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Health Systems Responsiveness To Elderly Optimal Aging In Rachuonyo North Sub-County Of Homa Bay County, Kenya.

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ABSTRACT: Optimal aging in the elderly has become an important concept globally due to increasing number of people aged 60 years and above and their subsequent pressure on health services. The elderly, the expectant mothers and children under the age of five years are world vulnerable populations and whereas in Kenya, the latter two have guiding packages for health care, the elderly on the contrary lack such focused provisions. The study investigated the responsiveness of health system on elderly optimal aging in Rachuonyo North Sub-county of Homa Bay County, Kenya. It was guided by Systems and Symbolic interactionism theories. The study employed a descriptive cross-sectional explorative survey design. Semi structured questionnaires, interviews, focus group discussions and observations were used as methods of data collection. Study population was 10,033 elderly with sample size of 385 determined by Taro Yamane's formula with margin of error of 5%. Respondents,45 Key Informants and five 10 focus group discussion members were obtained bycluster and purposive sampling methods. Cronbach alpha was used to determine the reliability of the questionnaire and at least .7 was ascertained. Validity was determined by experts'reviews, pretesting tool and training research assistants. Quantitative data was analyzed using SPSS version 20. Qualitative data was analyzed through content framework. In a scale of 1 to 5 the study established that there was moderate level of optimal ageing with mean response of 2.61, statistically significant ($r = .247$; $p < 0.05$). The study recommended the use of specific care package to guide service delivery to the elderly.

Key words: Ageing, Health System, Optimal Ageing, Responsive Health,Vulnerable Populations,

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I. INTRODUCTION

Background of the study

The global increase the elderly by 56 percent from 901 million in 2015 to a projected 1.4 billion by 2030 has had impact on all human institutions, (UNFPA, 2012). Since the increase has not had corresponding categorized responses among many nations particularly the developing nations (Gachuhi and Kiemo, 2005), it is causing worldwide strain on resources specifically health services and the mechanisms to adequately addresshealth problems and risk factors of old age (Beard et al., 2012; Mubila, 2012). The strain compromises among others, the social aspect of health-care with respect to optimal ageing.Optimal aging is the capacity of an individual to function across many domainsin spite of one's medical conditions (Smith, 2007). Older persons in good health are perceived to enjoy greater sense of personal wellbeing and can participate in economic, social, cultural and political activities. Virtues of optimal ageing include among others positive emotions, absence of feeling of loneliness, social desirability, intellectual functioning, undertaking activities of daily living. Elderly in low and middle-income countries do not experience optimal aging as compared to adults in other age groups(UNDESA, 2015). In Sub Saharan Africa (SSA), Aboderin (2015) reveal that health-care services are deficient in their responsiveness to the needs of the elderly De Silvia, (2009) maintained that patient satisfaction with non-medical aspects of care, is often associated with better compliance with treatment instructions, prompt seeking of care and a better understanding and retention of medical information. Longevity often predisposes people to live with physical impairments thus Miller et al. (1999) reported that majority of the elderly suffer varied multi-morbidity conditions. In Kenya, Lasisi (2015) found that old age diseases are often assumed by the elderly and are taken to be normal accompaniments of ageing leading to laxity in seeking for treatment promptly.The demographic Health Survey, Rachuonyo sub-county, recorded an increase by 38% of elderly population between 2014and 2017 and now top the other sub counties with number of the elderly.The elderly, the expectant mothers and the children aged below 5 years are the world vulnerable populations (CDC, 2012). In Kenya, health services to expectant mothers and children under 5 years is guided by specific care packages, the "Focused Antenatal Care" and "Integrated Management of Childhood Illnesses" respectively. This is because these two cohorts have unique care needs that go beyond the scope of general care which is guided by the Medical model (Green*et al.*,2002). The impacthas had improved health outcomes for mothers

and children marked by reductions in ill-health and deaths (KNBS, 2014). Managing care for the elderly however lack such focused care provision (UNFPA, 2012). It is against this background that the study sought to investigate the responsiveness of health system by seeking to determine the level of optimal aging among the elderly in Rachuonyo North Sub-County of Homa Bay county". The study would enable the elderly to take active role in self-carewhich would contribute to benefitthe nation through their rich experiences and virtues.The study would also assist to nurture harmonious relationship between health care service providers and the elderly. It would also inform policy on the current state of care for the elderly and finallycontribute new knowledge to enrich care services of the elderly. In terms of scope, it was confined to Rachuonyo North Sub County and was limited to elderly who had received health care services at the sub-county health facilitiesas main respondents. The study also targeted 45 health care service providers in Rachuonyo North Sub County health facilities as Key Informants. The tools used for data collection were questionnaire, interview schedules, focus group discussion guides and observations. It covered the social relations aspect of care and took three calendar years from 2015 to 2018.The study was guided by systems theory and theory of symbolic interactionism.

In Kenya, studies by Kabole et al., (2013) and HelpAge, (2001) revealed lack of responsiveness in Kenya health system to the elderly in many forms and under different circumstances and places including the hospitals. In this study, the investigator has however not met any literature on care of the elderly in the study area.

II. METHODOLOGY

This study adopted an exploratory descriptive cross-sectional case survey design which sought to explore a phenomenon: the conception on the experience of the elderly on how the health system manage care in Rachuonyo North Sub-County of Homa Bay County. Research design according to Bhattacherjee, (2012) is a comprehensive plan for data collection in an empirical research project, a "blueprint" for empirical research aimed at answering specific research questions or testing specific hypotheses, and must specify at least three processes: the data collection process, instrument development process, and sampling process. All these conditions were successfully met in this study. The exploration aspect of the design was used to explore the salient feelings and perceptions of the elderly on the experiences of their care in health facilities and also how they were treated by the general population. The descriptive aspect provided an accurate explanation of the feelings and experiences of the elderly. The study included all eligible respondents from the age of 60 years upwards. It also collected data from all levels of health facilities in the study area. The investigation focused on the elderly social aspect of care. It enabled the study to investigate detailed analysis of research objectives and provided information on the experience of the elderly towards their care. Rachuonyo North Sub-County is located to the North East of Homa Bay county and covers an area of 412.5 km2 and has elderly population of 10,033 as shown in table 3.1.The target population was 10,033 (HCIDP, 2013) and the sampling frame was made up of the elderly who had received health care services managed by the County government and private organizations within the sub county.

Table 3. 1: Rachuonyo North Ward population and elderly population.

County Ward	**Elderly**
West Rachuonyo	1614
North Rachuonyo	1462
Central Rachuonyo	830
Kendu Bay Town	1261
Wangchieng	2064
Kanyaluo	1595
Kibiri	1207
Total	**10,033**

Source: HCIDP 2013

A sample population was drawn from the Sub-County population of 10,033 elderly by using Taro Yamane's formula (Yamane, (1967).

$$n = \frac{N}{(1+N(e^2)}$$

Wheren = is the required sample size, N = is population of the elderly (10,033), e = is the precision level at 95% with a ±5 margin of errorprecision of 0.05. Using theTaro Yamane's formula, the required sample size was calculated to be 385. The sample was selected using cluster and purposive sampling methods. The generated ward samples were again distributed based on the population of the locations as shown in table3.2. The study adopted the already stratified administrative boundaries of the seven electoral wards and the 23 locations.Participants for Focus Group Discussions were selected purposively because of their ability to explore

perception and behaviors' in target group (Mugenda & Mugenda, 2011). Data collection involved mixed method of both quantitative and qualitative approaches. Mixed method helped to validate the research study and ensured better results thanusing a single method. Triangulation was employed so that diverse viewpoints could cast light upon a topic. It also assisted the investigator to realize areas of convergence and divergence such that deficiencies in one method was made up for by the strengths of a different method as pointed out by Alvi, (2016).

Table 3.2 Distribution of Questionnaires

Ward	Ward elderly population	Sampled Elderly	Locations	No of questionnaires
West Rachuonyo	1614	62	4	62
North Rachuonyo	1462	56	4	56
Central Rachuonyo	830	32	3	32
Kendu Bay Town	1261	49	2	49
Wangchieng	2064	79	4	79
Kanyaluo	1595	61	3	61
Kibiri	1207	46	3	46
Total	**10,033**	**385**	**23**	**385**

Primary data on optimal aging and health system's responsiveness was collected from the main respondents using questionnaires which had both closed and open-ended questions. The questionnaire was developed in a deductive way to capture both descriptive and inferential statistics and was administered by research assistants. Reliability of the questionnaire was ascertained by testing the internal consistency by conducting the Cronbach's alpha which showed the instruments to have adequate reliability for the study by scoring .786 against the acceptable minimum threshold of .06. The descriptive data was captured on a five-point Likert scale of between 1-Strongly Disagree, to 5=Strongly Agree. The inferential data were captured by the open-ended aspect of the questionnaire. A total of 376 elderly were reached against the estimated 385.Focus group discussion was moderated by the investigator to 10-member groups of mixed gender in five sites in the study area. The chiefs of the twenty-three locations in the study area and the management of health facilities were informed about the data collection by letters. The research assistants were trained on the research tool to ensure accuracy and efficiency. Data was analyzed using SPSS version 20. The mean score response was calculated by dividing total score per item by number of respondents per item. The mean scores were interpreted using intervals of 1.00-1.44 = very low level; 1.45 – 2.44 = low level; 2.45 – 3.44 = moderate level; 3.45 – 4.44 = high level; 4.4.5 – 5.00 = very high level. The results were presented using both the descriptive statistics and inferential statistics. Statistical tests, Pearson product-moment of correlation and regression analysis were used to investigate the relationship between the variables. Pearson Moment Correlation Coefficient analysis was used to investigate the relationship betweenHealth System responsiveness and the perceived level of optimal ageing among the elderly. All tests of significance were computed at $\alpha = 0.05$. The multiple regression model adopted was $Y = \beta 0 + \beta 1X1 + \beta 2X2 + \beta 3X3 + \varepsilon ij$ where y is the dependent variable, $\beta 0$ is the constant, $\beta 1$, $\beta 2$ and $\beta 3$ are regression coefficients to be computed, εij is the error component with mean zero. Where: Y is Optimal Ageing, X1 Observance of respect for persons, X2 Client Orientations, X3 Preparedness to Care for the Elderly. Diagnostic testswerepreliminarily performed to ensure that there is no violation of the appropriate assumptions of correlation and multiple regressions.Approval and permission to conduct the study was granted by the National Council for Science and Technology (NACOSTI), through the Rongo University School of Post Graduate Studies. Consent for the study was obtained from the study participants after the nature of the study was explained to them.

III. Results of the Study and Discussions

The demographic information investigated included gender, age, marital status, educational level and income generating activity. The findings and discussions were presented in the figures and tables that follows.In figure 4.1, it is evident that majority 227 (60.4%) of the elderly were females. Given that the study respondents were selected randomly without any bias to a particular gender, it implies that majority of the elderly in Rachuonyo North Sub County were females. This is not surprising because generally there are more females than males in Kenya as reported by Kimathi, (2009) and Gondi (2009) that majority of older persons in Kenya are women, many of who live in the rural areas (Byl, Punia, Owino, 2013) and hence ageing is a woman's world.

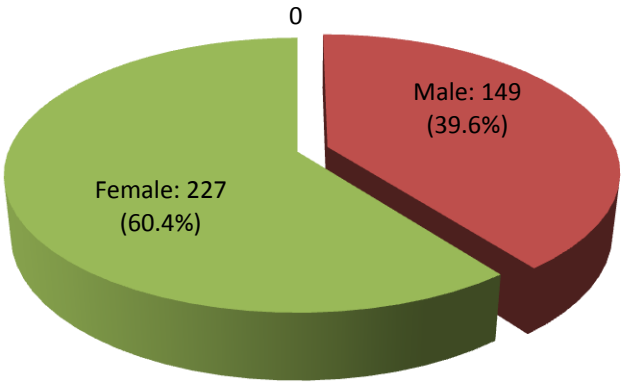

Figure 4.1 Gender Distribution of Respondents

The finding also concurred with the UNDESA, (2015) forecast that three quarter of women aged 60 years and over worldwide will be living in the developing world where every one in seven persons will be an older woman. By the year 2014, the number of women outlived men globally by 4.5 years on average and made up 54 per cent of those aged 60 and over. This could be due to the fact that there is relatively high mortality rate among males than females in this age group in Rachuonyo Sub County thus implying low resilience of males to life stressors against optimal aging. The study is therefore a true reflection of the contemporary global demographic indicators on the number of females over males. Since both genders were represented in the study, the findings can be generalized to all gender.

On the ages of the respondents (shown in Figure 4.2), the study established that a significant majority 319 (84.8%) of the elderly were in the age group of 60-69 years and 70-79 years. Those who were above 80 years only formed the lowest proportion of the elderly in Rachuonyo North Sub-county, with only 9 (2.4%) of them being aged between 90-100 years.

4.3.2 Age of the Respondents

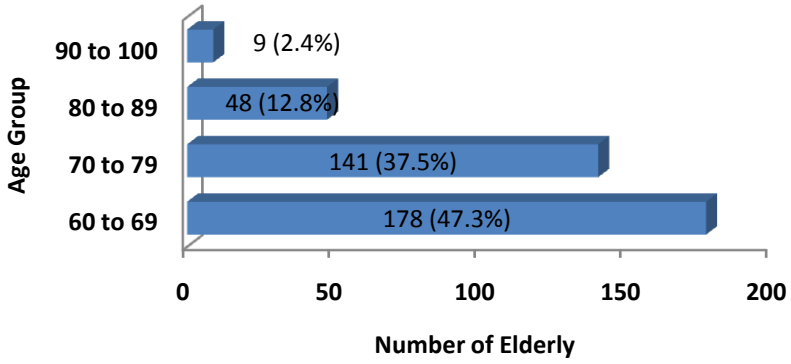

Figure 4.2Age Distribution of the Respondents

The result revealed a negative correlation between age of the elderly and years lived such that as age advances from 60 years, the number of living elderly decreases. This trend could be attributed to health complications of old age which impact on optimal ageing negatively and which could be lessened by good health care services and good lifestyles, (Smith, 2003). The finding concurs with findings of Gondi (2009) that population of Kenya has kept increasing over years with improvement in life expectancy. Although longevity often predisposes people to live with physical impairments, age periods has no supremacy over the gains and losses of developmental changes across life-span (Aboderin 2010).

The study further sought to investigate the marital status of the elderly given that optimal ageing could be influenced by marital status; hence it is important to understand how it was distributed among the respondents. Their findings were presented in Table 4.2 which indicated that majority, 206 (54.8%) of the elderly were married, slightly below average number 141 (37.5%) of them were widowed and that 25 (6.6%) were widowers. This implies that marital status has an impact on ageing.The finding is mirrored by the result of a study report by Gondi (2009) that life expectancy is higher in women (60.4) than in men (52.8).

Table 4.1. Distribution of Marital Status of the Respondents

Status	Frequency	Percent	Cumulative Percent
Married	206	54.8	54.8
Widow	141	37.5	92.3
Widower	25	6.6	98.9
Separated	4	1.1	100.0
Total	**376**	**100.0**	

This could mean that death rate among males was higher than females in this cohort. It reflects a study by Chaves et al., (2009) that confidants and close family cohesion impacts positively on optimal aging.

Table 4.2. Distribution of Elderly Respondents' Educational Level

Education Level	Frequency	Percent	Cumulative Percent
Primary or none	328	87.2	87.2
Secondary	45	12.0	99.2
Tertiary College	2	.5	99.7
University	1	.3	100.0
Total	376	100.0	

Table 4.3 revealed that a significant majority 328 (87.2%) of elderly had no formal education or only had primary level of education. Those who attained secondary education were 45 (12.0%), those who attained tertiary/college education or university education only formed less than one out of a hundred 3 (0.8%) of the elderly persons who took part in the survey. This finding is mirrored by Aboderin (2010) that there is broad lack of formal education among the elderly in SSA and also by the KDHS (2008-2009) report that 77% of women and 40% of men in Kenya never went to school. However, Beales (2009) showed that educational attainment is a key determinant of life-style and the status an individual enjoys in a society, therefore has strong effect on individuals' attitude towards health behaviors and quality of aging. In terms of Income Generating Activity,table 4.4 showed that, although the elderlies are engaged in various economic activities for maintaining livelihood, many of them were engaged in farming and business. This was reflected by the fact that majority 271 (72.1%) indicated that they were doing farming while some 57 (15.2%) of them were in other business.

Table 4.3. Distribution of Respondents Income Generating Activity

Business Engagement	Frequency	Percent	Cumulative Percent
Farming	271	72.1	72.1
Business	57	15.2	87.2
Teaching	13	3.5	90.7
Fishing	5	1.3	92.0
Other Activities	30	8.0	100.0
Total	**376**	**100.0**	

A relatively small number 13(3.5%) take up teaching in the various academies within the sub county. This could be a response to the Kenya Vision 30 of harnessing talents of high cadre retirees' contribution to development and the United Nations resolutions 46/91 of December 1991 that older persons should have the opportunity to work or to have access to other income generating opportunities. It also confirms Karpf (2012) and Matt (2009) assertions that it is the willingness and productivity of an individual that maters and not chronological age. It emerged in focus group discussions that whether old or not, women do most domestic chores. These views in essence castigate the notion of stereotyping the elderly as non-productive consumers of resources which is detrimental to their potential contributions to inclusive sustainable development (UNECA, 2012). The findings further reflect UN, (2016) and HelpAge (2001) reports that in sub-Saharan Africa the elderly population are making other vital contributions to their families and communities therefore socioeconomic roles of the elderly remain very important thus they deserves holistic care to realize optimal aging.

In order to establish the level of optimal ageing, data was collected through the use of a ten itemed-Likert-scaled score questionnaire. The constructs of the questionnaire were assessed by the responses; Strongly

Agree (5), Agree (4), Undecided (3), Disagree (2) or Strongly Disagree (1) the elderly responded on the items based on their own assessment of their personal experience with the social aspect of care. Rating levels of optimal aging ranged from very low to very high as shown in Table 4.5. The result revealed that there was moderate level of optimal ageing among the elderly in Rachuonyo North Sub-County. This was mirrored by a mean response of 2.61 (SD=0.43) with most of the constructs indicators rated just barely above moderate level of optimal ageing.On the construct that "I do not have any prolonged health conditions due to my old age status", Table 4.5 indicated that majority 262 (69.7%) of the elderly had many prolonged health conditions due to their old age status. Therefore, the mean response of 2.36 (SD=0.56) implied a moderate level of optimal ageing.The qualitative response in the questionnaire revealed that a sizeable number of ailments were associated with old age i.e. allergy, body pains, loss of sensations, chest pains, breaking bones, skin problems, loss of sight and hearing loss, dehydration, high blood pressure, body weakness and tiredness, loss of appetite, loss of voice, ulcers, urine blockage. The other ailments were associated with the environment under which the elderly is found i.e. diarrhea, HIV/AIDS, Malaria, respiratory tract infections, meningitis, typhoid, vomiting (Miller, 1999). This finding affirms the studies by Mubila (2012) and Mc Murray (2003) that majority of the elderly suffer varied multi-morbidity conditions. A report by the UNDESA (2015), indicated that unipolar depressive disorders are a leading cause of disability in females, followed by hearing loss, back and neck pain, dementias (i.e. Alzheimer's), and osteoarthritis. In men, hearing loss is the leading cause of disability, followed by back and neck pain, falls, chronic obstructive pulmonary disease and diabetes mellitus. Since most of the manifestations occur at the home environment where the family or community support system is the most likely first-hand help, there is need for health system to actively link families in the care of the elderly. This view is supported by Franklin (2013), who in assessing potentially inappropriate medication in elderly in the UK health system, castigated inappropriate medication effects in the elderly due to poor social supervision.

Table 4.4.: Respondents' Views on Optimal Ageing

Indicators of Optimal ageing	**1**	**2**	**3**	**4**	**5**	**Mean**	**SD**
I do not have any prolonged health conditions due to my old age status.	124 (33.0%)	138 (36.7%)	10 (2.7%)	62 (16.5%)	42 (11.2%)	2.36	0.56
I am always in good health and do not suffer disability from age-related chronic non-communicable disease.	131 (34.8%)	126 (33.5%)	16 (4.3%)	47 (12.5%)	56 (14.9%)	2.27	0.32
Despite my age I am still able to do most of my things alone and take charge of my family decisions.	118 (31.4%)	92 (24.5%)	18 (4.8%)	63 (16.8%)	85 (22.6%)	2.75	0.48
I am fully dependent on the support of young persons in my family to do my things.	62 (16.5%)	72 (19.1%)	26 (6.9%)	102 (27.1%)	114 (30.3%)	2.64	0.87
I often have difficulty remembering recent conversations, names or events.	56 (14.9%)	58 (15.4%)	21 (5.6%)	114 (30.3%)	127 (33.8%)	2.47	0.78
I am able to take care of myself because I do my basic care needs such as washing, dressing etc.	108 (28.7%)	103 (27.4%)	15 (4.0%)	74 (19.7%)	76 (20.2%)	2.75	0.65
I hardly use walking stick or any physical support garget.	117 (31.1%)	111 (29.5%)	18 (4.8%)	56 (14.9%)	74 (19.7%)	2.63	0.34
I have limitation in engaging in instrumental activities of daily living such as shopping, lifting and carrying, riding bicycle, driving etc.	70 (18.6%)	73 (19.4%)	20 (5.3%)	104 (27.7%)	109 (29.0%)	2.71	1.02
I fully take in social activities such as church, community meetings, funerals, chiefs' meetings etc.	97 (25%)	85 (22%)	14 (3.7%)	101 (26%)	79 (21%)	2.95	0.94
Mean Average level of Optimal Ageing among the Elderly						2.61	0.43

On the construct "I am always in good health and do not suffer disability from age-related chronic non-communicable disease", 103 (27.4%) of the elderly agreed that they are always in good health and do not suffer disability from age-related chronic non-communicable diseases, but the majority 257 (68.3%) revealed that they are always in bad health and often suffer disability from age-related chronic non-communicable diseases. The mean response of 2.27 (SD=0.32) signified low level of optimal ageing which agreed with the majority of the

Elderly responses. On the contrary, the Elderly who agreed 103 (27.4%) with the construct "I am always in good health and do not suffer disability from age-related chronic non-communicable disease" reflect the results of a study in Kenya by Lasisi (2015), that old age diseases are assumed by the elderly and taken to be normal accompaniments of ageing, as a result, there is laxity in seeking for treatment, however, in focused group discussions, members confirmed that elderly were often laxed in seeking health care services. On the constructs "Despite my age I am still able to do most of my things alone and take charge of my family decisions", the results of the survey show that quite a significant proportion of the elderly are unable to be fully self-reliant, they mainly depend on other people to meet their daily needs. Only 148 (39.4%) of the elderly who took part in the survey agreed, with certainty, that despite their age they are still able to meet most of their activities of daily living and to take charge of their family decisions. Therefore, the mean response of 2.75 (SD=0.48) implied a moderate level of optimal ageing.In regard to the construct "I am fully dependent on the support of young persons in my family to do my things", many 216 (57.4%) of the respondents accepted that they invariably depend on the support of younger persons in their family to meet their daily needs. The mean response of 2.64 (SD=0.87) implied a moderate level of optimal ageing. It may be concluded that since the elderly often have no option for assistance, they have to undertake these activities personally. On the construct "I often have difficulty remembering recent conversations, names or events", majority 241 (64.1%) of the respondents indicated that they often have difficulty remembering recent conversations, names or events with a mean response of 2.47 (SD=0.78). The mean response suggested a moderate level of optimal ageing. It is true that substantial cognitive deterioration over time represents a diagnostic criterion for dementia diseases. Chaves, (2009) attests that cognitive impairment is a common ailment in old age, however, application of a responsive health systems can reduce cognitive decline and improve wellbeing among the elderly. On the other hand, in regard to the construct "I am able to take care of myself because I do my basic care needs such as washing, dressing etc", it emerged that quite a respectable proportion 150 (39.9%) of the elderly are able to take care of themselves in regard to their basic care needs such as washing and dressing, translating to a mean of 2.75 (SD=0.65), suggesting moderate level of optimal ageing.In addition, on the construct "I hardly use walking stick or any physical support garget", 130 (34.6%) of the sampled elderly were found to be able to independently walk without any support. Majority 228 (60.6%) of them could hardly walk without the help of walking stick or any garget for physical support. The mean response 2.63 (SD=0.34) suggested a moderate level of optimal ageing. It is therefore indicative that a significant number of the elderly do not experience optimal aging in terms of physical fitness thus need assistance. In terms of the construct "I have limitation in engaging in instrumental activities of daily living such as shopping, lifting and carrying, riding bicycle, driving etc.", the findings of the study established that about average number 213 (56.7%) of the elderly suffer significant decline in physical fitness and robustness therefore are unable to actively engage in physical activities, reflecting an optimal ageing mean score of 2.71 (standard deviation=1.02). For instance, although some 143 (38.0%) of the surveyed elderly denied this fact, a majority 213 (56.6%) of them accepted that they have limitations in engaging in instrumental activities of daily living such as shopping, lifting and carrying etc. The mean response 2.71 (SD=1.02) suggested a moderate level of optimal ageing. In regards to "Fully taking social activities such as church, community meetings, funeral managements, chiefs' meetings etc. social interactions" it emerged that despite the age, a moderate number 180 (47%) of the elderly were able to interact socially (mean=2.95; standard deviation=0.94). The mean response suggests low level of optimal aging. From all the five FGDs, it emerged that the elderly participates in these activities as opinion leaders. A good health status is a major goal of development and is also a driver of economic growth and social progress. Older persons in good health enjoy greater sense of personal wellbeing and can participate in economic, social, cultural and political life. On the other hand, poor health reduces the capacity of older persons to generate income, curtail their productivity and compels them to depend on other people.The study sought to establish whether the health system responds to the observance of respect for persons in caring for the elderly for optimal ageing. In order to establish the level of observance of respect for Persons in caring for the Elderly on optimal ageing, Likert-scaled questionnaire was used to collect data on the views of respondents on each of the themes; dignity, confidentiality and autonomy. Using the responses; Strongly Agree (5), Agree (4), Undecided (3), Disagree (2) or Strongly Disagree (1), the elderly responded on the items based on the various aspects of observance of respect for persons in caring for the elderly. The data was summarized and presented in Tables 4.6-4.8

IV. SUMMARY OF KEY FINDINGS

The key findings were that there was moderate level of optimal ageing among the elderly with a mean response of 2.61 (SD=0.43) as shown in table 4.5 with most of the constructs indicators rated just barely above moderate level in the scale of 1 to 5. Based on demographic data the study revealed that there were more female's elderly, 227 (60.4%) than males, 149 (39.6%) as evidenced by figure 4.1 indicating that Rachuonyo North Sub County has more females than males. Ageing is further shown by the pattern of gender distribution shown in figure 4.2which suggests that as age advances from 60 years, the number of elderly declines. The

study also revealed that majority 206 (54.8%) of the elderly are married as shown in table 4.2 thus suggesting that companionship is appositive factor for optimal ageing among the elderly. Ageing is again shown by the study in the level of education in table 4.3 that a large percentage 87.2% of the elderly attained primary level schooling or never went to school. The study finally revealed that elderly who are involved in a kind of income generating activities as revealed by table 4.4 indicating that elderly optimal aging had some economic backup.

V. CONCLUSION

From the findings of this study and the summary, it is concluded that there is need for a specific guiding package for care service delivery for the elderly. In as much as the demographic aspect of ageing had a moderate score, the health care guiding package would enhance the relational aspect at the health facilities. The guiding care package would act as a base from where health facility care would cascade to include the extra facility care in the community. The focused care for the elderly would be more feasible when delivered in elderly specific departments to be consistent with those of the other vulnerable group.

VI. RECOMMENDATIONS

Drawing from the findings of this study, it is recommended to the National government through the Ministry of health to develop a relevant guiding care package for service delivery to the elderly.

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