# EFFECTS OF OLDER PERSONS' CASH TRANSFER PROGRAMME ON THE ECONOMIC AND SOCIAL WELFARE OF OLDER PERSONS IN KOROGOCHO LOCATION, NAIROBI CITY COUNTY, KENYA

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## DECLARATION

This project proposal is my original work and has not been presented for examination in any other university.

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This Project Paper has been submitted for examination with my approval as a University Supervisor.

Signature: …….. Date: ……

**Prof. W. Onyango-Ouma**

## DEDICTION

To my brother Dickson Odhaimbo Nyagaya. Forever in my heart.

To Stephanie, Fabian and Denzel, be encouraged by the words of Hillary Clinton, “never doubt that you are valuable, and powerful, and deserving of every chance and opportunity in the world to pursue and achieve your own dreams.”

## TABLE OF CONTENTS

## LIST OF FIGURES

## LIST OF TABLES

## LIST OF MAPS

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## ABSTRACT

The purpose of the study was to investigate the unmet economic and social needs of older persons living in Korogocho Location, Nairobi City County and to determine the effects of the Older Persons' Cash Transfer on the needs of those beneficiaries. The objectives of the study were; to investigate the economic and social needs of older persons living in Korogocho Location and to determine how the OPCT has improved their economic and social welfare. The study adopted a descriptive research design and sampling was done purposively to select 50 recipients of OPCT as the sample size. Data was collected qualitatively using semi-structured interviews, key informant interviews and focus group discussions. The findings of the study revealed that although the OPCT has improved the economic and social welfare of its beneficiaries especially on the purchase of basic needs and access to healthcare, the fund was not enough in cases where recipients did not have any other source of income. This study therefore recommends that the relevant government agencies should train the recipients on capacity building to find alternative sources of income as well as on how to properly manage the fund they receive. It further recommends that the amount disbursed to the recipients be reviewed as the cost of living keeps soaring yet the amount remains the same.

## ABBREVIATIONS AND ACRONYMS

**CT** - Cash Transfer
**OPCT** - Older Persons' Cash Transfer

**UN** - United Nations

**AU** - African Union

**NARC** - National Rainbow Coalition

**HIV** - Human Immunodeficiency Virus

**AIDS** - Acquired Immunodeficiency Syndrome

**NSSF** - National Social Security Fund

**NHIF** - National Hospital Insurance Fund

**OVC** - Orphans and Vulnerable Children

**PWSD** - Persons with Severe Disability

**FGD** - Focus Group Discussion

**MDGs**- Millennium Development Goals

# CHAPTER ONE: BACKGROUND TO THE STUDY

## 1.1 Introduction

Social protection can be defined as the protection of individuals and households in periods when they cannot engage in gainful employment due to unemployment, illness, disability or old age (UNRISD, 2010). It refers to policies and actions, including legislative measures, which improve the capacity of the poor to sustain their lives and to enable income-earners and their dependents to maintain a reasonable level of income through decent work (GoK, 2011). Devereux and Sabates-Wheeler (2004) state that social protection describes all public and private initiatives that provide income and consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalized with the overall objective of reducing the economic and social vulnerability of the poor as well as vulnerable and marginalized groups. Social protection instruments are administered in the form of cash transfers, feeding programmes, food subsidies, social or health insurance, microfinance, subsidized agricultural inputs, public works programmes, waivers and exceptions, and skills development. According to Bachelet (2011) social protection refers to policies and actions, including legislative measures, which enhance the capacity and opportunities for the poor and vulnerable to improve and sustain their lives, livelihoods and welfare; enable income earners and their dependents to maintain a reasonable level of income through decent work; and ensure access to affordable healthcare, social security and social assistance.

There is a growing focus in developing countries on the role of social protection programmes towards reducing poverty and help boost the capacity of the poor and vulnerable groups. If implemented successfully, social protection programmes can contribute to reducing poverty among these groups. However, despite the growth of

social protection programs in the world, most developing countries have not been able to effectively implement the programmes (Babu, 2003).

According to Vincent and Cull (2009), vulnerable groups require social protection to protect their livelihoods and each of these groups requires different forms of social protection, ranging from social transfers, for example, grants to the elderly and cash transfers; social services, including; home based care, education and health insurance; and social transformations, that is, broader policy and legislative changes to ensure the rights of vulnerable groups.

Social protection programmes by design need to balance the goals of: preventing shocks that may have a negative effect on the lives of poor people, reducing the impact of shocks that may have a negative impact on the poor; and helping vulnerable groups such as older women, children who have been orphaned, sick people and persons living with disabilities to cope with shocks (Farrington, 2007). Social protection can be classified into three categories: social insurance, social protection and social transfers. Social insurance is gradual contribution which is pooled together and disbursed when a permanent change such as retirement occurs. Social assistance refers to free education, feeding programmes or healthcare. Social transfers are regular and usually predictable transfers mainly from the government to its people. They are usually in form of grants or pensions to poor and vulnerable people (Browne, 2015).

Social protection policies have continued to gain prominence around the world. Such policies comprise labour market, social insurance and social assistance. Social assistance can be defined as non-contributory transfer programmes that target populations that are vulnerable to poverty and shocks. One such type of social assistance is cash transfer where formal institutions such as Governments and NGOs

send regular cash remittances to selected recipients who meet a specific criterion in order to meet their minimum consumption needs (Garcia, 2012) .According to Bachelet (2010), social protection enhances the capacity and opportunities of the poor to improve and sustain their lives, livelihoods and welfare by cushioning them against poverty.

In Africa, for example social transfers are gaining momentum following the growing evidence that regular transfers have more impact with respect to reducing vulnerability, poverty and social risks. For instance, the large-scale cash transfer programmes in Southern Africa have contributed to reduction in the poverty gap. In Lesotho, the Old Age Pension scheme, benefitting persons aged 70 years and above has had ripple effects in the immediate community through job creation and also led to a reduction in the rates of dependency (Help Age International, 2006) whereas evidence from studies conducted in Malawi report that the Mchinji Social Cash Transfer Scheme recorded an impact in the local economy (Davis and Davey, 2008). Furthermore, in Zambia, a study reported that over three quarters of the Kolomo Social Cash Transfer Scheme was spent locally, leading to economic growth (Lund et al, 2008).

### 1.1.1 Kenya and Social Protection

The 2010 Constitution defines older persons as people aged 60 or more years. The OPCT programme, however, targets persons aged 65 or more who have attained additional criteria including income status, geographical area location and being non-beneficiaries of another CT programme. According to the 2009 Kenya Population and Housing Census, there were 1.3 million people who were above 65 years of age, 20.6 million were aged 15-64, meaning a handful will be crossing the 65+ age yearly. Considering the population increases by about 1 million yearly and a declining crude

mortality rate from 11/1,000 in 2007 to 8.93/1,000 in 2011, the number of those ageing is expected to increase significantly by 2030 (Government of Kenya, 2009).

Kenya has ratified a number of International Declarations on the welfare of older persons. The Universal Declaration of Human Rights of 1948 clearly declares that all human beings are born free and equal in dignity and rights. The World Summit for Social Development, which was held in Copenhagen in March 1995, brought together world leaders, who pledged to eradicate poverty and foster social integration. The Madrid International Plan of Action on Ageing was adopted in April 2002. It is comprehensive and clear on the roles of governments in facilitating the well-being of older persons. It also emphasizes on the elimination of age discrimination (UN, 2002). The Madrid Plan of Action has guided the course of thinking on ageing across the world. It calls for change in attitudes, policies and practices so that the potential of older population can be fulfilled (UN, 2002). International Plan of Action on Ageing; UN Principles and Rights of Older Persons to independence, participation, care, self – fulfillment and dignity, the African Union Policy Framework and Plan of Action on Ageing, and the 2006 Livingstone declaration seeking integration of social transfers in annual work plans and national budgets are also other international instruments which Kenya has signed.

In the Constitution of Kenya, 2010, articles 21, 43 and 57 carter for the welfare of older persons. The Constitution of Kenya obligates the state to take measures to ensure participation, personal development, dignity, respect and protection of older persons. Article 10 (2) defines the responsibility of the state to protect older persons. Further, Article 21(3) shows the state's obligation to address the needs of older persons. Finally,

Article 43 (3) obligates the state to provide social security to older persons (Government of Kenya, 2010).

The National Policy for Older Persons and Ageing was enacted by Parliament in February 2009. The policy provides a comprehensive framework to address the unique challenges that older persons in Kenya face, and recognition of their rights, as distinct right holders and participants. The policy also takes cognizance of the fact that ageing is a process which starts from the time one is born and hence the need to prepare for old age in human development. The policy recognizes that older persons are an important segment of the national population whose rights must be recognized, respected, protected and promoted (Government of Kenya, 2014).

Kenya's Vision 2030 aims at transforming Kenya into a middle income country by 2030. It consists of three pillars: economic, social and political. The Social Pillar aims at investing in the people of Kenya through different initiatives of social welfare projects. This has a direct impact on the welfare of older persons (Government of Kenya, 2013). The National Social Security Fund (NSSF) fund was established in 1965 by an Act of Parliament (CAP 258 of the Laws of Kenya) in order to administer a provident fund scheme for all workers in Kenya. The National Hospital Insurance Fund NHIF was established in 1966 to meet the health needs of the Kenya population. It manages the contributions of its members and registration for membership is mandatory for formal employees and voluntary for informal workers.

The NARC government put priority on addressing poverty, unemployment and inequality and so social protection programmes were initiated in 2004 to help address these problems. Cash transfers were first implemented in 2004 to help orphans and vulnerable children and poor older persons (Ikiara, 2009). The OPCT borrowed mostly

from the OVC Programme. It is the sole social protection programme that helps older persons who are not on pension. The main goal of the OPCT is to build the capacity of older person while giving them a direct cash transfer (Mathiu and Mathiu, 2012).

The OPCT is an initiative of the Government of Kenya among National Safety Net Programmes (NSNP) coordinated by the Social Protection Secretariat under the Ministry of Labour, Social Security and Services. The National Safety Net Programme is supported by the World Bank, The UK Department for International Development (DFID), the Government of Sweden, the Australian Department of Trade and the United Nations Children's' Fund (GoK, 2016). Currently called "Inua Jamii", the OPCT was first piloted in three sub counties in 2007/2008 targeting 300 households with each household receiving KES 1,000 per month. In 2009/2010, it was scaled up to 33,000 households in 44 sub counties with each household receiving KES 1,500 per month. In 2011/2012, some 36,036 households benefitted with a monthly allocation of KES 2,000 per household per month and since then, the programme has been scaling up each year. By 2015/2016, 320,636 beneficiaries had been enrolled in all the 47 counties (GoK, 2016).

### 1.1.2 Older persons' population in Kenya

The world's population is ageing. Between 2015 and 2030, the population of people who are aged 60 and above is projected to grow from 901 million to 1.4 billion and by 2050, the global population of older people will be 2.1 billion (UN, 2015). By 2015, one in five people in Europe and North America were aged 60 and above. In urban areas, the population of older people is growing faster compared to rural areas. This has resulted in an increase in concentration of older people who live in urban areas. In sub-Saharan Africa, older people constitute only 5 per cent but this is projected to increase

to 10 per cent by 2050. The older population in sub-Saharan Africa will outstrip all other world regions from 46 million to 694 million by 2100 (UN, 2014Majority of the world's population reside in urban areas. In 2014, 54% of people lived in urban areas and this population will rise to 66% in 2020. In Africa, 61% of urban residents lived in informal settlements in 2013. More than half of the population of Nairobi residents dwell in slums and informal settlements (UN, 2014).

According to the 2009 Kenya Population and Housing Census, there were 1.3 million people who were above 65 years of age while 20.6 million were aged 15-64, meaning a handful will be crossing the 65+ age yearly. Considering the population increase by about 1 million yearly and a declining crude mortality rate from 11/1,000 in 2007 to 8.93/1,000 in 2011, the number of those ageing is expected to increase significantly by 2030. In Kenya, forty four percent of the people were aged below 15 years, 52 percent were aged 15 to 64 years and 4 percent were aged 65 and above years in 1999 (Government of Kenya, 2009). According to the 2009 Kenya Population Housing Census results, older persons consisted of 1, 926,051 (ten percent) of the total population. The population of older persons had increased in Kenya from 270,000 to 1.4 million between 1999 to 2009 as shown in the National Population and Housing Census. By the year 2020, this population is projected to rise to 2.6 million (GoK, 2014).

### 1.2 Problem Statement

The world is rapidly ageing and older persons have become one of the most vulnerable segments of the population. Older persons constitute a sizeable percentage of Kenya's population of the poor and they face many challenges during their lifetime. For instance, they are involved in the care for the sick, orphaned children or children whose parents

are engaged in work far away from home (Gondi, 2009). Older persons are also vulnerable to hunger and famine due to food insecurity as a result of lack of means and resources for food production. In Kenya, many older persons reach old age with minimal literacy skills which limits them in terms of employment. Inadequate skills, coupled with declining physical strength constrain income and security among older persons (GoK, 2014).

Although the Government of Kenya's OPCT is now operational, there is still economic strain among older persons living in informal urban settlements. Forty three percent of households containing an older person are estimated to be living in absolute poverty on less than 1.90 dollars a day (Ezeh et al, 2006). In Korogocho, close to thirty five percent of older persons live in households where there is one child below the age of 15 years (Ezeh et al, 2006) .There is need to investigate the effects of the OPCT on the economic and social welfare of older persons, particularly those living in informal urban settlements.

**The study was guided by the following questions:**

1. What are the economic and social needs of older persons living in Korogocho Location, Nairobi County?
2. How has the OPCT impacted the economic and social welfare of the recipients living in Korogocho Location, Nairobi County?

### 1.3 Objectives of the Study

#### 1.3.1 General Objective

To explore the effects of OPCT on the economic and social welfare of older persons living in Korogocho Location, Nairobi City County.

### 1.3.2 Specific objectives

1. To investigate the economic and social needs of older persons living in Korogocho Location, Nairobi City County.
2. To determine how the OPCT has improved the economic and social welfare of recipients living in Korogocho Location, Nairobi County.

## 1.4 Assumptions of the Study

1. Older persons living in Korogocho Location have several unmet economic and social needs.
2. OPCT has improved the economic and social welfare of the recipients living in that Location.

## 1.5 Justification of the Study

Older persons are part of the society and their needs are as important as those of any category of the population. All over the world, the population of older persons is increasing rapidly. Previous studies which have been conducted on OPCT have focused on the programme evaluation and fund disbursement (Kimosop, 2013, Mwanzia, 2015 and Omolo, 2017). The findings of this study will provide additional information to already existing literature on cash transfer funds and their effects on the economic wellbeing and social capital of beneficiaries living in informal urban settlements.

## 1.6 Scope and Limitations of the Study

This study was conducted in Korogocho Location in Nairobi City County and it sought to explore the needs of older people as well as the effects of OPCT on the economic and social welfare of recipients of the fund. The study explored the different unmet needs of older people and identified different ways in which the OPCT fund has improved the economic and social aspects of the lives of the recipients. This study was

guided by Resilience theory and purposive sampling was used to select the number of respondents who participated in the study.

This study relied on information that was provided by recipients of OPCT who lived in Korogocho Location. This had limitations since they may not have given correct information and some may not have been willing to participate. To guard against this, proper consent was sought from the respondents and they were assured of confidentiality and the purpose of the research.

### 1.7 Definition of Terms

**Cash Transfers**- These are regular noncontributory payments of money provided by governments or non- governmental organizations to individuals or households with the objective of reducing chronic or shock-induced poverty while addressing social risks and reducing economic vulnerability.

**Social Protection-** Refers to policies and actions including legislative measures, which enhance the capacity and opportunities for the poor and vulnerable to improve and sustain their lives, livelihoods and welfare, enable income-earners and their dependents to maintain a reasonable level of income through decent work, and ensure access to affordable healthcare and essential services (GoK, 2009).

**Older person**- The Constitution of Kenya, 2010, Chapter 17 Article 260 defines an Older Person as any person above the age of 60 years. However, for the purpose of this study, an older person refers to a person above 65 years and who is a beneficiary of OPCT.

**OPCT**- A programme providing predictable cash to older persons who have met certain criteria of KES 2,000 every moth paid after two months at the rate of KES 4,000.

**Household**- Persons living together and eating from the same pot.

**Effect**- Significant impact of an intervention on the intended target population.

**Informal settlement**- Residential areas where a group of housing units has been constructed on land to which the occupants have no legal claim, or which they occupy illegally; unplanned settlements and areas where housing is not in compliance with current planning and building regulations(unauthorized housing).

# CHAPTER TWO: LITERATURE REVIEW

## 2.1 Introduction

This section reviews literature that was relevant to the research problem. The literature was based on the evolution of cash transfers as instruments of social protection, types of social assistance programmes in Kenya and the effects of OPCT.

## 2.2 Evolution of Cash Transfers as Instruments of Social Protection

Cash transfer can be defined as a state-run cash transfer programmes whose main aim is to guarantee a minimum level of consumption to the recipients (HelpAge, 2007). Cash transfers are regular non-contributory payments of money provided either by governments or non-governmental entities to individuals or households based on their economic needs and with the aim of strengthening their capacity and improving livelihoods (Onyango-Ouma and Samuels, 2012). Cash transfers promote wealth creation; prevent beneficiaries from suffering shocks while transforming their relationships within the society (Orinda, 2014) .Cash transfers started in the 16$^{th}$ Century in Europe after the government of England accepted collective responsibility in ensuring that the poor and vulnerable were given special consideration (Hanlon et al, 2010) This was followed by implementation of old age insurance and sickness benefits in the late 19$^{th}$ century. In the 20$^{th}$ century, the United Nations helped the development of social protection by making provision of adequate standards of living as a human right (Hanlon et al, 2010).

According to Basset (2008), cash transfers to the poor and vulnerable were beneficial since they gave people more security and promoted labour mobility. It was from Europe that cash transfers spread to the USA, Canada and other countries such as Australia and South Africa in the mid-20$^{th}$ century. By the 1990s, a wave of new programmes started

in several countries in Latin America such as *Progresa* in Mexico, *Familias en Accion* in Columbia and *Bolsa Familia* in Brazil. This new model of cash transfer programmes in Latin America had impact on beneficiaries' health, nutrition and education for the targeted population at relatively low cost and which contributed to increased adoption of cash transfers as instruments of social protection in different parts of the world (Ferreira et al, 2007).

In Africa, social protection programmes were introduced in the 1990s with a goal of reducing abject poverty among vulnerable groups and evidence suggests that in Zambia, the funds resulted in startup of small scale businesses, beneficiaries reported accumulating more assets and increased production. Further evidence suggests that in Malawi, there was growth in economy and increased enrolment of children in school while in Kenya, evidence suggests that social protection programmes have led to beneficiaries being able to acquire basic needs (Hassan, 2018).

For many decades, social protection has been implemented in Kenya in different forms. As an effort to cushion its citizens against vulnerabilities, the Government of Kenya established the NSSF in 1965 and NHIF in 1966. Thereafter, the Government started formulating a national social protection framework which entailed holding national consultation meetings with various actors. Although the contribution to NHIF is low, due to high incidence of poverty, the contributory amount is still too high to be afforded by many Kenyans and the fund is more skewed in favor of employed Kenyans. Although NSSF was the only national institution that provided social security in the Country, its efficiency in providing social security has been undermined by many allegations of corruption (HakiJamii, 2007).

### 2.3 Types of Social Assistance Programmes in Kenya

Kenya's social protection policy builds on the Constitution of Kenya, 2010, which includes the right to social security and also binds the state to provide social security to all citizens who are unable to support themselves and their dependents (CoK, 2011). Currently, the Government of Kenya is implementing social assistance programmes which target specific beneficiaries. These include: Older Persons' Cash Transfer (OPCT), the Cash Transfer to Orphans and Vulnerable Children (CT-OVC), the Hunger and Safety Net Programme (HSNP) and the Persons with Severe Disability Cash Transfer (PWSD-CT) (World Bank, 2013).

Through the cash transfer programmes, beneficiaries have attested to improved household food security, access to basic healthcare, retention of children in schools, enhanced social support networks, esteem and dignity. However, none of the existing cash transfer programmes has attained universal coverage and currently, the programmes are reaching only about 813, 381 households countrywide (African Institute for Health and Development, 2017).

The Government of Kenya, in partnership with other development partners is currently implementing social assistance programmes which target various categories of beneficiaries. The main cash transfer programmes are the Older Persons' Cash transfer programme, The Cash Transfer for Orphans and Vulnerable Children (OVC-CT), the Hunger and Safety Net Programme (HSNP), the Persons with Severe disability Cash Transfer (PWSD-CT) and the Food Urban Subsidy Cash Transfer (UFS-CT) which was phased out in 2014 when the HSNP was launched (World Bank, 2013).

**Table 2.1: Types of Social Assistance Programmes in Kenya (World Bank, 2013).**

| Programme | Year Launched | Implementing Agency | Transfer Value per Household | Coverage as at 2015/2016 Household | County |
|---|---|---|---|---|---|
| CT- OVC | 2004 | MLSP | KES 2,000 | 365,232 | 47 |
| OPCT | 2006 | MLSP | KES 2,000 | 320,232 | 47 |
| PWSD- CT | 2011 | MLSP | KES 2,000 | 41,374 | 47 |
| HSNP | 2007 | HSNP Secretariat | KES 2,550 | 101,630 | 4 |
| Total household coverage | | | | 828,468 | 47 |

*The Cash transfer to Orphans and vulnerable Children* was launched in 2004.This programme aims to improve the welfare of children in poor household by supporting the households with monthly disbursements to improve education, healthcare and wellbeing.

*The Older Persons' Cash Transfer* was established in 2006 and its aim is to support older persons and help them enhance their livelihoods. The fund targets households that are extremely poor and which have household members aged 65 and above.

*The People with Severe Disability Cash Transfer* was launched in 2011 with an aim of supporting persons with severe disabilities and who are able to take care of themselves. Beneficiaries include those who need care such as feeding and.

*The Hunger Safety Net Programme* was launched in 2007 to respond to growing food insecurity in agriculturally unproductive areas such as in arid and semi-arid lands. The programme disburses cash transfer every two months to extremely poor households in four constituencies.

*The Urban Food Subsidy Cash Transfer* was launched in 2008. Its objective was to improve the livelihoods of vulnerable residents of informal urban settlements. The

programme focused on provision of food to vulnerable households. However, it was phased out in 2014.

The cash transfers programmes from the National Safety Net Programme which aim to reduce the poverty and vulnerability among the beneficiaries (World Bank, 2013).

### 2.4 Unmet needs of older people

The global population of those aged 60 and above has increased steadily from eight percent in 1980 to thirteen percent in 2015 and this population is still set to rise to twenty two percent in 2050. This rapid growth in population has been greatly influenced by decline in fertility and an increase in socio-economic development. Worldwide, the population of older persons will double to 2 billion. This growth in population poses many challenges to older persons especially due to their high poverty levels, diminishing ability to engage in paid work, changing cultural values and norms as well as HIV and AIDS and non-communicable diseases (UN, 2015).

Ageing is a gradual process and older persons are usually frail and are prone to illness, disability and even death. The changing dynamics of families and migration in search of employment have had an effect on the available care for older persons. The traditional care that was available to older persons is now under threat (Kalache, 1991). Families continue to suffer from the effects of urbanization. Sometimes, family members abandon older relatives and it becomes a challenge for the older persons to fend for themselves because of lack of opportunities. The abandonment of older members of the family is a practice that has been influenced by accusations of witchcraft. In extreme cases, the older persons experience humiliation or even murder. This is common in Kisii and Nyamira Counties in Kenya where several media reports have reported incidences of older persons being burnt to death on accusations of

witchcraft. The Daily Nation newspaper reported on 22nd October, 2016 that five older persons were burnt to death on accusation of witchcraft.

HIV and AIDS have had a devastating effect on older persons in the better part of sub-Saharan Africa where the burden of older persons as care givers of AIDS orphans is very high. As care givers, the older persons are at risk of infection since they are care providers and are key in the provision of home-based care for people living with HIV and AIDS yet they are mostly not targeted by prevention and awareness campaigns (Help Age International, 2009). Older persons are not only affected by HIV/ AIDS as care givers but they also at risk of contracting the virus through sexual activity. Unfortunately, they are not targeted with information and training because the assumption is that they are no longer sexually active and therefore at low risk.

Older persons are parents of those infected by HIV and AIDS and they provide care during illness and incur costs during death while also remaining as the sole care givers of children orphaned by HIV and AIDS. Studies show that grandparents are the primary care givers of AIDS orphans in many parts of Sun-Saharan Africa (Nyambedha et al., 2003).

Due to high levels of poverty in developing countries such as Kenya, older persons often cannot afford the very basic needs like food, housing and healthcare. Although housing is a basic need, many urban dwellers seek shelter in informal urban settlements where they suffer chronic poverty and destitution. Older persons are also unable to access proper nutrition and this increases their health risk which limits their participation in economic and social activities (Gondi, 2009). According to Help Age International (2007), the most prevalent infectious diseases among older persons are respiratory tract infections and urine infections, although they also suffer from typhoid,

arthritis and diarrhea. Older persons are also affected by hypertension and other cardiovascular diseases such as diabetes, cancer and eye, nose and ear problems. Older persons face health challenges because of their frail and vulnerable nature. Sometimes, deteriorating health results in disability and therefore the older person may need the help of a care giver. In many cases, they do not have resources to pay for care. In Kenya, like many African societies, there are cultural practices of care for older persons. The family is a major institution that ensures that older persons are well taken care of. However, due to globalization, there has been a shift in the family structure from the traditional extended family to modern, nuclear and small families and this has been accelerated by migration (World Bank, 2013). A great number of older persons either forgo health services of they end up being impoverished due to the need to pay for health services.

When people grow older, they are subjected to a role-less role where they do not have anything to contribute anymore. This results in alienation because, for example when older men can no longer provide for their families and they have to rely on their children to provide for them, they feel helpless and unworthy (Mudege and Ezeh, 2009). With the decline in family support, many older persons are exposed to poverty. This can be attributed to the growing economic constraints and declining family values. This has caused more destitution to older persons (Ezeh et al., 2006).

Older persons in Kenya face a number of challenges. To begin with, there is no specific law at national and county levels that promotes and protects the rights of older persons despite the fact that older persons constitute a sizeable segment of the population that is poor. Several factors impact on the health and wellbeing of older persons and these include nutrition, housing, access to healthcare, water, sanitation, income and

challenges of HIV and AIDS. In terms of roles, older persons are under pressure to take up the role of parents due to disintegration of the family. Other roles include traditional health and cultural practices, community leadership and decision making. Older persons are vulnerable to hunger and malnutrition due to poor incomes and they end up consuming foods that are low in nutritional value (GoK, 2014).

Older persons face challenges due to their physical advancement of age. The majority of them rely on care givers, especially those with physical disabilities. Older persons are also at risk of age-related illnesses which require regular medical attention. Such health challenges hinder their economic production and prospects of income (Omolo, 2017).

Most social protection programmes in Kenya carter for persons who were previously engaged in formal employment. Such schemes disadvantage people who lived in poverty and were not able to raise the monthly membership contributions (Gondi, 2009).

Finally, older persons suffer from different forms of elder abuse such as physical assault, insults, threats, negligence, sexual abuse, financial deprivation and denial to participation in decision making. All these types of abuses result in physical and emotional suffering and injury which cause pain, violation of human rights and decreased quality of life for the older person (WHO, 1999).

### 2.5 Effects of Cash Transfers

CT programmes promise to break the cycle of the intergenerational transmission of poverty, as well as spurring growth "from the bottom". In the short run, CTs that are somewhat durable and display a minimum level of generosity offer to cushion the worst of food-insecurities, insure families against risks and shocks, reduce the scope of child

labour, empower women, provide capital for investments and savings, and equip families with a sense of hope for the future, enabling them to plan ahead and invest in their farms, businesses, jobs, health, and children. OPCT in particular has supported beneficiaries to pay for medicine or transport to health facilities. Beneficiaries have also been motivated to start small-scale income generating activities OPCT has also had an effect on seasonal household food security in that a majority of recipients have acknowledged that their immediate families were able to take at least two meals per day when the funds were available. However, due to the consistently escalating cost of living and high number of dependants, some beneficiaries cannot afford three meals per day (GoK, 2014).

Studies have suggested that cash transfers are an effective means of reducing poverty and enhancing adequate living standards for beneficiaries worldwide. Cash transfers improve household welfare by increasing food consumption, improving health, raising self-esteem and improving diet. However, impact evaluations have shown that smaller households benefit more than larger households because when a household has more individuals, consumption is higher (GoK, 2016).

Cash transfer programmes impact positively on the socio-economic well-being on beneficiaries. This is because most beneficiaries have the ability to meet their basic household needs while some also invest part of the fund in small scale business which earns them an income (Omolo, 2017). OPCT also increases the ability of beneficiaries to have food, shelter, clothing and access to healthcare. However, cash transfers are not adequate in meeting the overall needs of most beneficiaries (Mwanzia, 2012). Nevertheless, cash transfers have an effect on household income because of the increase of disposable income. There is evidence of increase in consumption and nutrition (Kabeer and Waddington, 2015). Cash transfers are the most popular programmes

which have addressed poverty in the continents of Africa, Asia and Latin America. Cash transfers reduce poverty among poor households while supporting them economically. Studies suggest that several cash transfer programmes have reduced poverty among recipients in Colombia, Nicaragua, Mexico and Honduras (Saavedra, 2016).

Cash transfers are one of the main factors that contribute to poverty reduction. Evidence suggests that cash transfers have reduced poverty, increased school enrollment and attendance, improvement in accessing and utilization of health services, promotion of economic empowerment, autonomy and self-determination and reduced child labour (Hagen-Zanker et al., 2010). A study conducted by International Labour Organization in Brazil, Chile, India, Mexico and South Africa reported that there was an improvement in family health, expenditures, household purchase of food items in Brazil while in Chile, recipients became more proactive in solving their problems and in India, there was increased participation over household decision making (ILO, 2013).Western countries such as the United States of America and Germany reported successfully implementing social protection programmes which were driving factors to their attainment of the MDGs. However, this has not been the case in most developing countries due to the fact that their economies are just emerging and their systems have little capacity which can address specific needs of older people (Hassan, 2018).

There is evidence from studies conducted in Africa and in Latin America that cash transfers have reduced chronic poverty and destitution among recipients by improving education enrollment and school attendance, improvement in health and nutrition, employment, improvement in economic growth especially for vulnerable populations such as women and older people where cash transfers have given them stability,

security and affordability (HelpAge, 2009). Cash transfer programmes have been reported to alleviate poverty and suffering for many households. In Brazil, after *Bolsa Familia* was launched in 2003, five million citizens exited from chronic poverty, hunger and suffering and after only six years, the programme had reduced poverty by nearly eight percent (HelpAge, 2010). The aim of cash transfers is to improve household purchasing power while giving the household members the power to set their own priorities as well as the choice of items to purchase when they need them (HelpAge, 2007). Through cash transfers, households are able to improve hygiene and dignity and with better quality and nutritious foods, they are able to improve their work options and revive their ambitions to work and have a secure future (Fisher et al., 2017).Cash transfers increased secondary school enrollment in Kenya, Ghana, Malawi, Lesotho, South Africa and Zambia and they have considerably reduced morbidity while increasing access to preventive care (Lund et al., 2008).

A study conducted on the impact of Progresa on consumption found that by the end of 1999, the fund had covered nearly three million families and there was a link between household income and expenditure on food and variety where beneficiaries of the fund purchased foods rich in nutritional value and a varied diet (Hoddinott et al., 2006).

There is evidence suggesting that cash transfers empower marginalized populations such as women and the elderly and evidence suggests that cash transfers reduce gender-based violence and increase women's decision making abilities (Hagen-Zanker et al., 2016). Cash transfers have improved livelihoods for extremely poor beneficiary households especially for households that relied on the cash transfer as their main source of livelihood (Fisher et al., 2017).

Cash transfers have positively impacted on the welfare of their beneficiaries with most of them reporting that through the programmes, they are able to buy food, they also started small scale businesses, and they were able to educate their dependants and their social status increases in the communities where they live (Omolo, 2017). Cash transfers in Kenya have had effects on the well-being of recipients. Studies have shown that recipients who previously had only one meal per day were able to get more meals after being enrolled in the programme, usually an increase to two or three meals and this improves their nutrition and health. Further evidence suggests that in households where children were enrolled in the orphans and vulnerable children's cash transfer programme, there were improvements in the number of meals per day and this has also been reported in the OPCT programme where many respondents' number of meals per day changed after being enrolled in the programme (Kisurulia et al., 2015).

OPCT has had an impact on the number of meals because recipients of the fund place food as one of the key expenditure priorities. However, many beneficiaries do not get balanced diets due to insufficiency of the fund although reports suggest that households have been able to use the OPCT to purchase livestock and poultry which they resell at a higher value and which they also eat (Kimosop, 2013).

### 2.6 Theoretical Framework

This study was guided by resilience theory as postulated by Adrian Van Breda (2001). According to Van Breda, resilience is the capacity of an individual to cope during difficulty, the thing an individual does to avoid being harmed by life strain, the presence of protective factors (personal, social, familial or institutional safety nets) which enable an individual to resist life stress. Resilience is the capacity to maintain competent functioning in the face of adversity or major life stressors The theory has moved from being limited in nature to being broader and focusing on the individual, to seeing the

household and the community while considering a range of risk-protective factors (Ciccheti, 2010). Resilience therefore involves the individual (self-regulation, self-efficacy and self-determination), household (close relationships with family members), community (social assets such as school as well as a sense of connectedness) and protective factors (Kimhi, 2015).

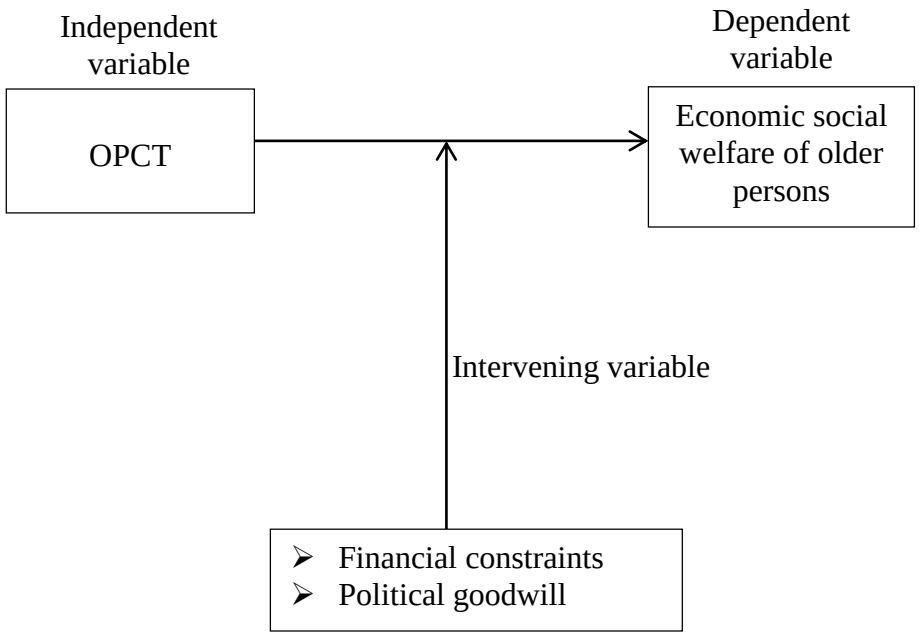
Resilience theory focuses on life's stressors and how to respond to them in a way that an individual is able to overcome them. It focuses on daily challenges and how individuals can cope using support systems (Deithier et al., 2011). This theory emphasizes the strengths that individuals and systems demonstrate and which enable them to rise above adversity. Cash transfers are designed to support venerable populations such as older persons and help them improve their lives while increasing their resilience amidst the challenges that come with old age.

### 2.6.1 Relevance of the Theory to the Study

According to Deithier (2013), resilience theory focuses on support systems which help individuals to deal with challenges while working on improving their livelihoods. Cash transfers are designed to support the beneficiaries improve their living conditions. This study seeks to explore the effects of the OPCT on the economic and social welfare of the beneficiaries living in Korogocho Location.

OPCT is the independent variable. Through regular disbursement of the cash, beneficiaries are able to meet their economic and social needs hence a decrease in poverty and vulnerability. Cash transfers can have an impact on the economic and social welfare of the beneficiaries by empowering them to be more productive. However, shocks can affect the extent to which the OPCT improves the lives.

**Figure 2.1 Conception frame work**



# CHAPTER THREE: METHODOLOGY

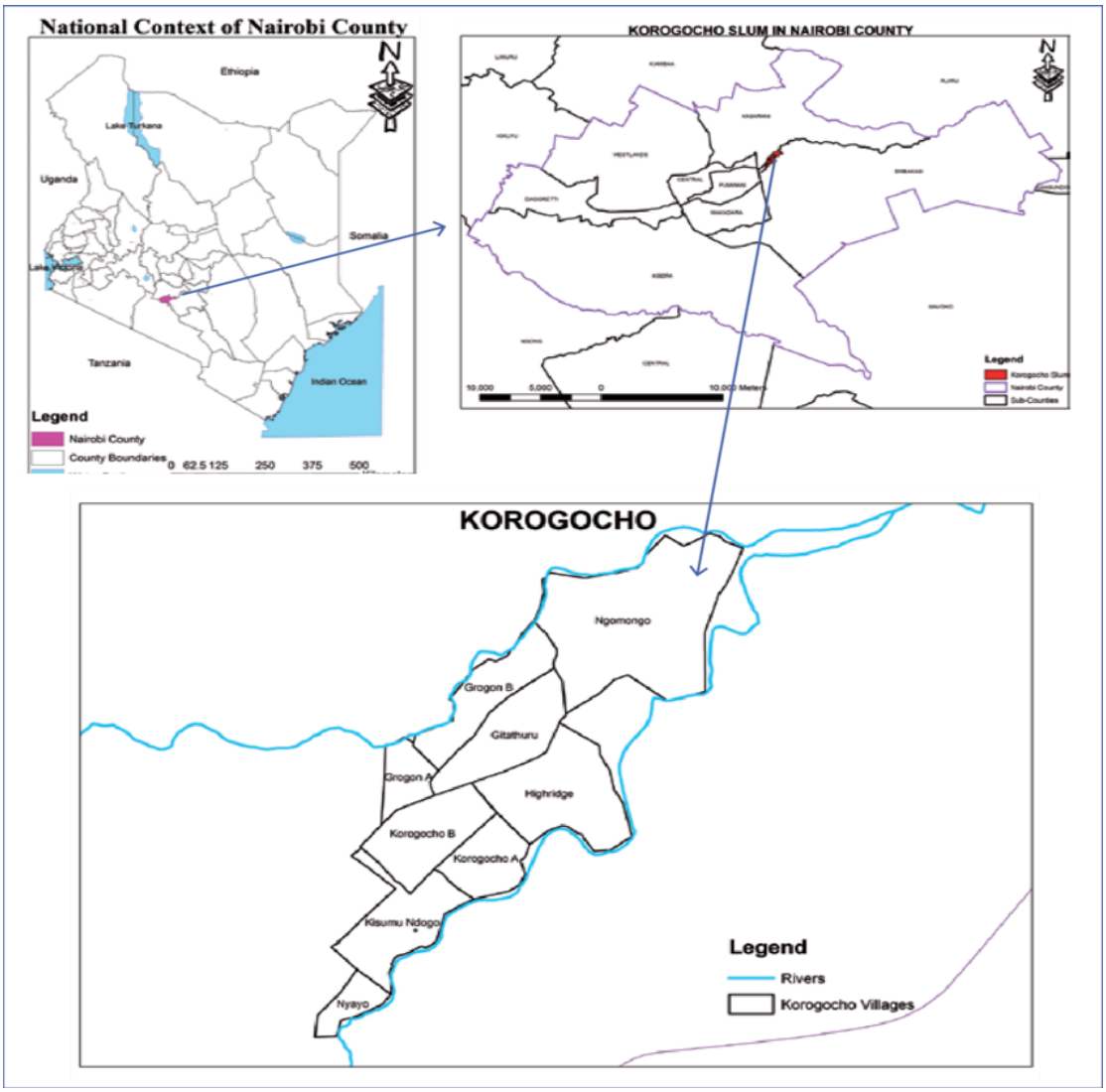
## 3.1 Introduction

This section outlines the methodology that was used in conducting this study. It describes the study site, research design, study population, sampling technique, defining validity and reliability of the research tools, methods of data collection, data processing and analysis. This section ends with a discussion of ethical consideration.

## 3.2 Research Site

This study was carried out in Korogocho Location, Kasarani Sub-County (Fig. 3.1). A majority of the urban poor live in informal settlements, with around 2 million people living in Nairobi's slums. They comprise more than half the capital's population yet are crammed into only 5 per cent of the city's residential areas, and 1 per cent of all land in the city. It is estimated that 50% of Kenya's population will be living in urban areas by 2050 (Oxfam, 2012). About 60% of Nairobi's population is slum residents with a high population density. Korogocho was ranked among the poorest slums in Nairobi by the Central Bureau of Statistics. (World Bank, 2013).

This means that this settlement is impoverished and older persons living here face many challenges and are vulnerable. Located eleven kilometers northeast of Nairobi City, Korogocho is one of the largest slums in Nairobi. Korogocho Location is divided into nine villages: Grogan A, Grogan B, Gitathuru, Highridge, Korogocho A, Kisumu Ndogo, Nyayo, Ngomongo and Ngunyumu. The population in this Location is mostly poor. There is little infrastructure, houses are mostly made of recycled materials and there is no proper sewerage system. The main dumping site of Dandora borders Korogocho to the east and south east and it is where some residents of Korogocho make a living by scavenging for food and scrap metal (Mudege and Ezeh, 2009).




**3.1 Map of Korogocho Location, Nairobi County. Source: Google Maps.**

### 3.2.1 Housing conditions

Most households in Korogocho Location live in one-roomed houses that serve multiple purposes, including sleeping, sitting, cooking and eating. Over 95% of the households cook in the same room they use for sleeping. Over 90 percent of the households do not have any organized mechanism for garbage disposal, while fewer than 5 percent have their own toilets. Similar patterns are observed for water supply: over 90% of the households depend on poor-quality water distributed by vendors or kiosks for which

they pay three or more times the tariff charged by the Nairobi City County Government to pipe water to middle or upper income households (Ezeh, et al., 2006). Most houses in Korogocho are made of mud and tin sheets.

### 3.2.2 Economic Activities

One of the biggest challenges to the economic well-being of older people in the urban informal settlements is the informality of their economic activities. A majority of the residents work in the informal sector, and even those who have formal employment often lack job security despite working in high-risk jobs (Ezeh et al., 2006).

### 3.2.3 Health Facilities

Korogocho Location is served by only one Health Facility which is the Korogocho Health Center. Like in many urban slums, the public healthcare system delivery has not been at par with the population growth. The nature of slums has made it difficult for development of hospitals due to access of these areas. Insecurity in the slums and poor infrastructure affects development of health and other institutions in the slum. Besides the two public health facilities, there are also a number of private health facilities in Korogocho (Ziraba et al., 2014).

### 3.2.4 Educational Facilities

There are only two public primary schools in Korogocho Location with a number of private institutions spread across the villages. There is no single government secondary school in the whole Location. Korogocho and Ngunyumu are the only primary schools in the slum (Ngware et al., 2013).

### 3.3 Research Design

This study used a cross-sectional descriptive design which sought to answer questions on the state of the participants, their behavior, attitudes and characteristics (Mugenda and Mugenda, 2003). Primary data was collected using semi-structured interviews, key informant interviews and focus group discussions. The data was organized into appropriate themes, analyzed and presented in summary.

### 3.4 Study population and unit of analysis

The study population consisted of all older persons living in Korogocho and who were receiving OPCT and the unit of analysis was the individual older person receiving the OPCT.

### 3.5 Sample population and sampling procedure

A total of 50 older persons were sampled purposively for this study. The researcher obtained a list of all beneficiaries living in Korogocho Location from the Ruaraka Sub-County Social Development office. As at Financial Year 2016/2017, there were 510 beneficiaries living in Korogocho Location. The list was aggregated by sex and 25 participants were selected from each sex.

### 3.6 Data Collection Methods

#### 3.6.1 Semi- Structured Interviews

Fifty semi-structured interviews were conducted using a semi-structured interview questionnaire (Appendix i). The questions captured information on the use of OPCT and the effects it had on the economic and social welfare of the recipients.

### 3.6.2 Key Informant Interviews

According to Krishna (1989), key informant interviews involved interviewing a select group of individuals who were likely to provide needed information, ideas, and insights on a particular subject. Only a small number of informants were interviewed and such informants were selected because they possessed information or ideas that could be solicited by the researcher. The researcher conducted three key informant interviews with the area local administrative chief, a Community Health Volunteer and social protection officer in Korogocho Location. The, key informant interviews were conducted using a key informant interview guide (Appendix ii).

### 3.6.3 Focus Group Discussions (FGDs)

A total of two FGDs were held with each FGD comprising members of the same sex and each group consisted of six to eight participants who were recipients of Older Persons' Cash Transfer and were living in Korogocho Location. The data was collected using FGD guides (Appendix iii)

### 3.6.4 Secondary Sources

Secondary sources were used progressively through books, journal articles and internet sources throughout the study.

### 3.7 Data processing and Analysis

The data collected from In-depth interviews, key informant Interviews and focused group discussions was summarized, grouped, coded and analyzed thematically for interpretation.

### 3.8 Ethical Considerations

The researcher observed anonymity by not identifying the ethnic or cultural background of respondents, refrained from referring to them by their names or divulging any other sensitive information about them. During research the researcher protected the information given in confidence by the respondents. This enhanced honesty towards the research subjects by protecting them from physical and psychological harm thereby ensuring that the researcher did not ask embarrassing questions.

This research strived to avoid harming the respondents in any way and the researcher did not ask questions that could embarrass the respondents or which could force them to divulge information which could cause them anxiety. The researcher explained the purpose and consequences of the study. The respondents were asked for informed consent to participate in the study. In cases where older persons who were sampled were too old or frail to respond, consent was sought from their care givers.

During the study, the researcher maintained confidentiality of data records and ensured the data were secure. The names of the respondents, their residences and any other demographic information was strictly used for the purpose of the study.

# CHAPTER FOUR: UNMET NEEDS OF OLDER PERSONS LIVING IN KOROGOCHO LOCATION, NAIROBI COUNTY

## 4.1 Introduction

This chapter presents the finding of the study based on the first study objective which was to investigate the economic and social needs of older persons living in Korogocho Location and the assumption that older persons living in Korogocho Location have several unmet needs. The chapter gives details of the demographic characteristics of the respondents and a breakdown of the economic and social needs of older persons living in Korogocho Location, Nairobi County.

## 4.2 Demographic characteristics of the respondents

### 4.2.1 Gender of respondents

Out of the 50 respondents who participated in the study, 25 (50%) were female while 25(50%) were male as shown in the figure below.

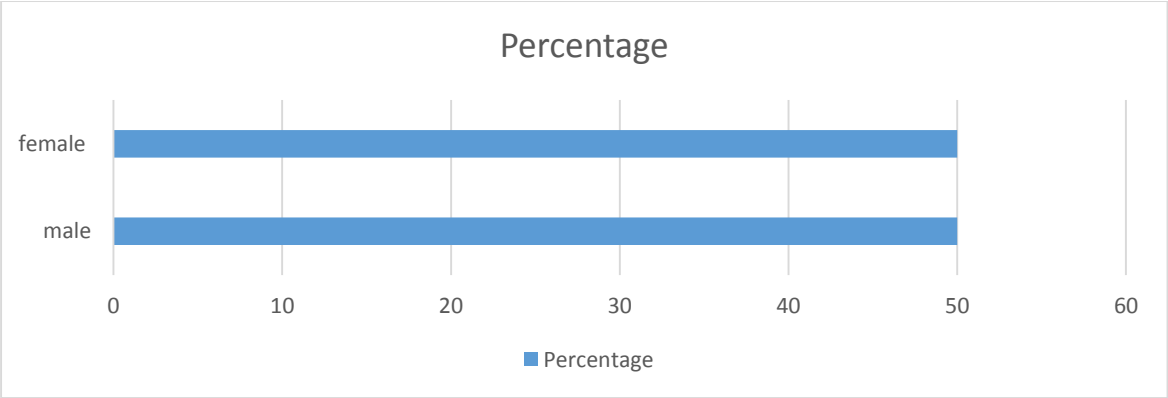



**Figure 4.1: gender of respondents**

### 4.2.2 Age of respondents

Out of the fifty participants who participated in the study, twenty of them (40%) were aged between 65-70 year, a further twenty six (52%) were aged between 71- 75 years while four participants (8%) were aged between 76-80 years.

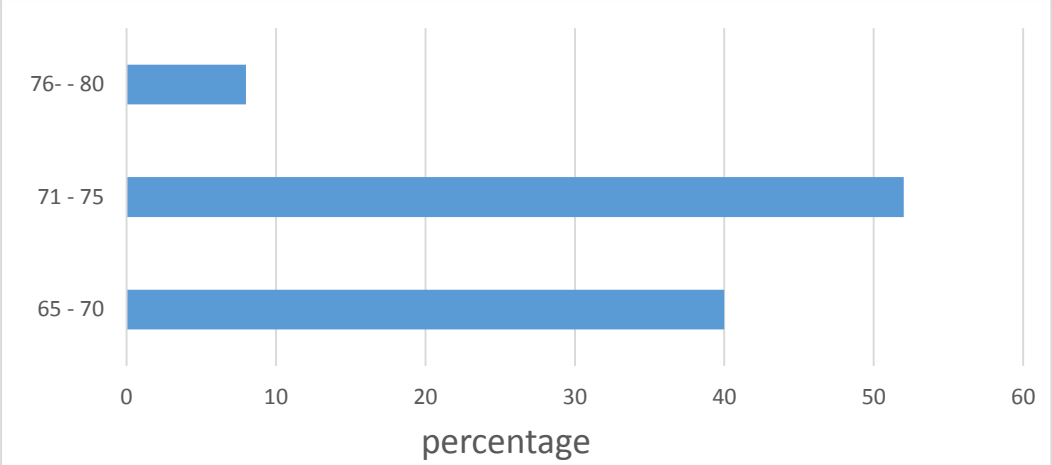



**Figure 4.2: age of respondents**

### 4.2.3 Marital status of respondents

There were differences in the marital status of the respondents. Out of the total sample, 10 respondents (20%) were married and living with a spouse while a majority comprising 80% were living with no spouse with 24 respondents (48%) having been widowed and 8 respondents (16%) of the respondents separated from their spouses. A further 4 respondents (8%) were single as shown in the figure below

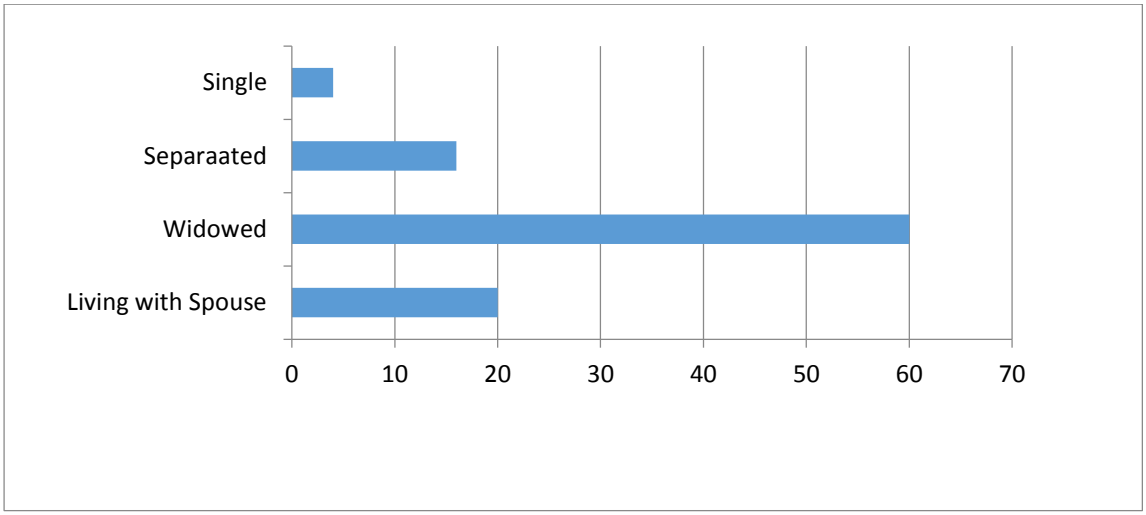



**Figure 4.3: marital status of respondents.**

### 4.2.4: Respondents' educational level

Forty two respondents (84%) had attained primary education, while the other eight (16%) had never gone to school. There was no single respondents who had gone beyond primary school as shown in figure 4.2.4 below.

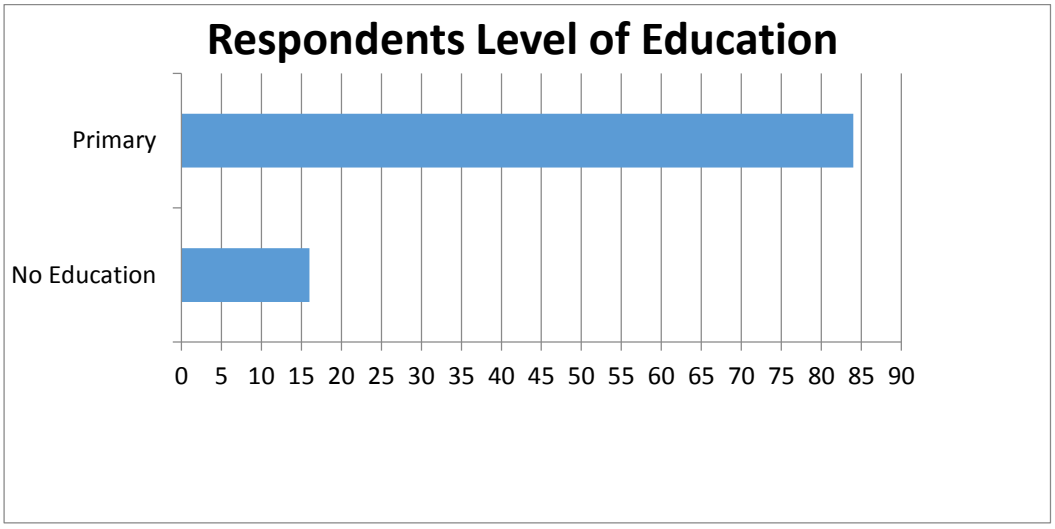



**Figure 4.4: Respondents Education Level**

### 4.3 Unmet needs of older persons living in Korogocho Location, Nairobi County

#### 4.3.1 Food

80% of the respondents reported that they were usually not able to buy food as regularly as they would wish. They are consequently forced to eat foods that are poor in nutritional value such as "anyona" (stale bread that is sold as crumbs and measured on quantity based on one's ability to purchase) or "helicopter" (fish whose stake has been removed). The other 12% said that they do not buy the kind of foods they would wish to buy due to lack of resources. These were the words of a 72-year old female respondent:

*"Food is the biggest need of any human being. You need food to live. As a widowed older person living with disability, sometimes I lack money to buy food. I depend on well-wishers on those days."*

Another male respondent aged 77 said:

*"My income is very little and I can only afford a basic diet without considering nutritional value. As long as I get food, I am grateful."*

Forty percent of the respondents reported that since they had children who were depending on them, the cost of buying food was high since generally the cost of living keeps going up and sometimes feeding their families is a challenge. As one male respondent aged 75 years old said:

*"Here in the slums, we can only afford rejected food. Some of the foods sold to us are brought from the Dandora dumping site and sold to us and since they are cheaper foods, we just buy them because that is what we can afford. Sometimes, the food is either contaminated or expired and it causes diseases to us. But that is what we can afford so we still buy anyway."*

Another female respondent aged 80 years said:

*"The cost of living has gone up. These days, with one hundred shillings you get very little food unlike a few years ago when that same amount of money would last me for even a whole week. "*

### 4.3.2: Housing

The main materials which most of the dwelling units where the respondents lived were made of old metal tins and mud on the walls and recycled rusty iron sheets on the roofs. As is with the case of most residents of informal settlements in urban areas, most of the respondents moved from their rural homes to the city in search of better opportunities and they settled in the informal settlement of Korogocho. Eighty eight percent of the respondents reported that they live in rental housing units therefore they have to pay rent every month. The amount charged for rent varied from KES. 500 to as high as KES. 1000. The respondents who pay for rent therefore have to look for

money every month to pay rent and this becomes a challenge for them due to scarcity of resources.

Although twelve percent of the respondents reported that they lived in their own dwelling units, they also felt that their housing conditions were poor. One female respondent said:

*"Sometimes I don't have money to pay for rent and I have to talk to the landlord so that he can allow me to stay while looking for money. It becomes very difficult when I accumulate arrears. "*

Another male respondent aged 69 years said:

*"The houses which we can afford are very small and I have to sleep there with my grown children. There is no privacy. It is very difficult for me and I wish I could afford better housing."*

All the respondents agreed that they were not satisfied with the housing conditions in the informal settlements. As was reported during the key informant interviews, the building materials which are mostly recycled mud or tin walls are not durable and when it rains, the houses get damaged. The housing conditions also expose them to theft and abuse. A female respondent said this:

*"When you sleep at night, it is very easy for an intruder to break in the house. An elderly neighbor was attacked in her house at night and she was raped."*

Another female respondent attributed the poor housing conditions she was living in to lack of education. She said:

*"If I had gone to school, I would have a better life today. I would not wish for my children to live in poor conditions in their old age as I have lived."*

One male respondent aged 69 years said:

*"Most of us live in dilapidated and very old houses."*

### 4.3.3 Education

Fifty percent of the respondents were living with dependants who were mainly their grandchildren. They responded that they had an obligation to support these children due to the deaths of the children's parents and this placed a burden on them because they have to educate these children despite their limited resources and their incapacity as older people. Aside from the educational needs, the respondents mentioned food, shelter, healthcare and upkeep as some of the care giving obligations that strain their resources. A 74-year old female respondent said:

*"I am a widow who lives with three school-going children and these children have to go to school. I do not have an income to pay for their secondary education because I still have the responsibility to look for food, clothes, accommodation and all their other needs."*

These sentiments were affirmed by the key informants who emphasized that older people do not have opportunities for work which can earn them an income to fend for themselves and their dependants and that the responsibility of educating their grandchildren was putting a toll on their resources and health. One key informant had this to say:

*"There are very many orphans who live with their old grandparents in this community. These children are not able to school fees because their grandparents are old and do have resources. Since their parents have died, they are left to drop out of school and fend for themselves and their families."*

### 4.3.4 Healthcare

Majority of the respondents listed physical health problems which they attributed to their age. The conditions mentioned were diabetes, high blood pressure, body aches,

joint pain, problems with urination and general body fatigue. Mental conditions such as depression and memory lapse were also mentioned.

A female respondent aged 79 years said:

*"I am growing older and weaker. I suffer from diabetes and I am required to take very expensive drugs which I cannot afford. I am a widow and my children who would have taken care of me also died so I have no one to help me get my medication."*

Another female respondent aged 80 years said:

*"I suffer from arthritis and I have very painful joints. I cannot afford my medication."*

Majority of the respondents attributed old age, physical and social isolation and poverty as the causes of their health problems. For respondents who live with other household members, they felt that they were better off because they had other people to discuss their health problems with. Majority of the respondents preferred seeking healthcare services in the modern health facilities around the community or buying over the counter medication although a few reported using herbal medicine as well.

During the FGDs, the respondents raised the concern of transportation cost to reach better health facilities such as Kiambu and Mama Lucy hospitals. This was a big challenge for older persons living with disability and who do not have care givers. Although they felt they would get better services there, the respondents felt that these facilities are difficult to access because of the distance and the cost involved. They also cited overcrowding, stigma against certain diseases, slow service delivery and discrimination of older people in service delivery in the government hospitals. For this reason, one respondent said she preferred using herbal medicine that are readily available in the community.

### 4.3.5 Income opportunities

A majority of the respondents (98%) reported not having any savings because their main source of livelihood was the OPCT which was all used on expenses for basic needs. This made it very difficult for them to start and sustain any small-scale business. One key informant emphasized that the allocation of OPCT is very little and it was never enough for beneficiaries to save and start any form of business.

Of the fifty respondents interviewed, none was employed in the formal sector nor receiving pension. Whereas some of the respondents reported being engaged in the informal sector, the income they reported to be receiving was very low. Sixteen respondents (32%) were engaged in small scale business, six respondents (12%) were casual labourers while twenty eight respondents (56%) were not engaged in any income generating activity. The types of small-scale business ranged from repairing shoes, collecting scrap metal, repairing broken plastic buckets and shoe shining business. A male respondent aged 69 years said:

*"The only time you can get money as a shoe shiner in this community is during the rainy season. Other times, there is no work so I don't do much. I am thinking of closing the business because the returns are very low. At the same time, I have to look for something else to do because I cannot entirely rely on OPCT since I have a very big family."*

Another male respondent aged 69 years and who worked as a scrap metal collector said:

*"There are so many young people who do this work and I am not able to cope because of my age. I do not have the energy to work as hard as I used to a few years ago but I have to do it because it is the only job that does not require any capital."*

A female respondent aged 69 year said:

*"I make porridge and sell it in the community. I am getting older and it is difficult to walk around with the porridge but I have to do it because it is the only job I know and even if I wanted to do a different job, I cannot because I don't have capital"*

As shown in the figure below, income opportunities is a big unmet need among older people living in Korogocho Location.

Majority of the respondents (98%) reported that they do not have any savings because their main income is the OPCT which is all used for basic needs while the other one respondent refused to answer the question on savings. This makes it very difficult for them to start and sustain any small-scale business. One key informant emphasized that allocations of the OPCT is little and it is not enough for beneficiaries to save and start businesses.

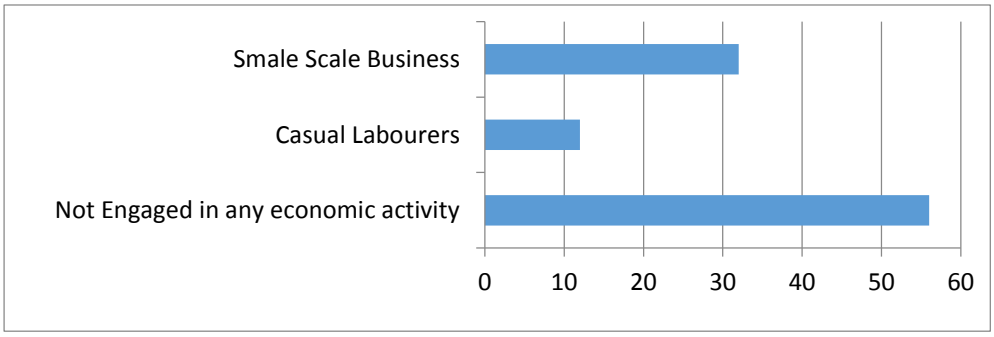



**Figure 4.5 Income Opportunities**

# CHAPTER FIVE: EFFECTS OF OLDER PERSONS' CASH TRANSFER ON THE ECONOMIC AND SOCIAL WELFARE OF RECIPIENTS

## 5.1 Introduction

This chapter presents the findings of the study based on the second study objectives which was to investigate the effects of OPCT on the economic and social welfare of older persons living in Korogocho Location, Nairobi City County. The chapter gives a detailed results of the effects of the OPCT on the economic and social aspects of the lives of the beneficiaries based on the unmet needs that the respondents reported that they have.

## 5.2 Effects of OPCT on the economic welfare of the recipients

### 5.2.1 Effects of OPCT on purchase of food

All the respondents were in agreement that OPCT alone was not enough to carter for all their needs although a majority of them (92%) responded that the fund had positively impacted their lives while 8% reported that there was no impact in their lives. These sentiments resonated with those reported by the key informant who said that although the fund cannot be enough for all the basic needs of the recipients, the fact that it was a guaranteed income provided the recipients with financial security and many of them can borrow items from nearby traders ad once they receive the fund, they are able to repay their debts. This was also highlighted in the FGDs where participants listed food and shelter as some of the needs that the fund has been able to take care of for them. The responses varied across gender with women expressing confidence about being able to purchase food more than men. Female respondents reported that the fund has enabled them to purchase foods that are of high nutritional value while others said that since they started receiving the fund, they are not worried about where they will get food since they are able to stock some food in the house. During the FGDs, most of the

respondents agreed that OPCT had enabled them to have more than one meal per day and that they do not sleep hungry anymore.

### 5.2.2 Effects of OPCT on housing

Most of the respondents (88%) reported that they live in rental houses which required them to pay a monthly rent of between KES. 500 to KES. 1000 while 12% of the respondents reported to be living in their own dwelling units. The needs for OPCT on paying rent was therefore different between those who live in their own houses and those who live in rented premises. There was an association between respondents' gender and their perception towards the effect of OPCT on housing needs. Further, variation in marital status also brought difference in the usefulness of OPCT on housing needs with female respondents who were widowed reporting that they find it very difficult to pay rent as compared to respondents who were either married or cohabiting. Respondents who lived in their own dwelling unit did not see any improvement as far as OPCT is concerned since they still live in the same houses where they used to live even before they were enrolled in the programme. A 69-year old male respondent had this to say:

*"I live in the same house where I used to live before I was enrolled in the programme. I have lived in this house for the past 40 years so nothing has changed much in my housing condition."*

One male respondent aged 79 years old has this to say:

*"Most of the time, I use the fund to buy food because I live in my own structure. I wish I could get more money to help me buy land and build a home that I can retire to. Living here is not good for my age. I should be living upcountry with my relatives but I don't have land there so I cannot go*."

Majority of the respondents were dissatisfied with life in the informal urban settlements and they wished to go and live elsewhere. A female respondent aged 66 years old said: *"If I had money, I would migrate and live in the rural area near my relatives. Living here is difficult because the cost is very high and everything is expensive. If you don't have money, you become a beggar."*

### 5.2.3 Education

Thirty respondents reported that they lived with school-going dependants and all of them agreed that the OPCT was not enough to carter for the educational needs of these dependants, because mostly the fund is meant to support them on basic needs. Again, twenty female respondents felt they were more burdened on providing care for dependants especially to orphaned grandchildren as compared to their male counterparts. Female respondents who were widowed cited change in marital status as a contribution to deprivation of resources and hence their inability to support the educational needs of their dependants. Some respondents reported that due to lack of school fees, some children had dropped out of school and they had nothing much to do. These sentiments also emerged during the discussion with the key informants who felt that older persons who lived with school-going dependants were not able to meet the educational costs for these children therefore they needed to be helped. A 66-year old male respondent said:

*"I have grandchildren whose parents died and who are in school and most of the time, they are usually sent home for school fees. I do not have any other source of income and my wife who would have supported me died last year."*

### 5.2.4 Healthcare

All the fifty respondents who were interviewed reported challenges with their health and lack of resources to seek proper medical care. They further said the OPCT was not enough for them to seek healthcare the way they would wish and so in most cases they opt for cheaper alternatives such as the clinics within the community or pharmacies to but off-the-counter drugs. This also emerged during the interviews with the key informants who emphasized that poor health in old age makes it difficult for older people to seek employment opportunities and lack of resources limits their pursuit for medical care.

Majority of the respondents' (90%) preferred seeking health care services in facilities within the community to cut back on cost. In cases where they are referred to other health facilities such as Kiambu and Mama Lucy, they are able to use the OPCT to cover their transportation and other costs although they felt the money is not enough to afford them proper healthcare. The respondents mentioned that they occasionally visit health facilities which are located outside of the community and in such instances, they need transportation. The OPCT fund has been useful for them in such occasions where they need to board vehicles and motorbikes to seek treatment. When they do not have money to use for transport, they cannot go to those facilities and they have to wait until the money is sent to them for them to go.

### 5.2.5 Income opportunities

Twenty respondents reported that they were engaged in other income generating activities apart from receiving the OPCT. Respondents who were recipients of OPCT and at the same time engaged in other income generating activities reported a high monthly income while those who solely relied on OPCT reported a low income. None

of the fifty respondents interviewed was a recipient of statutory pension and whereas some reported relying on family members to help support them, others relied on private sources such as churches and NGOs for further support.

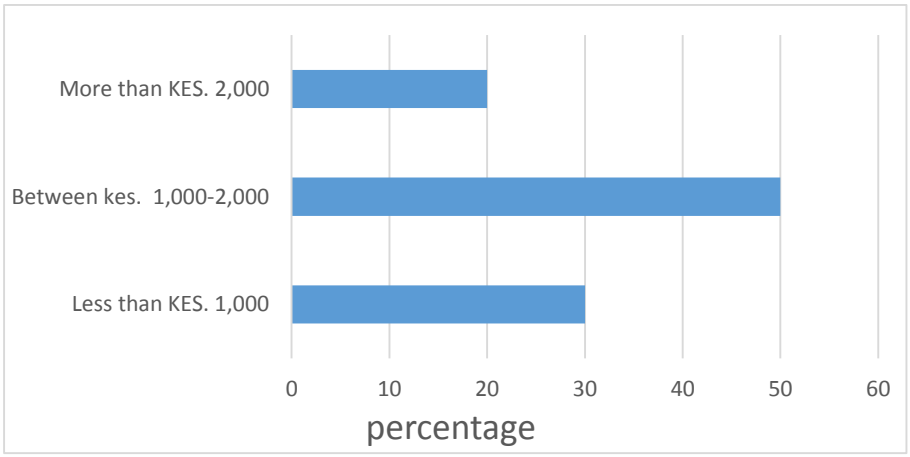



**Figure 5.1 Income opportunities**

### 5.3 Effects of OPCT on the social welfare of recipients

#### 5.3.1 Relationship with other household members

Twenty five respondents (50%) said that there was no change in their relationship with household members since they started receiving the fund while 25 respondent (50%) said there was change in their relationship with members of their households because they felt more appreciated and involved in making decisions in the household. During the FGDs, some of the beneficiaries said that their household members were very appreciative of the OPCT and they were viewed the same with high reverence. One female respondent aged 68 years said:

*"When I get the money, I am able to buy foods that are high in nutrition such as chicken and this really excites my family because they are able to eat nice foods once in a while."*

Another female respondent aged 71 years said:

*"There is really no difference in the way my family views me because the money I receive is mostly spent on medication since I have been diabetic for five years. I still*

*have to ask my children for money to buy medicine despite the fact that I receive the OPCT."*

### 5.3.2 Engagement with the community

Asked if their engagement with the community had changed since they started receiving the OPCT, 10 respondents, (20%) said there was improvement on their relations with the community. The other 40 respondents (80%) said there was no change in the way they relate with the community since they started receiving the OPCT. Here is what a 78-year old male respondent said:

*"I have been invited to several stakeholders' meetings where the input of an older person was needed. It has become very easy for the Village Eder to identify me because everyone in the village can see how my life has changed since I started receiving the OPCT."*

A 69- year old female respondent said:

*"We are now more visible and active in the community. We are usually invited to attend functions and our advice is taken seriously by members of different forums, unlike previously when we did not have status and dignity and we were perceived as poor and destitute."*

The respondents who said that their interaction with the community had improved gave examples of church functions, fundraising events and small investment groups. One female respondent aged 68 years said:

*"I am now able to participate more and I am also a member of a women group which has ten members and we meet once every week to borrow and lend each other through table banking. If I was not having an income, nobody would invite me to such groups."*

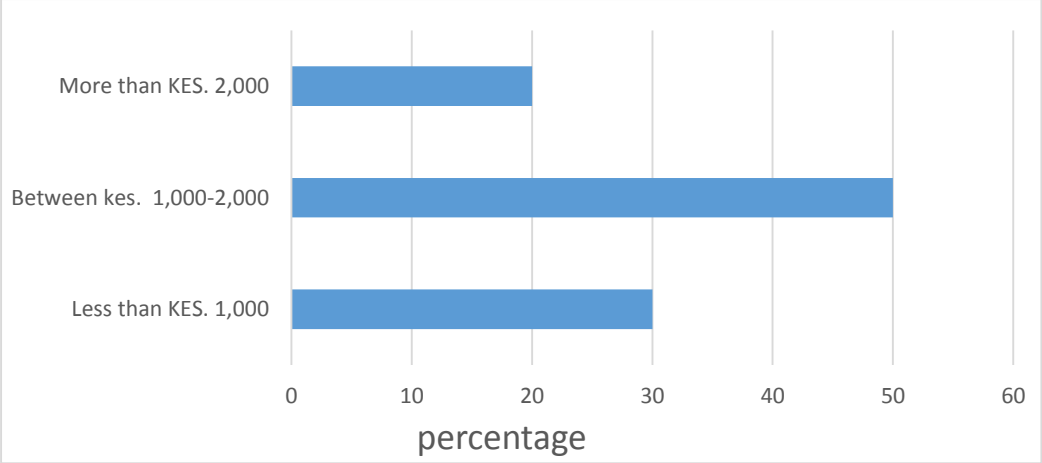



**Figure 5.2: Engagement with the community**

### 5.3.3 Relationship with older persons who are non-beneficiaries of OPCT

Forty respondents (80%) said there was no difference in the way they related with older persons who are non-beneficiaries of OPCT. It however emerged from the other five respondents (10%) that there has been a negative change of attitude resulting in jealousy and bad will between recipients and non-recipients of the fund in the community because some of the non-beneficiaries feel that the enrolment into the programme was not objective and that they were unfairly left out of the programme. The other five respondents (10%) said that they were viewed by their fellow older persons who were not enrolled in the programme as deserving of the fund.

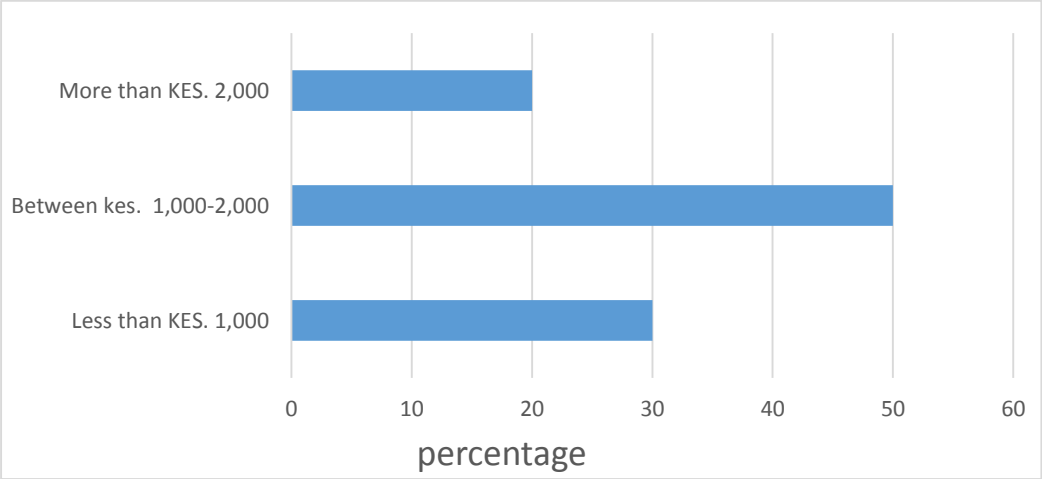



**Figure 5.3Relationship with older persons who are non-beneficiaries of OPCT**

### 5.4 Suggestions for Improvement of the Fund

The key informants suggested training for beneficiaries of cash transfers. This is because when these beneficiaries receive the fund, they misplace priorities and spend it on non-important needs and this keeps the cycle of poverty. Other suggestions raised by the key informants were: training on income generating activities other than the OPCT, monitoring the use of the fund and increasing the allocation of the OPCT as what is currently being disbursed is very little.

The beneficiaries suggested that the fund should be increased so that it can be enough for their basic needs and also to help them start up small businesses that could help them sustain themselves.

# CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

## Conclusions

This study sought to investigate the effects of OPCT on the economic and social welfare of older persons living in Korogocho Location, Nairobi City County. The study found that older persons living in this location have several unmet needs. The findings revealed that a majority of older persons were not able to purchase enough quantity of food as well as the kinds with higher nutrition contents as they wished due to insuffient resources. The study also found that older people lived in rental houses where they were not comfortably able to pay the monthly rent because of poor income prospects. Furthermore, a majority of older people were not satisfied with the poor housing conditions of their residential units and most of them were willing to relocate to better places given a chance. On educational needs, some older people were living with school-going dependants whom they could not educate due to meagre resources. A majority of older people also have face challenges in access to healthcare because of the high cost involved and the long distance to and from government health facilities.

The study found that OPCT had a positive effect on the economic and social welfare of older people because it offered them financial security and they were able to take items from the nearby shops and pay later when they received the fund. With the use of the fund, older people were also able to to buy foods that were of higher nutritional value and they were able to pay their rents while those who lived in their own houses were able to improve the conditions of those houses. In terms of education, OPCT was not enough to carter for the educational needs of dependants who lived with older people. Although older people used the OPCT fund to seek healthcare services, the money was not enough for all their healthcare needs and distance remained a barrier

for most of them to seek better healthcare services in government facilities that were located outside of their residence.

In relation to the findings of the study, OPCT has a positive effect on the economic and social welfare of older persons living in Korogocho Location, Nairobi City County. The fund has empowered them to meet their basic needs and their social status in the community has also improved.

**Recommendations**

This study focused on the effects of the OPCT fund on the economic and social welfare of older persons living in Korogocho Location which is a low income urban setting. The study recommends a similar study in a rural setting to compare the findings. The beneficiaries of the OPCT fund were not satisfied with the amount of money being disbursed to them at the rate of KES. 4.000 after every two months. They expressed their concern that the cost of living keeps rising in Kenya. In view of this, the Government of Kenya should consider the cost of living and review the amount disbursed to the recipient. The study also recommends further research to evaluate the overall impact of the OPCT on the beneficiaries, their households and the society at large.

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## APPENDICES

### Appendix I: Semi- structured interview guide

**Consent**

Hello. My name is Linda Oloo and I am student at the University of Nairobi where I am studying for the degree of Master of Arts in Gender and Development. I am conducting research on the effects of Older Persons' Cash Transfer on the Economic and Social Welfare of Older Persons living in Korogocho Location. This research is for academic purposes only. Any information given will be treated with utmost confidentiality. Your participation in this study is voluntary and if you are not comfortable answering some of the questions you will be asked, you will not be forced to do so. Your identity will not be revealed to anyone else and you will not suffer any harm in the course of the interview. You are free to ask any questions regarding this study and if you may have further inquiry, you can ask through the contact that I will give you later on.

Thank you.

**1. Demographic Characteristics**

a) Name of participant _____

b) Sex

Male Female

c) Age

65-70 71-75 76-80 81 –above.

d) Marital Status

Married Widowed Divorced Never Married

e) Level of Education

| | | | |
|---|---|---|---|
| Never went to School | Primary | Secondary | College |

f) Total number of individuals living in the same household _____

**2. Economic Activities**

a) Is the amount received in cash transfer enough for your basic needs?

Yes. _____ No. _____

b) How do you spend the cash received from the transfer? Please rank from the list provided below from the most important to the least important.

| Use | Rank |
|---|---|
| Food | |
| Housing/Rent | |
| Clothes | |
| Healthcare | |
| Educational support to others | |
| Debts | |
| Business | |
| Supporting others | |

c) What would you say are some of your unmet needs?

**4. Social status and Social Relations**

How has your engagement with the community changed since you became a beneficiary of the e cash transfer?

**5. Challenges associated with OPCT**

Are there any challenges associated with the cash transfer? If yes, please explain.

**6. Recommendation**

What recommendations would you give for the improvement of the OPCT?

**Appendix II: Key informant interview guide**

1. In your opinion, do you think the money given to the recipients is enough?
2. What are some of the needs of older people living in this community?
3. How has the OPCT improved the welfare of the beneficiaries?

4. Are there mechanisms to monitor how the beneficiaries spend the cash they receive?
5. In your opinion, how can the fund be improved?

**Appendix III: Focus Group Discussion guide**

1. What are the needs? Please list them.
2. What are the economic benefits of OPCT?
3. What are the social benefits of OPCT?
4. What challenges do the beneficiaries of OPCT face?
5. How can the fund be improved?