had missed five months of rent payments.

5.1.2 Employment

The qualitative research at midline sought to understand how engaging in work and employment opportunities changed for beneficiaries of the COVID-19 CT after the onset of the pandemic (i.e. March 2020).

The midline qualitative interviews indicate that almost all respondents were working prior to the pandemic. Respondents were employed in casual work (e.g. cleaning houses; working in construction), running their own business (e.g. tailoring; selling tea and *mandazi*, fresh produce, or clothing), or in salaried jobs, including for formal sector businesses (e.g. insurance companies; Kenya Power), as teachers, or as employees in informal businesses. With the onset of the pandemic and the containment measures, all respondents, regardless of sector, felt their employment had become less secure, with their ability to work being severely hampered by the restrictions and economic impacts. Across the board, both male and female respondents in Nairobi and Mombasa spoke about the negative impact this had on their household income, food security (Section 5.1.4), and general standard of living, as well as the strategies they employed to support their families (Section 5.1.5).[44]

Respondents interviewed as part of the qualitative research who were engaged in casual work, reported that it had become harder to find casual jobs, resulting in many not being able to work on a daily basis, as had been the norm prior to March 2020. This was largely driven by a reduced demand for labour, as people did not want to employ people from outside their household for fear of contracting COVID-19. Social distancing requirements also meant that large employers, such as construction sites, had to reduce the number of people they could employ each day. Those looking for casual work were also reluctant to travel too far from home or to busy sites to look for work. This scarcity of jobs meant some people were only able to find work once or twice a week, and in some cases more than a week would pass without finding work. Respondents also reported taking on casual jobs they would not normally accept (e.g. pushing carts), while others noted that they had to accept lower remuneration (see Figure 19 and Figure 20) and, in some cases, workers would receive payment in-kind.

> *'The only thing that I have done is to look for casual jobs, because for sure there are no permanent jobs. Getting jobs has been a problem. You get a job today, but the following day you don't have [one].'*
>
> Male beneficiary (64), Mombasa

> *'But now, when [I] go look[ing] for work, I don't find [it]. I just come and struggle and sometimes I go some places, but they don't pick me. And, if they do pick me, I don't find good money, I find like 200, 300 [shillings], that's it. … I just go and look and maybe you find ones for cleaning pitchers and arranging stuff. … It's not like in the past, where you used to get KSH 1,000 or KSH 1,000 plus. Right now, it's KSH 800 or KSH 500.'*
>
> Female beneficiary (36), Mombasa

For those engaged in business in the informal sector, COVID-19 restrictions reduced the amount of trade and the number of customers, and the general economic slowdown meant

44 These findings are broadly consistent with the emerging evidence of the effects of COVID-19, including specifically in Africa. See, for instance, Furbush *et al.* (2021).

people had less money to spend. However, respondents reported that engaging in business at least meant they were likely to be able to earn something (albeit small amounts) most days.

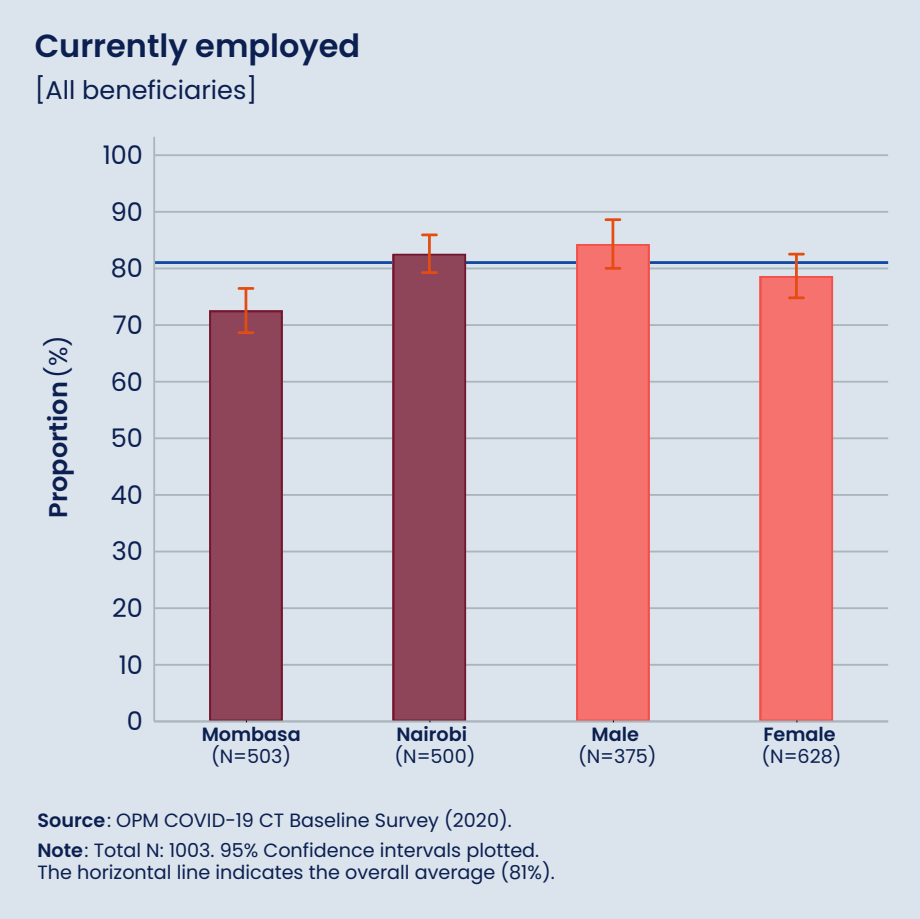
The crisis also affected the minority of respondents engaged in salaried employment. A number of respondents had been working in schools (e.g. as teachers or in catering) prior to the onset of the pandemic, but lost their jobs with the school closures and had to seek casual employment. Respondents working in other types of formal employment also reported losing their jobs or reducing their salary. One respondent had been laid off; another was put on a reduced salary and asked to stay home due to his age, while the cessation of movement order resulted in one respondent getting stuck in Nairobi during the lockdown and being unable to return to their job in Mombasa. Respondents reported turning to 'hustling' (i.e. casual work) or starting small businesses (e.g. selling clothing or water). However, one female respondent, a single mother in Nairobi, noted she lost her job during the COVID-19 pandemic but could not afford to look for work as she had to care for her infant children. This is illustrative of the additional barriers faced by women to engaging in work, exacerbated during the pandemic.

The quantitative baseline survey findings described the situation eight months into the crisis. In general, the quantitative baseline findings echoed the qualitative findings, but provided further detail on the situation by gender and location.

In November 2020, an average of 81% beneficiaries reported being currently employed,[45] with significant differences across counties and gender: this employment figure was 10 percentage points larger in Nairobi than in Mombasa, and 6 percentage points lower among the group of beneficiary women in comparison to their male counterparts (Figure 15). When focusing on the seven days prior to the survey, only 64% of beneficiaries mentioned having undertaken any economic activity during that timeframe. This is highly consistent with the findings of the World Bank's HFPS, which shows that, during the week of 16 November 2020, 68% of respondents in urban areas reported having undertaken any economic activity in the week prior to the survey.

45 In the quantitative survey, respondents are considered to be 'employed' if, in the seven days prior to the survey, they undertook any work for pay, business, farming, or other activity to generate income, even if only for one hour. Respondents are also considered employed if they did not perform any income-generating activity in the seven days prior to the survey, but considered they have a job (for pay) to which they will definitely return.

Figure 15: Proportion of currently employed among all beneficiaries at baseline



Source: OPM COVID-19 CT Baseline Survey (2020).

Note: Total N: 1003. 95% Confidence intervals plotted. The horizontal line indicates the overall average (81%).

Sector-wise, 41% of respondents were providing personal services, while 32% were involved in buying, selling, and/or repairing goods. Only a small proportion (11%) were employed in the construction sector. These estimates were consistent across counties, but hide significant differences between genders (Figure 16): the proportion of female beneficiaries providing personal services and trading/repairing goods were 26 percentage points and 16 percentage points larger than among the group of men respectively. In contrast, almost no women were employed in the construction and the transport sectors, compared to 25% and 9% of men, respectively.

With respect to the type of employment, in November 2020, almost half of beneficiaries were casual workers, 35% owned their own business, and 14% were employed by someone else. Only 2% were farmers, breeders, or fishers, which is consistent with the qualitative finding that a couple of respondents had temporarily moved to rural areas during the crisis (Section 5.1.5). As with the employment sectors, these estimates were consistent across counties but again hid significant differences between genders (Figure 17). The proportion of female business owners was 20 percentage points larger than that of men (44% versus 24%), while this proportion was 12 percentage points and 7 percentage points lower for the groups of casual workers and formal employees respectively.

Figure 16: Proportion of currently employed across sectors at baseline, by gender

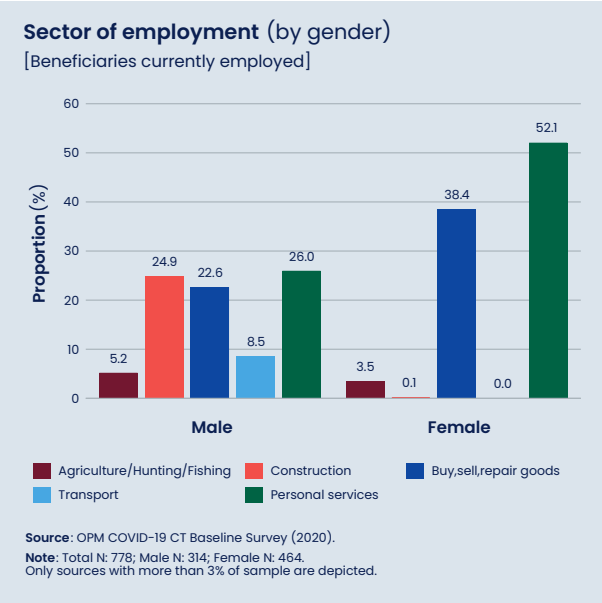
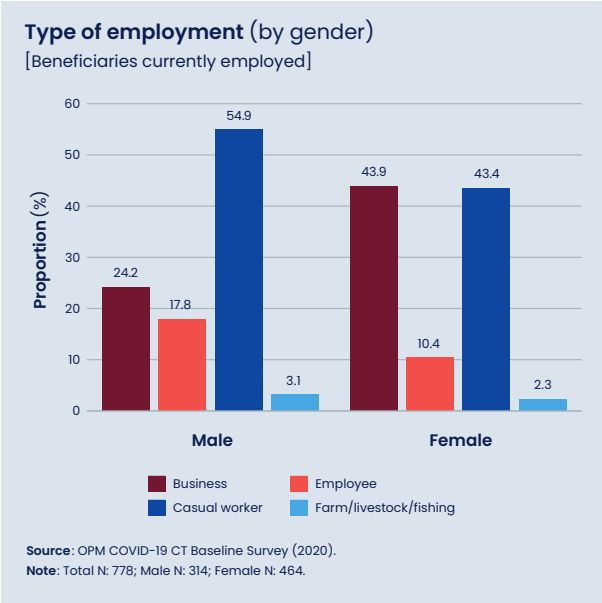
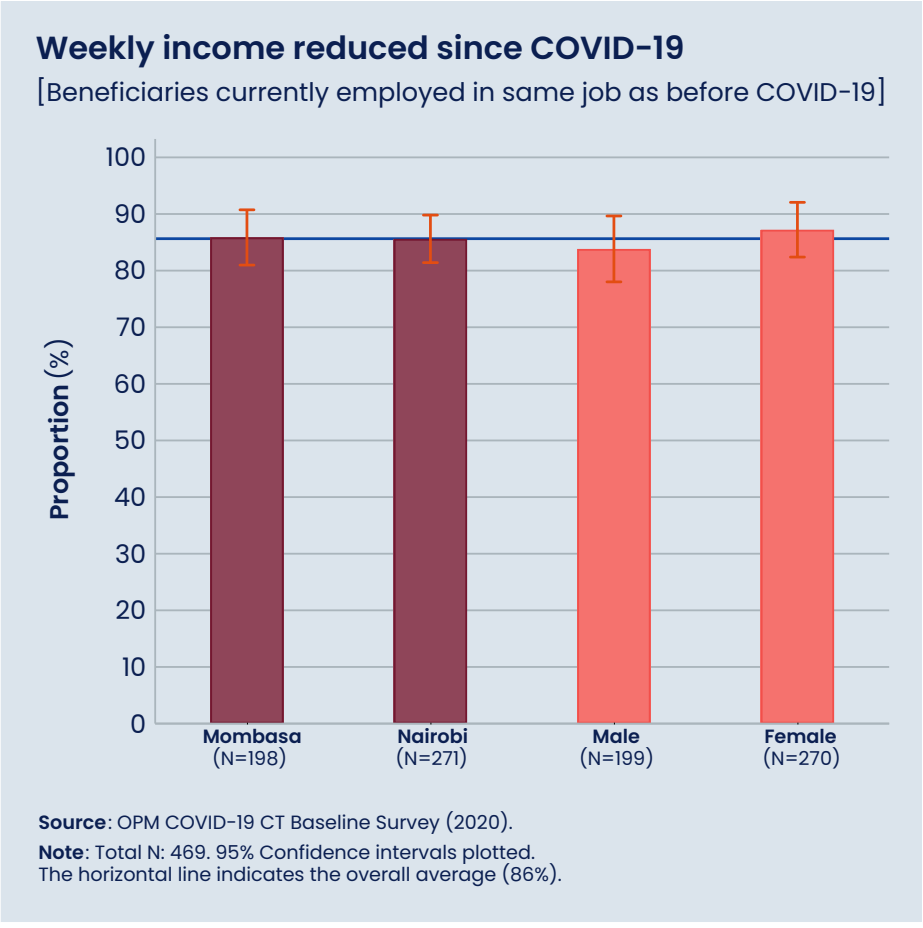


Figure 17: Proportion of currently employed across types of employment at baseline, by gender



Among employed beneficiaries, more than half (64%) reported still working in the same job as they had before the COVID-19 pandemic. However, within this group, most beneficiaries (86%) stated that their employment-related income had reduced since the start of the economic crisis (see Figure 18), as was the case for all respondents interviewed during the midline qualitative research, due to either lower payment or working fewer hours.

Figure 18: Proportion whose weekly income reduced among those employed in same job as before the pandemic



As seen in Figure 19, the lost amount of employment-related income since the start of the pandemic was highly similar in both counties: an average loss of KSH 1,649 per week. However, this figure was significantly larger among the group of male beneficiaries (an average weekly loss of KSH 2,179 compared to KSH 1,211 in the case of women), consequently reducing the income gender gap. Indeed, while female beneficiaries were earning an average of KSH 1,627 less than their male counterparts before the pandemic, this amount reduced to KSH 658 per week in November 2020.

Regarding employment types, the drop in weekly income was significantly larger among business owners and casual workers, who experienced an average loss of KSH 1,887 and KSH 1,618, respectively, compared to KSH 1,157 in the case of wage employees (Figure 20). This loss in earnings made the already existing wage gap across types of employments more acute. In fact, while business owners and casual labourers were earning an average of KSH 687 and KSH 816 less than their employee-counterparts before the pandemic, this amount increased to KSH 1,433 and KSH 1,291 per week in November 2020 respectively.

Figure 19: Change in average weekly income among those employed in same job as before COVID-19, across county and gender

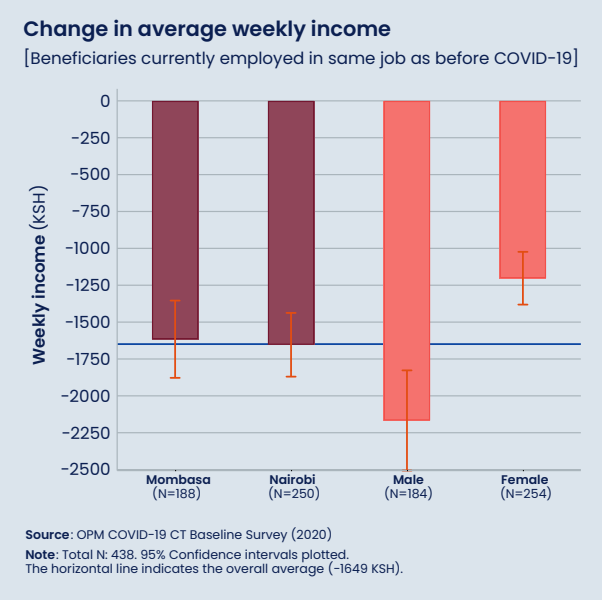
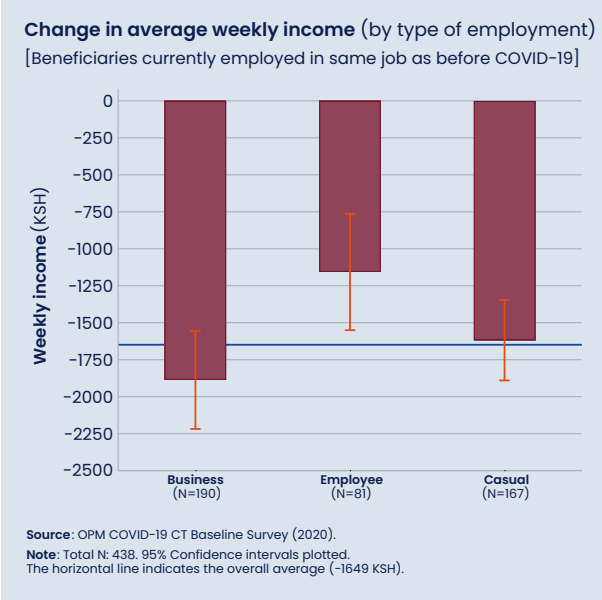


Figure 20: Change in average weekly income among those employed in same job as before COVID-19, across type of employment



When asked about the main reason for this reduction in income, Figure 21 shows that more than half the respondents (58%) mentioned official COVID-19 legal restrictions,[46] followed by a reduction in their customer base (25%), other reasons[47] (8%), and lack of inputs (5%).

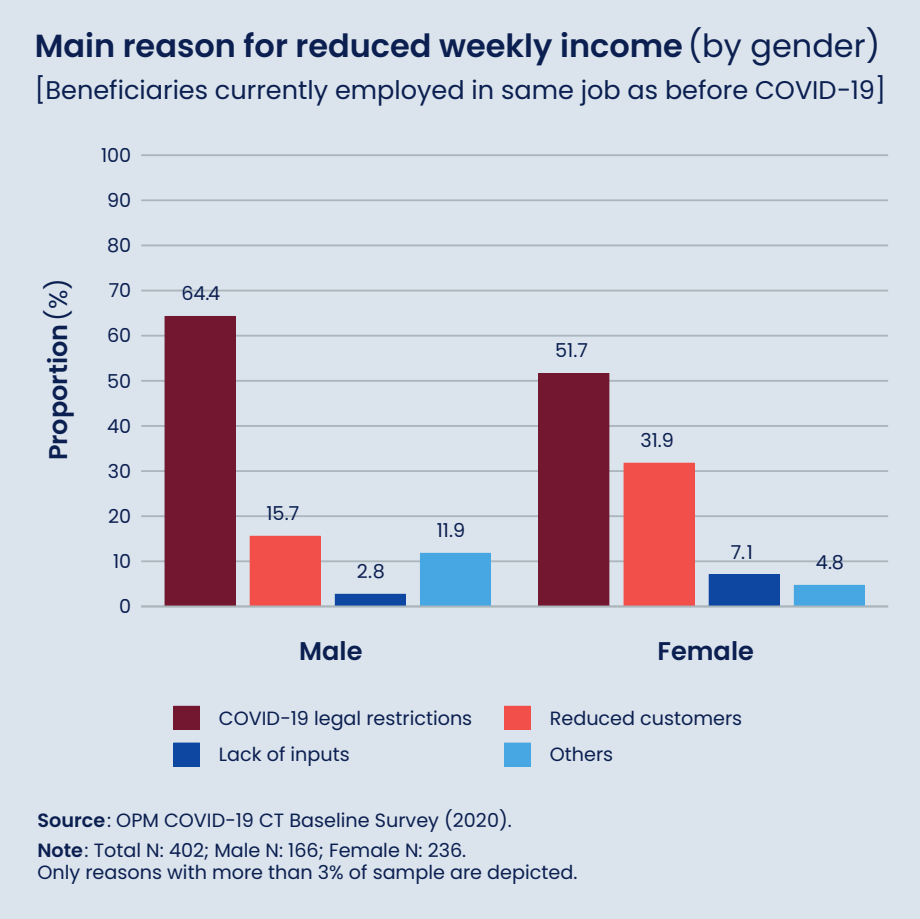
These estimates were consistent across counties, but presented significant differences between genders, which were probably triggered by the existing differences in employment types between men and women. For example, the fact that the proportion of female business

46 This includes 'usual place of work closed due to COVID-19 legal restrictions' and 'not able to go to place of work due to movement restrictions'.

47 This includes 'usual place of work closed for reasons other than COVID-19 restrictions' and 'increased competition from other businesses'.

owners was 20 percentage points higher than that of men (Figure 17) could explain why the percentage of women reporting a reduced customer base as the main reason for their income reduction was 32%, compared to 16% in the case of men. Similarly, the proportion of female beneficiaries who reported lack of inputs as the main reason for income reduction was 7%, compared to 3% among male beneficiaries.

Figure 21: Proportion whose weekly income reduced since the pandemic across main reasons for such reduction, across gender



Source: OPM COVID-19 CT Baseline Survey (2020).
Note: Total N: 402; Male N: 166; Female N: 236.
Only reasons with more than 3% of sample are depicted.

5.1.3 Other income sources

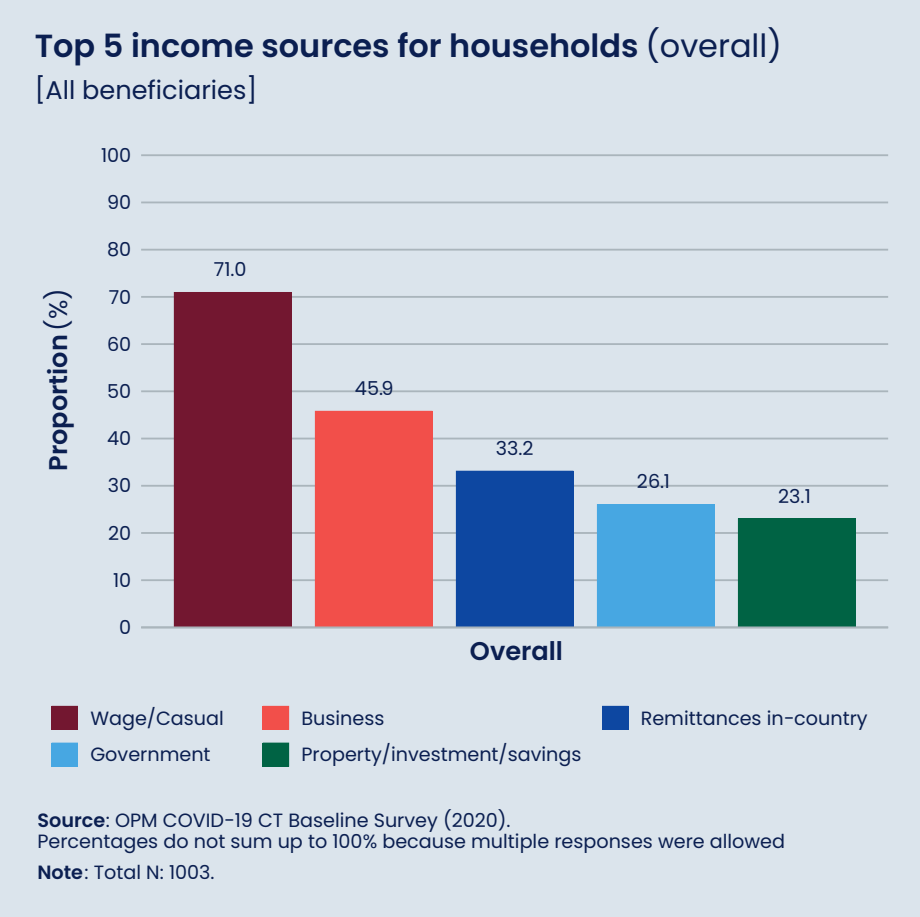
As shown in Figure 22, the most common income sources for the beneficiaries' households in the 12 months prior to baseline (November 2020) were wage and/or casual employment (71%), followed by income from business (46%), remittances from family/community within the country (33%), government transfers (26%), and property/investment-related income (23%).

These results were consistent across genders, although significant differences were observed in some of these categories between locations. Despite wage-related and business-related income being the first and second most common income sources in both counties, the proportion of beneficiaries receiving income from these sources was 11 percentage points and 10 percentage points lower in Nairobi than in Mombasa respectively. The same occurred with the proportion of beneficiaries who received income from property and/or investments, which was 21% in Nairobi, compared to 35% in Mombasa. On the contrary, 28% of beneficiaries

reported receiving income from the government[48] in Nairobi, compared to 17% in Mombasa.

At least 90% of the respondents who mentioned having obtained income from any of these sources in the 12 months prior to baseline stated that the amount of such income had decreased since the pandemic. This is consistent with the fact that the COVID-19 pandemic not only impacted employment levels, but also triggered restrictions to mobility, which negatively affected the flow of remittances. The only exception to this trend was government-related income, where just over 20% of respondents reported that their government-related income had not decreased.

Figure 22: Top five household income sources in the 12 months prior to baseline



Source: OPM COVID-19 CT Baseline Survey (2020).
Percentages do not sum up to 100% because multiple responses were allowed
Note: Total N: 1003.

The qualitative research did not explore household sources of income.

5.1.4 Food security

The qualitative research at midline also asked respondents about their access to food and their eating patterns prior to and during the pandemic (March to November 2020).

Before COVID-19, respondents described a situation of food security: they did not recall worrying about having enough food for their families and were able to eat what they

48 Any income or assistance that the beneficiary's household received from the government, which is not derived from an employment-related relationship'

perceived to be a balanced and diverse diet. Respondents spoke about being able to eat at least three meals per day, in some cases more, and having access to the food they wanted to eat. A number of respondents spoke about always having food stocks at home as they were able to buy food in bulk, as well as frequently (e.g. weekly) eating more expensive foods, such as meat, biryani, pizza, etc. It is likely that respondents' very positive recollection of their situation prior to the pandemic was affected by confirmation bias, resulting in a positive description of the past in relation to the difficult circumstances during the crisis.

However, with the onset of the pandemic, all respondents spoke about the negative impact of the crisis on their access to food. As described in Section 5.1.2, many households were no longer receiving a regular income (particularly those employed in casual employment) and/or earned a reduced income, which affected the way in which they bought food. Respondents described how they were only able to buy small quantities of food when they earned money, which resulted in households buying food more frequently and in smaller quantities. In addition, households were no longer able to afford the same food as before COVID-19. Therefore, to continue to feed their families, respondents described how they had changed the quantity and quality of food eaten (Box 10).

Box 10: Changes in food security for Sylvia's household in Mombasa during COVID-19

Sylvia* (22) was a teacher in Mombasa prior to the onset of COVID-19, with plans to enrol in college in early 2020. When the schools closed, she lost her job and started a small business selling clothes to support her household of 10. Before COVID-19, her household did not lack money for food, rent, electricity, etc., nor did it incur debts to pay bills. Sylvia describes how the crisis has affected their food security.

'Interviewer: *Okay, so how has eating at home become? How has it been, feeding at home?*

Respondent: *It has become hard because you may get some breakfast and miss lunch, so you just eat anything that your stomach can hold.*

Interviewer: *And how many times do you eat in a day?*

Respondent: *It depends. There is a day you may have breakfast and miss lunch or supper, [or] you get supper [but] you miss breakfast and lunch. But, there is no day we have had three meals a day since Corona started.*

Interviewer: *Okay, and have you reduced the amount of food that you are taking at home?*

Respondent: *Yes, it has reduced. … We used to eat food that anyone liked. People used to eat and get full, but now we are eating so that we don't starve to death.*

Interviewer: *What kind of food did you used to like, or what food [do] you have to reduce now, or [what food have] you stopped eating now?*

Respondent: *In the past, we used to like eating. … Us coastal people, we like eating fried rice, biryani … We used to eat ugali only once, but now we eat it almost the whole month.*

Interviewer: *Okay, and in the family, who do you think stopped eating certain foods or [who is] reducing the amount of food they eat? Who in the family?*

Respondent: *Dad and Mum, they forego eating so that we don't miss food. Because food is not enough for everyone.'*

* Name has been changed for anonymity.

In the first instance, respondents noted that they had to cut down on luxury foods such as meat (including chicken and fish), beans, rice, eggs, chapatti, biryani, bread, and milk, consuming these items once or twice per month (if at all). They also spoke about reverting to drinking 'strong tea' (i.e. without milk). Overall, most respondents reported a daily diet of *ugali, githeri,* and greens (e.g. kale and cabbage), as described by a male beneficiary from Mombasa:

> *'Something with quantity not quality, you have to squeeze your budget and go for such things. … For example, 1 kilogramme of beef goes for KSH 400. If you convert that to vegetables, you find [the beef] so expensive. So the situation has changed us to become more of vegetarians than before, and affected the entire budget. If you buy vegetables for KSH 100, it would be enough for you and the entire family and leave some, but KSH 100 [of] beef would not be enough, even for one person. That's why I'm saying I would not afford [it], I call them expensive things. Let me not use the word "expensive", but "affordable". … For me, that is the major challenge. In short, it makes you eat what you don't want. Your pocket dictates what should be put on the table.'*

It was also common for respondents to speak about having to cut down on the quantity of food eaten by reducing the number of meals they ate per day, with some households only eating once per day. As a result of living hand-to-mouth (Section 5.1.2), respondents also described that, in exceptional circumstances (e.g. when they had not earned money for a few days), they were not able to eat at all. When possible, adults would prioritise feeding children, trying to minimise the number of meals the children had to skip. A few respondents also noted that they tried to cook only once per day to reduce the amount (and therefore the cost) of fuel and cooking oil used, with one respondent even describing buying only small quantities of food so she did not have food to store and could turn off the fridge. Further, most respondents noted that, when household members were able to eat, they were often given smaller portions.

These findings were corroborated by the quantitative survey, which used a simplified[49] HFIAS to quantify households' food security levels. HFIAS is a tool developed under United States Agency for International Development's Food and Nutrition Technical Assistance (FANTA) project to consistently measure households' access to food (Coates *et al.*, 2007).[50] It is a methodology based on the idea that households' experiences of food insecurity in terms of access cause predictable responses, which can be captured and summarised using a quantitative scale. In particular, the HFIAS used in this study is based on a set of nine occurrence questions, which represent apparently universal domains of the household food insecurity experience and allow the assignment of households along a continuum of insecurity severity, from food secure (scores close to 0) to severely food insecure (scores close to 9).

It is important to highlight here that the HFIAS is not an all-encompassing measure of food insecurity.[51] HFIAS focuses primarily on a household's access to food, and therefore also

49 Following the approach of the World Bank's 'High Frequency Mobile Phone Surveys of Households to Assess the Impacts of COVID-19' initiative. More information is available at https://documents.worldbank.org/en/publication/documents-reports/documentdetail/567571588697439581/questionnaire-template.

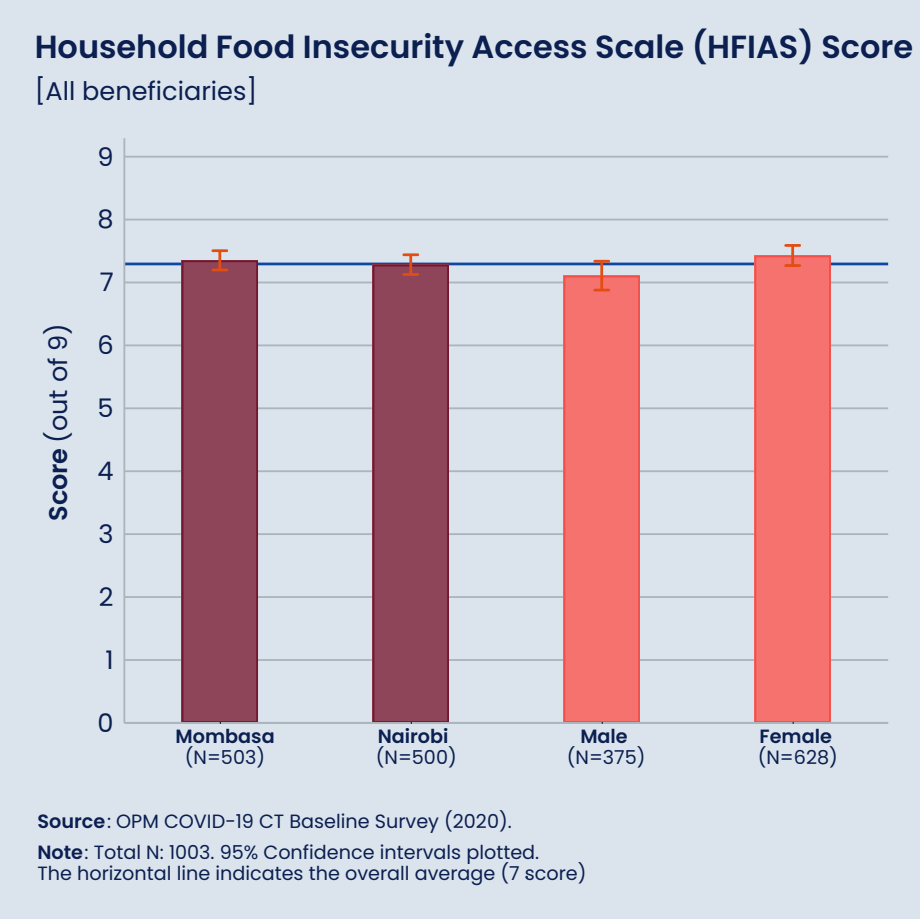
50 More information available at www.fantaproject.org/monitoring-and-evaluation/household-food-insecurity-access-scale-hfias.

51 According to the common Food and Agriculture Organization's definition, food security has four dimensions, namely food availability, access, utilisation, and stability.

captures local food availability. Nevertheless, HFIAS questionnaires usually refer to the household's experience over a 30-day period so that longer-term stability and seasonality aspects cannot be analysed.

Indeed, as indicated by the qualitative interviews, the quantitative results showed that, at baseline, the average HFIAS score was 7.3 (Figure 23). This indicates considerable insecurity in terms of access to food among the sampled population. This result was consistent across both locations and beneficiaries' gender.

Figure 23: Average HFIAS score at baseline

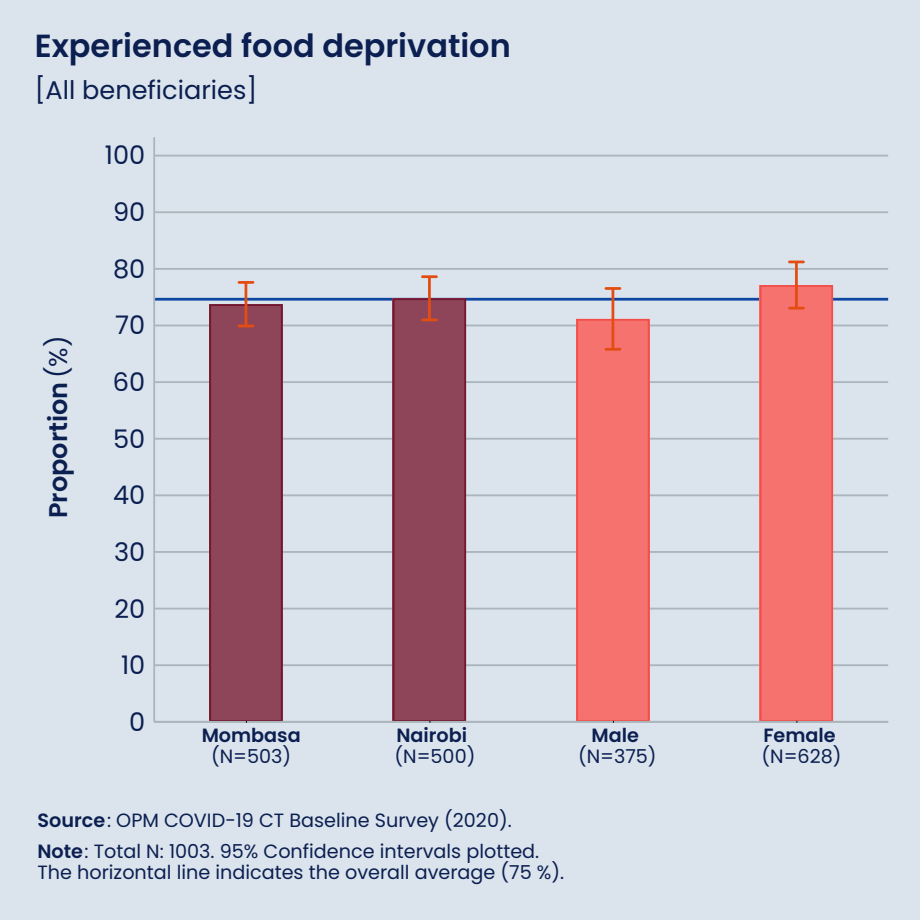


It is important to mention that the nine questions composing this score relate to three different domains of insecurity in terms of access to food: anxiety and uncertainty about the household food supply; insufficient food quality (in terms of variety and household preferences); and insufficient food intake (in terms of reduced quantity of food eaten in a meal and/or reduced number of meals). The questions in the latter domain, and in particular the last three questions of the scale, deal with the most severe food insecure experiences and are often reported to assess households' levels of food deprivation and actual hunger. This helps complement the HFIAS, which, in contrast, reflects a broader range of household food insecurity (Ballard *et al.*, 2011).

The quantitative survey findings indicated the severity of the food security crisis. At baseline, three-quarters of beneficiaries reported having experienced at least one of the food

deprivation situations in the four weeks prior to the survey.[52] This proportion was consistent across both geographies and beneficiaries' gender (Figure 24). While few respondents in the qualitative research explicitly spoke about skipping all meals in a day, respondents alluded to the fact that they were only able to eat when they earned money, noting that, otherwise, they would 'sleep hungry'.

Figure 24: Proportion who experienced food deprivation in the four weeks prior to baseline



Source: OPM COVID-19 CT Baseline Survey (2020).

Note: Total N: 1003. 95% Confidence intervals plotted. The horizontal line indicates the overall average (75 %).

5.1.5 Use of coping strategies

In both rounds of the qualitative research, respondents described the coping strategies they used during the pandemic in the face of reduced income and employment opportunities. As discussed in Section 5.1.2, while almost all respondents continued to look for work throughout the crisis, finding work (especially casual jobs) was very difficult. Prior to the pandemic, respondents recalled taking their children out on the weekends (e.g. to see wildlife) and being able to eat out or purchase luxury goods (e.g. paying for beauty treatments). However, almost all respondents noted they were no longer able to spend money on small, non-essential items with the onset of the pandemic and had to budget carefully with the money they had. A female beneficiary in Mombasa describes these changes.

52 These include the following questions: In the past four weeks, was there ever no food to eat of any kind in your house because of lack of money or other resources? In the past four weeks, did you or any household member go to sleep at night hungry because there was not enough food? In the past four weeks, did you or any household member go a whole day and night without eating anything because there was not enough food?

'Some of the household stuff had to change, like paying for TV stations like GoTV, [or] taking the kids out on Sundays; that had to change. Instead of buying serviettes, you buy tissues; your priorities first. I had to cut cost on some things because you don't know about tomorrow. Basically, yes, I had to cut off some things.'

The qualitative research found that respondents no longer had enough money (income and savings) to meet their own needs and the needs of their household. Almost all respondents spoke about borrowing money from friends and families and buying food, and other items, on credit. A minority of respondents reported borrowing money from a moneylender. In addition, the majority of respondents noted they had deferred their rent payments, in some cases paying only a portion of their rent and in others deferring the payment entirely. Whether households had access to this coping mechanism was at the discretion of the landlord. A minority of respondents also noted that they had to move to a smaller house as they could no longer afford their rent or were locked out of their house for failing to pay rent.

However, some respondents (men and women) perceived they had limited access to 'coping strategies' that offered them credit, especially further into the pandemic. For example, as family and friends also felt the economic impacts of the crisis, respondents could not continue to borrow as easily from others. One respondent noted that he also no longer had access to his merry-go-round (i.e. savings group) as neither he nor the other community members could contribute to the scheme. Further, some respondents described that there were limits to how much they could borrow from shop owners or landlords. If they were unable to make any repayments, they could not continue to purchase food on credit. Similarly, if they were unable to pay their landlords even a portion of the rent, they would eventually face eviction.

Respondents also mentioned some other less-common coping strategies that they had used. These included the sale of assets such as TVs, radios, smart phones, tables, beds, shoes, etc. or the sale of livestock or stores of maize in their ancestral family homes (or rural homes). Three respondents reported that they had returned, with their families, to their rural homes, while another two had sent their families back while remaining in the city themselves. Finally, a few respondents described the need to carefully use the resources they had available to them by avoiding the use of public transport (including to find casual work), cutting down on washing clothes (to reduce expenditure on water and soap), reducing the frequency of showering, and reducing their use of electricity.

'Because one can of 20 litres goes for KSH 20, and normal usage per day—that is, if she is not using the borehole water—on laundry, cooking, bathing can take four to five jerrycans per day, but when she uses the one for the borehole she will use one or two jerrycans. So can you notice the difference? So at the end of the day, you find out that you have saved.'

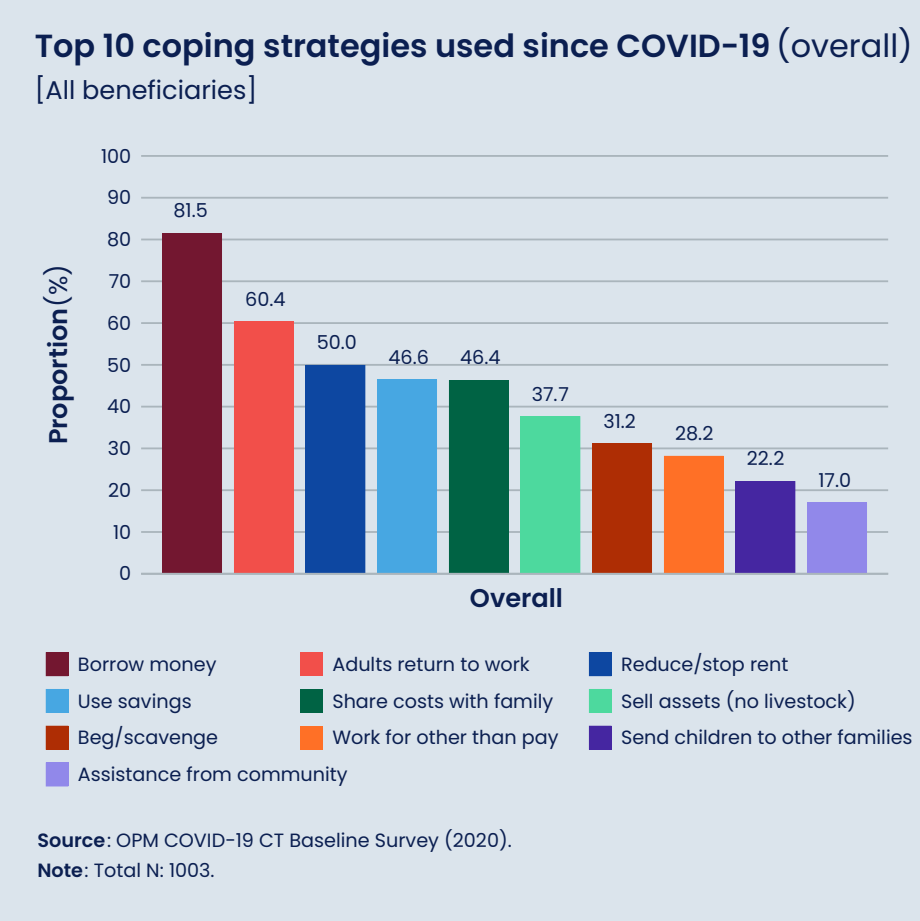
Male beneficiary, Mombasa

The baseline quantitative survey results corroborated the qualitative findings, with beneficiaries reporting having used a number of coping strategies (five different strategies on average) since the start of the COVID-19 pandemic. Regardless of location and gender, the most common coping strategy was borrowing money, which was reported to have been used by 82% of respondents (Figure 25). This proportion was significantly higher in Mombasa (87%) than in Nairobi (81%).

Borrowing money was followed by adults returning to work (60%), reducing or stopping to pay rent (50%), using savings (47%), and sharing costs with other family members (46%). As with the borrowing of money, the proportion of beneficiaries using savings was significantly higher in Mombasa (63%) than in Nairobi (44%).

Other common coping strategies were selling assets other than livestock (38%), begging/scavenging (31%), working for other remuneration rather than pay (28%), and sending children to other families or households (22%). These strategies, however, hide significant differences across locations and gender: respondents in Nairobi were more likely to send children to other families or households (24% versus 15% in Mombasa), and more female beneficiaries decided to work for remuneration other than pay and/or beg/scavenge when compared to male beneficiaries (33% versus 23%, and 35% versus 26%, respectively).

Figure 25: Top 10 coping strategies used by beneficiaries since the start of the pandemic



Source: OPM COVID-19 CT Baseline Survey (2020).
Note: Total N: 1003.

When asked about their plans for the following month, beneficiaries expected to use an average of three coping strategies compared to the average five used since the pandemic started. This is probably explained by the fact that, at the time of the interview, respondents already knew about the COVID-19 CT and that they would be receiving a monthly transfer over the next three months.

Regardless of location and gender, the most common plans were directly in line with the strategies that had been used since the start of the pandemic, except for the use of savings.

This may again be related to the fact that beneficiaries expected imminent receipt of the COVID-19 CT and therefore did not foresee the need to continue using their savings to meet their most pressing needs, or because the availability of their savings had decreased over time.

Over three-quarters of beneficiaries reported that adult members aimed to return to work in the coming month, while 51% expected to borrow money. It is important to note that the latter percentage is considerably lower than the 82% of beneficiaries who mentioned having borrowed money since the COVID-19 crisis started. As indicated by the qualitative findings, this is probably due to the fact that some respondents perceived they could not continue to borrow as easily from others further into the pandemic, since family and friends also felt the economic impacts of the crisis and other lenders (e.g. at food shops) might have been concerned they would be unable to repay their debts.

Other planned strategies for the following month were sharing costs with family members (38%), working for something other than pay (35%), and reducing or stopping to pay rent (34%). It is important to highlight that the proportion of female beneficiaries planning to share costs with family and/or reducing their rent was 15 percentage points and 10 percentage points lower than that of male beneficiaries respectively.

5.2 Uses and benefits of the COVID-19 CT

This section describes the main uses of the COVID-19 CT over time (Section 5.2.1) and beneficiaries' perceptions of the effect of the CT on their wellbeing (Section 5.2.2). In Section 5.2.1, we draw on the findings from the midline and endline quantitative surveys, as well as the midline and endline qualitative research. In Section 5.2.2, we only draw on the midline and endline qualitative research.

5.2.1 Main uses of the COVID-19 CT

Beneficiaries received three payments from GiveDirectly: in November and December 2020, and in January 2021.

Both the midline and endline quantitative surveys[53] found that almost all respondents (96% and 94% respectively) had used all the money received from GiveDirectly, while another 4% and 6% mentioned having spent some of it. Regardless of geography, gender, or time, the most common use of the money was to buy food, as indicated by an average of 95% of respondents (Figure 26).

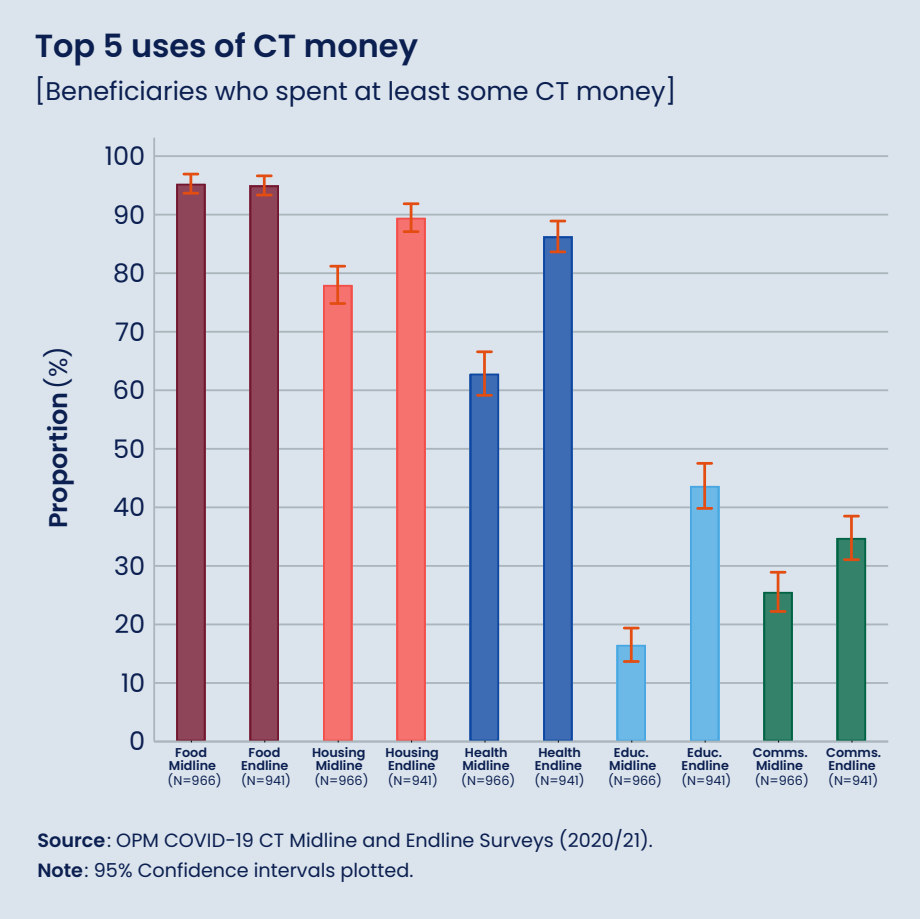
At endline, food consumption was followed by expenditure on housing, health and hygiene, communications, and education. The exact proportion of respondents spending CT money on these categories, however, significantly increased between midline and endline. For example, the proportion of respondents spending money on housing significantly increased from 78% to 90%, regardless of geography and gender. This increase was experienced across all three housing subcategories: rent payments and water and energy usage. Similarly, the proportion of respondents spending money on health and hygiene significantly increased from 63% to 83%, a change mainly driven by the rise in the proportion of beneficiaries using CT money for hygiene

53 The midline survey was conducted around three weeks after the first COVID-19 CT payment, while the endline survey took place around three weeks after the third and final COVID-19 CT payment.

purposes, which went from 57% to 82%. Finally, the proportion of beneficiaries spending on education and communications increased from 17% to 44%, and from 26% to 35%, respectively.

This is probably explained by the fact that, at endline, most beneficiaries had already received three CT payments (compared to one payment at midline), leaving them with more resources to cover additional pressing needs other than food. Further, the majority of schools were closed in Kenya between March 2020 and January 2021 (apart from candidate years, which returned to school in October 2020). Therefore, expenses related to education were limited at the time of the first and second payments (November and December)—only a couple of respondents in the qualitative research reported spending money on tuition for children while they were not at school—but rose at endline, which coincided with schools reopening.

Figure 26: Top 5 uses of CT money at midline and endline



Source: OPM COVID-19 CT Midline and Endline Surveys (2020/21).
Note: 95% Confidence intervals plotted.

These findings are echoed in the qualitative interviews from midline and endline. It is worth noting that, while the CT was targeted at the individual level, respondents reported using the money for household expenditure—in particular food, rent, and hygiene (water and soap)—and investing in business. Almost all respondents suggested that, while the money was helpful and greatly needed, it was not sufficient to meet all their household needs (Section 4.1.4). In only three cases, the support from GiveDirectly was augmented by receiving food packages (particularly around Christmas) or by participation in GoK programmes, including the *Kazi Mtaani* (urban public works programme).

In line with the quantitative survey findings, almost all respondents in the qualitative research reported using the first payment to purchase food stocks in bulk for their household and to restock staples such as flour, rice, cooking oil, sugar, etc. This allowed them to increase the number of meals eaten per day to two or three, although they did not enjoy the dietary diversity (including eating their preferred foods) they had had prior to COVID-19. Another common use of the money was to pay a portion of their rent arrears and (in fewer cases) to repay other debts (e.g. at food shops or electricity and water bills). However, respondents described the importance of repaying their landlords and other creditors to show they were creditworthy and keep these channels open for the future.

> 'Respondent: *The one that came recently, I used it well, because I bought stock. …*
>
> Interviewer: *When you say stock, what do you mean?*
>
> Respondent: *Food. Food like milk, so that my children won't skip breakfast. And you clear the debt at the shop. So that when you don't have money, you can still take some goods from the shop without having any problems with the shopkeeper.'*
>
> Male beneficiary, Nairobi

Aside from purchasing food and making rent payments, another frequently mentioned use of the CT money, in line with the quantitative findings, was for hygiene-related or health-related expenditure. Respondents spoke about prioritising using the money to buy water and soap, as well as masks, hand sanitisers, and other sanitary products they had not consistently been able to afford throughout the crisis. Further, respondents also mentioned taking children or elderly household members to the hospital or buying medicines, which they had not been able to do before receiving the money.

Finally, a few respondents used the money to set up small businesses in cases where they had lost their jobs, where they wanted to diversify their income sources, or where they wanted to have a source of daily income. Others with existing businesses had used the money to expand by purchasing more stock.

> *'Since I used the money that you people were giving out, I can at least say there have been little changes and the money has helped me. … I had already set up a salon so, with this money, I bought things like oils, lotions, and more. … So those are the things that I have stocked and I am currently selling them.'*
>
> Female beneficiary, Nairobi
>
> *'I took [KSH] 2,000 and bought food, then put the other [KSH] 2,000 into the business so that I could get at least 50 or 100 shillings a day to help me forge forward.'*
>
> Female beneficiary, Mombasa

In general, the qualitative research found similar patterns of expenditure when respondents were asked about their use of the second and third payments, with exceptions relating to the timing of the payments. Overall, while respondents did not speak about spending the money on non-essential items, three respondents spoke about using the second payment to buy special items for Christmas:

> *'Let me say it was December. I had to buy wheat flour, salad, so that I could cook chapattis. I bought home baking flour, you know, we were on a festive season. The things were the same, they were food products, but only that they were different.'*
>
> Female beneficiary, Mombasa

As mentioned above, the third payment coincided with the reopening of schools and many respondents reported using the third payment for education expenses, including school fees, transport, uniforms, books, and stationery and school supplies for their children. No respondents (during the endline qualitative interviews) said their children would be unable to return to school because of lack of money when the schools reopened in January 2021. This was supported by the quantitative survey, which showed a sharp increase in spending on education at endline (Figure 26).

5.2.2 Recipient perceptions of the effects of the COVID-19 CT on their wellbeing and welfare

Throughout the qualitative interviews, respondents described the way in which they had used the money and the benefits this had had on their welfare in terms of food security, not having to take on more debt, ensuring their children could return to school, etc. However, the CT also affected other, less quantifiable aspects of wellbeing.

Respondents in the qualitative research either noted directly, or implied, that the money had reduced their stress and the pressure and worry they had felt about needing to provide for their families. This was because they felt the CT allowed them to plan. This may be reflected in the quantitative baseline finding that beneficiaries expected to use fewer coping strategies going forward once they knew about the COVID-19 CT (Section 5.1.5). One respondent, who relied on casual work to support the household, described the relief of knowing there were food stocks at home, while another described how having food at home reduced the pressure to find casual work each day and meant they did not need to accept bad jobs (for low pay or for degrading work).

> 'Respondent: *So, getting this support feels like the burden has been taken off your shoulders.*
>
> Interviewer: *I want to understand you better because, when you tell me "burden", my burden and your burden are different; what has been taken off your shoulders? Please mention them by their names?*
>
> Respondent: *What has been taken off? Do you believe that stress kills? So stress has been reduced … life stress, because you will leave in the morning not knowing what you will bring back for your family. … At least I know there is food. My children are okay.'*
>
> Female beneficiary, Mombasa

Others described that the money meant they no longer needed to ask or beg for help from others. For some women, the need to borrow or beg had affected their perception of their own financial independence. One female respondent noted that the money, which she had invested into a small business, had brought her financial independence, while another female respondent described how her loss of independence had affected her wellbeing:

> *'So this one really affected me. Especially the day I received my babies, because this was the time that I would take good care of them. And the new norm was also here. I got very frustrated, but there was nothing that I could do but learn to live with it. It is not easy to beg for help, because I am the one who used to provide. But now the tables have turned against me. It is very bad and if I [hadn't been] strong, I would have suffered from depression.'*
>
> Female beneficiary, Nairobi

Aside from reducing stress, the CT also allowed households to move from only purchasing essential food and goods to being able to purchase small items that brought them joy:

> *'I remember the last time I received money from GiveDirectly, I bought beef for my family and we really celebrated because we had not had it for a very long time.'*
>
> Male beneficiary, Mombasa

The qualitative research sought to understand whether the CT had any impact on intra-household relations. For the most part (regardless of whether other household members knew about the money or not), respondents did not feel there had been any changes to intra-household relationships since receiving the money. A minority of respondents noted that relations had improved or that the money (or items bought with the money) had brought happiness or joy to household members. In fact, in many cases, the recipient of the CT had not told their partner/spouse that they had received the money, which was possible as the CT was individually targeted and paid privately to the beneficiary's mobile phone. The CT was kept secret for a number of reasons. For example, one male respondent felt that if his wife knew about the money she might 'misuse' it. In contrast, a female respondent noted that she did not tell her husband about the money to ensure he would not be disincentivised from continuing to search for work. Despite this secrecy, respondents noted they still used the money to pay for household expenses, allowing their partners to think they had earned the additional money through work.

Finally, most respondents also did not perceive the CT to have altered community relations, given that the cash was delivered privately to the recipient's mobile phone. In cases where the community did know about the transfer, there were mixed feelings about whether this might cause jealousy. On the one hand, one respondent explained that many initiatives were being implemented to support vulnerable households, so although one household might receive money from GiveDirectly, another might receive support from elsewhere. Another respondent felt feelings of jealousy might be mitigated because they would use the money to help others, as it was likely they themselves might need help in future.

On the other hand, another respondent noted that they kept receipt of the money secret to ensure others in the community did not ask for support. Further, several respondents felt that the CT had caused jealousy within the community. This was related to the registration approach, as one respondent described how people in the community felt those who received GiveDirectly support had registered secretly without telling others about it.

5.3 The impact of the COVID-19 CT

This section assesses the potential impact the COVID-19 CT payments may have had on cash recipients across the key variables of interest: food security (Section 5.3.3) and the use of coping strategies (Section 5.3.4). Additionally, and given that employment and other household income sources can also have an effect on food security levels and the use of coping strategies, Sections 5.3.1 and 5.3.2 start by analysing how these variables evolved over the COVID-19 CT implementation period.

In particular, we draw on data from the baseline, midline, and endline quantitative surveys to descriptively show how the variables of interest changed over time among the CT beneficiaries. We then provide a measure of impact on those indicators that can be more directly linked to the COVID-19 CT when controlling for confounding factors. These findings are complemented by findings from the endline qualitative research, which sought to understand the channels of impact.

5.3.1 Employment

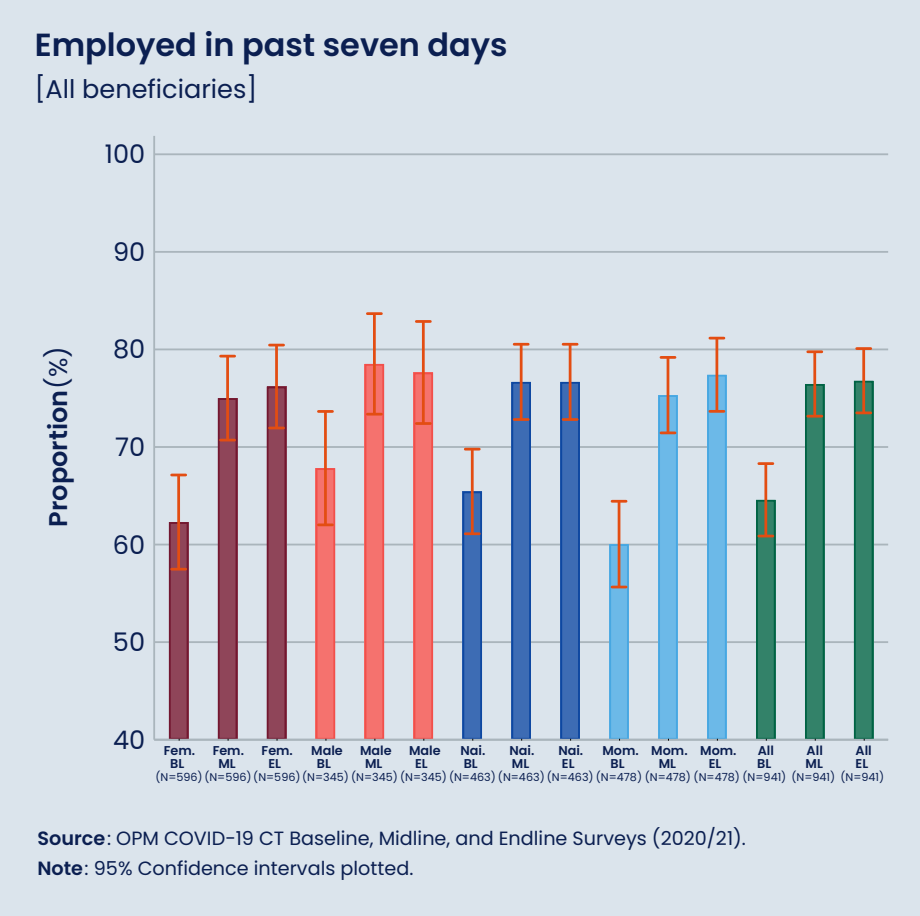
As shown by Figure 27, the average proportion of beneficiaries who reported having worked in the seven days prior to the interview significantly increased from 64% at baseline to 77% at endline.[54] This positive trend is in line with the findings of the World Bank's HFPS, which shows that the proportion of the urban population who stated having worked in the seven days prior to the interview increased from 68% in the week of 16 November 2020, to 82% in the week of 15 February 2021. Although, estimates from both surveys are not directly comparable, such a similar increase seems to suggest that the contribution of the COVID-19 CT on the overall employment level is limited.

However, a positive effect on employment was confirmed by more sophisticated regression analysis (Volume II), which seems to indicate that receiving the COVID-19 CT increased the chances of undertaking an economic activity in the seven days prior to the survey by 10% on average. This effect holds when controlling for both time-invariant and time-variant beneficiary characteristics. A good example of the latter is a variable indicating whether the beneficiary was employed 'independently',[55] which appears to have a significant effect on the probability of being employed. This is not surprising, given that a possible channel through which the reception of the COVID-19 CT may affect work patterns is self-employment, which tends to benefit from an injection of cash.

54 It is also interesting to note that this corresponds to a significant reduction in the proportion of beneficiaries who reportedly stayed at home, which dropped from 78% at baseline to 57% at endline, as shown in Figure 5. However, while the reduction in people staying at home may be related to the parallel reduction in COVID-19 cases between December 2020 and March 2021, our findings on employment show that the biggest change (increase) in employment among beneficiaries occurred between baseline and midline, and then stabilised between midline and endline. This appears to suggest that the trend we observe in employment is unlikely to be explained by changes in the pandemic.

55 This means being employed in their own business and/or casual work, rather than working for someone else (wage workers).

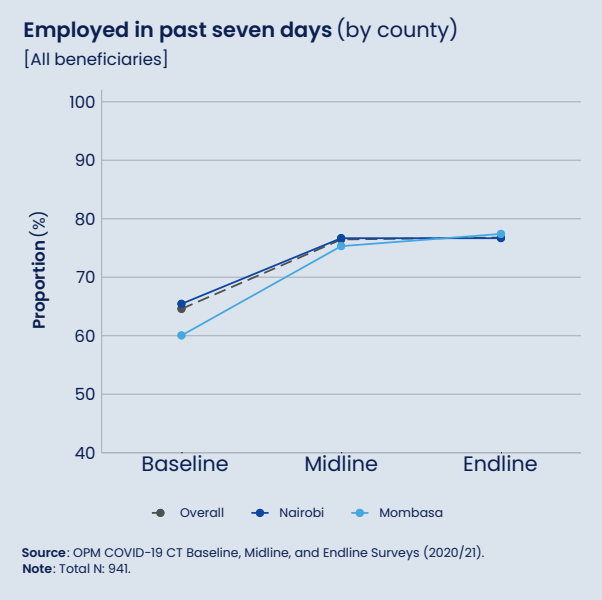
Figure 27: Proportion of employed in past seven days among all beneficiaries at baseline, midline, and endline



Source: OPM COVID-19 CT Baseline, Midline, and Endline Surveys (2020/21).
Note: 95% Confidence intervals plotted.

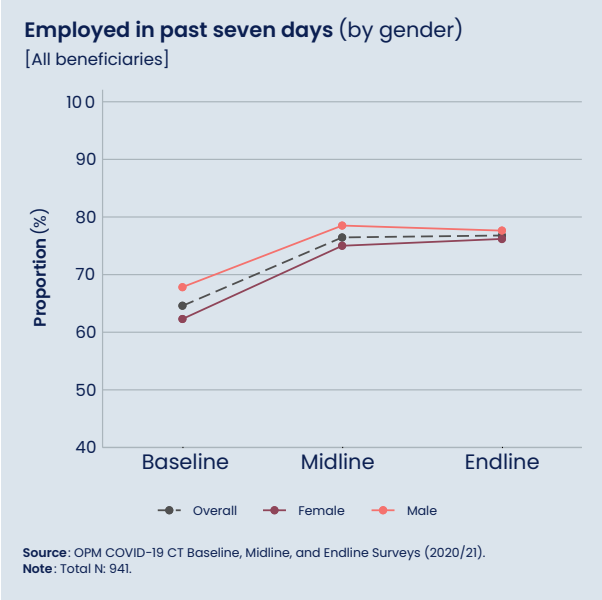
The increase in employment levels held both across locations and genders, although it was slightly larger in Mombasa and among female beneficiaries (see Figure 28 and Figure 29 respectively). It is important to highlight that the proportion of beneficiaries employed in the different sectors of the Kenyan economy did not experience any significant change over time. The same can be said regarding the type of employment held by the beneficiaries.

Figure 28: Proportion of individuals employed in the past seven days among all beneficiaries at baseline, midline, and endline, by county



Source: OPM COVID-19 CT Baseline, Midline, and Endline Surveys (2020/21).
Note: Total N: 941.

Figure 29: Proportion of individuals employed in the past seven days among all beneficiaries at baseline, midline, and endline, by gender



Source: OPM COVID-19 CT Baseline, Midline, and Endline Surveys (2020/21).
Note: Total N: 941.

The amount of weekly income obtained from employment significantly increased from KSH 1,008 at baseline to KSH 1,816 at endline. This increase was confirmed by the regression analysis, which indicated that weekly income from employment increased by an average of KSH 745. This result holds when we control for time-invariant characteristics and the type of employment held by the beneficiary.

As with the proportion of beneficiaries who undertook some sort of economic activity in the seven days prior to the survey, the increase in employment-related income was slightly larger in Mombasa and among female beneficiaries. As seen in Figure 30 and Figure 31, this is due to the fact that the average weekly income experienced a minor decrease between midline and endline in Nairobi and among male beneficiaries, while it continued to increase in Mombasa and among women.

Figure 30: Average weekly income among individuals employed in the past week at baseline, midline, and endline, by county

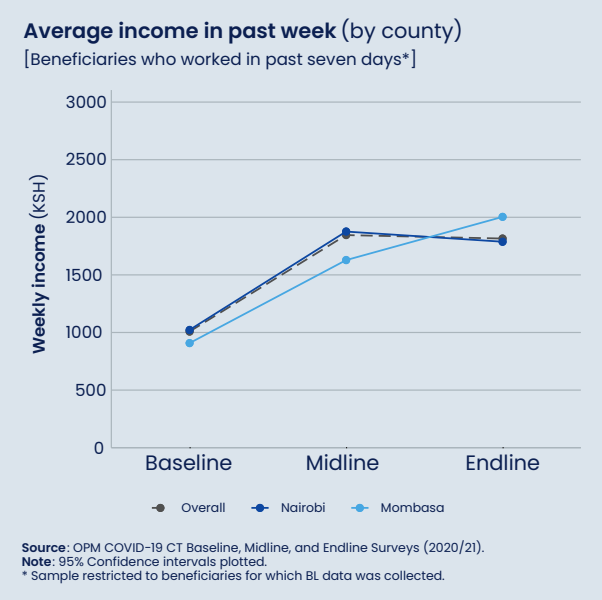
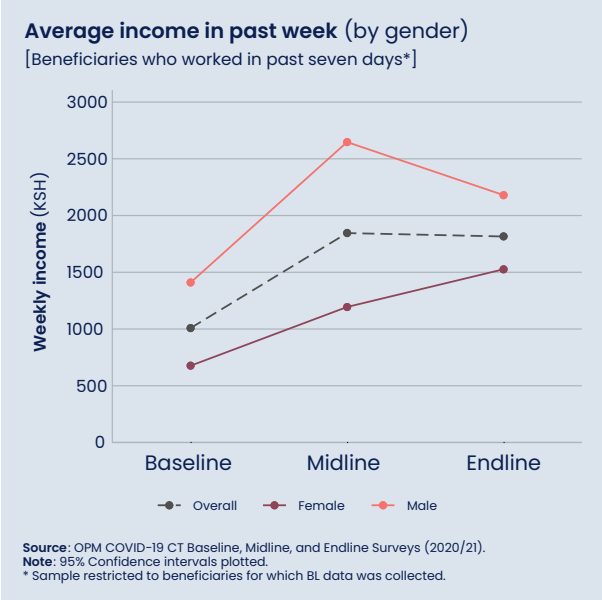


Figure 31: Average weekly income among individuals employed in the past week at baseline, midline, and endline, by gender



The qualitative research supported the quantitative finding that those employed in their own business or in casual work (i.e. employed 'independently') appeared to have a higher probability of being employed. The qualitative research asked respondents whether the CT had impacted their ability to find or engage in employment. Almost all respondents continued to look for or engaged in work while receiving support from GiveDirectly, with only one respondent reporting that they had stopped working since receiving the CT.

Most respondents were not able to link receiving the CT to their employment opportunities. However, when probed, it was more common for respondents to link the CT to improvements in their business. Respondents noted that they were able to use the money to either start a small business or to expand their business by purchasing stock, in order to increase their sales. One respondent recounted how she was able to restart her business, which had closed during the crisis when she could no longer afford rent. Although small businesses did not bring in large amounts of income, many respondents noted that this was an important source of daily income, which was important for food security (Section 5.3.3):

> 'Interviewer: *Can you say the way you started this business? Can you say it helped you get work?*
>
> Respondent: *It helps me a bit because it helps bring food to the table. Even if I don't add work a lot, we don't miss food like before.'*
>
> Female beneficiary, Nairobi

Moreover, a small number of respondents noted that the money had helped them with transport fares to get to or find casual work, while one female respondent noted that, because she was able to eat properly, she was better able to take on and perform casual work.

Box 11: Lessons on employment

- The COVID-19 CT appears to have had a positive effect on beneficiaries' employment levels.
- Quantitatively, when controlling for both time-invariant and time-variant beneficiary characteristics, receiving the COVID-19 CT appeared to increase the chances of undertaking an economic activity in the seven days prior to the survey by 10 percentage points on average.
- This is particularly true for beneficiaries employed 'independently', that is, those employed in their own business and/or casual work, who appear to have had a higher probability of being employed in the seven days prior to the survey.
- The increase in employment levels triggered an increase in the amount of weekly income obtained from employment by an average of KSH 745.
- Gender wise, the increase in employment levels and weekly employment-related income was slightly larger among female beneficiaries than among their male counterparts.
- The qualitative research found that beneficiaries struggled to link the CT to employment opportunities. However, for those that did, they had most commonly used the money to start or expand their own businesses. In a minority of cases, beneficiaries used the money to ease barriers to employment, such as transport fares to look for or go to work.

5.3.2 Other income sources

Overall, no significant changes were observed with respect to the income sources for the beneficiaries' households over time. At endline, when asked about their households' income sources over the past four weeks, most beneficiaries (71%) mentioned wage and casual employment, followed by income from business (42%), remittances from family/community within the country (18%), and property/investment-related income (14%).

These findings were highly consistent with those from midline, with just a few exceptions. First, the proportion of beneficiaries who reported obtaining business-related income significantly increased from 36% to 42% from midline to endline, a change mainly driven by beneficiaries in Nairobi. Similarly, income from property/investments went from 7% to 13%, also triggered by the experience of female beneficiaries in Nairobi. Finally, the proportion of beneficiaries obtaining income from the government decreased from 7% at midline to 1% at endline, a reduction which was consistent across locations and genders.

Box 12: Lessons on other income sources

- Overall, the COVID-19 CT seems to not have had any significant effect on other household income sources apart from employment.

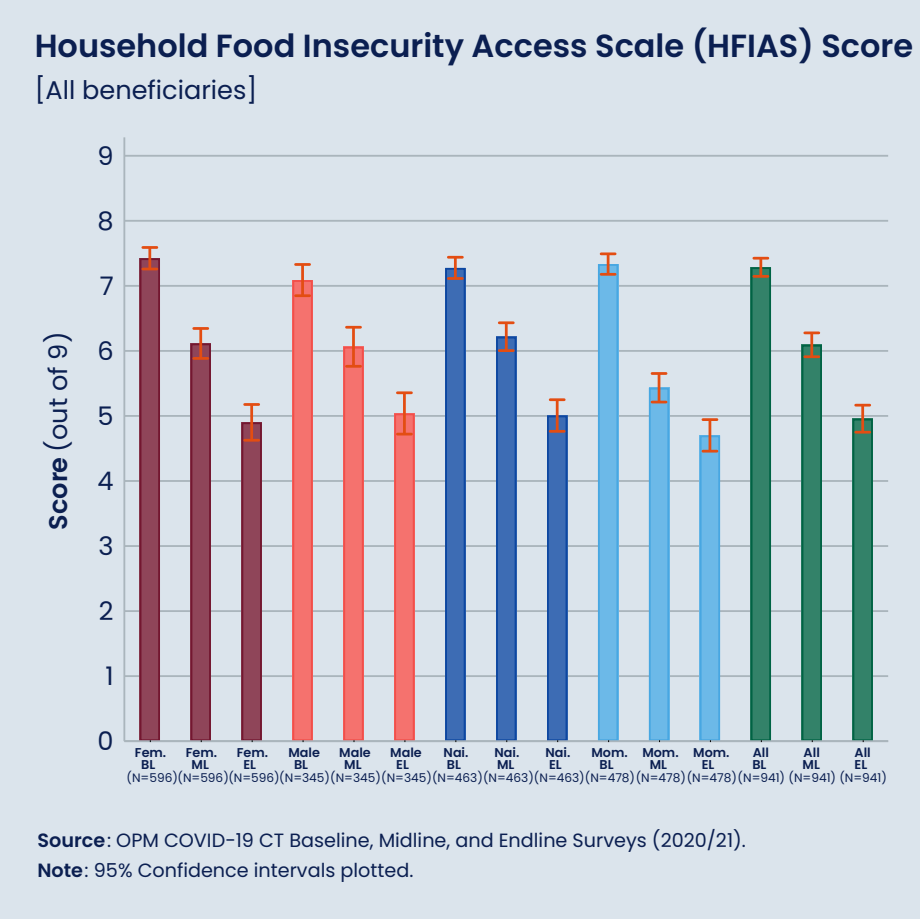
5.3.3 Food security

The average HFIAS score significantly decreased from 7.3 at baseline to 5 at endline, which represented an improvement in the food security condition of the survey respondents. This improvement seems to be more pronounced than the change reported by the World Bank's HFPS, which shows that during the week of 16 November 2020, 28% of adults reported having skipped a meal on the seven days prior to the survey, compared to 26% in the week of 15 February 2021. It is important to highlight again that estimates for both indicators are not directly comparable, but the relatively smaller drop of the latter seems to indicate that the COVID-19 CT had a positive effect on the food security condition of its beneficiaries.

This result was further confirmed by our regression analysis, which controlled for time-invariant characteristics, the beneficiary's sector of employment, the number of income sources in addition to employment of the beneficiary's household, and a proxy for vulnerability.[56] It is estimated that receiving the COVID-19 CT reduced the HFIAS score by 1.7 points on average.

Furthermore, by disaggregating this effect between midline and endline in our regression analysis, we were able to show a cumulative effect of the CT over time, with the food security improvements increasing between midline and endline: receiving the CT decreased the average HFIAS score by 1.4 points from baseline to midline and by 2.3 points from midline to endline.

Figure 32: Average HFIAS score at baseline, midline, and endline

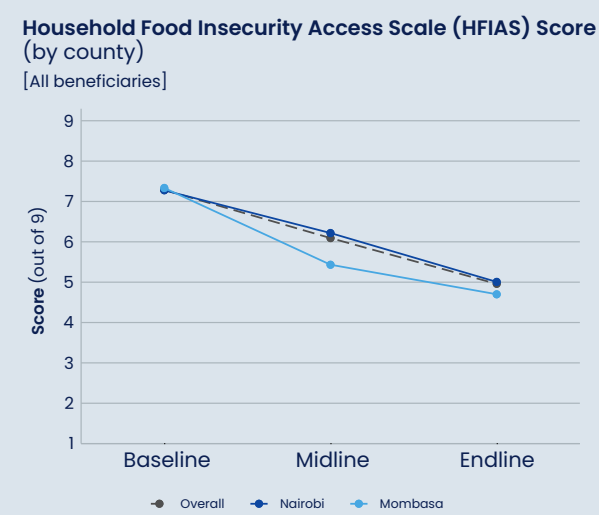


Source: OPM COVID-19 CT Baseline, Midline, and Endline Surveys (2020/21).
Note: 95% Confidence intervals plotted.

56 During the analysis phase, we used two different proxies for vulnerability status: receiving COVID-19 support from institutions other than GiveDirectly, as an indication of relatively more vulnerability; and household's access to water, as an indication of relatively less vulnerability. Regardless of the proxy used, regression results were always consistent. Nevertheless, we consider that the first proxy could be prone to endogeneity issues in some model specifications, and therefore decided only to report results using the latter variable.

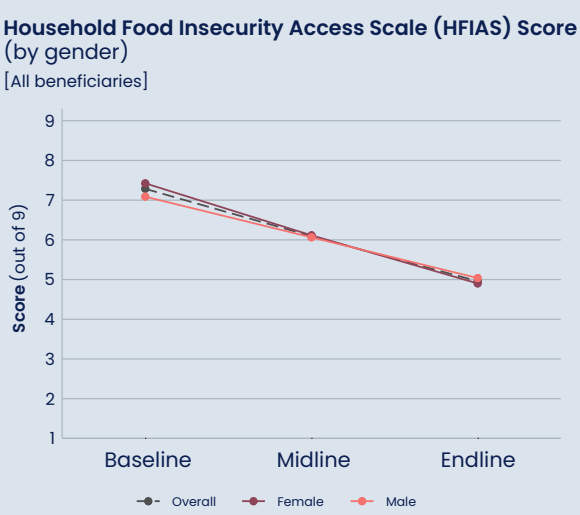
As shown in Figure 32, this reduction was consistent across counties and beneficiaries' gender, although the decrease was slightly larger in Mombasa and among female beneficiaries (see Figure 33 and Figure 34).

Figure 33: Average HFIAS score at baseline, midline, and endline, by county



Source: OPM COVID-19 CT Baseline, Midline, and Endline Surveys (2020/21)
Note: Total N: 941.

Figure 34: Average HFIAS score at baseline, midline, and endline, by gender

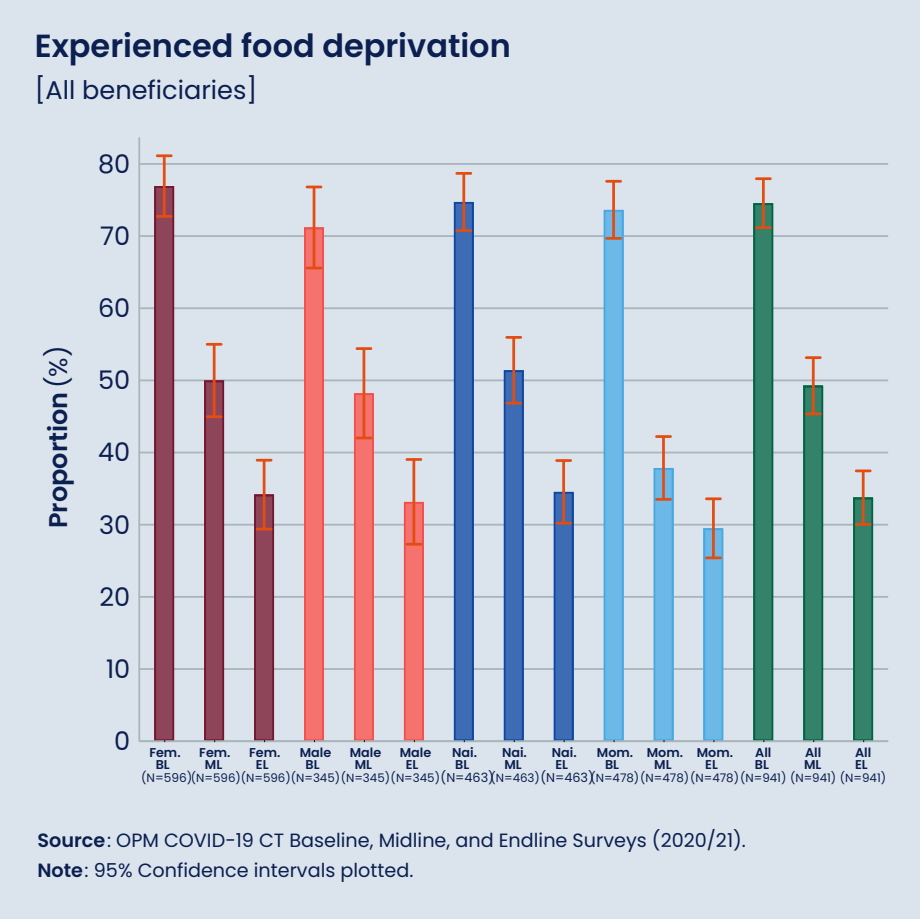


Source: OPM COVID-19 CT Baseline, Midline, and Endline Surveys (2020/21).
Note: Total N: 941.

Similar to the HFIAS score, the proportion of beneficiaries who reported experiencing some sort of food deprivation in the four weeks prior to the interview significantly decreased from 75% at baseline to 34% at endline. This result was further confirmed by our regression analysis, which used the same control variables as those used for estimating the impact on the HFIAS score. Regression results estimated that receiving the COVID-19 CT reduced the probability of experiencing some sort of food deprivation situation by 32% on average.

In this case, by disaggregating this effect between midline and endline in our regression analysis, we were also able to show a cumulative effect of the CT over time: receiving the CT decreased the probability of experiencing food deprivation by almost 40% at endline, compared to 25% at midline.

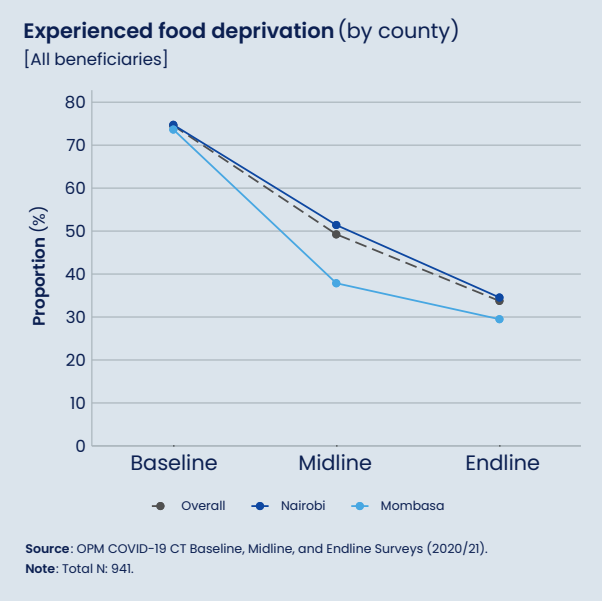
Figure 35: Proportion of beneficiaries who experienced food deprivation in the four weeks prior to the interview, at baseline, midline, and endline



Source: OPM COVID-19 CT Baseline, Midline, and Endline Surveys (2020/21).
Note: 95% Confidence intervals plotted.

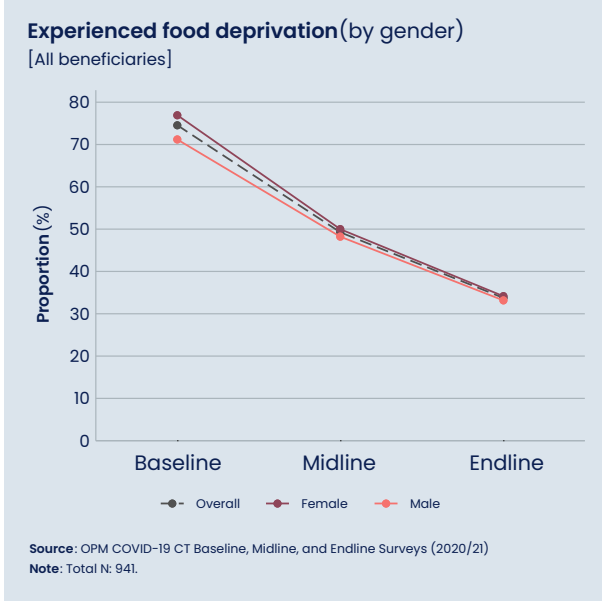
As shown in Figure 35, this reduction was consistent across counties and beneficiaries' gender Figure 32, and considerably larger in Mombasa and among female beneficiaries (see Figure 36 and Figure 37).

Figure 36: Proportion of beneficiaries who experienced food deprivation in the four weeks prior to the interview, by county



Source: OPM COVID-19 CT Baseline, Midline, and Endline Surveys (2020/21).
Note: Total N: 941.

Figure 37: Proportion of beneficiaries who experienced food deprivation in the four weeks prior to the interview, by gender



Source: OPM COVID-19 CT Baseline, Midline, and Endline Surveys (2020/21)
Note: Total N: 941.

The qualitative interviews corroborated the quantitative finding that food insecurity reduced as a result of receiving the CT, and also explained how the CT improved food security. Almost all respondents used all or part of the money to buy food for their households, with many stocking up in bulk on staple items such as flour and rice. Respondents noted that this meant they no longer had to worry about providing food to their households on a daily basis, which had become dependent on earning a daily income, and knew there was food at home. Respondents reported that they were able to buy food stocks lasting from 10 days to the whole month, depending on how large their family was and the proportion of the transfer that was spent on food. Most respondents also noted that they were able to eat more meals per day (two or three) and go back to drinking tea with milk. While the money was also used to increase the diversity of foods eaten, many respondents commented that they did not fully return to eating as diverse a diet as they had before the pandemic and did not fully reintroduce their preferred foods, such as meat, although in some cases respondents noted they had bought meat on an exceptional basis to enjoy with their households. This was likely because the CT was known to be time-bound and respondents explained they expected they would struggle to buy food again once the period of support was over.

A female beneficiary from Nairobi summarised the changes:

> *'No, there is no more eating githeri only. I changed from buying githeri, and [with] that money used for buying githeri we would instead buy 1 kilogramme of maize flour. And because there is paraffin, you prepare [it] for them and they eat. So that money changed things, even if it wasn't a million, but it changed how people were eating in my house. To say the truth, it changed the way people are eating completely. They were surprised to see that I am cooking kale with onions. They used to tell me, "Mum, you are cooking for us with onions, there is a very big change." Even if there was no meat, but they could see onion and tomatoes, so there was a lot of change. So, if you cannot be grateful, you never used to see even cooking oil for KSH 10, but you could now see cooking oil. And you are now seeing salad oil, tomatoes, and onions. There is some change.'*

Box 13: Lessons on food security

- Research findings showed that receiving the COVID-19 CT had a positive effect on households' food security.
- Quantitatively, when controlling for both time-invariant and time-variant beneficiary characteristics, it was estimated that receiving the COVID-19 CT reduced the HFIAS score by 1.7 points and the probability of experiencing some sort of food deprivation by 32% on average.
- Gender wise, the decrease in the HFIAS score and the probability of experiencing some sort of food deprivation was slightly larger among the group of female beneficiaries.
- Furthermore, by disaggregating this effect between midline and endline in our regression analysis, we were able to show a cumulative effect of the CT over time, with the food security improvements increasing between midline and endline.
- The qualitative research indicated that improved food security came through increasing dietary diversity, although not to pre-pandemic levels, and increasing the quantity of food eaten and number of meals eaten per day. Further, beneficiaries were able to buy food in bulk rather than on a daily basis.

5.3.4 Use of coping strategies

At endline, beneficiaries reported having used an average of three different coping strategies in the four weeks prior to the survey, compared to an average of five strategies reported at baseline. This significant decrease in the number of coping strategies was confirmed by our regression analysis, which controlled for time-invariant characteristics and whether the household received income from formal employment, informal employment, and/or business, with a proxy for vulnerability.[57] It is estimated that receiving the COVID-19 CT reduced the number of coping strategies used by the beneficiary's household by 1.3 on average.

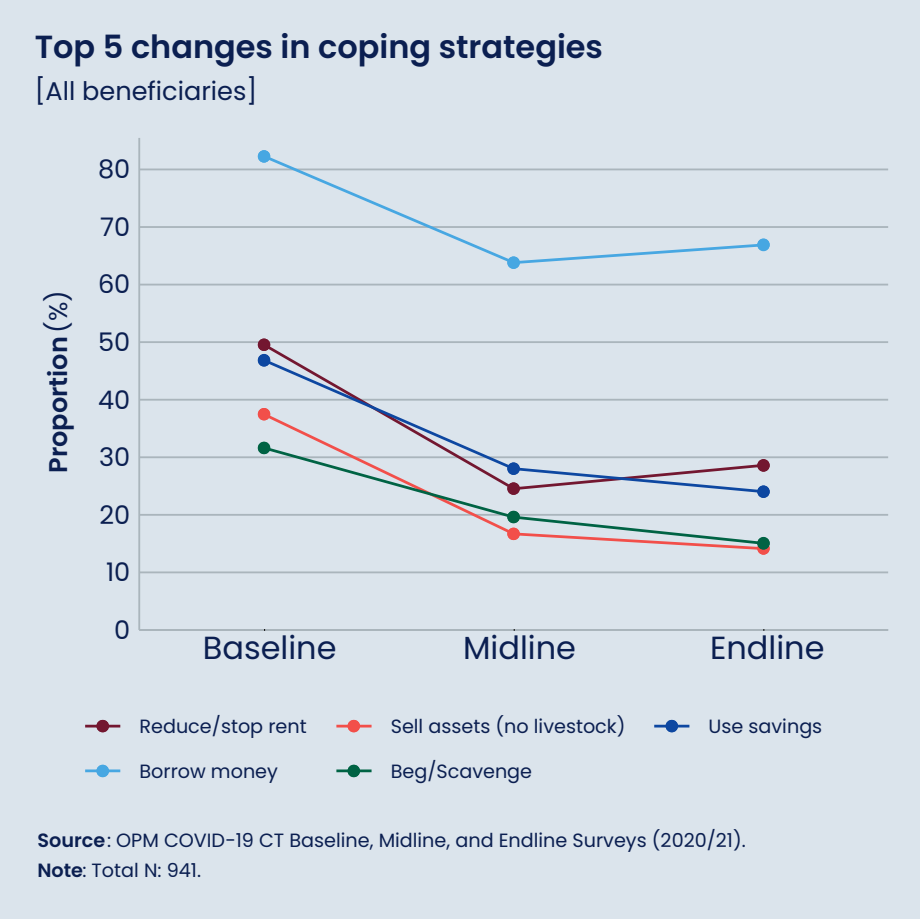
This decrease was significant and consistent across counties and beneficiaries' gender. Regardless of geography and gender, the most commonly reported coping strategy at endline was still borrowing money, which had been used by 67% of respondents. However, this was still significantly lower than at baseline, where 82% of respondents mentioned having made use of this strategy since the COVID-19 pandemic started. Indeed, regression analysis showed that receiving the COVID-19 CT reduced the probability of borrowing money by 20% on average.

The proportion of beneficiaries making use of the other coping strategies significantly decreased across most other categories as well, and such reductions were consistent across geographies and gender. The most acute changes were observed in the use of savings and the sale of assets other than livestock, where the proportion of beneficiaries dropped an average of 23 percentage points. This is probably explained by the fact that, having made use of these strategies before, the availability of savings and assets among beneficiaries was already diminished at endline. Similarly, the proportion of beneficiaries who reduced or stopped their rent payments dropped by an average of 20 percentage points, and 17 percentage points in the case of the practice of begging/scavenging.

57 As already explained in footnote 56, this refers to a household's access to water.

In all cases, regression analysis confirmed that, controlling for other factors, receiving the COVID-19 CT significantly decreased the probability of making use of such specific coping strategies. It is important to highlight that, when disaggregating this effect between midline and endline in our regression analysis, we were able to show that there was no cumulative effect of the CT over time. This can be seen in Figure 38, which shows that, for all top five coping strategies, the drop in the proportion of beneficiaries making use of each strategy was significant between baseline and midline, but became insignificant from midline to endline.

Figure 38: Top five coping strategies used by beneficiaries with the largest changes between baseline and endline



Source: OPM COVID-19 CT Baseline, Midline, and Endline Surveys (2020/21).
Note: Total N: 941.

The qualitative research also found that respondents were able to stop using some of the negative coping strategies they had been employing during the crisis. During the period of support from GiveDirectly, many respondents reported that they no longer had to ask (or beg) family or friends for money or support and did not need to buy food on credit. Most of the respondents also used the money to pay their rent arrears, either fully or in part, or to repay debt, including to shopkeepers where they had bought food on credit. This was motivated by a desire to remain creditworthy should they need to defer rent payments or make purchases on credit in future. Some respondents also reported they had not needed to sell any assets since receiving the CT.

5.3.5 After the COVID-19 CT

As part of the qualitative research at endline (i.e. in February 2021), respondents were asked about their perception of the future after the CT came to an end. About half the respondents painted a positive picture for 2021 in terms of the economic outlook and their employment/income prospects, with the remainder feeling the situation would remain the same and a few respondents feeling quite hopeless. In general, the improved outlook was linked to a belief that COVID-19 infections were reducing and that the economy was opening, which would mean better employment opportunities in the year ahead.[58]

Most respondents noted they would continue to engage in casual employment until better opportunities became available. To this end, one respondent noted they might move back to Mombasa from the rural area where they were living as the situation improved. For respondents who invested in business, there was an expectation that this investment would bring them a small, but relatively steady, income flow in the coming months, with a female respondent in Nairobi describing how her groundnut business served this purpose:

> *'The money from groundnuts, when a child falls sick—maybe it is on a Saturday or Sunday—I take the groundnuts money and buy paracetamol. If it is diarrhoea, I rush to the chemist and buy medicine. If I don't have anything to cook, oil, or something like tomatoes, onions, it is the money from groundnuts that I use. I realised that it was a wise thing that I did to put some money on groundnuts, as it regenerates that way. No matter how much I lack, I cannot be unable to afford tomatoes for KSH 10 just from the groundnuts money. That is how it is.'*

However, for others, the future seemed to offer limited options, with a few respondents noting that they were still unable to find work. One respondent noted he was planning to send his family to the village to earn money from farming. In another more extreme case, a respondent described her fear that she could not afford to pay for her trading licence for her business and would therefore have to resort to seeking casual work or, in the worst case, prostitution.

As part of the endline quantitative survey, respondents were asked about their plans for the following month. Respondents still expected to use an average of three coping strategies, the same number anticipated at baseline and reported at midline and endline. Regardless of location and gender, the most common plans were directly in line with the strategies reported at baseline: 75% of beneficiaries reported that adult members would aim to return to work, 56% expected to borrow money, 46% planned to work for something other than pay, and 35% planned to share costs with family members. The proportion of beneficiaries who were planning to stop or reduce their rent payments significantly decreased from 33% to 26% between baseline and endline, a change that was exclusively driven by the group of male beneficiaries.

58 The endline qualitative research took place prior to the 'third wave' of COVID-19 cases in Kenya and the introduction of additional containment measures on 26 March 2021, which affected Nairobi and four surrounding counties.

Box 14: Lessons on the use of coping strategies

- Our quantitative approach showed that receiving the COVID-19 CT reduced the number of coping strategies used by the beneficiary's household by 1.3 on average.
- When we analysed each coping strategy independently, regression analysis confirmed that, controlling for other factors, receiving the COVID-19 CT significantly decreased the probability of making use of a specific coping strategy.
- These findings were consistent across genders.
- The qualitative research also found that beneficiaries reduced their use of negative coping strategies, including borrowing money/begging and selling assets. Respondents were also found to use the money for positive coping strategies, including investing in small businesses to diversify their income.

06 CHAPTER

Conclusions and implications for policy

Community members participate in COVID-19 Prevention in Mathare, Nairobi.
Photo: ©UN-Habitat/Kirsten Milhahn

6.1 Conclusions

In this chapter, we summarise some of the key findings that have emerged from this study, including from the impact evaluation and the process review. The conclusions are organised along the DAC criteria that led the development of the study research questions at the evaluation design stage.

6.1.1 Relevance

The COVID-19 CT was relevant for the target population of individuals living in informal urban settlements in Nairobi and Mombasa. Our quantitative and qualitative findings show that the COVID-19 pandemic had a noticeable negative impact on individuals' employment and income sources, as well as on their food security and use of coping strategies to deal with the economic downturn. The amount and timing of the COVID-19 CT were also appropriate (as we discuss in more detail below in the conclusions concerning efficiency), although the delay to the COVID-19 CT implementation may have weakened some of its effectiveness. For example, almost all beneficiaries had used negative coping strategies to deal with the impacts of the pandemic in the period between March and October 2020. Therefore, the COVID-19 CT was unable to prevent beneficiaries from using negative coping strategies altogether, but rather reduced the extent to which this was needed during the period of support.

CT beneficiaries reported that their employment had become less secure due to the COVID-19 pandemic. Individuals engaged in casual work reported that it had become harder to find casual jobs, with the scarcity of jobs meaning that people were only able to find work once or twice a week and had to take casual jobs that they would not normally accept. Quantitative data indicate that less than two-thirds of beneficiaries were still working in the same job in November 2020 (at the time of our baseline survey) as they had before the COVID-19 pandemic. Most of them (86%) said their employment-related income had reduced since the start of the pandemic. While the lost amount of employment-related income was highly similar in Nairobi and Mombasa, we detected some gender differences, as men's income reduction was significantly larger than women's (an average weekly loss of KSH 2,179, compared to KSH 1,211 in the case of women).

The food security of the CT beneficiaries was severely affected by COVID-19, as reduced income and employment affected both the quantity and quality of food they bought. Prior to the pandemic, respondents described buying food in bulk and having food stocks at home; while at baseline, they were only able to buy food when they earned money. This resulted in households buying lower-quality food more frequently and in smaller quantities. The quantitative measure of food security developed as part of this study, a simplified version of HFIAS, calculated an average HFIAS score among CT beneficiaries of 7.3 at baseline, which suggests considerable insecurity in terms of access to food before the start of the COVID-19 CT. Further, at baseline, three-quarters of beneficiaries reported having experienced at least one food deprivation situation in the four weeks prior to the survey

Coping strategies, including negative strategies, were widely used by CT beneficiaries to deal with the economic effects of the COVID-19 pandemic, especially due to the reduced income and employment opportunities. Qualitative and quantitative findings both highlighted that borrowing money, especially from family and friends, was the most common coping strategy adopted. However, some respondents perceived that they had limited

access to coping strategies that offered them credit further into the pandemic. As family and friends also felt the economic impacts of the crisis, respondents could not continue to borrow as easily from others. Other common coping strategies were reducing or stopping to pay rent, using savings, and sharing costs with other family members. There were significant differences across geographies and gender: for instance, beneficiaries were more likely to borrow money in Mombasa than in Nairobi, while more female beneficiaries decided to start or return to work for remuneration other than pay and/or beg or scavenge compared to male beneficiaries.

6.1.2 Efficiency

The remote targeting approach used for the CT based on existing lists of individuals compiled by NGOs was appropriate in the context of the COVID-19 crisis, given the need to achieve rapid and remote enrolment of beneficiaries, but faced several challenges. However, the lack of clear targeting criteria and only loosely focusing on vulnerable groups in urban informal settlements was an issue, as it led to some confusion among partners. Another crucial issue was the low quality of the data provided to GiveDirectly by partner NGOs. This led to high levels of rejection, mainly because of mismatches between the names provided and M-PESA records. These issues negatively affected the equity of the targeting, as the same vulnerable groups were either included or excluded depending on the local partner NGO used in a particular area.[59] It is reasonable to argue that the emergency nature of this COVID-19 CT intervention prevented, to a great extent, the adoption of a more equitable targeting approach. Simpler, clearer, and more transparent targeting criteria that were better aligned to the populations most in need could have been developed and implemented using a combination of geographic and categorical criteria. However, this more principle-based or poverty-based targeting approach would only have been feasible with a more extensive data collection exercise. The latter would have slowed down the process or required smart targeting tools that were not feasible within Kenya's data protection laws or according to current agreements between GoK and mobile providers. Overall, therefore, the approach to targeting was efficient, allowing scale while keeping costs low.

The transfer amount of KSH 4,000 was in line with other COVID-19 responses and can be considered appropriate as an individual entitlement. However, it has generally been used to contribute to a household's needs rather than covering only the needs of an individual. For this reason, only around half of partner NGOs felt the amount was entirely adequate. The choice of cash rather than in-kind transfers, for instance, was considered the right form of support, as it allowed choice in spending to meet differing needs and provided knock-on benefits as a stimulus to local markets.

The timing of the transfer was delayed but still relevant in the context of the COVID-19 pandemic, especially as it coincided with a second spike in infections in Nairobi and Mombasa. The three-month duration is in line with global and national norms for COVID-19 CTs. Although receiving the support earlier (during the first phase of the COVID-19 crisis) might have prevented the adoption of some more detrimental coping strategies, the CT was delivered at a time when other support mechanisms had been exhausted and therefore played an important role. However, it is worth highlighting that a shorter delay in implementation—starting the disbursement of the COVID-19 CT a few months after the onset

59 GiveDirectly partnered with several NGOs in each informal settlement. Therefore, if an individual was dropped from one list, they may have been included on another list if they had engaged with another partner prior to this programme.

of the crisis, but still considerably sooner than October 2020—could have achieved even better outcomes. Receiving the money earlier, when some economic activities had already restarted, would not only have avoided some of the more detrimental coping strategies, but it may also have improved resilience among the whole target population. The COVID-19 CT could have enabled earlier diversification of income among beneficiaries, thereby preventing them from drawing down on assets and support networks to such an extreme extent, while simultaneously having positive multiplier effects on the local economy, which would further increase resilience.

6.1.3 Effectiveness

The effectiveness of the targeting approach was mixed. While it was able to reach residents of urban informal settlements, who are arguably some of the poorest urban residents and most affected by the economic impacts of COVID-19, as discussed above the targeting approach was not sophisticated enough to ensure reaching the most vulnerable within these locations. Although there is evidence that the NGOs' lists included beneficiaries from vulnerable categories such as orphans, PWD, widows, and caregivers, some partner NGOs were frustrated by the lack of opportunities to collect new data, believing their beneficiary lists did not necessarily fully include those most in need of assistance.

The payment mechanism based on mobile money transfers was effective in delivering cash relatively easily, cheaply, quickly, and directly to those in need, while minimising opportunities for corruption. This finding is in line with evidence emerging from similar COVID-19 responses using mobile payments. The coverage of mobile money provider Safaricom in urban areas is high, and both beneficiaries and partner NGOs had high levels of satisfaction using M-PESA. However, partner NGO datasets were found to be of low quality, which was an issue, as not all information was sufficiently accurate or comprehensive to identify individuals' ID numbers and M-PESA registrations when cross-checked against Safaricom's database. GiveDirectly's data show that 80% of instances of ineligibility were due to a mismatch between beneficiary lists and the names registered with M-PESA. This also points to limitations relating to the sole use of M-PESA, key among which is the potential exclusion of the most vulnerable.

The communication and CRM processes established by GiveDirectly were broadly effective. Both partner NGOs and beneficiaries were aware of, and using, the CRM system, which seemed to be functioning well, as well as leading to the timely resolution of most issues raised. The communication from GiveDirectly, mainly through SMS, was also generally reported to be clear and direct, and was appreciated by those successfully enrolled.

GiveDirectly set up different internal monitoring processes and metrics for different stages of the project that can be considered effective. The different stages included enrolment, post-payment follow-ups, and internal audit case management. Monitoring data were collected directly by GiveDirectly (but not by partner NGOs), mostly through SMS and call surveys. GiveDirectly submitted monthly progress reports to FCDO based on all monitoring data collected, which provided regular and useful updates on implementation. GiveDirectly also had regular bilateral calls with partner NGOs.

6.1.4 Coherence

Coordination mechanisms were pursued by GiveDirectly as part of the COVID-19 CT with both NGOs and government stakeholders providing COVID-19-related cash. In particular, GiveDirectly participated in KCWG, which is a mechanism for coordinating with other cash stakeholders, and proactively shared information on its CT implementation with the COVID-19 Secretariat, the unit established within the President's Special Delivery Unit to coordinate the COVID-19 response. GiveDirectly also shared information with the EU consortium and WFP, which are also running large COVID-19 cash programmes.

Coordination on specific aspects of the CT implementation remains weak due to lack of clear government direction and access to Single Registry data, however, and there is no requirement to comply with agreed good practices. For instance, coordination on targeting lacks clear government direction and only relies on the goodwill of individual agencies. Similarly, it is not easy for NGOs to access data in the Single Registry, which leads to frustration and duplication. Each separate COVID-19 response intervention established its own CRM, with no clear mechanisms to ensure coordination between them.

6.1.5 Impact

The COVID-19 CT had a discernible impact on the two key outcome indicators of interest: food security and the use of coping strategies. The CT beneficiaries used most of the money received to improve their own food security situation and that of their household, while also reducing the number of coping strategies employed to deal with the effects of the COVID-19 pandemic. The beneficiaries' employment status and related income sources also improved, and some of these improvements appear to be associated with the CT.

The employment opportunities of CT beneficiaries increased over the course of the study timeframe from baseline to endline, which in turn led to an increase in the amount of weekly income obtained from employment. Although these employment trends may partially be due to changes in COVID-19-related restrictions over time, CT beneficiaries did link the CT to improvements in their business. Some respondents noted that they were able to use the money to start a small business, expand their business by purchasing stock, or pay for transport to go to or look for work. This seems to be confirmed by our quantitative findings, which showed that receiving the COVID-19 CT increases the chances of undertaking an economic activity, especially for CT beneficiaries employed in their own business and/or in casual work.

The effect of the CT on food security levels was clear, with our quantitative analysis estimating that, when controlling for both time-invariant and time-variant beneficiary characteristics, receiving the COVID-19 CT appeared to reduce the HFIAS score by 1.7 points and the probability of experiencing severe food deprivation by 32% on average. The quantitative analysis was also able to show a cumulative effect of the CT over time, with the food security improvements increasing between midline and endline. Our qualitative interviews corroborated the quantitative finding that food insecurity had reduced as a result of receiving the CT. Almost all respondents used all or part of the money to buy food, with many stocking up on staple items such as flour and rice, which meant they no longer had to worry about providing food to their families on a daily basis.

The use of coping strategies decreased significantly from baseline to endline, from an average of five strategies reported at baseline to an average of three coping strategies reported at endline. This decrease was significant and consistent across counties and gender, and while the most commonly reported coping strategy at endline was still borrowing money, this was only used by 67% of CT beneficiaries, compared to 82% of beneficiaries borrowing at baseline. The qualitative research also found that respondents were able to stop using some of the coping strategies they had employed during the crisis. Many respondents noted they no longer had to ask family or friends for money or support, and did not need to buy food on credit.

6.2 Implications for policy

A number of policy implications follow these conclusions, which can be useful for all stakeholders involved in the COVID-19 CT (FCDO, GiveDirectly, and their partner or other NGOs). Beyond these direct stakeholders, some of the recommendations presented here are relevant for the social protection sector as a whole and, as such, are directed at GoK to improve the design and implementation of shock-responsive CTs within the context of Kenya's social protection system. While GoK may not be considered a direct stakeholder as it was not directly involved in the COVID-19 CT, FCDO could use the evidence and recommendations presented in this report as part of their ongoing social protection work with GoK, and to advocate for some lessons to feed into GoK's programming.

The use of an emergency CT is an appropriate tool to deal with the most severe consequences of large, sudden, and long-lasting shocks such as the COVID-19 pandemic. The COVID-19 CT beneficiaries greatly benefited from the reception of the CT and used most or all the money they received to meet immediate food consumption needs and stop using negative coping strategies. It is thus advisable to continue employing this type of unconditional CT in similar contexts of crisis, especially when more structural systems and mechanisms for the development, implementation, and coordination of shock response interventions are not in place (or are not fully operational).

However, effective use of social protection to respond to shocks requires ex ante preparation in order to facilitate swift and efficient action at the onset of a crisis. Government guidance and strategy is required for responses to different kinds of shock, with institutional mechanisms for strategic collaboration across sectors (specifying roles and responsibilities, etc.) established in advance (O'Brien *et al.*, 2018).

In relation to cash programming specifically, such guidance should stipulate the relevant target populations and the methods to identify them (e.g. using existing available datasets), appropriate transfer values and durations (or methods for establishing and agreeing those), payment modalities, use of existing delivery systems (management information systems, G&CM, etc.), and M&E frameworks.

In relation to identifying the appropriate target populations, criteria ought to be transparent and implemented equitably, with all those qualifying under the criteria included in the programme. This means qualifying populations should be treated equally, no matter where they are located or who the implementing partner is. Target populations should be as closely aligned as possible with the populations most affected by the shock in question.

Regarding setting transfer values, the experience of the COVID-19 CT suggests that, while

individuals were targeted for the CT, they often used the money received to meet the needs of the whole household. If interventions aim to support household needs, the amount provided to individual beneficiaries (e.g. through mobile money platforms, which necessarily target individuals) should be calibrated accordingly. In order to mitigate the risk of 'double dipping' (multiple individuals from the same household receiving the benefit), mobile and/or other data (e.g. GPS data, Single Registry data, or NGO lists) could be used for verification.

Agreements with key stakeholders in the delivery chain should be secured in advance. These include agreements between data owners on protocols for sharing data for verification and coordination of targeting. The experience of the COVID-19 CT indicates that mobile providers are one such key stakeholder with whom advance agreement with GoK on the use and sharing of mobile data will be required (e.g. with customer consent and in accordance with GDPR legislation). Additional agreements on exemptions for automatic debt repayment (e.g. FULIZA) may also be necessary.

Non-government actors need support and coordination from the government. In the case of cash programming, KCWG provides a platform that GoK could leverage to organise and provide support and coordination for non-government actors. Further, the SPS's mandate to coordinate social protection needs to be recognised and understood by intergovernmental departments and the SPS needs to have sufficient institutional capacity to act on this. The SPS also needs to play an active role in coordination fora (including the KCWG) to input into decision-making and facilitate coordination.

The experience of the COVID-19 CT has shown that one key area where support is needed is improving data quality in terms of currency, relevance, completeness, and accuracy.[60] The government should provide support to NGOs delivering emergency cash programming to help build their capacity to gather and maintain high-quality data, as well as link it to the Single Registry (or ESR). Crucially, data collection also needs to include processes to obtain full informed consent from respondents, to support data sharing and coordinating the response. However, there is a risk that excluding people from support on the basis of not consenting to data sharing may result in exclusion of the most vulnerable people. Therefore, NGOs need to ensure that only crucial data is collected and shared (i.e. data is proportional to the goal), that consent procedures are fully transparent in explaining the purposes of data collection, and that procedures for accountability are established. This will also apply to the GoK's data collection efforts as part of implementing the ESR.

NGO datasets could be linked to the Single Registry (or ESR) via the existing 'complementary module'. However, for this to be possible, the Single Registry complementary module, and the Single Registry itself, has to be properly functioning. Experience of the COVID-19 CT (and other experience)[61] shows this is not currently the case. Developing and investing in processes and procedures that allow swift access to data housed in the Single Registry (and soon, the ESR) will be important to ensure that the database is used in times of shock.

NGOs could also be encouraged to use the HTT, or as far as possible to align their own

60 'Completeness' refers to the number of records stored in a social assistance registry compared to what would be perceived to be a full set of records. 'Relevance' refers to whether the data contain the variables required for the intended purpose including targeting (demographic and socio-economic indicators) and delivery (contact and payment details). 'Currency' refers to the degree to which the data are sufficiently up-to-date. 'Accuracy' refers to the degree to which data are free from errors and omissions. See Barca and Beazley (2019)

61 See Doyle and Ikutwa (2021) and Gardner *et al*. (2017).

registration tools with the HTT to enable compatibility of datasets within the Single Registry. Training on the use of the HTT could be provided alongside and/or as part of other support delivered to NGOs through KCWG (or another appropriate forum).

Furthermore, the quality of existing data underpinning the Single Registry itself requires improving if it is to be of optimal use in coordinating and facilitating responses to shocks across the social protection sector. This will require building capacity to gather and maintain high-quality data in the Single Registry and its underpinning datasets by the relevant contributing government agencies.

Government should build its capacity to utilise mobile technology. The COVID-19 CT has demonstrated the value and efficiency of mobile technology, for example SMS platforms, as a core element across the CT delivery systems chain, from registration and enrolment to payments, G&CM, communications, and M&E. Another principle of effective shock-responsive social protection is the strengthening of routine social protection systems (O'Brien *et al*., 2018). Capacity to use this technology should thus be embedded in the delivery chains of Kenya's routine social protection programming such that it can easily be deployed in the context of shocks, with additional actors able to piggy-back on a functional existing system.

M-PESA has provided an efficient and effective payments system. Including mobile money providers as a payment service provider option offered to routine social protection beneficiaries has the potential to vastly improve the quality of the Single Registry data (especially in terms of currency and accuracy). Developing the existing routine social protection payments system to include mobile money service providers would also build government capacity to manage contracts with these providers, as well as providing a useful model for contractual arrangements between emergency response actors and mobile money service providers in the event of a shock.

While acknowledging the advantages of mobile money services in delivering both routine and emergency social protection programming, it is important to recognise that they may exclude an especially vulnerable portion of any target population—those who lack the formal documentation (such as national ID) required for M-PESA registration, or those without a mobile phone registered in their own name. Furthermore, reliance on a single mobile provider (e.g. Safaricom) can lead to the exclusion of potential beneficiaries who may use different providers. The use of mobile money transfers in the future (either for shock response or routine social protection) should therefore take these risks into account. This implies the need for strategies to support registration to mobile payment mechanisms of especially vulnerable groups (e.g. working with mobile providers), while partnering with multiple mobile providers if possible. At the same time, alternative payment modalities will still be required to serve those who cannot or choose not to use mobile money as a payment option. Further research is required to better understand who is excluded from mobile money services and how best to support their inclusion.

6.2.1 Recommendations

- **Determine a single government institutional mechanism to coordinate shock-responsive social protection**, including both social protection and humanitarian actors.
- **Develop guidance detailing response options for different kinds of shock**: guidance for cash programming to cover identification of target populations, transfer values and durations (and methods for establishing and agreeing them), payment modalities, use of existing delivery systems, and M&E frameworks.
- **Negotiate agreements with mobile money service providers on the use and sharing of data in the event of shocks**, including exemptions for automatic debt repayments.
- **Explore options for building government capacity to utilise mobile technology in routine social protection delivery systems.**
- **Support NGOs to improve data quality and utilise the HTT through KCWG.**
- **Explore options for including mobile money providers in routine social protection payment services.**
- **Conduct research to better understand who is excluded from mobile money services and how best to support their inclusion.**
- **Develop functional protocols and processes to improve the quality and accessibility of the Single Registry.**

References

Barca, V. and Beazley, R. (2019). 'Building on government systems for shock preparedness and response: the role of social assistance data and information systems'. Canberra: Commonwealth of Australia, Department of Foreign Affairs and Trade. Available at https://www.dfat.gov.au/sites/default/files/building-government-systems-for-shock-preparedness-and-response.pdf

Doyle, A. and Ikutwa, N. (2021) 'Towards Shock-Responsive Social Protection: Lessons from the COVID-19 Response in Kenya', Oxford Policy Management, Oxford. Available at https://maintainsprogramme.org/wp-content/uploads/Maintains-COVID-19-SRSP-responses-Kenya-case-study-final.pdf.

Furbush, A., Josephson, A., Kilic, T., and Michler, J.D. (2021) 'The Evolving Socioeconomic Impacts of COVID-19 in Four African Countries', *Policy Research Working Paper 9556,* World Bank Group, Washington DC. Available at https://openknowledge.worldbank.org/handle/10986/35205.

Gardner, C., Riungu, C., O'Brien, C., and Merttens, F (2017) 'Evaluation of the Kenya Hunger Safety Net Programme Phase 2: The Legacy of HSNP Phase 2: Systems, Practices and Lessons Learned', Oxford Policy Management, Oxford. Available at www.opml.co.uk/files/Publications/a0013-evaluation-kenya-hunger-safety-net-programme/hsnp-legacy-systems-practices-lessons-learned.pdf?noredirect=1.

Gardner C., Doyle, A., Farhat, M., Brockerhoff, S., Merttens, F., and Ikutwa, N (2020) 'Maintains Research Study 1: Opportunities of, and Obstacles to, the Utilisation of the Enhanced Single Registry', Oxford Policy Management, Oxford. Available at https://maintainsprogramme.org/wp-content/uploads/Maintains-Kenya-Study-on-the-Opportunities-of-and-Obstacles-to-the-Utilisation-of-the-ESR.pdf.

Gentilini, U., Almenfi, M., and Orton, I. (2020) 'Social Protection and Jobs Responses to COVID-19: A Real-Time Review of Country Measures', World Bank, Washington DC. Available at: www.socialprotection.org/discover/publications/social-protection-and-jobs-responses-COVID-19-real-time-review-country.

GiveDirectly (2020) 'Process for NGO and CBO List Partner Vetting for COVID-19', amended 03 June.

KNBS (2019) 'Economic Survey 2019 Highlights', GoK, Nairobi. Available at www.knbs.or.ke/?wpdmpro=economic-survey-2019-highlights.

KNBS (2020) '2019 Kenya Population and Housing Census Volume IV: Distribution of Population by Socio-Economic Characteristics', GoK, Nairobi. Available at https://www.knbs.or.ke/?wpdmpro=2019-kenya-population-and-housing-census-volume-iv-distribution-of-population-by-socio-economic-characteristics.

O'Brien, C., Scott, Z., Smith, G., Barca V., Kardan, A., Holmes, R., Watson, C. and Congrave, J. (2018) 'Shock-Responsive Social Protection Systems research: Synthesis report'. Oxford Policy Management, Oxford, UK. Available at https://www.opml.co.uk/files/Publications/a0408-shock-responsive-social-protection-systems/srsp-synthesis-report.pdf?noredirect=1.

Oxfam (2020) 'COVID-19 and Vulnerable, Hardworking Kenyans. Why It's Time for a Strong Social Protection Plan', Oxfam, United Kingdom. Available at https://oxfamilibrary.openrepository.com/bitstream/handle/10546/621095/bp-kenyasocial-protection-101120- en.pdf;jsessionid=DCD4993989B538E0E349BD1E2F728D79?sequence=1.

Statista (2020) 'Customers of M-Pesa from 2017 to 2020', Available at https://www.statista.com/statistics/1139190/m-pesa-customer-numbers/.

World Bank (2020) 'Kenya Economic Update, November 2020', World Bank, Washington DC. Available at http://documents1.worldbank.org/curated/en/957121606226133134/pdf/Kenya-Economic-Update-Navigating-the-Pandemic.pdf.

World Bank (2021) 'A game changer for social protection? Six reflections on COVID-19 and the future of cash transfers', Available at https://blogs.worldbank.org/developmenttalk/game-changer-social-protection-six-reflections-covid-19-and-future-cash-transfers.

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