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Effect of Health Care Service Programmes among the Elderly in Kajiado North Sub-County, Kajiado County, Kenya

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Abstract*: This study set to establish effects of cash assistance and health care programs among the Elderly in Kajiado North Sub-County in Kenya. Descriptive survey research design was adopted in the study. The sample size of the elderly was 249. Purposive sampling was used to select key informants from the organization providing the social service programs in the sub-county. Questionnaires were used to collect data from the respondents. The collected data was analyzed with the help of Statistical Package for Social Science (SPSS). Descriptive and inferential statistics were used in presenting the quantitative data. Inferential statistics was used in establishing the relationship between the variables under study. There was a significant relationship between social service programs and the wellbeing of the elderly in Kajiado North Sub County ($p<0.015$). There was a positive association between cash transfers and health care services and the wellbeing of the elderly. The study recommends that there is need for empowering the social service programs in the county so as to support the needs of the elderly. This empowering may be in terms of resources such as finance, human resource and food. Additionally, the study also recommends that the government should set more funds and encourage private investors to contribute towards the social service programs. The social service programs should also come up with the right recreational activities that can be friendly to the elderly people.*

Keywords: *Cash assistance, Recreation, Programs, Elderly, Kajiado, Kenya*

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1. Introduction

The World Population Ageing 1950-2050 Report, defines population ageing as a process by which older individuals become a proportionally larger share of the total population in a country. Mba, (2010) refer to population ageing as a summary term for shifts in the age structure of a population toward older ages. The effect of the population ageing can be attributed to the fall in the fertility rates and of mortality decline at older ages. In many countries the aging of population is measured by an increase in percentage of either people reaching 60 years of age or elderly people of retirement age, which may be aged 60 or aged 65 depending on societies.

As of 2019, the percentages on the age rate have increased compared to 2017. This is whereby it has been noted that the population of aged people above 65 years is growing at fast rate compared to all other age groups (Abrams, & Mehta, 2019).. Data presented by the World Population Prospects (2019) indicated that by 2050, one in six people

in the world will be over 65 years of age (16%), up from one in 11 in 2019 (9%).

Moreover, within the developed countries like Europe and Northern America, it has been estimated that by 2050, one in four persons living in Europe and Northern America could be aged 65 or over. In 2018, for the first time in history, persons aged 65 or above outnumbered children under five years of age globally. The number of persons aged 80 years or over is projected to triple, from 143 million in 2019 to 426 million in 2050 (World Population Prospects, 2019). With such fluctuations, it is important for research studies to be conducted to examine the welfare of the aging population as well as the service delivery systems that have been put in place for such populations.

Social service definition varies among countries depending on the level of institutional development. For instance, in the UK, social service is conceptualized as personal and this narrows its scope. This is whereby a personal social service is a support and care initiatives which are set to meet the social protection needs of individuals. In the US, the scope of social service is narrowed to services which support groups or individuals who are considered to be socially disadvantaged. This includes people with disability, those who lack social protection and those affected by diseases. However, this scope of definition excludes various aspects such income, education, healthcare and culture. However, in Korea, the term has been defined as services that are provided for the purpose of improving the welfare and quality of life among individuals or society in general (Lee, 2010).

The increased calls for social service programmes around the world are an emerging concern among various governments. This is largely attributed to various factors such as the increasing rapid population aging, rising divorce rates, falling birth rates, labor and job insecurity, and a widening gap between the rich and the poor. As a result, the social service programs are required for the purpose of responding to the increased demand of welfare services that have been influenced by the socio-environmental changes (Lee, Majer, & Kim, 2019).

In terms of studies, developed nations that grew into aging countries have made greater efforts in conducting studies and coming up with social policies to supporting the aging communities above 50 years of age (Mba, 2010). In the US, for instance, extensive studies have been conducted since the end of World War II about changes along the life cycle and life after retirement. UK has not been left behind and the aging policies have been in place since 2000. Moreover, the aging population continues to increase and the elderly (aged 65 or older) accounted for 17% of the population in 2010. According to ONS (2018e), there are nearly 12 million (11,989,322) people aged 65 and above. Out of this population, 5.4 million people are aged 75+, 1.6 million are aged 85+, over 500,000 people are 90+ (579,776), and 14,430 are centenarians (ONS, 2018f). Around the world, aging advanced countries have mainly pursued policies that supported the social participation of the 50 plus generation focusing on employment, extending the retirement age, and returning those in their 50s or older who are unemployed for a long time to the labor market (Fragoso & Valadas, 2018).

In Japan, a wider range of studies has been conducted since the 1980s about the ripple effect of retirement in terms of socioeconomics (Kinsella, & Phillips, 2005). Germany became an aging country in 1932 and was an aged country in 1972. Around the world, aging advanced countries have mainly pursued policies that supported the social participation of the 50 plus generation focusing on employment, extending the retirement age, and returning those in their 50s or older who are unemployed for a long time to the labor market (Lee, Majer, & Kim, 2019).

The same issue of aging has also been evident in countries like Korea. Since the year 2000, Korea has been transforming into an aging country. This was evident when the percentage of the elderly above 65 years of age or older exceeded 7% of the total population. The country has become an aged country in the shortest period of time globally, as the percentage surpassed 14.2% in 2017. According to a forecast presented by the Statistics Korea (2017), the percentage of those aged 65 or older will sharply increase from 12.8% in 2015 to 30% in 2045, and the average life expectancy will reach 82.9 years. While policy actions have been put in place to address population aging, baby boomers, who account for the largest proportion of the population in Korea, are beginning to retire early (Korea Institute for Health and Social Affairs, 2015; Economic Survey of Korea, 2018).

In Africa countries, the number of elderly people has been increasing over the couple of decades. Of all the continents Sub-Saharan Africa, having the tiniest proportion of elderly and which is ageing slower than the developed regions, is envisaged to witness the absolute size of its older population grows by 2.3 times between 2000 and 2030 (He, W., Goodkind, & Kowal, 2016).. This is because the continent has been considered as among the youngest continent on earth due to high number of young people compared to the elderly. However, this has been changing due to improve health systems and access to education among other measures. According to a study by the UN (2017) on population ageing, the population of the elderly people in Africa was considered to grow at a fast rate compared to any other region in the world. The projections noted that the population of the elderly aged 60 and over to increase more than threefold between 2017 and 2050, from 69 to 225 million. This is slightly higher than the projections by WHO which indicated that the population would increase to 163 million by 2050 However, in some African countries like Tunisia and Mauritius, that future has already reached, with percentages of elderly people much higher than the

continental average. The proportion of over-65s in Tunisia is 7.3 percent, and in Mauritius it is 6.9 percent

Many countries in Africa such as Nigeria, Ethiopia, Cameroon, among others have not yet fully adopted policies to support the social service programs for the elderly. Researchers found that a majority of adults aged 60 to 64 and around half of those aged 65 and older in Africa remain in the labor force. Many older Africans, particularly women, contribute substantial levels of unpaid home and care work. Health programmes for African older adults, especially those in rural areas, suffer from understaffing of health workers, insufficient financial resources, inadequate health coverage, and high out-of-pocket costs. Systems of organized long-term care have not yet been developed in most of Africa and long-term care remains primarily within in the family, predominantly by women.

South Africa having the highest percentage of older persons in Africa, still finds it overly hard and difficult to fully support the elderly and provide them with necessary support system they require for the well-being devoid of racial discrimination. Older age is estimated at being 5%. Approximately 5% (3.7 million) of the South African population is aged 60 years or older (Statistics South Africa, mid-year estimates 2009) (Lombard, & Kruger, 2009). It is projected that by 2015 the proportion of older persons in South Africa will have increased to 9.5% of the population, that is, 4.24 million. As they do worldwide, women (with an estimated 61, 6%) represent the largest number and proportion of older people in South Africa (RSA, Minister) (Lombard, & Kruger, 2009). An analysis of South Africa's elderly can therefore not ignore "the historical inequalities such as land deprivation and limited access to education which manifest through high levels of unemployment and underdevelopment in the country". Prior to 1994, White South Africans enjoyed a standard of living comparable to that of the developed nations of the world, while the majority of black South Africans were mired in poverty and had inadequate levels of education, while women were subjected to lowly positions in their rural and cultural settings and environments. While there has been progress, the degree of social inequality in the country still reflects "... islands of wealth in an ocean of poverty" (Lombard, & Kruger, 2009).

In Nigeria, the elderly, aged 65 years and above make up to 3.1% or 5.9 million of the total population of 191 million, which in raw numbers represents an increase of 600,000 during the 5-year period 2012–2017 (Population Reference Bureau, 2012) (National Council on Ageing 2016). The rising numbers of the elderly in Nigeria are as a result of the crude mortality rate that is gradually decreasing. Ageing in Nigeria is being witnessed against the background of socio-economic hardship, widespread poverty, the HIV/AIDS epidemic, and the rapid transformation of the traditional extended family structure (Togonu-Bickersteth, & Akinyemi, (2014). .Another cause for the increase in the older segment of the Nigerian population can be found in the declining fertility rate (although still one of the highest in Africa) that has continued to drop since the 1980s. In 2017, the total fertility rate registered at 5.5 compared with 6.8 in 1980 (Population Reference Bureau, 2017; United Nations Population Division & United Nations Statistical Division, 2015). Besides the reduction in fertility, improved health and sanitary conditions have also contributed to the rise in life expectancy. The effects of ageing among other factors results to dormancy, weakness, and vulnerability to contracting a disease, leading to discrimination against the elderly, social pariahism, and, sometimes, abandonment. It is with this profound causes that long lasting mitigation mechanism and policies need to be adopted to curb these social problems associated with the elderly.

In Kenya, as of 2020, population aged 65 years and above was 2.5 %. Population aged 65 years and above of Kenya fell gradually from 3.4 % in 1971 to 2.5 % in 2020 (Masci, 2006). One of the biggest increases in population ageing in Africa is expected to occur in Kenya where it is projected that by 2050, there will be a 470% increase in the number of older members of the society who will represent approximately 10% of the Kenyan population. According to Help Age (Kenya) (2014), more than half of the older members of the society live in absolute poverty. People ages 56 and above are the poorest age group in the country. Majority of older members of the society have no formal sources of income in their earlier years and therefore have no pension to fall back on for their care and protection during their old age.

2. Literature Review

Since its introduction in Brazil and Mexico in 1997, conditional cash transfer (CCT) programs have spread rapidly throughout the world, with more than 30 such programs in Latin America and the Caribbean (LAC), Asia, Africa, and North America (Fiszbein and Schady 2009). The majority of research on these programs' benefits has focused on schooling, nutrition, and health status of children and adolescents, as well as household consumption and savings. However, given the rising aging of the population, these CCT initiatives may have a significant impact on aging people, such as raising household resources or generating changes in household member time allocations (Rawlings & Rubio, 2003). .

The United Nations (UN) defines the elderly as a person who is 60 years or above. The world's population of elderly persons will nearly double from 12% to 22% between 2015 and 2050 with 80% expected to reside in low and middle-income countries (LMICs) by 2050. Elderly persons globally suffer from various health problems such as chronic conditions, injuries, depression from loneliness, malnutrition, visual problems, hearing loss and complex dental problems.

A variety of factors influence healthy aging, with society and the environment playing key roles. Poverty, stress, food, tobacco usage, environmental variables, and education are all factors that have an impact on one's health later in life. Access to safe, effective, and inexpensive medications and treatments, as well as accessible care systems, are critical components of high-quality health care for the elderly. Unfortunately, those with the highest health requirements have the least access to resources as they get older (WHO 2015). Support services that address the increasing health needs of elderly individuals are very important for their health. Acute illnesses become less common as people age, while chronic illnesses, which typically cause functional issues, grow more common. These issues necessitate a support system and a geriatric workforce that is well-versed in aging people (WHO 2015). Long-term support systems (LTSS) are critical for promoting the well-being and inclusion of older persons by providing a coordinated system of care that includes health and social services as well as community care activities.

Keeping older adults healthy and happy necessitates a variety of measures. Listening to patients and their issues, as well as providing assistance and resources, are vital at the micro level. Furthermore, it is critical that workers dealing with the elderly are aware of their particular requirements and beliefs that may influence their treatment.

Social workers can also teach health-care providers about the need of treating elderly patients with respect and dignity, which is crucial for their well-being (Rawlings, & Rubio, 2003). Mezzo work comprises assisting in the establishment of better-coordinated care systems that promote and maintain older individuals. Working with organizations and agencies to establish long-term care services and supports that can help people function and remain independent in their communities is one example. Mezzo therapies may also entail forming educational support groups for patients and their families, as well as increasing people's ability to manage with the illness's associated challenges and issues.

Healthy aging and matching health systems to the requirements of the elderly are important societal goals (WHO 2015). The creation of health policies that make health care services available and accessible to all older people should be the emphasis of macro-level social work. Social workers can utilize their advocacy abilities to ensure that policies take into account the special health care requirements of older people, as well as the development of resources and responsive care systems. Among the key activities that social workers might undertake include lobbying for effective laws and policies that pertain to older people, supporting programs, and enhancing access to care for all people. Joining coalitions and collaborating with other organizations, as with other advocacy initiatives, can be the most successful way to affect policy and system change.

With increasing life expectancy at birth and declining fertility, population aging is inevitable in many countries. By 2025, almost two thirds of the elderly population (those who are 65 years or above) will be living in developing nations, which already have an overburdened health care delivery system (World Health Organization [WHO], 2018)

By 2030 more people in the United States will be older than age sixty-five than younger than age five. Our health care system is unprepared for the complexity of caring for a heterogenous population of older adults—a problem that has been magnified by the coronavirus disease 2019 (COVID-19) pandemic (Terry Fulmer, David B. Reuben, John Auerbach, Donna Marie Fick, Colleen Galambos, and Kimberly S. Johnson, 2021). Here, as part of the National Academy of Medicine's Vital Directions for Health and Health Care: Priorities for 2021 initiative, we identify six vital directions to improve the care and quality of life for all older Americans. The next administration must create an adequately prepared workforce; strengthen the role of public health; remediate disparities and inequities; develop, evaluate, and implement new approaches to care delivery; allocate resources to achieve patient-centered care and outcomes, including palliative and end-of-life care; and redesign the structure and financing of long-term services and supports. If these priorities are addressed proactively, an infrastructure can be created that promotes better health and equitable, goal-directed care that recognizes the preferences and needs of older adults.

As life expectancy increases, so has the influence of mental illness on older persons' quality of life, especially at advanced ages (Newman, & Brach, 2001). In the United States for instance, 40 per cent of people aged 85 years and older suffer from Alzheimer's and related dementia (United Nations, 2013). At the global level, the number of people living with dementia is expected to nearly double every 20 years (Prince et al., 2015). Depressive disorders and symptoms also affect many older persons, particularly the most vulnerable among them living in long-term care facilities (World Health Organization, 2015). Depression can be triggered by factors such as isolation and loss of family members or friends, which are common in old age, diminishing quality of life as well as negatively interacting with physical health conditions. The need for mental health care in old age is thus growing in scope and urgency.

Currently, levels of investment in mental health tend to be relatively low. In high-income countries, annual spending on mental health for the general population is less than 2 dollars per patient. In low-income countries, it is less than 25 cents per patient (UN, 2013). At the same time, awareness of mental health diseases is also low. Many people believe that memory problems and feelings of

sadness or pessimism are a normal part of ageing and therefore either postpone or avoid seeking care (Levkoff, Cleary, Wetle, & Besdine, 1988). When care is sought, many countries have few medical professionals trained to diagnose or treat mental illnesses. For example, nearly half of the global population lives in countries where, on average, just one psychiatrist is available for every 200,000 or more people (UN, 2013). This puts heavy pressure on those medical professionals and leaves considerable unmet need for care.

Historically, older adults have benefited from advancements in public health such as vaccination programs and smoking cessation, but public health has not focused on aging services or programs (Fulmer, Reuben, Auerbach, Fick, Galambos, & Johnson, 2021).. However, recent work directed at creating age-friendly public health systems (in coordination with the Age-Friendly Health Systems movement) that leverages public health skills and capacity is gaining momentum. Attention to the need for an age-friendly public health system recognizes aging as a core public health responsibility and leverages the system's skills and capacities to improve the health and well-being of older adults. Age-friendly public health systems create the conditions at the national, state, and community levels that older adults need to live safely, healthfully, and productively. Programs and policies that ensure access to fresh food, exercise, and social engagement are examples. A 2017 pilot program in Florida, led by Trust for America's Health, showed the potential of these systems (Fulmer, Reuben, Auerbach, Fick, Galambos, & Johnson, 2021). Among the core elements of this work are targeted data collection and analysis; adaptation of existing programs, including emergency preparedness, to meet the needs of older adults; and improved coordination and collaboration with Area Agencies on Aging and key health care providers. A follow-up call for additional state pilot programs has garnered significant interest, and standards are being developed for certification. A proposal to expand this pilot work has been introduced in Congress with bipartisan support. Federal funds would support grants to states and localities, create a Healthy Aging program at the CDC, and provide the requisite technical assistance.

Social stigma is another barrier to accessing mental health care and obtaining an early diagnosis. It has been estimated that stigma is the main factor behind the large gap between estimated prevalence and actual diagnosis rates, with less than 50 per cent of dementia patients receiving a formal diagnosis (UN, 2013). Many dementia sufferers continue to be abandoned or hidden from public life. In some communities, older women with dementia are accused of witchcraft. In addition, patients with Alzheimer's disease or dementia are often easy targets for financial and physical abuse and other violations of their rights.

A study conducted by Muhli and Svensson (2017) concentrated on the well-being of people in old age, living at a residential care home (RCH), and how well-being can be supported in gerontological social work and care at the RCH. Based on empirical data consisting of well-being narratives with elderly residents (average age of 91), a dialogical performance analysis was undertaken about their experiences of well-being at the RCH. The findings of importance are reported through three themes: childhood memories as a source of well-being, family and work as a source of well-being, and opportunities for the well-being of the elderly at the RCH. To be an individual with others is a phenomenon of a personal sense of self and a phenomenon of sociality. Well-being is also found in the individual's self-renewal. Well-being is about a sense of both individual continuity and change. Well-being is created in social situations with others (including caregivers) in daily interactions and in human contacts at the RCH. This kind of individual self-renewal is about human growth and is a human need regardless of age. Consequently, the human growth in (and despite) old age at RCH should be the main target of gerontological social work and care.

According to Donelan, Chang, Berret-Abebe et al. (2019), health care management programs have become more widely adopted as health systems try to improve the coordination and integration of services across the continuum of care, especially for frail older adults. Several models of care suggest the inclusion of Registered Nurses (RNs) and social workers to assist in these activities. In a 2018, a national survey of 410 clinicians in 363 primary care and geriatrics practices caring for frail older adults, found that nearly 40 percent of practices had no social workers or RNs. However, when both types of providers did work in a practice, social workers were more likely than RNs to be reported to participate in social needs assessment and RNs more likely than social workers to participate in care coordination. Physicians' involvement in social needs assessment and care coordination declined significantly when social workers, RNs, or both were employed in the practice.

A desk research done by Help Age International (2010) in African countries identified under-financing of health systems, over-stretched health workforces, poor health management information systems (HMIS), unreliable supply of medicines, physical barriers to access health-care and distance- related barriers, as the main constraints that contribute to older people's poor access to health-care services. It was noted that older people lack access to a steady income, such as pension, or retirement benefit, or salaries from good employment. Even those who do receive pensions will find it difficult to cover their healthcare needs (Help Age International, 2013). In Kenya, it has been reported that the rise in the number of older people increases the burden of providing social services, including healthcare services (Help Age International, 2013). A study conducted in Kenya, identified that lack of finance, absence of family support, physical inaccessibility of health service providers and

practicing quacks are the major factors deterring older people from seeking healthcare services (Waweru et al., 2003).

A scoping review which focused on mapping the healthcare policies in sub-Saharan Africa (SSA) after the 2002 United Nations Madrid International Plan of Action on Ageing (MIPAA) with an eye towards to identifying strategies for promoting older people's access to health care, integration of older people's diseases into primary health care and the level of training and research in geriatrics and gerontology in SSA.

Kelly, Mrengqwa and Geffen (2019) presented findings of nine focus groups conducted with community-dwelling older adults in three areas (high, medium and low-income) in Cape Town, South Africa over 2 months in 2017. These discussions addressed primary health services available to older persons, their ability to access these services and their expectations and experiences of care. Findings showed that while participants in the high-income area had few challenges accessing quality care or support services, services available in lower-income areas were much less responsive and participants displayed low trust in the healthcare system, feeling that their needs were overlooked. Participants who experienced poor doctor-patient communication often failed to comply with treatment, while those who experienced patient-centered communication, either through the private sector or NGO-public sector partnerships had better perceptions of care (Kelly, Mrengqwa, & Geffen, 2019).

Wairiuko (2014) carried out a descriptive cross-sectional study targeting both elderly men and women aged 60 years and over, in Kibera informal settlement of Kenya. The study sought to identify factors influencing access to healthcare by the elderly. Data collection tools employing both qualitative and quantitative parameters were used in the study. A multistage sampling approach was used. Kibera urban informal settlement was purposively selected while the sub-locations Gatweekera, Kianda and laini-saba were randomly selected. Probability proportionate to size sampling of the elderly was done and systematic sampling was done to identify the respondents. Data was obtained from a total of 399 elderly using interviewer administered questionnaire. Key informant interviews on health facility managers were used to provide additional information. Data was analysed by SPSS and presented using tables, graphs and cross tabulations, while association between variables was assessed using Chi-square statistics and Odds Ratio. Thematic analysis was done on qualitative data. Findings showed that access to healthcare was at 40.4 %. Marital status, type of house, education was statistical significant in relation to access to health care services by elderly. The odds of access increased with those who lived in permanent houses.

According to Abodein (2010), the older populations are more likely to experience malnutrition, chronic physical and mental conditions, hearing and sight difficulties, depression and dementia. In echoing the observations of Help Age International (2013) report that the increased number of older population has promoted a burden in the provision of social services such health care provision, and that under-financing of health systems, over-stretched health workforces (from doctors to community health workers), poor health management information systems, unreliable supply of medicines, physical barriers to access healthcare and distance-related barriers contribute to older people's poor access to healthcare, this study seeks to analyse the extent to which the access to social service programs such as the health care services can promote well-being among the elderly in the community.

Access to health care refers to a person's capacity to obtain needed medical services from health practitioners when they are needed. The elderly require health services since their advanced age makes them prone to a variety of ailments (Wariuko et al., 2017). China's rapidly growing older population has resulted in increased demand for health care, with the majority of the elderly suffering from chronic ailments. Due to significant requirements in other areas such as maternal health and infectious diseases, the old population in Africa has received less attention. In Kenya, it is estimated that 30% of adults aged 70 and up require the services of a geriatrician. The government has made it a priority to provide health care to all citizens through various programs such as Universal Health Coverage (UHC). To accomplish the UHC goals, debates have erupted on how to best care for the aging population, which is at risk. Some of the proposals put forward include the implementation of social protection programs.

The majority of older people living in informal settlements had limited access to health care. Social safety policies have an impact on health-care access. Cash transfers, government participation in health care, and retirement benefits are examples of specific social protection programs that have an impact on access to health care. In the poll, the majority of respondents stated that they were satisfied with financial transfers, but that they only received government assistance on occasion and that they did not receive any retirement benefits.

CTs are a good public policy endeavor in the field of health promotion because they have the ability to address social determinants of health (SDoH) and health inequities. To synthesize the research on CTs' impacts on SDoH and health inequities in Sub-Saharan Africa, as well as to identify the barriers and facilitators of effective CTs, a systematic review was done (Owusu-Addo, Renzaho, & Smith, 2018).. A vast amount of evidence suggests that addressing the social determinants of health (SDoH) will improve health outcomes and reduce health disparities Disparities exist among and between countries in Sub-Saharan Africa (SSA). Pro-poor measures aimed at

reducing poverty, boosting education, living circumstances, employment, social cohesion, and access to health care are critical for improving health and resolving health inequities in SSA (Munodawafa et al. 2013). Cash transfers are a promising and widely utilized strategy that could aid in this approach (CTs).

Medical check-ups

National governments and international organizations have long recognized the necessity of effective health systems and universal health care. In Africa, the World Health Organization (WHO) has identified ageing and the health of older people as a major problem in the context of overall population health improvement. The Sustainable Development Goals have reaffirmed the idea that excellent health should be accessible to people of all ages around the world. To achieve this, a combination of methods is needed, including both health-related and social-protection programs like cash transfers. Cash transfers appear to play a key role in reducing some demand-side obstacles to healthcare for older people, particularly those connected to out-of-pocket spending, according to evidence. Cash transfers are used by the elderly to pay for transportation to medical facilities, consultation fees and treatment charges, health insurance, and medicines. Cash transfers help boost the well-being of older people by providing better access to food and sanitation, as well as increased confidence in the necessity of maintaining their health and self-esteem. However, older individuals in different nations believe that the monetary value of the cash transfers is insufficient to have a significant impact on their ability to seek healthcare or to encourage them to prioritize healthcare above other needs. Furthermore, most developing countries' cash transfer schemes have very limited coverage, and the amounts disbursed are almost always insufficient to meet recipients' basic needs (Tabor, 2002). Furthermore, even when cash transfers assist older people in attending health facilities, poor-quality health services often prevented them from receiving necessary care.

3. Methodology

This study aimed at collecting data with regard to individuals' opinion, attitudes, behaviours and habits, hence the research considered descriptive survey research design as appropriate. When asking participants about their views, opinions and behaviours, the participants give a self- report which in turn would require collection of quantifiable information (Mugenda, 2003). This design was deemed fit for this study because the study's main aim was to gather information on the social service programmes and the well-being among the elderly in Kajiado North Sub-County, Kajiado County, Kenya. The assessment focused on the service integration, accessibility, service delivery and participation. In order to obtain this information, survey tools, precisely questionnaires were used to gather data.

The target population for the study comprised of the elderly in Kajiado North Sub-County, Kajiado County who are above 50 years of age and the organizations providing social service programs. According to the 2019 census, the total population of the elderly people above 50 in the sub-county is 2,493. Therefore, the elderly in the community formed the unit of observation in the study.

The study used simple random sampling technique to select the elderly respondents to participate in the study. The process was handled carefully so as to draw a sample that would give relevant, accurate and valid information that aided the study. Simple random sampling technique allowed all the participants to have an opportunity of being selected to participate in the study hence no biasness in the selection of respondents. Purposive sampling technique was used to select the key informants from the organizations providing social service programs. These were purposively selected because they are directly involved in the provision of social service programs to the elderly and they may articulate some of the issues within the programs that may have an effect on accessibility, availability and contributions to well-being.

Primary data was collected by using questionnaires where necessary. Questionnaires were appropriate for this study as information collected is not directly observable. The method is popular especially in cases of large enquiries. The questionnaire which is semi structured was administered through drop and pick to the sampled population. Information obtained from questionnaires was free from bias and free from the researchers influence.

Secondary data was obtained through desk research and internet from past studies and scholarly articles on social welfare programs and well-being of the elderly. The questionnaire was administered to a total of 249 respondents and was later picked for data analysis and tabulated through the use of frequency tables and reports. The questionnaires comprised of close ended questions and they included the five point likert scale.

The study used both primary and secondary data collection techniques. Primary data was obtained by use of structured questionnaires. Kothari (2004) define a questionnaire as a manuscript that constitutes of a number of questions printed or typed in an explicit order on a form or set of forms. The questionnaire comprised of open ended and close ended questions. Drop and Pick later method of data collection was employed by the researcher to give respondents sufficient time to respond to the questions of the study. Secondary data was obtained from the review of literature on the social service programs and well-being of the elderly. This secondary data collected, was used to support the findings on the primary data and provide more information that may not have been captured by the respondents.

Descriptive statistics (frequencies and percentages) and inferential statistics (regression) analysis were used to analyze the data. Data was then coded and checked for any errors and omissions (Kothari, 2004). Frequency tables, percentages and means were used to present the findings. Responses in the questionnaires was tabulated, coded and processed by the use of a computer Statistical Package for Social Science (SPSS) program to analyze data.

The multivariate analysis namely multiple regression of analysis was adopted in this study. This analysis was used for the purpose of making predictions about the dependent variable based on its covariance with all the concerned independent variables.

The following multiple linear regression model was used to predict the relationship between social service programs and well-being of the elderly.

$Y= \alpha + \beta 1x1 + \beta 2x2 + \beta 3x3 + \beta 4x4 + \varepsilon$

Where:

Y = Well-being of the elderly
X1 = Cash Transfers
X2 = Health Care Services
X3 = Meal Programmes
X4 = Recreation Programs
α = Constant
ε = Error term

The researcher treated privately any information given by respondents that touches on their lives. The researcher assured the respondents that no private information was shared to the third party either in written or in any other form of communication. The respondents were rest assured that information provided was used solely for research purposes and that individual identity was not revealed. Natural culture of the respondents was highly respected by the researcher. The researcher explained the procedure to follow during data collection so that they could participate more willingly. The researcher obtained all necessary authorization including a letter from the university Department and research license from NACOSTI.

4. Results and Discussion

This section presents the results and findings on the social service programmes and the well-being among the elderly in Kajiado North Sub-County, Kajiado County, Kenya. The data was obtained from the questionnaires that were presented to the respondents. It covers two variables; cash assistance programmes and the well-being among the elderly, effect of the elder health care service programmes on their well-being.

Table 1: Effect of the Elder Health Care Service Programmes on Their Well-Being

	Statements	SD	D	UD	A	SA
a.	The health care services aimed for the elderly are easy to access in the area.	30%	60%	-	10%	-
b.	The cost of accessing health care among the elderly people in the community is low.	50%	10%	10%	10%	20%
c.	There are free medical checkups provided for the elderly people in my area through the social service programs.	20%	40%	10%	10%	20%
d.	The local government and other agencies always organize for medical camps in the area for the elderly people.	40%	30%	10%	20%	-
e.	The health care services provided by the social service programs addresses all the healthy needs of the elderly at no extra cost.	40%	10%	10%	-	40%

Key: SA- Strongly Agree, A-Agree, UD-Undecided, D-Disagree, SD- Strongly Disagree

An overwhelming majority (90%) disagreed and strongly disagreed that the health care services aimed for the elderly are easy to access in the area. Only a few (10%) were in agreement with the statement. this implies that most of the respondents were in disagreement that health care services can be easily accessed by the elderly in the community. As such, it is evident that there is a challenge among the elderly in the community in accessing health care services that are meant for them.

The elderly strain to receive health services that they are in policy entitled to receive. In Kenya, studies by Kabole et al (2013) revealed lack of responsiveness in Kenya health system to the Felderly in many forms under different circumstances and places including the hospitals. These findings are echoed by other findings that report strains and ineffectiveness in the health sectors especially on issues that pertain the elderly. Furthermore these findings were supported by another research by (Ochola et al. 2000) who noted that elderly respondents taking part in focus group discussions reported that public health providers utter discouraging remarks, that imply that the elderly who seek medical attention are not sick, but rather the problem is old age.

There is a visible strain therefore of the increasing number of the elderly on health resources. This strain in turn affect services and the mechanisms to address the accompanying health problems and risk factors of old age.

This study also asserts an observation made by on the fact that most Kenyans in the rural areas are extremely poor and lack access to basic services, including health. The elderly people especially in Kenya have serious shortcomings when it gets to accessing and managing health services in old age. Studies highlighted lack of finance, family support, physical inaccessibility of health service providers, and practicing quacks as the major factors that deter older people seeking healthcare services (Waweru et al., 2003,).

Whereas 60% of the respondents strongly disagreed and disagreed that the cost of accessing health care among the elderly people in the community is low, 30% strongly agreed and agreed. The remaining 10% were however not sure. This implies that the cost of accessing health care among the elderly people in the community is still high. Therefore, there is a challenge in terms of cost of health care services for the elderly that needs to be addressed.

Majority (60%) of the respondents strongly disagreed and disagreed that there are free medical checkups provided for the elderly people in their area through the social service programs. On the other hand, 30% were positive by agreeing and strongly agreeing with the statement. The remaining 10% were not sure. This implies that free medical checkups for the elderly are not that common in the communities and therefore something needs to be done.

Lack of medical checkup avenues for the elderly is a common thing in many societies today. Old age diseases are assumed by the elderly and taken to be normal accompaniments of ageing. Besides lack of avenues for medical checkup therefore, there is also a general laxity of the elderly persons in seeking for treatment.

If the elderly persons had regular checkup, probably, many illnesses that are associated with aging would have been taken care of. The leading cause of disability in elderly females includes depressive disorder, hearing loss, back and neck pains, mental confusion, and painful joints. Similarly in their male counterparts, leading cause of disability include hearing loss, back and neck pain, falls, lung diseases, and blood sugar disease. However, Miller et al. (1999) noted that majority of the elderly suffer varied multi-morbidity conditions and that delay to address them often have far reaching consequences.

The high numbers that noted lack of provision of free medical checkups to enhance wellbeing among the elderly is a clear indication that the health sector is not satisfactorily giving attention to the elderly as it is expected to. This aspect agrees with an assessment by the World Health Organization (WHO) (2015 in UNDESA, 2015) who give a warning on the fact that health systems around the world are not meeting expectations when it comes to the issue of meeting the needs of older persons. The report further note ho. Health of older people is not keeping up with increasing longevity; marked health inequities are apparent in ineffective the health sector has become in this particular aspect not just in developing countries but even in high-income countries. The elderly in low and middle-income countries do not experience optimal aging as compared to adults in other age groups. This therefore depicts both the inefficiency and unsustainability of the management of good programs even where there is effort in the health sector to cater for the elderly.

When asked to indicate whether the local government and other agencies always organize for medical camps in the area for the elderly people, 40% strongly disagreed, 30% disagreed and 10% were not sure. The remaining 20% agreed with the statement. This shows that the local government and agencies have not done much to provide medical camps for the elderly in the community.

The elderly generation increases as days go by. United Nations, Department of Economic and Social Affairs noted that the increase is causing worldwide strain on resources specifically health services and the mechanisms to adequately address health problems and risk factors of old-age which in turn decreases elderly potential for optimal ageing. Social aspect of health-care is one of the strains experienced (Aboderin, 2004).

Half (50%) of the respondents strongly disagreed and disagreed with the statement that the health care services provided by the social service programs addresses all the healthy needs of the elderly at no extra cost. A few (10%) were undecided whereas the remaining 40% strongly agreed with the statement. Lastly, the respondents were asked to indicate the extent to which the elder health care service programmes affected their well-being. The response given is as shown in Figure 1.

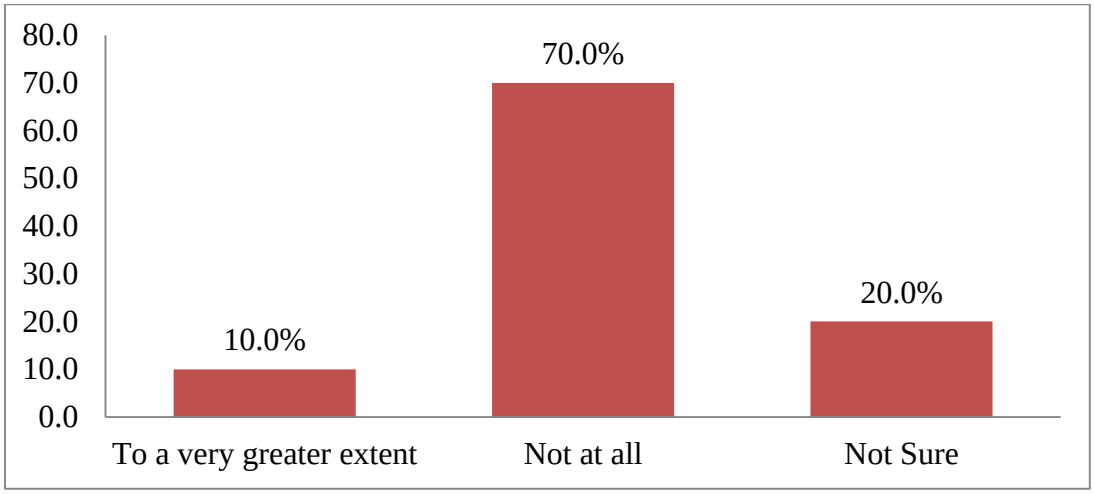

Figure 1: Extent to Which the Elder Health Care Service Programmes Affect Their Well-Being

Majority (70%) indicated that the elder health care service programmes had no effect on their well-being. A few (20%) were not sure of the extent of its effect on the well-being whereas the remaining 10% indicated to a very greater extent.

This shows that despite majority of the respondents considering that the health care service programmes are not influencing the wellbeing of the elderly there are few who consider it effective (Enssle, & Kabisch, 2020). This finding concurs with observations made from previous studies such as that by Help Age International (2010) which noted that under-financing of health systems, over-stretched health workforces, poor health management information systems (HMIS), unreliable supply of medicines, physical barriers to access health-care and distance- related barriers, as the main constraints that contribute to older people's poor access to health-care services. Another study by Waweru et al. (2003) identified that lack of finance, absence of family support, physical inaccessibility of health service providers and practicing quacks are the major factors deterring older people from seeking healthcare services. A study by Wairiuko (2014) showed that access to healthcare was at 40.4 % with the odds of access increasing among those who lived in permanent houses.

5. Conclusion and Recommendations

In terms of the cash assistance programs, the study concludes that there are only a pocketful of elderly people that have access to the cash. Many of them however, find the cash as inadequate and ineffective in addressing their needs as the elderly in the community. With regard to elderly health care programs, the study concludes that the health care programs are not effective in addressing the health care needs of the elderly in the community. There is still a challenge experienced especially with regards to cost of accessing the health care and lack of free medical checkups. Additionally, the programs do not address all the healthy needs of the elderly at no extra cost.

There is need for empowering the social service programs in the county so as to support the needs of the elderly. This empowering may be in terms of resources such as finance, human resource and food. Additionally, the study also recommends that the government should set more funds and encourage private investors to contribute towards the social service programs. This will help to increase the financial resources necessary for meeting the full needs of the elderly.

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