

**THE POTENTIAL OF CASH TRANSFERS TO STRENGTHEN THE CAPACITY
OF HIV AFFECTED FISHING FAMILIES TO TAKE CARE OF ORPHANS AND
VULNERABLE CHILDREN IN BUDALANGI DISTRICT, BUSIA COUNTY**

BY

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OCTOBER 2015

DECLARATION

I declare that this thesis is my original work and has not been submitted to any university or institution for any award

Sign.....

Date.....

Beryl Adhiambo Oyier

I certify that this thesis has been submitted by my approval as the university supervisor

Sign.....

Date.....

Prof. W. Onyango-Ouma

DEDICATION

I dedicate this work to my daughter Imora Simone, that you may always seek knowledge to the highest degree.

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ABSTRACT

This study investigated the potential of cash transfers to strengthen the capacity of HIV affected fishing families to take care of orphans and vulnerable children in Budalangi District, Busia County. The study examined fishing as a means of livelihood for families affected by HIV/AIDS, the indirect effect of cash transfers on fishing as a means of livelihood for families affected by HIV/AIDS and the use and effect of cash transfers on the lives of OVC and their families. The study sample included beneficiaries of OVC- CT, non- beneficiaries of OVC- CT, OVC, implementers and knowledgeable stakeholders in the issues of OVC- CT.

The study used exploratory ethnographic design and resilience theory to explain the relationships between variables. The data collection methods included in- depth interviews, focus group discussions, key informant interviews and structured observations. Qualitative data was presented descriptively according to the emerging themes using illustrations from the transcripts. Descriptive analysis, including frequencies, percentages and tables were used to describe the basic demographic characteristics of the sample population.

The findings indicate the potential of OVC-CT to strengthen the capacity of HIV affected fishing families to take care of orphans and vulnerable children in Budalangi. The dynamics of fishing as a means of livelihood in Budalangi in the era of HIV/AIDS, presents a lot of vulnerabilities for orphans in the region. OVC-CT offers an alternative source of

income for the OVC beneficiaries and shields them from vulnerabilities such as paid labour and transactional sex.

The study also found that OVC-CT also had indirect effects on fishing families affected by HIV/AIDS. Beneficiaries for instance have used the funds to buy fishing equipment and also as capital for fish trade. This has in turn improved household income, led to better living conditions and enabled households to bounce back to normal functioning.

The uses and effects of OVC-CT among fishing families affected by HIV/AIDS also demonstrates the potential of OVC-CT in strengthening the capacity of HIV affected fishing families. The study recorded the uses of OVC-CT in taking care of basic needs and the effects both positive and negative within the family and community setting.

It is concluded that OVC-CT has the potential of strengthening the capacity of HIV affected fishing families to take care of orphans and vulnerable children in Budalangi District, Busia County. OVC-CT has exposed beneficiaries to regular and consistent income. The orphans in HIV affected fishing families are now able to access education, health care and improved quality of life through access of basic necessities. The findings also show that OVC-CT has helped to reduce instances of paid labour and transactional sex for the beneficiaries.

Overall, OVC-CT has enabled HIV affected fishing families in Budalangi to rebuild their means of livelihood through investment in fishing livelihoods and enabling the fishing families affected by HIV to be resilient and bounce back to normal functioning.

LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AMPATH	Academic Model Providing Access to Health Care
ART	Anti-Retroviral Treatment
ARVs	Anti-Retroviral Drugs
BMU	Beach Management Unit
BWCs	Beneficiary Welfare Committee
CBS	Central Bureau of Statistics
CCTs	Conditional Cash Transfers
CHW	Community Health Worker
CSG	Child Support Grant
CT	Cash Transfer
OVC-CT	Cash Transfer for Orphans and Vulnerable Children
DAC	Development Assistance Committee
DCO	District Children's Officer
DCS	Department of Children Service
DFID	Department for International Development
EPRI	Economic Policy Research Institute (South Africa)
FGDs	Focus Group Discussions
HIV	Human Immunodeficiency Virus
ICRC	International Red Cross and Red Crescent Movement

IDIs	In-depth Interviews
IDS	Institute of Development Studies
IMF	International Monetary Fund
IOIE	Initial Operation and Impact Evaluation
KDHS	Kenya Demographic Health Survey
KAIS	Kenya Aids Indicator Survey
KIIs	Key Informant Interviews
LICs	Low Income Countries
MICs	Middle Income Countries
NACC	National AIDS Control Council
NCST	National Council for Science and Technology
NGOs	Non Governmental Organizations
ODI	Overseas Development Institute
OVC	Orphaned and Vulnerable Children
SCF	Save the Children's Fund
SIDA	Swedish International Development Cooperation
SSA	Sub Saharan Africa
UCTs	Unconditional Cash Transfers
UNAIDS	United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
VCO	Volunteer Children Officers
WHO	World Health Organization

CHAPTER ONE

BACKGROUND TO THE STUDY

1.1 INTRODUCTION

The international trend towards investing in social protection in poor countries has reached Sub-Saharan Africa, taking on a new urgency as HIV/ AIDS interacts with other drivers of poverty to simultaneously destabilize livelihoods systems, family and community safety nets. A new focus on the vulnerability of families and threats to the human capital of children with lifelong and intergenerational consequences has accelerated international, regional and national commitments to social protection programmes in heavily AIDS affected countries.

Social protection in the form of cash transfers which provides support for food purchases, transportation, education, health care, and other expenses is receiving increasing recognition as an important part of a comprehensive AIDS response. The urgency of cash assistance for food purchases is underscored by emerging evidence on the effect of good nutrition to slowing the progression of AIDS, and to the effectiveness of antiretroviral therapy, with consequences not only for people living with HIV but also their children, broader families, and communities (Apata *et al.*, 2010).

Cash transfer is rapidly gaining popularity as an effective intervention to enhance the participation of the poor in economic development, and to combat inequality, social exclusion and chronic poverty. Advocacy for cash transfer programs is driven by the fact that AIDS is the number one cause of prime-age mortality in sub-Saharan Africa (SSA) and the region

hosts approximately 25-30 million orphans, one third of whom have lost a parent to the disease. AIDS related prime-age adult mortality has seen life expectancy rates decline dramatically in the region and has severely weakened family support systems already stretched thin by extreme chronic poverty. In this context, CTs are increasingly being called for as an AIDS mitigation measure to help families cope with increasing dependency ratios and the associated burden of care and to protect the health and human capital development of orphans and other vulnerable children (OVC) (UNICEF AND UNAIDS 2004).

In Kenya, as in other countries of sub-Saharan Africa heavily burdened by HIV/ AIDS, orphans and vulnerable children (OVC) face poverty and despair (Bryant, 2009). The epidemic has increased the number of orphans in the country and also the vulnerability of affected households both through the loss of productive adults and through the impact of chronic illness. In response the Department of Children's Services (DCS) in the Ministry of Gender, Children and Social Development with assistance from UNICEF developed the Cash Transfer Programme for Orphans and Vulnerable Children (OVC-CT) (Republic of Kenya, 2012a).

The drive to develop OVC-CT in Kenya stemmed from the growing realization that some of the other elements of social protection in the Kenyan society especially family and communal mechanisms were breaking down in the face of the growing HIV/ AIDS pandemic. This analysis was starkly presented in the Human rights Watch publication in 2001, "*Kenya, in the shadow of death*" (Csete, 2001).

After a small pre-pilot phase of three districts, a second larger pilot phase was initiated in seven districts in 2006 followed by an expansion to 17 districts in 2007 and 2008. At the

same time the Government of Kenya expanded the Programme in other districts to an additional 30. The Programme expanded further in 2008/09 with a total of 30,315 households having received financial support by mid-2009. Additional expansion has been ongoing with a full scale target of over 300,000 households by the year 2015 (Ward *et al*, 2010).

The objective of the programme was to provide a social protection system through regular and predictable cash transfers to families living with orphans or vulnerable children (OVC) in order to encourage fostering and retention of OVC within their families and communities and to promote their human capital development. There are however unintended benefits that have occurred in the process of implementation wherein cushioning of people living with HIV and AIDS comes in (Bryant, 2009).

The case for OVC-CT is based on the assumption that modest but regular income from cash transfers helps households to smooth consumption and sustain spending on food, schooling and healthcare in lean periods without the need to sell assets or take on debt. Over time, transfer income can help households to build human capital (by investing in the OVC nutrition, health and education), save up to buy productive assets, and obtain access to credit on better terms.

1.2 STATEMENT OF THE PROBLEM

There is increasing global evidence that fishing communities are particularly vulnerable to HIV/ AIDS (Allison and Seeley, 2004; Allison and Seeley, 2005). This vulnerability likely leads to very high rates of sexual mixing within the fishing communities, where fishermen have sexual intercourse with different partners of different ages. This vulnerability is attributed mainly to the fishing communities' mobility, migration, time away from home,

access to cash income, commercial sex at landing sites as well as the subordinate economic and social position of women (Allison and Seeley, 2004).

The HIV/AIDS epidemic has stricken the heart of the family and community support structures in these areas. Evidence from past studies revealed that the aged and the young ones take up responsibilities of support and care of their needs (UNAIDS, 2006; Aids alliance, 2003). This epidemic is changing the family structures wiping out the middle generation of adults (both energetic men and women) leaving behind the old and young to support each other (HelpAge/AidsAlliance, 2003; Geballe et al., 1995). Family and community structures are weakened in the sense that the old and orphaned and vulnerable children can't support themselves in their everyday needs of food, health, education, clothing etc. The old carers and underage orphaned and vulnerable children are compelled to take on new roles of care and support because of the need to provide for daily needs.

The OVC- CT programme was initiated in the year 2004 with an objective of fostering orphans and other vulnerable children within families, and developing their potential. (Bryant 2009). This was meant to avert the effects of HIV/ AIDS in families. Evaluation has shown that it has had several impacts including increased secondary enrolment, improved health, prevention of early sexual debut among children, increased the real household consumption levels of recipient households by some Ksh 274 per adult equivalent, reduced poverty by 13 percent, increased food expenditure and dietary diversity (Ward *et al.*, 2010).

Cash transfers can thus both *protect* living standards (alleviating destitution) and *promote* wealth creation (supporting transition to more sustainable livelihoods). Depending on context, they may also help *prevent* households from suffering shocks and *transform*

relationships within society, and between citizens and the state (Guhan, 1994; Devereux and Wheeler, 2004). This study sought to investigate the potential of OVC- CT to strengthen the capacity of families to take care of orphans and vulnerable children. The study sought to answer the following questions:

- What are the dynamics of fishing livelihoods among families affected by HIV/AIDS?
- What is the use and effect of cash transfers on the lives of OVC and their families?
- What are the indirect effects of cash transfers on fishing as a means of livelihood for fishing families affected by HIV/AIDS?

1.3 RESEARCH OBJECTIVES

1.3.1 GENERAL OBJECTIVE

To explore the potential of CT to strengthen the capacity of fishing families affected by HIV/AIDS to take care of OVC in Budalangi District, Busia County.

1.3.2 SPECIFIC OBJECTIVES

1. To examine fishing as a means of livelihood among families affected by HIV/AIDS.
2. To examine the indirect effects of cash transfers on fishing as a means of livelihood for fishing families.
3. To examine the use and effects of OVC cash transfers among fishing families affected by HIV/AIDS.

1.4 JUSTIFICATION OF THE STUDY

In Kenya as one of the sub Saharan countries heavily burdened with HIV/AIDS; orphans and vulnerable children face poverty and despair. OVC-CT in Kenya stemmed from the growing

realization that some elements of social protection such as family and communal mechanisms are breaking down in the face of growing HIV/ AIDS pandemic.

The findings of this study should generate an understanding on the potential of cash transfers to strengthen the capacity of fishing families affected by HIV/AIDS. This should guide the designing of necessary and specific interventions and programs to reduce the risks and vulnerability of HIV transmission among targeted communities.

The study should also be instrumental in achieving the social pillar of vision 2030 as well as millennium development goal by ensuring that the institution of the family is strengthened since it will be addressing elements of social protection within the family.

Finally the study should add to the bank of knowledge on CT and HIV/ AIDS and expose knowledge gaps for further research.

1.5 SCOPE AND LIMITATIONS OF THE STUDY

This study was conducted in Budalangi District, Busia County in Western Kenya region and intended to investigate the role played by cash transfer in strengthening fishing families affected by HIV/ AIDS. It collected the views of OVC, guardians, community members and leaders who monitor the programme including Voluntary Children Officer (VCO) and District Children Officer (DCO).

The study used resilience theory to establish how the OVC-CT has been used to protect orphaned children and fishing families affected by HIV/ AIDS. The study explored the potential of cash transfers to secure basic subsistence and reduce poverty while also

strengthening the education, health and nutrition for fishing families affected by HIV/AIDS. Although there are other forms of social protection apart from the OVC-CT, this study did not delve into such.

Due to financial limitations, the study was not able to look into other issues such as impacts of conditions and policy implications among others. Other than finances, other methodological limitations in terms of sampling, data collection, possible analysis and the inability to study the entire population called for generalization of findings. The time allocated for the study may not have been sufficient to source for all the information required for the study.

The study involved minors and this may have been a limitation since some children might have felt intimidated and therefore failed to provide full information. The fact that the minors may not be in a position to give consent might have also limited the study in cases where there was no one to consent on their behalf.

1.6 DEFINITION OF KEY TERMS

An orphan: Refers to a child who has lost one or both parents.

A child: As used here is a person who is under the age of 18 years of age.

A vulnerable child: In this study refers to one whose safety; wellbeing and development are for various reasons, threatened. This includes children who are emotionally deprived or traumatized.

Orphaned and vulnerable children: A person who is under the age of 18 years whose safety; wellbeing and development are for various reasons, threatened. This includes children who are emotionally deprived or traumatized

Cash transfer: Is a form of social protection involving direct transfer payment of money to eligible people in this case OVC.

Vulnerability: Refers to the conditions determined by physical, social, economic, environmental and political factors or processes, which increase risk and susceptibility of people to the impact of hazards.

Potential: As used here refers to the possibility of or likelihood of cash transfers to strengthen families

1.7 ASSUMPTIONS OF THE STUDY

The study makes the following assumptions:

1. Fishing is the main means of livelihood among HIV affected fishing families in Budalangi.
2. OVC-CT has both positive and negative effects for fishing families affected by HIV/AIDS in Budalangi.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This section covers a range of issues on cash transfer in relation to HIV/AIDS affected families. The section reviews how OVC-CT confers resilience to HIV/ AIDS affected families in terms of protection, prevention, promotion and transformation. This chapter also presents the theoretical and conceptual framework used in this study.

2.2 THE BACKGROUND OF OVC-CT AND HIV/ AIDS

HIV/AIDS epidemic is placing tremendous strain on the already limited resources and capacity of older people who are caring for orphans and vulnerable children. It is widely acknowledged that the loss of the middle generation of adults severely reduces the income and consumption capacity of families affected by HIV/AIDS. This is particularly the case for older people and orphans and vulnerable children. Most of the older-headed households surveyed in Juba, Sudan, were living on less than US\$1 a day – far below the income required to provide for the needs of multiple household members (Help Age International, 2002; Oppong and Agyei, 2004).

Several developing economies have recently introduced (conditional) cash transfer programs which provide money to poor families contingent on certain behavior, usually investments in

human capital, such as sending children to school or bringing them to health centers (Rawlings and Rubio, 2003).

Cash transfers are direct, regular and predictable non-contributory cash payments that help poor and vulnerable households to raise and smooth incomes (DFID, 2011). In Africa, The Child Support Grant (CSG), which targets supporting the child directly within the household for her/his development, was first institutionalized in South Africa as a poverty alleviation mechanism within a social development paradigm (Paxson and Schady, 2008).

Kenya introduced the OVC-CT in 2004, as an investment on human capital after the realization of adverse effects of HIV and AIDS pandemic leaving many orphans vulnerable. This was to help foster the vulnerable orphans within a family set up and help develop their human capital (Bryant, 2009). The specific objectives of the project in terms of household and child welfare according to Ward *et al* (2010) are:

Education: Increase school enrolment, attendance and retention for 6 to 17 year old children in basic school (up to standard 8).

Health: Reduce the rates of mortality and morbidity among 0 to 5 year old children, through immunizations, growth control and vitamin A supplements.

Food security: Promote household nutrition and food security by providing regular and predictable income support.

Civil registration: Encourage caregivers to obtain identity cards within the first six months after enrollment.

2.3 FISHING AS A MEANS OF LIVELIHOOD AND VULNERABILITY TO HIV/AIDS

In Kenya, the HIV epidemic presents a mixed picture. Although overall HIV prevalence is 6.3%, this belies great disparities across key high-risk populations. For example, sex workers, injecting drugs users, men who have sex with men and mobile populations such as fisher folk and truckers have prevalence ranging from 20-50% (Caputo, 2003).

The fishing community in Kenya predominantly resides in the Lake Victoria region in Western Kenya.

The Lake Victoria region has the highest HIV prevalence in Kenya (KDHS, 2008/09). Of Kenya's eight provinces, Nyanza province, located in the Lake Victoria Basin, has been the most affected by the HIV epidemic. In Nyanza province, the HIV prevalence among adults aged 15-49 years is estimated to be 13.9 percent which is double the HIV prevalence of the second highest province (KDHS, 2008/09). The average HIV-infection rate in Nyanza Province, which falls within the lake basin, is currently documented at 15.3% compared with the national prevalence rate of 7.4% (KDHS, 2008/09).

There is increasing global evidence that fishing communities are particularly vulnerable to HIV and AIDS (Allison and Seeley, 2004; Allison and Seeley, 2005). This vulnerability is attributed mainly to the fishing communities' mobility – migration, time away from home, access to cash income, commercial sex at landing sites as well as the subordinate economic and social position of women (Allison and Seeley, 2004).

There is also very high rate of sexual mixing within the fishing communities where fishermen have sexual intercourse with different partners who are either married to other men or engage

in commercial sex. Lake Victoria, the world's second largest freshwater lake is renowned for its rich harvests of tilapia and Nile perch. Sadly, the region has also gained a reputation for having the highest HIV prevalence rate in Kenya. In the villages along the shores of Lake Victoria and on the isles that dot its surface, HIV and AIDS has taken a heavy toll. The likelihood of high prevalence in this specific population may pose a huge challenge to the rest of the population as fishermen are likely to have sex with local women when they bring their catch to the mainland, acting as a bridge for spreading the virus to the general population. Such lifestyle of people involved in the fish trade could be one of the reasons for the high prevalence rates in the region.

Surveys conducted since 1992 in ten low- or middle-income countries in Africa, Asia and Latin America for which data were available (Brazil, Cambodia, the Democratic Republic of the Congo, Honduras, Indonesia, Kenya, Malaysia, Myanmar, Thailand and Uganda) show that, in all except one (Brazil), HIV prevalence rates in fishing communities are between 4 and 14 times higher than the national average prevalence rate for adults aged 15 to 49. These considerable rates of HIV infection place fishing folk among groups more usually identified as being at high risk; they are greater than those for other mobile populations such as truck drivers and the military in all countries (again except for Brazil) for which relative data are available. Because fishing folk are numerous compared with people in other subpopulations with high HIV prevalence, such as injecting drug users, military personnel and prisoners, the number of fishing folk likely to be HIV positive may be very high, making them a priority for support for prevention, treatment and care programs for HIV and AIDS.

Populations are engaged in a multiplicity of forms of movements which vary in terms of spatial, temporal and social characteristics as well as their motive and purpose. The inter-

connectedness of population mobility and disease has long been recognized, and HIV may not be an exception (Jeeves, 2001). Specifically, population mobility has been shown to be associated with risk of HIV infection. However, the individual's risk will depend on the context in which mobility occurs, although it may itself be confounded with other risk factors for HIV (Jeeves, 2001). There are at least two key ways in which mobility is tied to the spread of HIV. These include vulnerability to risky sexual behaviour and challenges in accessibility of the mobile populations for HIV intervention programs and services (Dodson *et al.*, 2003).

2.4 OVC- CT USES AND HIV / AIDS

According to ODI Kenya country briefing report 2012, the OVC- CT cash in Kenya is used by the beneficiaries to purchase basic household necessities (food, bedding, clothing) and housing materials, meet school requirements (levies, uniform, extra tuition) and pay health bills. These expenditures are related directly to the programme's strategic objectives (education, health, food security and civil registration). The CT is also reported to be sometimes used to develop livelihood activities, including starting small businesses, purchasing domestic animals, engaging labour, investing in small-scale farming and contributing to informal savings groups.

According to Bryant (2009), beneficiaries reported that they used the money mainly on items such as food, school uniforms, textbooks, and cooking oil. However, beneficiaries added that the amount of funds was not enough to cover the full extent of the family's basic needs.

A synthesis of findings from surveys in sub-Saharan Africa found that the primary use of cash transfers was to purchase food in six out of the seven programmes reviewed (Adato and

Bassett, 2008). While in Ethiopia's PSNP, 15 percent of participants spent some of their unconditional transfer on education (Devereux *et al.*, 2006). Studies in Lesotho have also shown that those receiving a social pension are buying uniforms, books and stationery for their grandchildren (Samson *et al.*, 2007).

2.5 OVC- CT AND EMPOWERMENT OF HIV / AIDS AFFECTED FAMILIES

Cash transfer programme can assist AIDS-affected families by (1) securing their basic subsistence when illness prevents them from working to secure a livelihood; (2) keeping children from leaving school because of an inability to pay fees or because labour is needed at home; (3) enabling people to invest in a small income generating activity; and (4) increasing the agency of communities where local organizations participate in targeting, monitoring, or service delivery (Adato and Bassett, 2008).

The Kenyan country briefing report reported OVC-CT to have also contributed to the empowerment of vulnerable groups by giving them a voice in the community, such as in community meetings. Social capital has been generated and social groups have been formed around the CT; these groups also offer informal psychosocial support to widows living with HIV and AIDS and advise elderly grandmothers on how to handle OVC. Finally, the local economy has been stimulated, with a trickledown effect meaning most people in the community have benefited either directly or indirectly from the CT (Onyango-Ouma and Samuels, 2012).

The OVC- CT programme has also been reported to benefit caregivers and empower women. Caregivers' health has improved through increased capacity to purchase medicines (e.g.

ARVs), and they report “feeling stronger and having more energy due to their better nutritional status as a result of improved diets” (Jackson *et al*, 2011: 16). Most caregivers (92%) – the majority of whom are women – decided how to use the transfer alone or in consultation with other adults in the household. Female caregivers also reported that this contributed towards a feeling of empowerment (Republic of Kenya, 2012: 85).

Cash can empower poor individuals and households to make their own decisions for improving their lives; it can support girls’ education and promote better access and utilization of healthcare and other basic social services (Slater, 2009).

While the Kenyan OVC-CT targets transfers explicitly to orphans or AIDS-affected vulnerable children, there is emerging evidence that targeting programmes to the extreme poor, using indicators that capture AIDS-affected households (e.g. high dependency ratios or presence of a household member with a chronic illness) helps to reach children affected by AIDS (Webb, 2007). In addition Caregivers’ health has improved through increased capacity to purchase medicines (e.g., ARVs) (Jackson *et al*, 2011: 16).

According to Bryant (2009), as a result of phase one of the Kenyan OVC-CT, children who had HIV were receiving antiretroviral (ARV) treatment, which they had not been able to afford previously (ARV treatment was not free at that time). Other household members were benefiting from the cash subsidy. Between 30% and 50% of adult members of the beneficiary households were HIV positive or had developed AIDS, and, anecdotally, data reported by workshop participants also identified that part of the cash transfers was used to buy ARVs.

As a result of OVC-CT Programme, trained volunteers visited beneficiary households to conduct awareness-raising sessions on vital health and family issues, including nutrition, child and maternal health, and prevention and treatment of chronic illness, such as malaria

and HIV/AIDS. Working closely with the community, these volunteers also linked people up with local services, provided by the government, NGOs, community-based organizations, and faith based organizations. HIV-positive household members were referred to programs that provide free access to ARVs (Bryant, 2009).

Cash transfers can have benefits across the spectrum of HIV prevention, treatment, care and support. Transfers may play a role in HIV prevention by reducing the factors that place people at risk of infection by reducing school drop-out, migration, and girls' and women's social and economic inequality. Some of the most robust results have come from a recent impact evaluation in a high-prevalence district of Zomba- south eastern Malawi (Temin, 2010).

A pilot for adolescent girls in Zomba district in south-eastern Malawi has demonstrated that both conditional cash transfers (CCTs) and unconditional cash transfers (UCTs) to girls improved school attendance and decreased early marriage, pregnancy, and importantly, HIV infection rates, among beneficiaries. The UCT programme had a much greater positive impact on delaying early marriage. Researchers found that sexually active beneficiaries reduced their risky behaviour (Baird *et al.*, 2010).

A randomized control trial in rural Uganda found better HIV treatment adherence scores amongst programme participants than the control group. This led the researchers to conclude that the modest cash transfers of \$5-8 per month to defray the costs of transportation may be an important strategy to reduce costs and improve treatment outcomes in rural, resource-limited treatment settings (Temin, 2010).

2.6 THEORETICAL FRAMEWORK

The study used resilience theory. Resilience theory has its roots in the study of children who proved resilient despite adverse childhood environments (Kaplan *et al.*, 1996). The theory addresses the strengths that people and systems demonstrate that enable them to rise above adversity and in this case families rising above HIV/ AIDS pandemic.

The emergence of resilience theory is associated with a reduction in emphasis on pathology and an increase in emphasis on strengths (Rak and Patterson, 1996). O’Leary (1998) notes that the theory calls for a move away from vulnerability/deficit models to focus instead on triumphs in the face of adversity hence the focus on how OVC cope up with life in an HIV and AIDS and orphan hood prone areas.

The theory is a strength based model that focuses on supports and opportunities which promote life success, rather than trying only to eliminate the factors that promote failure. Resilience is primarily defined in terms of the “presence of protective factors (personal, social, familial, and institutional safety nets)” which enables individuals to resist life stress (Kaplan *et al.*, 1996, p. 158).

2.6.1 RELEVANCE OF THE THEORY TO THE STUDY

The relevance was derived from the four tenets of resilience theory which was used to explain the study.

Risk or predisposition to bio-psychosocial or environmental conditions which in this case focused on how HIV/ AIDS pandemic has weakened families and pre-disposed them to a myriad of bio-psychosocial problems.

Exposure to a high-magnitude stressor where the HIV/AIDS affected families were exposed to both social and psychological stress like stigma and physical stresses of the disease effects. Stress response which in this case looked into the coping strategies that the affected families have used.

Return to baseline and normal functioning, which in this case looked in to the impacts of OVC-CT and how it is strengthening HIV/AIDS affected fishing families.

2.6.2 CONCEPTUAL FRAMEWORK

It was conceived that the OVC-CT was the independent variable and that the income from OVC-CT was used to strengthen the family as an institution (dependent variables). It was envisaged that the modes of strengthening the family depended on the use of the OVC-CT money so that certain uses could be protective such as shelter, health, nutrition; others preventive, promotional and transformational as shown in the figure below:

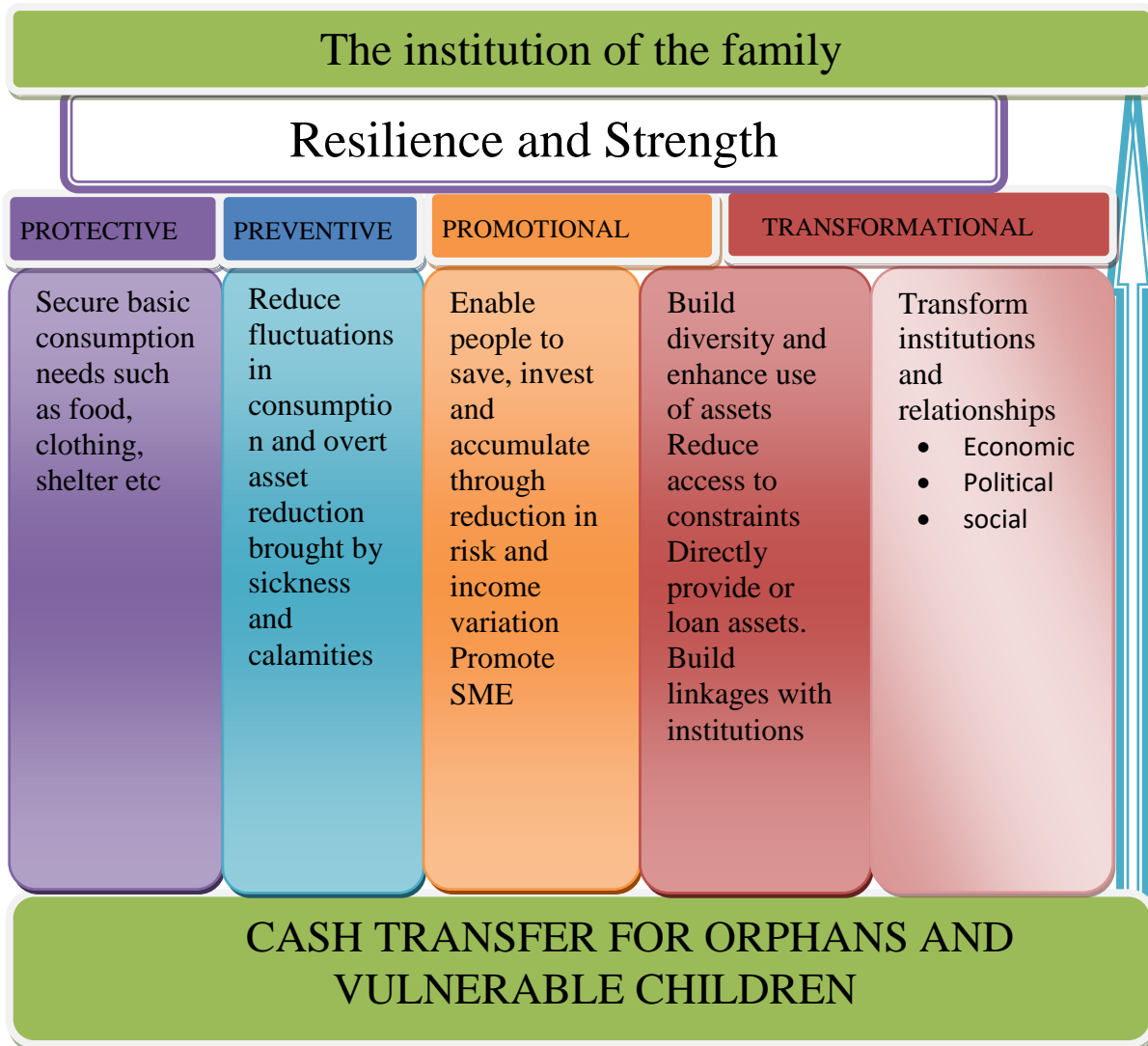


Figure 1 : An asset-based social protection framework

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

This section presents the context within which the study was conducted. It gives a description of the research site, study design, study population, sampling procedures, data collection methods, and analysis. The section also looks into the ethical considerations.

3.2 RESEARCH SITE

This study was conducted in, Budalangi District, Busia County. Busia County lies in the western part of Kenya. The main ethnic groups in the study location are Luhya (Abamanyala sub-tribe) and Luo, both of whom are originally fishing communities.

The estimated population of Busia County is about 442,700 people in 2009, and poverty incidence was 69.8% in 2005/06. Livelihood strategies include subsistence and cash crop agriculture as well as fishing. Agricultural production is the lifeline of the economy, with subsistence crops contributing nearly 36% of average household income and employing over 81% of the workforce. A key livelihood in the study location is fishing. Bukoma beach is widely known in the country as one of the busy beaches in Lake Victoria.

Budalangi District was selected because there was an existing OVC-CT programme.

3.3 RESEARCH DESIGN

The study used exploratory ethnographic design which collected qualitative and quantitative data. The quantitative data included the basic demographics of the study population. The data collection was done in three phases each phase taking at least two weeks. The study commenced by pre-testing the instruments and making necessary adjustments within the first week of the study. The first phase involved Key Informant Interviews from which the general information on the programme operation was obtained.

This phase also allowed the researcher to access the beneficiaries' registers and samples the respondents with the help of the District Children's Officer (DCO) and Voluntary Children's Officer (VCO). The second phase involved In-depth Interviews (IDIs) followed by Focus Group Discussions (FGDs) in the third phase. Direct observation and note taking was applied throughout the study.

All qualitative data was recorded, transcribed, coded and classified according to themes in an excel spreadsheet and thematic analysis done based on the set objectives. Basic demographic data was presented in tabulation and descriptive analysis done.

3.4 STUDY POPULATION

The study population included all fishing families affected by HIV/AIDS in Bukoma sub-location. The respondents were family heads who were either beneficiaries or non-beneficiaries of the OVC-CT. These involved men and women of age range from 26years old to 77 years old. Four (4) children from child headed families between age 17 and 21 years old were also be identified by the researcher as respondents. These respondents were not

necessarily children by virtue of their current age but by the fact that they started being family heads before the age of 18, which is the adult age in Kenya.

3.5 SAMPLE POPULATION AND SAMPLING PROCEDURE

The study used the Budalangi district OVC-CT beneficiary register as a sampling frame. The sampling procedure was purposive based on the characteristics of the participants required. The information of the participants were obtained from the district OVC-CT register with the help of the DCO and the VCO. Non-beneficiaries were sampled purposively based on the characteristics of the participants required from the OVC-CT waiting list register, with the assistance of the VCO. The unit of analysis for this study was the fishing household affected by HIV/AIDS.

A total of 6 respondents for Key informant interviews (KIIs) were selected purposively with the help of the DCO based on their knowledge of the OVC-CT programme and the dynamics in the study area. A total of 6 Focus group discussions (FGDs) were conducted and participants were selected from the OVC-CT beneficiary register while non-beneficiary participants were selected conveniently with the help of the VCO from fishing families affected by HIV/AIDS in the OVC-CT waiting list. A total of 15 In-depth interviews were conducted with both OVC-CT beneficiary and non-beneficiary fishing families affected by HIV. The beneficiaries were drawn from the OVC-CT beneficiary register while the non-beneficiaries selected conveniently with the help of the VCO from the OVC-CT waiting list. Four (4) of these in-depth interviews were conducted with child headed families who are beneficiaries of the OVC-CT program and were drawn from the register with the help of the VCO. Participants recruited for FGDs were different from those recruited for IDIs for

triangulation of data. Five (5) case studies were also conducted in homes of OVC-CT beneficiaries from fishing families affected by HIV/AIDS. With the help of the VCO these participants were drawn from the OVC-CT register. The study also employed the use of structured observations and the researcher observed 6 sites of interest within the community. The researcher used observation to check information given by participants during the entire data collection period for the study.

3.6 DATA COLLECTION METHODS

This study involved the collection primary and secondary data. Primary data involved the use of existing registers while secondary data was collected through use of qualitative and quantitative data collection methods. All the information was recorded using voice recorders and notes taken during sessions. The collection methods were as follows:

3.6.1 KEY INFORMANT INTERVIEWS

This involved a total of six Key Informant Interviews (KIIs) sampled from the district level, community level and from an NGO dealing with orphans affected by HIV/ AIDS. The KIIs informants included the DCO (1), VCO (1) Beneficiary Welfare Committee (BWC) (1), Beach Management Unit (BMU) (1), Community Health Worker (CHW) (1) and an informant from a HIV/ AIDS related NGO operating within the study area. The KIIs collected information on programmatic areas, including recruitment, benefits and effects of the OVC-CT programme on fishing households affected by HIV/AIDS.

3.6.2 IN-DEPTH INTERVIEWS

This was conducted with the OVC-CT programme beneficiaries and non- beneficiaries. The in-depth interviews sought to explore the use of OVC-CT money in HIV affected fishing families, varied perceptions on the indirect effects of CT on fishing as a means of livelihood and the effects of these to orphans and vulnerable children in HIV affected fishing families. A total of fifteen participants were sampled purposively based on the list below: Non-beneficiary female (2); male beneficiary (1); female headed family non- beneficiary (1); female headed family beneficiary (3); child beneficiary (1); child headed family (3); male headed family (3); HIV+ female beneficiary (1).

3.6.3 FOCUS GROUP DISCUSSIONS

Focus Group Discussions were conducted with community members from fishing families affected by HIV/AIDS. FGD questions were structured around key vulnerabilities in the community, community coping strategies, individual coping strategies, perceptions on HIV/AIDS in the area, perceptions on fishing as a means of livelihood and the relationship of these with the OVC-CT program. The different focus group discussions were separated by gender and by members benefiting or not benefiting from the OVC-CT program. Groups also included HIV+ and HIV- members. Participants recruited for FGDs were different from those recruited for IDI's for triangulation of data. A total of six FGDs were conducted for this study.

The participants were sampled purposively and the groups were as follows: Adult male beneficiaries (1); adult male non-beneficiaries both HIV+ and HIV- (1); adult female beneficiaries all HIV+ (1); adult female beneficiaries both HIV+ and HIV- (1); adult female non- beneficiaries all HIV+ (1); adult female non- beneficiaries both HIV+ and HIV- (1).

3.6.4 STRUCTURED OBSERVATION

This method used an observation checklist to collect data. The researcher identified key areas that gave insight on programme beneficiaries' means of livelihoods, interactions, non-verbal communication and access to different services in the community. Observations took place in 6 points such as the comprehensive care clinic, at the beach, at the fish market, at the post office during cash collection and at a HIV/ AIDS support forum.

Five individual cases were also observed at family level. The individuals were program beneficiaries and were identified by particular characteristics of gender, age, kind of OVC taking care of, HIV status and occupation. The researcher visited the individuals on various occasions, observing and holding discussions with different members of the family and triangulating findings. This gathered information that could otherwise not be spoken by the informants.

3.7 DATA PROCESSING AND ANALYSIS

All interviews were recorded, transcribed and translated. Data was then entered into Excel spread sheet where it was organized into themes and sub-themes for coding and in depth analysis. Descriptive analysis, including frequencies, percentages, tables and cross-tabulations, were used to describe the basic demographic characteristics of the sample population. Qualitative data was presented descriptively according to the emerging themes using illustrations from the transcripts.

3.8 ETHICAL CONSIDERATIONS

This study sought for a research permit from the ministry of higher education through the National Council for Science and Technology (NCST). The participants were made fully aware of the risks and benefits involved in participating in the ethnographic study . The participants were also assured and reassured that confidentiality and anonymity would be maintained throughout the study.

Verbal informed consent was taken from all the respondents before any discussion or interviews took place. The participants were duly informed of the risks of getting involved in the research if any and also of their right to withdraw from participating at any time during the interviews or discussions. Interviews and discussions were conducted in a safe place and at a convenient time with the respondent so as to ensure least disturbance from their daily lives.

CHAPTER FOUR

FISHING AS A MEANS OF LIVELIHOOD AMONG HIV AFFECTED FAMILIES IN BUDALANGI

4.1 INTRODUCTION

This chapter presents the findings of the study on fishing as a means of livelihood for HIV affected families in Budalangi. It also presents the socio- demographic characteristics of the fishing families.

This chapter also shows findings on the HIV/AIDS situation among fishing families in Budalangi. The findings are then discussed and compared to other studies that have been done on OVC cash transfers.

4.2 SOCIO-DEMOGRAPHICS OF THE FISHING FAMILIES

The socio- demographic profile of the sample population is presented in table 4.1 below.

All the informants in the study were either fishmongers or fishermen while others subsidised fishing with farming. In the 70 households that were mapped the study found out that there were generally more female beneficiaries than male beneficiaries.

This could be due to the fact that care giving is a work left to women within the community.

The child headed households were categorized under single in the marital status category.

Table 1 Socio-Demographic Characteristics of Informants

Age Range	No.	Percentage %
60 and above	14	20
50-59	23	33
40-49	20	29
30-39	10	14
Below 30	3	4
Total	70	100
Average age = 50		
Gender		
Male	29	41
Female	41	59
Total	70	100
Level of Education		
No Education	24	34
Completed Primary	34	49
Completed Secondary	7	10
Tertiary	5	7
Total	70	100
Marital Status		
Single	3	4
Married	31	44
Widowed	36	52
Total	70	100
Household Size Range		
1-3	3	4
4-6	16	23
7-9	38	54
10-12	9	13
13 and above	4	6
Total	70	100
Average household size= 6		
Occupation/Livelihoods		
Fishing	38	54
Fish Monger	25	36
Fishing and Fish Monger	2	3
Fishing and Farming	5	7
Total	70	100

Source: Survey 2012

4.3 DYNAMICS OF FISHING AS A MEANS OF LIVELIHOODS IN BUDALANGI IN THE ERA OF HIV/AIDS

This study established that there are various kinds of fishing in Budalangi, which include (1) deep sea fishing using nets; (2) use of hooks and lines; and (3) use of basket trawlers (*kokoro*). There is also a range of occupations related to the fishing activities including fishing, processing and trading. This study found that age and gender play a key role in the dynamics of fishing livelihoods.

This study also found out that pulling of *Kokoro* is the main type of fishing in Budalangi. It does not only involve adults of both gender but also involves children as young as 12 years of age. The different kinds of fishing livelihoods as illustrated in text, exposes people of all ages to very high rates of sexual mixing where fishermen have sexual intercourse with different partners of varied ages. This study found that orphans are most vulnerable because the need to provide one's basic needs exposes children to early sexual debut, where they receive sexual favours from fishermen. This is likely to increase transmission of HIV/AIDS in both children and adults. A respondent had this to say when asked about fishing livelihoods in Budalangi:

With kokoro you'll find a mixture of both gender including men, women and children. Most children have been lost in the lake doing fishing especially orphans and vulnerable children. When they go fishing, they start at four o'clock in the morning until evening. They come back home with fish and pocket money. Since they do not have both parents, their guardian may direct them to go back fishing the next day. The fishing is called "bring the rope" as people pull the rope together in the same pattern then it is coiled by the last person at the back of the team. It is for those who have enough energy. (Source: Key Informant Interview with Community Health Worker Budalangi).



Photo: Women and children pulling out fishing net from the lake as boat approaches the shore in Bukoma Beach Budalangi.

This study established that fishing is the main economic activity in the study area and all households depend on fishing as a means of livelihood. Men mostly go into the water using boats while women and children pull the trawler baskets on the shores of the lake. Children also fish with fishing rods and catch small fish that they sell for as little as 10 Kenya shillings for a piece of fish or sometimes they take it back home to use for food. They use the money they earn either to feed their siblings back home or entertain them by watching videos in the local video places.

Women traders buy fish directly from the fishermen, both deep sea or trawler fishermen. The women then proceed to sell the fish either on the beach or to local markets. The study found out that sexual favors among fishermen and women traders is likely to escalate HIV infection rates in the region. High rates of promiscuity in the region as the study found out, is likely to result in to increased vulnerability children due to breakdown of marriages. A voluntary children's officer reported:

Fish trade has resulted in breaking of marriages because most of the fishermen are lustful and if they seduce you and you refuse he can't sell you his fish. This also contributes to a lot to diseases and there are a lot of separation cases resulting into children suffering because of broken homes. (Source: Key Informant Interview with Voluntary Children's Officer)

Fishing as a means of livelihood was found to present a lot of vulnerabilities for orphans in the region. Communities in Budalangi as this study found, rely on fishing livelihoods. Observations from this study also showed that fishing activities require high energy levels as the activities require a lot of manual labour and exposure to harsh weather conditions. Interviews, informal conversations and observations at the beach, at the market and in the comprehensive clinic, presented HIV/AIDS as the common illness in the community.

HIV/AIDS is likely to reduce output because of the constant illness and low energy levels. HIV/AIDS also sometimes results to death leading to orphan-hood among fishing families. This might result to high rates of orphan-hood with no solid support systems. Orphans are in turn exposed to early sexual debuts as they try to fend for their basic needs and this might result to increased infections of HIV. The Ampath Clinic OVC social worker reported:

As the people of Bunyala we mostly depend on fishing and in fishing there are many problems like the deadly disease of AIDS. Female children have been forced to engage in prostitution because when one goes to the lake and doesn't get fish they won't survive at home. Therefore both males and females engage in relationships because fishing is the main activity. There are women who were abandoned by their husbands but they've been able to build and feed their families because of the fishing business. Many men have run away to Uganda and there have also been a lot of deaths from HIV/AIDS because some have been tested and they've refused to accept their status and have run away to the lake and no longer take the drugs resulting to death. You'll find many women who are widowed in this area and once they know their status they spread the disease especially to the visitors who do not know their status. Many have died and there are a lot of orphans left behind. (Source: Key Informant Interview with OVC Social Worker)

There was a general perception by the community members who participated in the study that fishing as a means of livelihood contributes to the spread of HIV/ AIDS because there is a lot of transactional sex that goes along with it.

Respondents felt that by fishermen having lots of money, they lure women and young girls into promiscuity. They also indicated that the more women a fisherman had, the more he could access cheap labour on his boats hence encouraging a polygynous lifestyle. This kind

of lifestyle presents a likelihood of contracting HIV from the numerous partners an individual has. A community health worker had this to say:

Sometimes a mother is in the fish trade business and because the demand for fish from the fishermen is higher than supply, she might send her daughter to engage in transactional sex so that they get favors. (Source: Key Informant Interview with Community Health Worker)

The study also found out that the youth who practice fishing engage in a lot of alcohol drinking because they have a lot of money. Once drunk, there is the danger of promiscuity under the influence of alcohol which is likely to escalate the infection rates of HIV/AIDS.

In line with the findings of this study, a survey in ten low- or middle-income countries in Africa, Asia and Latin America (Brazil, Cambodia, the Democratic Republic of the Congo, Honduras, Indonesia, Kenya, Malaysia, Myanmar, Thailand and Uganda) found that, in all except one (Brazil), HIV prevalence rates in fishing communities are between 4 and 14 times higher than the national average prevalence rate for adults aged 15 to 49. These considerable rates of HIV infection place fishing folk among groups more usually identified as being at high risk (Dodson *et al.*, 2003).

In addition, fisher folk have been reported to be one of the key high-risk populations with HIV prevalence ranging from 20-50% (Dodson *et al.*, 2003). This echoes responses from this study where respondents attribute high HIV prevalence to transactional sex for fish and lots of money around the lake that attract the poor and vulnerable groups.

The vulnerability to HIV and AIDS is also attributed to the fishing communities' mobility – migration and time away from home i.e. movement to and from Uganda as found out by Allison and Seeley, (2004). Findings of this study are in line with other studies that have attributed the prevalence of HIV and AIDS around the fishing regions to access to cash

income, commercial sex at landing sites as well as the subordinate economic and social position of women (Allison and Seeley, 2004).

Essentially, fish for sex trade, popularly known as *customer* in Budalangi is likely to be one of the fishing livelihoods that propagate the spread of HIV/AIDS in this community. The subordinate economic and social position of women might always put them at a disadvantage of risky sexual behaviour.

4.4 HIV/AIDS SITUATION AMONG FISHING FAMILIES IN BUDALANGI.

Following from the section above on how fishing as a means of livelihood impacts on the health of families in the era of HIV/AIDS, this section outlines the HIV/AIDS situation among fishing families in Budalangi.

The OVC-CT in Kenya is a grant programme that started in 2004 with the aim of setting up a system of regular and predictable unconditional CTs to households living with OVC as elaborated by Onyango-Ouma and Samuels (2012). In Budalangi, HIV/AIDS is a criterion to be enrolled in the OVC-CT program. This is because previous studies have shown that HIV/AIDS infection in Kenya is high and the CT was to help foster the vulnerable orphans within a family set up and help develop normal functioning (Bryant, 2009).

This study found out that HIV/AIDS is likely to reduce output because of the constant illness and low energy levels. HIV/AIDS also sometimes results to death among fishing families, leaving behind many orphans. This is likely to result to high rates of orphan hood with no solid support systems. Orphans are likely to be exposed to early sexual debuts as they try to fend for their basic needs and this might result to increased infections of HIV. The money

from OVC-CT is intended to help these vulnerable families with orphans to pay for basic needs like food, clothing shelter and education (Onyango-Ouma and Samuels, 2012).

Out of the sampled population 33% (N=23) were HIV positive while 78% (N=55) were affected. This meant that they were either fostering HIV positive orphans, living with orphans as a result of HIV or were widows as a result of the same.

Widows marked the highest percentage, 52% (N=36) of the respondents as shown in table 4.1 in chapter 4.

Among the widows, 62% (N=22) were living with HIV/ AIDS while 38% (N=14) were widowed as a result of HIV and AIDS. Perceptions of death toll in the area as a result of HIV and AIDS was generally high resulting into high numbers of OVC.

For instance, a respondent had this to say:

In this area you have to be very careful because people are dying at a very high rate out of this disease. Especially those working in the lake, you have to be careful with them. (Source: Interview with 42 year old HIV+ female beneficiary of OVC-CT)

Another respondent reported:

Since my parents who were the family bread winners died of AIDS, life has been very difficult. Since we were left with our grandmother we have to do everything and even look for money to fend for the family. At times we forgo school just to look for money for upkeep from fishing. (Source: Interview with 15 year old beneficiary orphan from a child headed household)

The study found that in Budalangi, the HIV/AIDS epidemic is one of the most destructive crises ravaging most families in the community. The tragic and untimely loss of parents and productive citizens has not only affected families, but also the fishing industry, farms and other workplaces, schools, health systems, and governments. The epidemic is touching almost every facet of life.

As HIV/AIDS rates continue to soar in Budalangi, household poverty deepens and children are increasingly pressured to financially contribute to the household as shown in the excerpt above. The lake has become the place where children orphaned and made vulnerable by HIV/AIDS often turn to supplement lost wages and earn a livelihood.

In the absence of capable adult caretakers, children themselves take on responsibilities for the survival of the family and home. In Budalangi, children in most families share duties even when parents are healthy; these duties increase in case the parent is sick or not around. In numerous HIV/AIDS affected households children have not simply increased the amount of work that they do but have also assumed decision-making and responsibilities that transform roles within families and households.

A beneficiary mother reported:

I used to go fishing but nowadays I cannot because I am weak and sick. It is my children who have been helping me and they have to go to the lake get some fish either to sell or for us to eat. (Source: Interview with 37 year old HIV+ mother)

Children assume adult roles as heads of household because there are no alternatives. They care for parents and younger siblings who are sick and dying from HIV/AIDS. They take charge of the care and running of the homes for themselves and their siblings. They work long hours doing household tasks, supervising younger children and engaging in income-generating work such as fishing or fish trading in order to support the family. Many quit school and jeopardize their own health and developmental needs to take on roles as parent, nurse and provider.

The women have also been highly affected since they are the main care givers for sick family members and for children orphaned by the HIV. They have to look for cash to fend for the affected families despite being sick or stigmatized. All of these factors have disempowered

them economically and consumed their time that would otherwise be used on productive ventures. Furthermore women are especially at risk of contracting HIV because of the interplay of biological, economic, and cultural factors. More importantly, powerlessness, dependence, and poverty tend to diminish women's ability to protect them from unsafe sex rampant in the lake region. The women's choices are limited by their inability to negotiate when or with whom to have sex the need for economic support from fishermen. In addition, because most infected women are of childbearing age, many have infected their children and they risk infecting more and thus face difficult choices about childbearing.

Economic stability of the society has therefore been ravaged as the fishing industry suffers loss of labour. The economic viability of small and commercial fish businesses are compromised by a loss of energetic people to provide labour. This goes hand in hand with a study by the Food and Agriculture Organization that found that in the ten African countries most severely affected by HIV/AIDS, Kenya inclusive, the workforce will decline between 10 percent and 26 percent by the year 2020.

Expenses have been rising for the treatment of AIDS and AIDS-related opportunistic infections. Allocating scarce resources from the affected families for HIV/AIDS has diverted attention from other development and welfare priorities, making affected fishing households poorer.

4.5 INDIRECT EFFECTS OF OVC- CT ON FISHING AS A MEANS OF LIVELIHOOD

While the entire mapped households were either fishermen or fishmongers, 45% (N=32) were beneficiaries of OVC- CT. Fishing is the main economic activity in Budalangi and nearly all families are engaged in at least one of the fishing livelihoods. Beneficiaries of the OVC cash transfers mentioned that the money helps them in their fishing businesses. They mentioned that women mostly use it as capital to buy fish stock for trade while men mostly use it to buy fishing equipment such as fishing nets and boats.

Fishing and fish trade as the study found out, is a delicate business because there are so many risks involved. Fishing equipment such as boats and nets sleep in the waters overnight because of the kind of fishing. This poses a high risk of constant loss of equipment because the frequency of the boats and nets being stolen is very high. The likelihood of a poor fisherman to constantly replace these equipment is low. This frequent loss of capital and investment, impacts negatively on the household and community economies. The peasant fish farmers are exposed to a cycle of poverty, where they don't grow their trade but keep replacing equipment. Respondents mentioned that OVC-CT helps them to replace their equipment whenever they are stolen from the waters. They highly depend on this regular income from the OVC cash transfers because it helps them to invest and maintain their fish trade.

A HIV+ male beneficiary of the OVC-CT reported:

Sometimes our fishing equipment is stolen in the waters and we don't have money to buy more equipment. When we receive the money from cash transfers, we use it to buy fishing equipment because fishing is what sustains us every day. (Source: Interview with 58 year old HIV+ male beneficiary of OVC-CT).

Fish trade also requires a lot of capital which the women might not afford most of the time.

Buying stock from the fishermen as discussed in the previous chapters not only implies on

financial aspects but also on moral aspects. Women sometimes have to engage in transactional sex in order to get stock. These vulnerabilities are propagated by lack of money for the women to trade with. When these vulnerable women are exposed to transactional sex, the likelihood of further sinking into poverty is high because of disease burden from HIV.

OVC-CT has been a huge relief to women traders who are beneficiaries of the program. Beneficiary mothers and widows reported using the money from OVC-CT to trade in the fish business. Women can now depend on a reliable source of income that they can use to restock their fish and sell within the community and also to other markets.

For instance a respondent said this about OVC-CT and the impact on her fish trade:

Cash transfer has helped me because after I pay for the children school fees whatever remains I use it in the omena (dagga) business. This has really helped me in re-stocking and maintaining my customers. (Source: Interview with 42 year old HIV+ female beneficiary of OVC-CT).

Fish also requires high levels of preservation because it easily goes bad. There are several ways of preservation mentioned by the women traders of Budalangi. These methods include: sun drying, smoking and deep frying. Some of the commercial methods used for example refrigeration, is way beyond their means and is only used by rich business men who come from other areas outside Budalangi.

If a fish trader has no money to buy fuel for smoking or deep frying her fish then it poses huge business losses that are not sustainable. Loss of capital and investment is likely to increase levels of poverty, dependency ratios and vulnerabilities for the women and girl child. OVC-CT has helped most of these women traders to access capital for fish stock and preservative commodities to help sustain their business. This has been a huge relief for the women because they don't have to keep on borrowing and expose themselves to transactional sex.

A HIV+ fish trader had this to say for instance:

This money has removed me from the jaws of death. Fish trade is not easy because you need money for the stock and you also need money to buy oil and firewood to preserve the fish. Sometimes the weather is not favorable to sun-dry. Most of the time there is no money for preservation and when demand for fish is low it all goes bad. It is very frustrating to lose money all the time. (Source: Interview with 28 year old HIV+ female beneficiary of OVC-CT).

OVC-CT has had indirect effects on fishing as a means of livelihood for fishing families affected by HIV/AIDS. These indirect effects have majorly helped to sustain the fishing and fish trade business which is high risk with constant loss of capital and investment.

It is concluded that the OVC-CT was found to have boosted the fishing industry in terms of investment. Respondents in the study mentioned that men used the CT money in buying fishing equipment while women used it to increase the amount of capital invested in fish. These findings have been confirmed by Adato and Basset (2008), who reported that cash transfers enable families to invest in fishing equipment such as nets and to enhance fish trade especially for women. These indirect effects of OVC-CT on fishing as a means of livelihood have a multiplier effect to individuals and the community. By using the money to enhance the fishing livelihood, families are now empowered economically. Financial empowerment is likely to cushion both women and children from risky behavior such as transactional sex.

CHAPTER FIVE

USES AND EFFECTS OF CASH TRANSFERS AMONG HIV AFFECTED FISHING FAMILIES

5.1 INTRODUCTION

Following on from chapter four on how OVC-CT has impacted fishing livelihoods, this chapter outlines how HIV affected fishing families in Budalangi use the OVC- CT money and the effects of the same in strengthening their families. The study found both positive and negative effects of OVC-CT on HIV affected fishing families such as on their economic wellbeing, social wellbeing and on their general quality of life. The findings in this study are also compared to other studies that have been done on the use and effects of OVC-CT on families.

5.2 USES OF OVC-CT

Figure 5.1 shows the use of OVC-CT by percentage among fishing families affected by HIV/AIDS in Budalangi. The highest use of the cash within the household as this study found out is on household expenditure. This is qualified by the fact that the cash is meant to secure basic consumption needs and strengthen poor and vulnerable households who are the target group for the program (Onyango-Ouma and Samuels, 2012).

CT expenditure by percentage

■ Hh expenditures ■ School expenditures ■ Health expenditures ■ Investments ■ Others

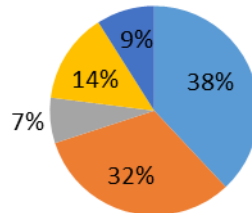


Figure 2 : OVC- CT expenditure by percentage

Household expenditure falls within the strategic objectives of the CT program hence the use within the household. Most OVC needs are implemented within the household including feeding, clothing and shelter thus the bulk of the cash finds its use within the household. This is in tandem with the findings of Adato and Basset (2008), in a synthesis of findings from surveys in sub-Saharan Africa which indicates that the primary use of cash transfer money was to purchase food in six out of the seven programmes reviewed.

The study found out that uses within the household include expenditures on food, utensils, household furniture, shelter, bedding and other household needs. There are also significant increases in the proportion of beneficiary households owning household assets such as buckets, mobile phones, radios, and bicycles.

A grandfather beneficiary for example had this to say about the use of OVC cash transfer:

This money is meant to help us so that we can get food and also support the children by feeding them properly. So when I get the money, I ensure that these orphans have food. (Source: Interview with 72 year old HIV- male beneficiary)

5.3 POSITIVE EFFECTS OF OVC-CT

The study found out that the OVC cash transfer as a huge relief for HIV affected fishing families. This is because it has improved their general wellbeing as presented in figure 5.2 Respondents confidently mentioned positive effects, by 90% (n= 63) of the people who participated in the study. Responses resonated around HIV being associated with poverty and the living conditions and quality of life of HIV affected fishing families having greatly improved because of the OVC cash transfer. The outcomes mentioned were either at family or community level.

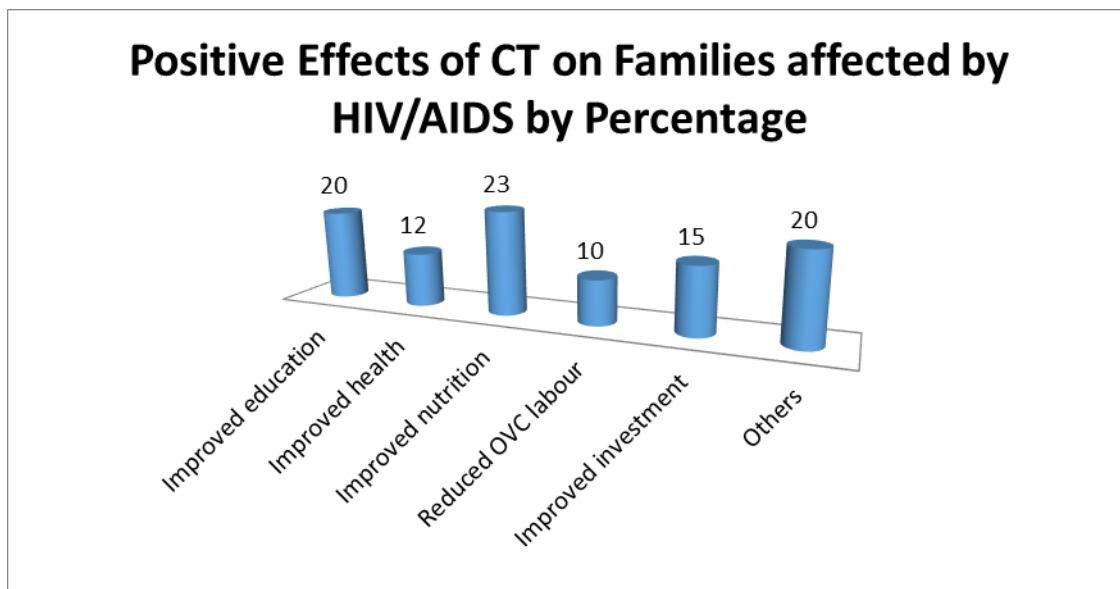


Figure 3: Effects of OVC-CT cash on HIV affected fishing families

5.3.1 Reduced poverty levels in the community

As reported by the respondents, the study found out that the OVC-CT cash has increased the amount of monthly income within households. This has reduced household poverty and as a result community poverty. The OVC in such households are now able to feed properly, have clothes, access health care and attend school.

A respondent had this to say:

The community is happy because it has reduced poverty; children are going to school up to secondary level. (Source: Key Informant Interview with Voluntary children's officer Budalangi)

As a result of reduced poverty the study established that dependency through constant borrowing from one another has reduced since the poorest of the poor can now afford to invest some money.

It has reduced cases of begging from one another. The beneficiaries were taught on the need to invest these funds. (Source: Key Informant Interview with Community health worker, Budalangi)

5.3.2 Improved community income and saving patterns

The study found out that money from the OVC- CT programme circulating within the community has improved the community income. This has resulted from individuals who are beneficiaries having dependable income and can trade with the money within the community.

There is money circulating in the community because money is usually spent by beneficiaries in buying things from the community shops e.g. vegetables, and thereby boosting the community. (Source: Interview with 35 year old HIV+ male non- beneficiary)

The extra income has also resulted to increased household ownership of a number of assets, including motorcycles and bicycles. These mortor- cycles and bicycles are used as tools for trade within the community, which in turn has improve the economy of the community.

A respondent had this to say:

Before we got this money I can say that we were very poor. We did not have enough cooking utensils, and even fishing equipment. We did not have things like bicycles, mattress and so many other things which we now own. (Source: Focus Group Discussions with HIV+ male beneficiaries)

The study also found out that beneficiaries are equipped with skills on how they can save money from OVC-CT and their investments. Beneficiary households are more likely to hold savings than the non-beneficiaries because of the extra income that they earn.

These savings give them a form of financial support system in difficult times when they don't have access to money.

A respondent reported:

Most men here are fishermen who don't save for the future. We have a cooperative bank here and a few people are members so when they die, the family is left poor. Even a child who has passed his / her exams cannot go on with education .We encourage the beneficiaries to open accounts and save money from their investments. (Source: Key Informant Interview with District children's officer Budalangi)

5.3.3 Development of an Investment Culture

The findings showed that the use of CT money on investments and livelihood activities as presented in figure 5.1 above as a common phenomenon. Such uses range from investing in fishing activities, farming and micro- enterprises. Investments also include purchase of domestic animals, fish trading especially for women and purchasing of fishing equipment by men. Other investment activities mentioned by respondents in this study included: savings in banks, table banking and contributions to the informal socio- economic groups (merry-go-rounds).

The study found out that investment on fish related activities was more common. This is likely from the fact that fishing is the main economic activity in the study population. Most women and female children reported in investing in fish trading, by using the money as capital to buy stock and trade within and outside the region. On the other hand, men and male children were actively involved in fishing itself and invested the money in fishing equipment such as boats and fishing nets. This is in line with the findings by Caputo, (2003) where beneficiaries invest the cash in assets especially those related to fishing.

Investments have a multiplier effect and play a significant role in strengthening the economic capital of the beneficiary households as well as the non-beneficiaries.

OVC-CT has enabled beneficiary families to start small businesses like running kiosks; they have purchased domestic animals and they have also invested in small-scale farming.

Reports from focus group discussions indicated that reliable flow of income helps poor households to invest and diversify livelihoods. This has improved their long-term income generating potential. Investments have also enabled the beneficiaries to accumulate productive assets and avoid losing them through distress sales or inability to repay emergency loans as posited by Devereux, (2007) and Slater, (2006). Onyango-Ouma and Samuels, (2012) also confirm that the OVC-CT is invested in certain livelihood activities that can promote both short and long time investment.

5.3.4 Improved quality of Life

A number of HIV affected beneficiaries reported using the money to purchase drugs for opportunistic diseases and or to pay hospital bills for the guardians and the OVC. This was common response among the HIV positive respondents. OVC-CT has helped fishing families affected by HIV/AIDS to improve their access of health facilities as the study established.

For instance, a HIV positive mother reported:

I can say that this money has secured my life because initially when I started receiving this money, I was admitted in hospital on several occasions and it is this money that paid my hospital bills and got me out. I have also used it severally in purchasing drugs especially painkillers. (Source: Interview with 28 year old HIV+ mother)

OVC-CT has also helped to take care of the HIV positive orphans who need proper attention and nutrition. This is instrumental in home based care expenditures for the HIV positive individuals. The increased cash within the households allow for extra expenditures on health and it also contributes to improved nutrition which in turn translates to good health.

Beneficiaries of OVC- CT reported that the dependable income has enabled families to acquire basic needs such as food, clothing and proper shelter which is important for a balanced health. In addition, caregivers' health has improved through increased capacity to purchase medicines and they reported feeling stronger and having more energy due to their better nutritional status as a result of improved diets (Source: Interview with HIV+ 46 year old female beneficiary of OVC-CT).

A respondent for instance reported:

When you are sick you can't have the energy to work as compared to a healthy person. We have benefitted a lot because we no longer have worries about what the children will eat or how to dress them. All those worries have been forgotten and they can now comfortably eat and take their medication. Before this many people were dying due to stress. (Source: Key Informant Interview with HIV+ Beneficiary Welfare Committee member)

Another respondent said:

When on the ARV drugs, you should eat well and live in a peaceful environment free from stress. When the beneficiaries get this money, they have peace and can decide on what to buy and use to take drugs. The disease also makes someone weak and they cannot work. So if they had invested in a project or have saved some money, they can use it until they get better. (Source Key Informant Interview with Voluntary Children's Officer)

In line with the study by Adato and Basset (2008), cash transfers benefit HIV+ families by securing their basic subsistence when illness prevents them from working to secure a livelihood. Responses from interviews held with beneficiaries of OVC cash transfers in Budalangi confirmed these findings from previous studies.

This study also established that OVC cash transfer in Budalangi links its beneficiaries to health facilities in the region hence improving health care access. For instance, OVC cash transfer program partners with AMPATH to provide health services to HIV+ beneficiaries; both children and caregivers who are in the program. The beneficiaries are counseled on positive living and also encouraged to form support groups that give them psychosocial support.

An informant reported:

Our program links the beneficiaries to the health facility and AMPATH has really been our big partner especially to the children and care givers who are HIV positive and get drugs and the kitties. They are counseled on how to live positively and take care of themselves. (Source: Key Informant Interview with District Children's Officer)

As reported in the study, social support groups of people living with HIV/ AIDS have been created around cash transfers. These groups offer informal psychosocial support to widows and children living with HIV and AIDS (Onyango-Ouma and Samuels, 2012).

In addition, cash can empower poor individuals and households to make their own decisions for improving their lives; it can support girls' education and promote better access and utilization of healthcare and other basic social services (Slater, 2009).

The OVC cash transfer is therefore a huge relief for fishing families affected by HIV/ AIDS because it has improved their nutrition, improved their access of health care and improved their psycho-social wellbeing.

Psycho-social support through group therapies is likely to reduce stigma related with HIV/AIDS.

A community health worker reported:

There is what we call group therapy. The beneficiaries are brought together to share ideas among themselves. They share information about the need to take ARVs. We advise them to form support groups. (Source: Key Informant Interview with Community Health Worker)

Sensitization about HIV/AIDS counseling and testing brought multiple effects in reducing HIV/AIDS stigma as more people come out publicly to declare their status. Beneficiaries of the OVC- CT act as peer educators and give life testimonies to the other community members.

A HIV+ male respondent for instance reported,

Everyone knows my status even in Budalangi because we normally go round educating people. This is now like our religion. We have to talk about HIV and we tell people not to become infected like us because they might not endure what we've gone through. We believe that prevention is better than cure. We tell people to abstain and if not they should use

condoms because they are free. We usually hold public crusades and are usually given a chance to speak during funerals. (Source: Interview with 53 year old HIV+ male beneficiary)

HIV related stereotypes in the study population such as *chira* (curse) is still relatively high. This is a local belief where the local people suffer from unknown health outcomes if they do not follow taboo. Sensitization of HIV formed around OVC-CT has helped address some of these stereotypes.

Box 1: Researcher's experience of a case of chira (curse)

I witnessed a scenario where a man came to the volunteer's children's office to report his mother-in-law. He claimed that she wanted to kill his son with *chira* by carrying the child yet she was still sexually active. The child looked pale and emaciated with sparse hair. The man said taking the child to hospital was a waste of time because his mother-in-law had already passed *chira* on his son. This sparked a lot of emotion and the mother-in-law threatened to strip naked before her son-in-law, an action which is highly viewed as an abomination and could further cause *chira*. People thus rushed to stop this woman from stripping. The VCO seeing this advised that he could not handle such a case and took both parties to the police station.

There were high perceptions from the study population that the health of HIV+ orphans has improved because their nutrition has improved. Community members said that children were initially sent to school without breakfast but now families can afford to give them breakfast. They mentioned that children usually ate only one meal at home (usually supper) but it has now improved to two meals of breakfast and supper.

The findings of improved quality of life in this study is supported by the works Adato and Basset (2008), which indicates that the OVC-CT programmes have achieved impressive results with respect to increases in the quantity and quality of food consumption, and improvements in nutritional status.

5.3.5 Improved Access to Education

The findings from the study show that the cash is used to purchase school uniforms, learning materials, books and school levies. Respondents felt that OVC- CT helped a lot by allowing people to send children to school and cater for expenses.

When asked about the use of the money one of the OVC reported:

This money is like my parent. It is used to pay my school fees, to buy for me books, school uniforms and any other school requirement. If this money was not there I would have dropped out of school a long time ago. (Source: Interview with a 15 year old orphan from a child headed household)

The use of CT money on school fees and education related issues is very important in investing in the children's future and is a step towards achieving OVC's human rights and basic needs as reported by Bryant (2009).

The perceived educational benefits include improvement in both school performance and school attendance. Findings from this study showed that the beneficiaries mostly use the money to pay school fees for their children both at primary and secondary level. This has increased school enrolment, attendance and retention.

A mother caregiver reported:

This money has helped my children to go to school. Without it they wouldn't have made it this far and I'm really grateful. (Source: Interview with 33 year old HIV+ Beneficiary Mother)

These findings are therefore complementary to the study by Adato and Basset (2008), which reported that cash transfers has helped with keeping OVC in HIV/ AIDS affected fishing families from leaving school because of the inability to pay fees or excessive labor requirements at home.

In Budalangi, OVC cash transfers has significantly reduced the numbers of children dropping out of school and opting for paid labour [for instance fishing] so as to afford basic care. In

response to a question on how OVC and their families have benefited from the cash transfers, a respondent said:

Initially the children were not going to school and this resulted into an increase in school dropouts. There was a lot of promiscuity and cases of early marriages were high. Since I am HIV+, I might not be able to take care of my children whenever I am bedridden. The children will look for money at the beach in order to eat. Death rates and theft were on the rise and there was no development in the community. The money has helped us to provide for the children, avoid stress and secure their future. (Source: Interview with 42 year old HIV+ Male Beneficiary)

These findings also agree with DFID (2011), report which indicates that cash transfers tend to improve school enrolments and attendance, complement direct education investments, enables households to pay fees or other costs associated with attending school, reduces the burden on children particularly girls to contribute to family income and enabling them to participate in school.

5.3.6 Improved Social Relations

The study established that social relations for most of the OVC who are beneficiaries of the program have greatly improved. They are no longer a burden to the society because they no longer depend on people or go around begging for basic needs. This has likely reduced child abuse which resulted from effects of paid labour. Respondents mentioned that children would be involved in economic activities like fishing and some were even sent off to bigger towns to offer paid labour as house maids. Some children were also asked for sexual favours in order to be assisted by older men or relatives. Respondents mentioned that the high numbers of children who ran to the lake to fish for a living has also reduced considerably because they get financial support for OVC-CT. In a similar study by Orinda (2014), OVC-CT has contributed to the social acceptance of orphans and vulnerable children who were previously discriminated and perceived as a burden in the community.

The study also found out that OVC-CT has contributed to improved social relations at the community level. There is improved social acceptance of OVC who were previously discriminated against because they were perceived to be a burden. People are now more willing to foster OVC and see them as valuable additions to the household.

High dependency ratios negatively affects the OVC and therefore cash getting into OVC households through the CT programme is instrumental in supporting families as stated by Webb (2007).

When vulnerable families are empowered, there is likely less discrimination in the community. This study found out that widows and orphans from HIV affected fishing families are no longer discriminated against since they can now afford to educate and feed their children like any other normal family.

In response to how the OVC cash transfers have improved social relations for fishing families affected by HIV, a respondent reported:

Men are mostly the sole bread winners in rural Budalangi and a widow usually is considered poor since there is no one to provide for her. There are very many widows here because of HIV but now there is no difference between a widow and a woman whose husband is still alive because her children can now go to school, eat and dress properly. (Source: Focus Group Discussions with HIV+ female beneficiaries)

From the findings of the study, it is evident that there is a lot of good brought by the OVC-CT in the community of Budalangi. Fishing families affected by are now able to bounce back into normal functioning because they are economically empowered. Their quality of life has improved through access of basic needs such as food, clothing, shelter, health and education. This has in turn improved social relations in the families and community by reducing the OVC dependency levels.

5.4 **NEGATIVE EFFECTS OF OVC- CT**

This study found out a few cases of misuse of CT money during the study period. Misuse of OVC-CT has had detrimental effects both at family and community level. Misuse of OVC-CT occurs when families fail to use it of the program's intended purpose such as securing basic needs for the orphans and vulnerable children.

5.4.1 **Child Neglect**

Respondents mentioned negligence of children who should ultimately benefit from the CT money, as one of the ways OVC-CT is misused. Child neglect escalates the levels of vulnerability of orphans who seek alternative livelihoods through high risk behaviors. This in turn leads to a vicious cycle of poverty and HIV/AIDS transmission.

A key informant reported:

It is funny that some of the guardians who receive money on behalf of the orphans still discriminate against them. The orphans are mistreated and denied access to basic needs and the guardians use the money to benefit themselves and their own children. (Source: Key Informant Interview with Voluntary Children's Officer)

5.4.2 **Family and Community Tensions**

Following from the section above, child neglect and discrimination has high chances of leading into family and community tensions. This can further pose a threat of disrupting the family unit and having social misfits in the community.

Family misunderstandings are likely to occur when the funds are perceived not to be used for the intended purpose. This might lead to disgruntlements in the wider community which might in turn raise questions on the effectiveness of the program.

Tensions within the family and in the wider community expectedly lead to poor relations that might further propagate vices within the family and community.

A respondent for instance had this to say:

There are some beneficiaries who are not using the money properly. We get complaints from family members and from the community asking us to discontinue such people from the program. The problem is we cannot discontinue them at our level and there is a lot of bureaucracy at the headquarters in Nairobi. (Source: Key Informant Interview with District Children's Officer)

5.4.3 Alcohol and Liquor Brewing

Liquor brewing in Budalangi is an income earner for many widows in this community as the study found out through observations. A local brew known as *mulingilo* is common among the youth and it is drunk by both men and women.

Respondents reported some beneficiaries using the OVC- CT in alcohol brewing, liquor trading and liquor drinking. This was perceived as a misuse of the OVC- CT funds by the community members. Respondents quoted promiscuity, propagation of HIV/AIDS, early marriages, school dropouts, among other vices that are likely to be associated with alcohol trade and consumption.

When asked about misuse of the cash transfer funds, a respondent had this to say:

You know there is nothing that is entirely good in this world. My co- wife receives this money but instead of using it to feed her children, she uses the money to buy alcohol for men. This is not good because her children are suffering yet the government is trying to protect the children. (Source: Interview with 38 year old female, non- beneficiary of the program).

Another respondent mentioned:

This alcohol trade is rampant here and young widows are getting into this trade because they hope that it has quick money. The alcohol that they make is called 'mulingilo' and it looks like brown tea. Some of the beneficiaries use the cash transfer money to trade in the alcohol business. The alcohol is not good because once people are drunk, they have sex carelessly because I hear the alcohol also increases libido. We already have a big problem of HIV in this community and alcoholism is making the situation worse. (Source: Key Informant Interview with OVC Community Health Worker)

Overall, cash transfers are reported to be of great benefit to HIV affected fishing families. In line with Temin (2010), the cash transfers can have benefits across the spectrum of HIV prevention, treatment, care and support. Cash transfers may play a role in HIV prevention by reducing the factors that place people at risk of infection by reducing school drop-out, migration, and girls' and women's social and economic inequality (Temin, 2010). The study shows that the cash transfer program has helped the benefitting AIDS-affected fishing families by securing basic subsistence for families where illness prevents them from securing a livelihood. It has also helped in keeping children from leaving school because of inability to pay fees or engage in labour needed at home.

However, cases of misuse of the funds also lead to negative effects within the family and community. Misuse is likely to lead to tensions within the family that sometimes threaten to disrupt the family unit.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

The general objective of the study was to investigate the potential of CT to strengthen the capacity of fishing families affected by HIV/AIDS to take care of orphans and vulnerable children. Specific objectives were to examine fishing as a means of livelihood among families affected by HIV, to determine the use and effect of cash transfers on the lives of OVC and their families, and to examine indirect effects of OVC cash transfers on fishing as a means of livelihood for fishing families affected by HIV.

The study draws conclusions in line with its findings in regard to each specific objective. This chapter also outlines recommendations on the program, on improving livelihoods, on policy and on future areas of research.

6.2 CONCLUSIONS

From the findings of the study, it is evident that the OVC- CT has the potential to strengthen the capacity of HIV affected fishing families to take care of orphans and vulnerable children in Budalangi District, Busia County. OVC- CT has exposed beneficiaries to regular and consistent income which is used in the beneficiary households to acquire basic needs and has improved the quality of life for the OVC and their families. Fishing families weakened by HIV and AIDS are likely to be able to take care of the OVC by helping educate OVC and cater for OVC needs such as food, health, clothing and shelter among others.

The increased household income has led to improved diet and increased number of meals per day in the households. This has possibly led to improved nutrition among the HIV positive beneficiaries.

The OVC-CT has also supported fishing livelihoods by allowing beneficiaries to use part of the cash in acquiring fishing equipment as well as to boost their businesses. The use of OVC-CT money has led to a probable reduction in poverty and dependency in the entire community through investment and consistent income for fishing families.

In line with Guhan (1994), social protection has proved to be protective (protecting a household's level of income and/or consumption), preventive (preventing households from resorting to negative coping strategies that are harmful to children such as pulling them out of school and involving them in child labour) and as promotional (promoting children's development through investments in their schooling, health and general care and protection). This indeed fulfils the notion that social protection can also be transformative by helping to tackle power imbalances in a society that encourages, creates and sustains vulnerabilities. Social protection supports equity and empowerment; including that of children and young people as supported by Devereux and Sabates-Wheeler (2004).

There are however reports of negative use and effects of OVC-CT among the beneficiaries in the study area. Such negative uses include drinking, hoarding the money and use on non OVC preferences. As such the OVC-CT has been associated with some negative effects such as tension and conflicts within the HIV affected fishing families. Others also felt that the programme has made people view OVC as a source of income in the community and hence placed extra demands on the beneficiary families.

Overall, the risk or predisposition to environmental conditions which in this case focused on how HIV/ AIDS pandemic has weakened fishing families and pre-disposed them to a myriad of bio-psychosocial problems, has been alleviated through the OVC-CT through receiving a regular income used for basic needs and investments.

OVC-CT has also cushioned the beneficiary families from exposure to a high-magnitude stressor. OVC-CT has probably helped where the HIV/AIDS affected fishing families were exposed to both social and psychological stress like stigma and physical stresses of the disease effects.

In the overall analysis of this study, OVC-CT has helped HIV affected fishing families to be resilient and to return to baseline and normal functioning. HIV/AIDS leads to constant illness of the infected members of the family. This further leads to low energy levels and loss of energetic people to provide labour in the family and at community level. Loss of energetic people in turn makes orphans vulnerable as they try to fend for their families by engaging in risky behaviors. OVC-CT came in place and provided an alternative avenue of income earning that is predictable and dependable.

Fishing families affected by HIV/AIDS rebuilt themselves by investing in fishing livelihoods, for instance in equipment and fish trade. This enabled them to be resilient and bounce back to normal functioning.

OVC-CT has therefore strengthened fishing families affected by HIV/AIDS in Budalangi because of the numerous positive effects outlined in the study findings. These uses have offered protective, preventive, promotional and transformational benefits to the orphans in HIV affected families.

6.3 RECOMMENDATIONS

In line with the findings, the study makes the following recommendations:

1. The OVC-CT program should increase the value of the CT money. The study showed that OVC-CT has been used to improve livelihoods through taking care of basic needs and investing. The study found out that the 4000 Kenya shilling paid to beneficiaries every two months is helpful but does not meet their basic needs sufficiently. This is because of the large number of people living in one household and also because the costs of basic commodities have risen over the years.
2. The program should also enroll more families affected by HIV. Enrollment of more families affected by HIV will help secure the basic needs and improve the quality of life of more orphans. This will further reduce dependency levels in the coming future.
3. There should be public education to fishermen on dynamics of fishing and HIV/AIDS. These programs should be complementary to those of OVC-CT so that efforts to protect vulnerable groups in the community are realized. Capacity building and financial support to vulnerable groups are important in helping affected families bounce back to normal functioning.
4. Integrated research should be done in areas of improving livelihoods. Anthropologists need to work with the relevant stakeholders i.e. the Ministry of Agriculture, so as to increase output for fish farmers. Fish farmers should access preservation and storage equipment and materials for their products. Fish farmers should also access ready markets outside the local community. This area of research will improve livelihoods which are likely to reduce dependency levels.

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8.0 APPENDICES

8.1 IDI – BENEFICIARY ADULT GUARDIANS GUIDE

Family status and living arrangements

- How old are you? Are you married, since when?
- What is your household size (how many people do you stay with?)
- How many orphans do you stay with?
- How are you related to them?
- When did you start saying with them?
- When did their parents die?
- Who made the decision to foster them in your household?
- Who is the primary care-giver in your household?
- What do you do to earn a living?
- Do the orphans in your household go to school?
- How do you feel about living with orphans? Why

Key vulnerabilities and coping strategies

- What do you do to earn a living / what are your main activities? What about other family members?
- What difficulties/challenges, etc do you face in coping with life in this area? How do you cope with such challenges?
- What vulnerabilities/ shocks do orphans experience in this area? What do the orphans do to cope with such difficulties?
- What do you do when you lack food, are sick, you lack money, when the children are sick? What do they do?

- Which are your most effective coping strategies?
- Are there coping strategies you consider risky for the orphans? If so which ones and why?
- Are there coping strategies that work for the children/ OVC? If so which ones and in what ways?

Use

- Who collects the cash in your household? Who keeps the cash?
- What do you think the cash should be used for?
- What do you use the cash for?
- Who decides what to use the cash for? Are the children involved in the decision making concerning the use?
- Last time you received it what did you do with it?
- Is any of the cash used for things that are of particular benefit to your children? If so, what? / Are there particular uses of the cash that most concern children (school fees, books, uniforms, shoes, nutritious food); if so, what and how are these decided upon?
- Do you think the money is used in the best way possible? If not, how could it be improved?

Impacts on families

- Has the programme impacted on you in any way?
- How was your life before the introduction of OVC-CT
- How has it changed your life?
- Has it changed the lives of children? Has it made a difference in the lives of children?
In what ways?
- Does the CT help you cope with challenges you face in any way? What of children/
does the CT help them cope with challenges in any way.

- What do you consider as positive effects of the cash transfer?
- On you as an individual (ability, gender differences),
- On your family/household –
- On the OVC
- Has it changed your relationship with other members of the household? If yes, how, for the better/worse?
- Has it changed the status of OVC in the community? If yes, how, for the better/worse?
- What have been the specific effects of the transfer on the OVC? (e.g. stigma, exclusion at school, less pressure to engage in sexual favours)
- Are you a member of any formal or informal group? Is the group related to the CT programme?
- Did the group exist before the introduction of CT programme?
- Is the group in any way related to the CT programme?
- What improvements would you suggest for the programme?
- If the programme were discontinued, what effects would it have on the lives of the orphans?

8.2 IDI – NON-BENEFICIARIES ADULTS HIV+ OR HIV-

Probes: why, what, where, how, when, who, how often.

Demographics

- Residential area
- Marital status
- Sex
- Age

- Educational levels
- Number of children

Economic activities

- (Are you married, since when, who do you live with, who is the head of the household, the number of children you have, number of other dependents (e.g. older family members, members living with a disability or illness), who is the primary caregiver in your household?)
- Is this your original home or you migrated here?
- Have you migrated in the recent past? Or when did you move here?
- Where were you before?
- Why did you migrate here?
- Did you move with your whole family? If no, why not? Who is here?
- How often do you migrate to different areas? Or do you move to different areas regularly? Or do you plan to move again from here? If so, why, where to?

Household and individual livelihood and coping strategies

- What is your main source of livelihood/what do you do to survive/ what are your main activities?
- Do you make money and if so how?
- What does the household head do for a living?
- What about other family members?
- What is division of labour and economic assets in the household/ who does what activities? And why? Who owns what?
- Are you involved in any fishing activity? (Probe fishing, fish processing, trading/selling). Are other members of your family/household involved? If so, who, since when, what do they do, etc.?

- What kind of fishing are you involved in? What kind of fish do you mostly fish for?
- When did you start fishing, processing or selling fish? How long have you been fishing, processing or selling fish?
- How did you start fishing / processing /selling fish? Who introduced you/ how were you introduced?
- Do you fish/process/trade alone or with other people? If alone, why? If with other people, which people, why these, is it the same people every time, etc.?
- How often do you fish, process or sell fish? Tell me about your typical fishing / processing / selling day (what time you start, when you come back, what you do, etc. etc.)
- Whom do you sell your fish to after fishing? (For fisherman). Whom do you buy your fish from to sell? (for traders) Is it always the same people?
- Do you own any fishing equipment? Probe boats, nets etc. Since when? Do you rent any of these out? To whom, how often? How much do you charge?
- How much money do you make from your fishing activities? Probe if it is the same every day, week, and month?
- Which seasons do you make more money and why?
- When is the last time you did fishing? How did you do it? How long did it take? How much money did you make? What did you do with the money?
- What difficulties/challenges, etc do you face in relation to fishing?
- Do all people face these difficulties / challenges in relation to fishing or only men/women, fishermen/processors/sellers?
- What do you do to overcome these difficulties/ challenges? Or what are your coping strategies? How effective are these/each coping strategy (after each coping strategy ask how effective is it...)?

- What difficulties/challenges do you face more generally?
- What are your coping strategies?
- How effective are these/each coping strategy (after each coping strategy ask how effective is it...)?
- What forms of support have you received over time, from government, religious institutions, family, NGO, etc. – probe support in general and support for being HIV-positive.
- Which have been the most important and why?
- How does this form of support compare to the one this CT programme is providing?
- What does being poor/vulnerable mean to you?

Social networks (highlight differences between men/women, older/younger, etc.)

- If you are in (economic) trouble, need financial support, what do you do? Who do you turn to (state, family, church... *spider diagram*)? where do you go? What support do you receive (economic, in-kind)?
- If you are feeling sad, unwell, abandoned, badly treated, discriminated, etc. what do you do? Who do you turn to? Who takes care of you? Spouse, children, state, no one ..
- Have your social relationships/networks changed over time (also because of a result of being HIV+ and because of the CT programme)? Have they become stronger / weaker? How, why, since when...
- Are you a member of a group? (Formal and informal, e.g. Kin or clan groups, merry go round, church groups, etc.)
- If not why not?
- If yes, since when? What do you do/ what are the objectives of the group? How many members are there? How do you become a member? How often do you meet? What benefits do you get from belonging to the group?

- Is there an HIV-positive support group here? Are you a member? If no, why not? If yes, since when, what do you do, how often do you meet, etc. etc.?

Health seeking behaviour

- What are the common illnesses in this area?
- What do you do when you are ill?
- Where do you seek treatment when ill?
- Do you have any current health problem?
- What are you doing about this health problem?

Knowledge and Perceptions on HIV

- What is HIV?
- Do you know what causes HIV?
- Do you think HIV can be prevented? Or do you know how HIV infections can be prevented?
- Do you think HIV can be cured? If yes, what cures HIV?
- (If not HIV+) Do you know about ARV's? Or what are ARV's and what do they do?
- Do you know your HIV status? Can you tell me?
- How did you find out about your HIV status?
- Who else knows about your HIV status? (Does your spouse know about your status?)

Access to ARVs

- If HIV+, are you or OVC on any treatment? What are these treatments you/they are on?? Or Are you on ARV treatment?
- Since when have you/they been on ARV treatment?
- What ARVs do you take? When do you take them? How do you remember to take them?

- Do you/they face challenges taking ARVs? If so, why, which, what do you do to cope with these challenges?
- Where do you access your ARV's from?
- Since when have you/they been accessing them from there?
- Do you/they face challenges accessing your ARVs? If so, why, which, what do you/they do to cope with these challenges?
- How much do you/they pay for your ARVs?
- Do you/they pay for anything else?

Risk Perceptions and Practices (for HIV- person)

- What group of people are at more risk of HIV infection in your community, and why? (probe age group and sex)
- What practices/ behaviours in the community put people more at risk of HIV infection?
- Do you think that fishing as a means of livelihood puts people at risk of HIV infection? If so how? Why, who in particular, etc.?
- What can people in the community do to reduce these risks?
- Are there interventions/programs in the community that try to address the issue of HIV? What are these interventions? How do they work?

The CT programme

- What do you know about the cash transfer programme?
- For how long has it been running?
- What is its focus? What do you know about the programme goals?
- Who is selected/targeted? How are they selected? What process was involved?
- What do they receive? How often? From whom?
- Do you think the right people receive the cash transfer? If no, why?

- Do you think there are some people who should have received but didn't? If so, which people and why? (fair/unfair)

Effects

- What are positive effects of the cash transfer?
- On individuals (probe re age, ability, gender differences),
- On families/households - certain members of households, which, why (probe re male vs female headed households, extended family hhs, polygamous households, etc.),
- On the community as a whole (both in terms of bonding social capital – i.e. links to peers – and bridging social capital – i.e. links to authorities)?
- Have you observed any particular effects, both positive and negative, on children and young people in beneficiary households?
- What are the negative effects of the cash transfer?

Future programming

- If the programme were discontinued, what effects would it have on the lives of people here (e.g. no longer able to invest in x or y)?
- Do you think young people should be included in the programme? If so, what young people: poor /employed / unemployed / male / female / single / married, etc?
- How could the programme be made better to improve the situation of children and young men / women people in the community?

8.3 IDI GUIDE – PROGRAMME BENEFICIARIES– CHILDREN (10+)

Family status and living arrangements

- Children: How old are you? Who do you live with? How many siblings do you have? Who is your main/primary care-giver? Are you responsible for taking care of any one?

Household and individual livelihood and coping strategies

- What are your main activities? Inside the household (household chores; looking after other children, etc.) Outside the household (agricultural-related activities; other).
- Do these differ for boys and girls?
- Do you go to school? If yes, which grade? If no, when left (if went), why, etc.
- Do you engage in any activity which brings you money? If yes, who asks you to do this? What happens to the money you get? What do you do with the money you make? Who do you give the money to?

Information on fishing

- Are you involved in any fishing activity? (Probe fishing, fish processing, trading/selling). Are other members of your family/household involved? If so, who, since when, what do they do, etc.?
- What kind of fishing are you involved in? What kind of fish do you mostly fish for?
- When did you start fishing, processing or selling fish? How long have you been fishing, processing or selling fish?
- How did you start fishing / processing /selling fish? Who introduced you/ how were you introduced?
- How often do you fish, process or sell fish? Tell me about your typical fishing / processing / selling day (what time you start, when you come back, what you do, etc. etc.)
- What do you do with the fish after fishing? Probe sell, take home etc.
- When your family is in difficulty (e.g. lack food, someone is unwell, lack money, etc), how does this affect you? (Probe Do you take on any additional tasks? Do you continue to go to school? Etc.)

Health seeking behaviour

- Do you usually get sick? If so, how often?
- What illness do you get frequently? Common illness...
- What do you do when you are ill? Whom do you tell or where do you go?

Knowledge on HIV

- What is HIV?
- Do you know what causes HIV?
- Do you think HIV can be prevented? Or do you know how HIV infections can be prevented?
- Do you think HIV can be cured? If yes, what cures HIV?
- Do you know anyone with HIV? Can you tell me more about them are they a friend, neighbor or relative?

Social networks (highlight difference between girls/boys):

- Do you have friends here? How often do you meet with them? What do you do?
- If you are in trouble, e.g. need support at school, financial support, feeling sad, etc., what do you do? (Where do you go? Who do you turn to?)
- Have you changed friends over time? Have you more friends now than before? Or less friends now than before? How, why, since when...
- Are you a member of any group or club (at school, in your neighbourhood)? If so, since when, where/which? What do you do in the group?

The CT programme

- Do you know anything about the CT programme? What do you know?
- Since when has your family been a member of the programme/receiving a cash transfer?

- Do you know how your family was selected? (Who selected you? What process was involved? What did they do to select people? What do you think of that process, was it fair/unfair? Why?)
- Who in your household is currently receiving the cash transfer?
- Do you think the right people receive the cash transfer? If no, why?

Access/distribution

- Who in your household receives the cash? Do you know where they go to do so and how often? Do they have any difficulties in receiving the cash?
- Do you know how much cash is received? Is anything else received in addition?
- Do you know if the cash is supposed to be used in a particular way or for a particular purpose? If so, what?

Use

- What does your family/household use the cash for?
- Who decides in your family what to use the cash for?
- Last time, what did your family use it for?
- Was some of the cash used specifically for things that are of benefit to you or your brothers and sisters?

Effects

- Has this programme changed your life in any way?
- What are some of the positive effects of the cash transfer?
- On you
- On your brothers and sisters?
- On your family?
- Can you describe any ways in which your life has changed since receiving the transfer?

- In terms of your activities (at home, school, in the community)
- In terms of your relationships (at home, school, in the community)
- In terms of how you feel (physically, emotionally)
- In thinking of the most significant ways this programme has changed your lives, what comes to mind? ((e.g. access to school, better food, access to medicine, less time doing chores, less time doing paid work)
- Have there been any negative effects?

Future directions

- How could the programme be made better to improve the situation of children?
- If the programme stopped, how would this affect you?

8.4 KEY INFORMANT INTERVIEW GUIDE

Community leaders (Representative of a Fish Union, Women group leader, Youth leader, village elder, BWC member, VCO, Chief, Assistant Chief etc)

Demographics

- Residential area
- Marital status
- Sex
- Age
- Number of children
- Occupation (probe) role in the community
- What is your role in the community?
- Whom do you work with in the community? Probe men women and children.
- How do you work with these people? What kind of help or services do you offer them?

- Do you partner with any organization in the community? Probe which organizations and how they come in.

Targeting

- Is it fairly targeted, do you think some people have benefited more than others? If yes, which, why?
- Does it reach the most vulnerable groups? (insert probes around particular vulnerable groups, OVC, elderly, disabled, etc.) Probe: Does the age cut-off make sense? How is it determined?
- Are there some people who are not receiving it but deserve it? Are there some people who receive it but don't deserve/need it?
- Have you actively intervened to influence the selection process? If so, how? Why?
- Have you ever had to intervene to actively remove people from the programme? How? Why? Impact of this?
- How could the programme guidelines be adapted to your community needs/dynamics?
- Community livelihood and coping strategies
- What do people do to survive/ what are their main activities?
- What difficulties/challenges, etc do people face? When in difficulty what do they do? What are their coping strategies? How effective are these/each coping strategy (after each coping strategy ask how effective is it...)?
- What are the processes of fishing in this area? (probe stages involved and who is involved at each stage i.e gender)
- What are the different livelihoods related to fishing in this area? (probe who is involved in fishing, processing, trading within and beyond area.)

- What are the different risks associated with these livelihoods? (probe stage at which vulnerabilities come in for whom and why?) i.e risks for fisherman and risk for traders.

Health seeking behaviour

- What are the common illnesses in this area?
- Where do people seek treatment when ill? What do they do when they are ill?

Knowledge on HIV

- What is HIV? Do you know what causes HIV? Do you know how HIV can be prevented?
- What group of people are at more risk of HIV infection in your community (probe age group and sex at more risk and why?)
- What is the general feeling in your community towards HIV+ people?
- How does stigma manifest itself in your community?
- What strategies do people use when confronting or reducing stigma in your community?
- Have you noticed any changes in stigma and discrimination in the last few years? What do you attribute this to and why?
- What are the needs of people living with HIV (probe treatment, nutrition, social support etc)

Risk Perceptions and Practices

- What group of people are at more risk of HIV infection in your community, and why? (probe age group and sex)
- What practices/ behaviours in the community put people more at risk of HIV infection?

- Do you think that fishing as a means of livelihood puts people at risk of HIV infection? If so how? Why, who in particular, etc.? Is it different for men and women? If so how?
- What can people in the community do to reduce these risks?
- Are there interventions/programs in the community that try to address the issue of HIV? What are these interventions? How do they work?

CT Programme

- What is your role in the CT programme/What's your relationship to the CT programme?
- Are you involved in identifying beneficiaries? If, so how?
- What are the main issues, problems, challenges in identifying beneficiaries (probe validity of identify, what happens for newly vulnerable)
- How do specific groups get identified, registered?
- Are the numbers of potential beneficiaries restricted? How do you then select among the eligible?
- Do you think that the criterion for eligible vulnerable groups set by the programme coincides with the most vulnerable groups in your locality?
- Are you involved in programme implementation, monitoring
- What are the main issues, problems, challenges in programme implementation, monitoring
- Do you work with programme implementers? If so, how
- Effects of the cash transfer:
- How has the programme affected the community as a whole (positive, negative), how has it changed over time (lasting change or more transient change only?);
- have excluded groups become more empowered/vocal/involved;

- Have women, disabled, etc. become more empowered; if so, how can this be seen?
- Are people/excluded groups more able to speak to people in authority, to demand their entitlements, rights, etc.?
- has the programme had any unintended spin-offs/benefits; (healing divided communities/reinforcing social divisions, social division /fragmentation) (particularly in terms of any consequences for existing intergenerational transfers/care and support practices)
- Compared to other programmes/sources of support (church, remittances, NGOs, formal pensions, etc) how do you see this programme? How important is it compared to these others? (Amount, type of support (psycho-social support), consistency, regularity, etc.) How do other people see it?

Challenges

- What are the main obstacles to the programme working well? (Understanding of the scheme, unavailability of cash, not regular, capacity and attitudes of staff, etc.)
- Has it created any tensions – for example between beneficiaries and non-beneficiaries, or within the household between men and women, siblings, older and younger people, etc.?
- Has the programme led to tensions in the wider community? if so, between whom and who, why, what can be done to address these?
- Do they think recipients would prefer to receive something else? If so, what?
- Do they think conditions should be placed on receiving the cash? if so why and which?
- What do you think might be some of the challenges from the perspective of programme implementers (including capacity constraints –both in terms of substance e.g. limited gender or child-sensitive awareness – time, budget)

- Do you think these challenges are specific to this location or is your view that these are cross-cutting concerns, affect other areas of the country? Ideas to overcome them

Future directions:

- If the programme were discontinued, what effects would this have on ex-beneficiaries lives/livelihoods?
- How would you see the programme continuing in the future?
- What changes would you make, if any?
- What could be improved? (Probe: targeting, frequency, amount, complementary programmes, links to information, evaluations/ lesson learning etc.)
- How could the programme become more child, age, disability and gender sensitive?

8.5 FGD – BENEFICIARIES MAIN STUDY – ADULTS GUIDE

Theme 1: key vulnerabilities and coping strategies [*spend no more than 15 mins discussing the vulnerability context*]

- What are the key challenges people face in this community? As individuals? Within the household? Within the community? (probe: food insecurity, disability, health (HIV), drought, social exclusion, discrimination (on basis of age, gender, ethnicity), violence/ conflict, etc.)
- Are there particular challenges faced by children, young people in this community?
- Are there any noticeable changes in challenges faced in this community (over time; according to the season; according to the type of difficulty)
- What are the key coping mechanisms used in this community? What do people do when in difficulty? (probe: reduce consumption, take on more work, ask non-working family members to take on more work, selling assets (whose assets? women's vs men's), engage in labour-sharing strategies, labour pledging (lack of control when

labour returns are demanded = sign of deep distress), borrow/ go into debt, ask for support from extended family or friends, migrate domestically or internationally, rely on remittances)

Details on fishing

- What are the processes of fishing? (probe stages involved and who is involved at each stage i.e gender)
- What are the different types of fishing in this area? (Probe large, small, different type of boat owners etc.)
- What are the different livelihoods related to fishing in this area? (Probe who is involved in fishing, processing, trading within and beyond area.)
- What are the different risks associated with these livelihoods? (Probe stage at which vulnerabilities come in for whom and why?) i.e risks for fisherman and risk for traders.

Health seeking behaviour

- What are the common illnesses in this area?
- Where do you seek treatment when ill? What do you do when you are ill?

Knowledge and Perceptions on HIV

- What is HIV?
- Do you know what causes HIV?
- Do you think HIV can be prevented? Or do you know how HIV infections can be prevented?
- Do you think HIV can be cured? If yes, what cures HIV?

Risk Perceptions and Practices

- What group of people are at more risk of HIV infection in your community, and why? (probe age group and sex)

- What practices/ behaviours in the community put people more at risk of HIV infection?
- Do you think that fishing as a means of livelihood puts people at risk of HIV infection? If so how? Why, who in particular, etc.? Are the risks same for men and women? If different, how?
- What can people in the community do to reduce these risks?
- Are there interventions/programs in the community that try to address the issue of HIV? What are these interventions? How do they work?
- Stigma and Discrimination on HIV
- What is the general feeling in your community towards HIV+ people?
- How are HIV-positive people viewed by others in the community?
- How are people on ARVs viewed by others in the community?
- What strategies are used in confronting or reducing stigma in your community?
- Have you noticed any changes in stigma and discrimination in the last few years? What do you attribute this to and why?

Theme 2: CT programme

- Perceptions of programme and membership/targeting
- What does the programme consists of/what does the programme do for you?
- Where do you think this cash comes from?
- What do you know about the programme goals? How did you find out about this?
- Have you had any training/ information or education about the programme? If so, who provided this? In what format?
- Does the programme have any forum/occasions when you can meet and discuss social issues such as discrimination, rights to better treatment from others, changing social attitudes/norms?

- If not, do you think that would be useful? On what types of issues?
- How are people selected to receive the cash?
- Describe the process/your experiences of the process
- Who selected you?
- Did people have to disclose their status or their OVC HIV status in order to become a member? If so, to whom? How did you/they feel about that?
- What do you think about the selection process? Has it changed over time? (e.g. rotation of households as programme beneficiaries?)
- What has been the effect of this selection process on community relations, dynamics? (e.g. positive, negative)

Access and distribution:

- How much cash is given? How often? By whom? To whom?
- How or where is it distributed? Is the frequency of receiving it sufficient?
- How far away is the collection point? Are there safety issues in accessing the cash? (esp. for girls/ women)
- Is the amount of cash adequate?
- Are the payments regular and predictable?
- Do people use money from the CT for their fishing activities? How do they use it in their fishing activities? Or Has the CT helped them in relation to their fishing activities? If so, how has it helped? If not, why not?
- Has CT money changed the way people are involved in fishing activities? If so, how has it changed the way people fish and their other fishing related activities like trade?

Effects

- What are positive effects of the cash transfer?

- On individuals (probe re age, ability, gender differences),
- On households (probe re male vs female headed households, extended family hhs, polygamous households, etc.),
- On the community as a whole? (Both in terms of bonding social capital – i.e. links to peers – and bridging social capital – i.e. links to authorities)?
- What have been the specific effects of the cash transfer on the children in your household (can be both positive and negative)? (e.g. stigma, exclusion at school, less pressure to engage in sexual favours)
- In thinking of the most significant ways this programme has changed your lives, what comes to mind?
- Has the cash transfer impacted your psychological well-being in any way? If so, how? (translate as appropriate)
- What are the negative effects of the CT programme?
- Are there other people like you but who are not on the programme? How have things changed for your household compared to them over time? (e.g. building assets)
- How has CT impacted on HIV related stigma? Are people, including children who are HIV+ and receive CT viewed differently or it is the same? Has it reduced stigma and discrimination? Are people (including children and youth) disclosing their status more now? If not, why not, if yes, why, to whom, etc.? Is it the same for HIV+ men and HIV+ women/boys/girls? (e.g. do men/boys disclose more than woman/girls or vice versa?)
- Have the lives of HIV+ people, including children, improved because of CT? If yes, how? Is it the same or different from HIV-negative people? If different, how, etc. (probes on nutrition, treatment, access to social support etc.)

Theme 4: Future directions

- If the programme were discontinued, what effects would it have on your life?
- How would you see the programme continuing in the future?
- What changes would you make, if any?
- What could be improved? (probe: targeting, frequency, amount, complementary programmes, links to information, evaluations/ lesson learning; access to vocational training, literacy, psycho-social support, reproductive health, etc.)