PUBLIC PERCEPTIONS OF ELDERLY PEOPLE AND ELDERLY CARE INSTITUTIONS AND UPTAKE OF INSTITUTIONALISED CARE FOR THE AGED IN NAKURU COUNTY, KENYA

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A Research Thesis Submitted to the Institute of Postgraduate Studies of Kabarak University in Partial Fulfillment of the Requirements for the Conferment of Degree of Doctor of Philosophy in Counseling Psychology

KABARAK UNIVERSITY

NOVEMBER, 2019

DECLARATION

This research thesis is my original work and has not been presented for any award of a degree, diploma or certificate in this or any other university.

Signature: _____ Date: _____

Sellah Jerop Chepkwony

GDE/M/1362/09/11

RECOMMENDATION

To the Institute of Postgraduate Studies

The research thesis entitled **"Public Perceptions of Elderly People and Elderly Care Institutions and Uptake of Institutionalized Care for the Aged in Nakuru County, Kenya."** written by Sellah Jerop Chepkwony, is presented to the Institute of Postgraduate Studies of Kabarak University. We have reviewed the research proposal and recommend it to be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Counseling Psychology.

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DEDICATION

I dedicate this Thesis to my late Father, Benjamin Chepkwony, my mother Annah Chepkwony and siblings for their inspiration. I also dedicate this work to my family Mr. Abraham T. Koech, my children Brian, Shadrack, Louis, Faith, Festus, Jebet, Silvia, Emmy Jepkosgei, Janet Jemtai for their moral support and understanding. Not forgetting my Cousin Kitur and his family at Kabarak. For their continuous encouragement.

To the care givers for the aged; both formal and informal whose great work may not be seen and appreciated in society.

ABSTRACT

This study investigated Public Perceptions of Elderly People and Elderly Care Institutions and Uptake of Institutionalized Care for the Aged in Nakuru County, Kenya. This study was informed by the growing population of older people around the world at a time when traditional social support structures for older people are increasingly disintegrating. The disintegration of social support structures for older people, imply that society has to seek for alternative support structures such as institutional care. Specifically the study examined the influence of public perception of old people on uptake of institutionalized care, perceived public efficacy to address the needs of their aged dependants, public perception of the elderly dependants' self-efficacy, and public perception of institutional efficacy in taking care of the aged. A pilot study was carried out at Kericho County to determine validity and reliability of the study. The reliability coefficient of 0.862 and validity of 79.4% were attained hence the tool was both reliable and valid. The study was guided by exploratory research design. The study engaged 400 respondents for the questionnaire who were selected through random sampling and 7 key informants who were selected through purposive sampling. Data for the study was collected through the use of questionnaires and in-depth interviews. The study employed descriptive and inferential statistics for data analysis, which was aided by aided by use of SPSS (Version 21) and STATA 12. The results reveal that 57% of the public were not aware of the existence of the care homes in Nakuru County. Further, the uptake of institutional care for older people was most influenced by perceived importance of older people, the level of tolerance attitude of personnel of institutional homes, availability of social bonding program society for the older persons, health status, psychosocial Status of the elderly people, and the general competence of the care homes in terms of personnel and the physical infrastructure. In terms of areas for further study, this study recommends for an examination into the coping mechanisms of care providers in their adaptation to the challenging role of care provision in institutional homes.

Key words: Perception; self-efficacy; institutionalized care; elderly people

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LIST OF ABBREVIATIONS AND ACRONYMS

AARP	American Association of Retired Persons
APA	American Psychological Association
CAS	Center on an Aging Society
DHS	Department of Human Services
FGD	Focus Group Discussion
GoK	Government of Kenya
HAI	Help Age International
HIF	Health Insurance Fund
ILO	International Labour Organization
IRM	International Reform Monitor
NACG	National Alliance for Care giving
SPSS	Statistic Package for Social Sciences
UNPF	United Nations Population Fund
WHO	World Health Organization

OPERATIONAL DEFINITION OF KEY TERMS

Aging: Aging refers to the progressive physiological changes in an organism that lead to the decline of biological functions and of the organism's ability to adapt to metabolic stress. In this study, aging meant the behavioural, interaction, and physical changes that older people undergo as they grow older.

Care giving: In this study, care giving referred to the unpaid/paid support and assistance to aged family members or acquaintances that have physical, psychological, or developmental needs.

Institutional Care: Institutional care in this study meant paid care being given to elderly people enrolled in licensed homes. Institutional care is provided by specialists such as nurses, social workers, counselors and physiotherapists. Institutional care provider can be invited to attend to older people at home or older people are taken to professionals' premises.

Institutional Efficacy: Institutional efficacy referred to the ability of homes for older people to offer effective care giving to older people admitted in the homes. In this study, institutional efficacy of care homes for elderly was examined in the context of whether care homes had adequate staff to respond to the needs of older people admitted in their institutions, confidence in the management of care institutions for older people, the attitude of personnel of care institutions towards older people, whether care institutions had quality accommodation facilities for older people, whether formal care institutions had adequate facilities for physical exercise and whether these institutions had comprehensive programs for social bonding.

Older People/elderly/aged: World Health Organization (WHO) defines an older person as a person who is aged 60 years and above. Kenya defines an older person as a person who is aged 65 years and above. This study adopted an age of 60. However, this study focused on older people who could probably be admitted at institutional homes for older people.

Perception: In this study, perception referred to the belief primary care givers had toward their ability to care for their older relatives, ability of their older relatives to care for themselves, ability of institutional care homes to provide quality and adequate assisted care to their older relatives and belief about the aged and aging.

Primary Care Givers: This study adopted a definition of primary care givers as the individuals providing psychosocial support to older people at the family residence. In this study primary care givers were family members, relatives and friends who provide psychosocial support to older people without any monetary compensation. Primary care givers usually reside with older people. At the family level, primary care givers are spouses, daughters, sons and close relatives of the older people.

Self-Efficacy: In the context of the study, self-efficacy is what an individual believes he or she can accomplish using his or her skills under certain circumstances. The focus of the study was to establish from members of the public whether they believed that their elderly relatives in particular and elderly persons generally have the capacity to live on their own without the presence of their relatives.

Efficacy of Primary Care Givers: Efficacy of primary care referred to the belief by primary care givers in their ability to provide adequate and quality care to their older relatives. In this study, efficacy of primary care givers was examined in the context of the relationship primary care givers and their older relative prior to his/her old age, the occupation of the primary care givers, the psychological strength of primary care givers and uptake of institutional care for older people, whether primary care givers can take care of my older relative without major assistance from other people or organizations, whether primary care givers can take care of my older relative(s) notwithstanding their dependency level and whether primary care givers' financial status allow them to attend to their older relative(s)on the one hand and their influence on the uptake of institutional care for older people.

Efficacy of Older People: Efficacy of older people referred to the belief by primary care givers in their older relatives' ability to provide adequate and quality care for themselves. This study examined efficacy of older people in the context of older people's physical health, physiological health, economic status, psychological status of older people and alcohol and substance abuse. The ultimate objective was to determine whether they had the ability to take care of themselves or required external support.

CHAPTER ONE
INTRODUCTION

1.1 Introduction

This chapter lays the foundation of the study. It discusses the background of the study, statement of the problem, purpose of the study, specific objectives, research hypothesis, and significance of the study, scope of the study, limitations of the study and assumptions of the study. These are based on the public perceptions of elderly people and elderly care institutions and uptake of institutionalised care for the aged and the postgraduate choice of Universities in Nakuru County, Kenya.

1.2 Background to the Study

According to UNPF (2014), the number of elderly people in the world is estimated at 700 million, which represents about 10% of global population. It further projects that the population of elderly people will reach 2 billion by the year 2050, which was about 20% of the world's population. While in Africa, over 50 million, which is 5% of its population are elderly people. According to World Bank (2013) 5.1% of the Kenyan population is aged 60 years and above, making it the third highest after Ghana and Nigeria. These population demographics present significant implications for comprehensive care for the aged populations. Longevity of life that lead to high population growth among elderly people is something to be celebrated, since it is indicative of the progress humanity has made in the field of nutrition, health, medicine and related areas. Schroder-Butterfill & Fithry (2017) however, noted that the high population growth of elderly people in Kenya is coming at time when traditional institutions that supported elderly persons are quickly diminishing. Care provision to the elderly in society has relied historically on family members especially in developing countries.

The changing family structure, dynamic migration patterns and associated risks of ill health in later life, place a higher need for long-term care and support. Unfortunately the norms, religious and cultural traditions of these many countries place the duty of care on women; which in most cases is unpaid and informally provided thereby heightening the pressure on women's wellbeing, time and energy through a combination of competing demands (Hussein & Ismail, 2016). However, the fragmentation of the traditional large family groups into small family units as a result of socio-economic realities and dual career family orientation has drastically reduced the

number of people especially women who can provide care to dependent elderly family members (Gaddis & Klasen 2014). The increased female participation in the labour market as expressed by Cazes & Verick (2013) means that a shift towards paid work for care giving is quite necessary. This and tighter regulation of labour markets has resulted in the availability of a very small pool of family members who can provide care to the family. It can be observed that this disintegration of traditional care provision structures has left many elderly people vulnerable to solitary lives, mal-care and elder abuse (Cazes & Verick, 2013).

The grim reality that traditional family structures are no longer a reliable source of comfort to the elderly has led to the emergence of care provision arrangements outside the family, generally referred to as formal care (Zhang, Zeng & Fang, 2017). Although formal care services are still a new phenomenon in Africa in general and Kenya in particular, regions such as Eastern Europe, Asia and Latin America have had these services since 1950s (Gaddis & Klasen 2014; Schroder-Butterfill & Fithry, 2017; Zhang, Zeng & Fang, 2017). In Africa, Countries such as Zimbabwe and Botswana have been providing formal care services to their elderly populations since late 1990s (El-Badry, 2013). While the emergence of formal care services was thought to provide relief to elderly persons especially those from dysfunctional extended family and kinship systems, the uptake of these services especially in developing countries has remained extremely low. For instance in Zimbabwe and Botswana only 2.4%, and 1.5% respectively of the elderly persons have taken up formal care services (El-Badry, 2013). Although there is no empirical study on the uptake of these services in Kenya, evidence from the aforementioned countries suggests that the uptake of these services in Kenya may be equally low. Just like the East African countries, few formal systems of care exist and therefore instead, families provide most of the caring for children, the sick and aged. And the care deficit for the old exists due to the huge difference between the need for care and the available supply of caregivers (Schatz & Seeley, 2015).

The low uptake of formal care services for elderly people as previously indicated has raised concerns about the efficacy of formal care institutions for elderly people (Sole-Auro & Crimins, 2014). The African view of care for the elderly transcends private gain covering the societal gain (Lloyd-Sherlock, 2018). As such it is viewed as a societal responsibility to ensure the elderly people age gracefully. This view reflects wider African discourses about the need to avoid western norms and models of long term care

provision. The public perception with deep historical roots is engineered to have a closely knit society. Several other studies have focused on the role of institutional factors and its perceived efficacy to take care of elderly persons. For instance Sole-Auro & Crimins (2014) focused on the role of household and family composition in the provision of informal and formal care for incapacitated adults aged 50+ in Spain, England and the USA. Chen, Yamada, Nakashima, & Chiu (2017) analyzed the substitution of formal and Informal home care service use and nursing home service use and implications for a public health policy in Japan.

The physical and psychological health and coping ability of the care giver can be moderated by the specific domain of their self-efficacy for the caring role (Chenoweth et al., 2016). Therefore understanding the underlying processes that influence a person's ability to adapt positively to the caring role is an important prerequisite to the development of carer support systems. According to Chenoweth et al. (2016), one influential factor in this exercise is the carer's belief that they have the capacity to undertake complex tasks in caring for a family member. Self-efficacy often changes within the individual over time and in response to specific life experiences, such as taking on the carer role in adult life and having to deal with the changing behaviour and abilities in the elderly persons.

Several studies have focused on perceived self-efficacy of members of the public to take care of their elderly relatives or enlist the services of others. Factors that have been established by these studies as critical to individual's self-efficacy towards care provision for their elderly relatives are diverse. Values such as preferences, knowledge, and skills, as well as the accessibility, affordability, and adequacy of health care determine how caregivers manage tasks of care giving (Schulz, 2016). The experience in caregiving varies by distance in the sense that the longer the distance caregivers the higher the probability that they will be typically involved in providing social and emotional support, advanced care planning, financial assistance, and care-coordination. They would often share these responsibilities with a more proximal caregiver who provides assistance with personal care. However, being separated from the care recipient complicates communication about the care recipient's health and care needs, and poses formidable challenges to address those needs through service providers (Schulz, 2016).

Cultural embeddedness could also have a bearing on societal perception and influence the decision to provide care for the aged. For instance, Pharr, Francis, Terry, & Clark. (2014) found that caregiving was so embedded in the life experience of the Asian American, Hispanic American, and African American focus group participants. This was to the extent that the decision to care or not to care was irrelevant and that caregiving was just something that was done without question. The decision to provide care for one's family or community was deeply rooted in the cultural sub consciousness. This arose naturally without conscious thought. However, sometimes, the degree to which caregiving is culturally embedded and prescribed may preclude some caregivers from questioning the caregiving role and/or seeking support (Pharr et al., 2014).

Although several studies have focused on factors influencing efficacy of formal care institutions and members of the public to take care of elderly people in society, little has been done with regard to how perceived efficacy influences the uptake of formal care services for elderly people in society. In addition the bulk of research has been in the Western world where formal care services are not only advanced but are also being implemented in a socio-cultural context. This poses a knowledge gap especially in the developing countries with specific reference to Kenya. It is against this background that this study focused on the influence of public perceptions of elderly people and perceived efficacy on the uptake of institutionalized care services for the aged in Kenya in general and Nakuru county in particular.

1.3 Statement of the Problem

The disintegration of extended family and kinship ties due to changing value systems toward nuclear family, coupled with urbanization, wage labour and formal education have robbed society of traditional family caregivers such as children, women and young adults. This has left elderly people, without a reliable source of informal care providers. This situation predisposes them to diseases, hunger, abuse and other forms of degrading treatment. Formal care homes for the elderly people have consequently emerged in recent years in an effort to fill the void left by informal care providers. While these homes are meant to restore the dignity and authority of senior citizens in the society, it is disheartening that the perception of the society offers little support for the enrollment for these services in Kenya and other Sub-Saharan African countries. The Kenyan demographic surveys indicate increasing longevity and hence an increase of an ageing population in the backdrop of growing economic realities and diminishing family

constellations. According to the National Council of population and development, by 2009, there were more than 1.9 million people aged above 60 years in the country (NCPD, 2016). However, the demographic planning to accommodate the likely need for care homes lacks empirical support in Kenya. There is a dearth of information in regard to the public perception on the formal care for the elderly owing to the fact that this is a new concept in Kenya. This phenomenon perceived as a western thing is yet to gain traction in the Kenyan society (UN Department of Economic and Social Affairs Population Division, 2017). The bulk of studies on this subject have mainly focused on the developed nations. This limitation poses a knowledge gap with regard to developing countries and in particular Kenya. This study set out to bridge this knowledge gap by focusing on the influence of public perceptions on the efficacy of the formal care giving institutions as well as the perceived self-efficacy of elderly people on the uptake of institutionalized care services for the aged in Nakuru County in Kenya.

1.4 Purpose of the Study

The purpose of this study was to contribute to the improved welfare of the elderly people by providing an understanding of the phenomenon of formal care giving to services to the elderly persons.

1.5 Objectives of the Study

The study was guided by the following objectives:

i. To establish the influence of public perception of old people on the uptake of institutionalized care for the elderly in Nakuru County, Kenya.
ii. To explore the influence of perceived self-efficacy of elderly people on the uptake of institutionalized care for the elderly in Nakuru County, Kenya.
iii. To determine the influence of perceived self-efficacy of primary care givers on the uptake of institutionalized care for the elderly in Nakuru County, Kenya.
iv. To determine the influence of public perception of institutional efficacy to provide care for the elderly on the uptake of institutionalized care for the elderly in Nakuru County, Kenya.

1.6 Research Hypotheses

To achieve the objectives of the study, the following research hypotheses were posited and tested.

H_O1: Public perception of the elderly does not significantly influence the uptake of institutionalized care for the elderly in Nakuru County, Kenya.

H_O2: Public perception of the elderly person's self-efficacy does not significantly influence the uptake of institutionalized care for the elderly in Nakuru County, Kenya.

H_O3: Perceived self-efficacy of primary care givers does not significantly influence the uptake of institutionalized care for the elderly in Nakuru County, Kenya.

H_O4: Public perception of institutional efficacy to care for the elderly does not significantly influence the uptake of institutionalized care for the elderly in Nakuru County, Kenya.

1.7 Significance of the Study

The findings of the study will enable primary care givers gain insight into the critical issues they need to consider when assessing their own efficacy, older relative's as well the efficacy of institutional homes to provide effective care for older people. Primary care givers must assess their ability to provide care for their older relatives in the context of their appreciation of the role of older people in society, respect and value they attach to older people. They should also assess their ability in terms of their pre-old age relationship with older relatives, occupation, economic status as well as psychological strength. They need to assess the efficacy of their older relatives to take care of themselves in terms of their physical health, economic condition and psychological status. Primary care givers while assessing the efficacy of institutional homes to provide care for their older relatives should consider the attitude of personnel of these homes toward older people, availability of accommodation and physical exercises facilities for older people, existence of social bonding programs as well as the legal status of the institution.

The findings of this study are also significant to the management of institutional care homes. The management of these homes can use the findings of this study to improve the quality of their services through recruitment of staff with right attitude

toward their work and older people, provision of adequate and quality accommodation, social bonding programs and establishment of physical exercises infrastructure for older people. The findings of the study should also prompt the management of institutional care homes to start awareness campaigns about their existence and the services offered thereof as well regularizing their status with relevant government agencies. The management of institutional care homes can also use the findings of this study to seek for support from governmental and non-governmental institutions given that the study has revealed that older people experience numerous problems that require multi-sectorial interventions.

The findings of this study are also important to scholars and academia in the field of psychology, social gerontology, geriatric medicine and social work. This study has broadened the scope of empirical studies in Kenya in the field of psychology, social work and social gerontology, given that there is currently limited studies on older people generally and institutional care for older people in particular. The findings of this study can thus be used by other psychologists and social gerontologists to stimulate debates and further research in area of aging, care giving and institutional care homes.

This study has also revealed that indeed a significant number of older people are neglected by their primary care givers thus exposing them to various forms of abuse. Against this backdrop, institutional homes covered in this had under enrollments. The study has also revealed that many institutional homes lacked essential facilities and services thus undermining their ability to offer quality care to older people. The national and county governments can use the results of this study to initiate assistance programs to institutional care homes so as to help them expand their capacity and offer care to older people in society.

1.8 Scope of the Study

The proposed study was based in Nakuru County. The study covered all the 11 sub-counties of Nakuru County. The study covered members of the public aged between 18 and 59 years. The population of the members of the public aged between 18 and 59 years was estimated at 895,783 (Nakuru County Integrated Development Plan, 2013). Thematically, the study limited itself to perceived public efficacy to take care of elderly people, perceived efficacy of elderly people to take care of themselves, perceived efficacy of institutions for elderly people to take care of elderly people. The variables

under institutional efficacy investigated were personnel qualifications, adequacy and attitude toward elderly people as well the kinds of care giving services offered to elderly people in the institutions. Efficacy of elderly people was investigated in the context of their physical ability, health conditions, economic status and social networks. Public efficacy was investigated in the context of their relationship with elderly relatives, occupation and availability of relatives or friends to complement their efforts in care provision to elderly relatives. Examination into the socio-cultural factors was confined to the social role of elderly people, cultural obligation for care provision to elderly people and cultural sensitivity of care institutions.

1.9 Limitations of the Study

The proposed study encountered the following limitations:

One, due to the sensitivity of some filial relationships, some respondents were not free to give their honest opinion on their self-efficacy to take care of their elderly relatives for fear that some of the information if revealed may portray them as being neglectful and unconcerned about the plight of their elderly relatives. Further, some respondents elected to withhold some information especially those that touch on their past relationship with their elderly relatives. The kind of pre-old age relationship individuals had with their elderly relatives may influence the efficacy of members of public toward care provision for elderly relatives. The respondents were assured that the information obtained from the study would be used for purposes of the study and would not in any way be used against them. That the study would also allow respondents who wished to remain anonymous to do so. By applying the principle of confidentiality and anonymity the researcher hoped to encourage respondents to provide honest opinion on their self-efficacy to take care of their older relatives.

Second, some respondents failed to comprehend the entire physical and financial status of their elderly relatives. This is because elderly relatives hide some information either as a way of exaggerating their situation to warrant more attention from their dependants or withhold some information to demonstrate their efficacy and therefore lay ground for informal rather than formal care interventions. The study pressed the respondents to recall the frequency with which their older relatives were seeking medication, and who paid for the medication. Respondents were also pressed to recall (without stating the actual investment) whether their older relatives have any incoming generating activities, pension or other reliable sources of incomes.

Third, some respondents gave biased opinion on the efficacy of formal care institutions based on the kind of attitude they have toward these organizations. Respondents with negative attitude toward these institutions may portray these institutions as incompetent and thus unable to offer any meaningful services for their elderly relatives. However, positive attitude toward these institutions may make some respondents glorify these institutions and depict them as competent and effective in care provision. Therefore, selective perception may thus make some respondents knowingly provide false information just to assuage their perception of these institutions. The study employed triangulation method of data collection as a way of controlling for possible selective perception from the respondents. Data was collected from members of the public, management of formal institutions and government offices responsible for the regulation of formal care homes for the elderly. Data obtained from these diverse sources of information, was aggregated in order to provide a general portrayal of the formal care institutions. This approach helped a great deal in controlling possible selective perception from some respondents especially members of the public.

1.10 Assumptions of the Study

The study was based on the following assumptions:

i. Public perception of the elderly has a significant influence on the uptake of institutionalized care for the elderly in Nakuru County, Kenya.
ii. Public perception of the elderly person's self-efficacy has a significant influence on the uptake of institutionalized care for the elderly in Nakuru County, Kenya.
iii. Perceived self-efficacy of primary care givers has a significant influence on the uptake of institutionalized care for the elderly in Nakuru County, Kenya.
iv. Public perception of institutional efficacy to care for the elderly has a significant influence on the uptake of institutionalized care for the elderly in Nakuru County, Kenya.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter focuses on the constructs of public perceptions of elderly people and elderly care institutions and uptake of institutionalized care for the aged as well as the dynamics associated with the variables. The theoretical framework that informs this study and conceptual framework that show the inter-play between research variables is also presented.

2.2 General Overview of Literature Related to the Main Concepts

The process of aging results from the impact of the accumulation of a wide variety of molecular and cellular damage over time (Sgarbieri & Pacheco, 2017). The resultant affects of this a gradual n decline in physical and mental capacity, a growing risk of disease, and ultimately, death. But these changes are neither linear nor consistent, and they are only loosely associated with a person's age in years. While some 70 year-olds enjoy extremely good health and functioning, other 70 year-olds are frail and require significant help from others (World Health Organization, 2018). Other life activities that are associated with aging include; retirement, relocation to more appropriate housing, and the death of friends and partners. In developing a public-health response to ageing, it is important not just to consider approaches that ameliorate the losses associated with older age, but also those that may reinforce recovery, adaptation and psychosocial growth. The global statistics of aging portray a general rise in the number of older persons in the recent past with future projections showing a steady increase (Teerawichitchainan & Knodel, 2018).

World Health Organization's report revealed that people worldwide are living longer. Today, for the first time in history, most people can expect to live into their sixties and beyond. There will be more than 2 billion more people aged above 60 years by 2050 up from 900 million in 2015. About 125 million people are aged 80 years or older in 2018. By 2050, there will be almost this many (120 million) living in China alone, and 434 million people in this age group worldwide. By 2050, 80% of all older people will live in low and middle-income countries (World Health Organization, 2018). The 2017 United Nations department for economic and social affair's report indicates that over the coming decades, the number of older persons is expected to grow fastest in Africa, where the population aged 60 or over is projected to increase more than threefold

between 2017 and 2050, from 69 to 226 million. Africa is followed by Latin America and the Caribbean, where the older population is projected to increase more than twofold between 2017 and 2050, from 76 to 198 million (UN Department of Economic and Social Affairs Population Division, 2017). Asia also is expected to experience a twofold increase in the number of older persons, with the population aged 60 or over projected to increase from 549 million in 2017 to nearly 1.3 billion in 2050. Of the six major geographic regions, the older population is expected to grow most slowly in Europe, with a projected increase of 35 per cent between 2017 and 2050 (World Health Organization, 2018).

A longer life brings with it opportunities, not only for older people and their families, but also for societies as a whole. With the increase in the number of years one lives provide a chance to endeavor in activities such as furthering academics, pursuing new careers, or pursuing passions that could have been long neglected in the earlier years (Randel, German & Ewing, 2017). Older people also contribute in many ways to their families and communities. Yet the extent of these opportunities and contributions depends heavily on one factor: health. There is, however, little evidence to suggest that older people today are experiencing their later years in better health than their parents. While rates of severe disability have declined in high-income countries over the past 30 years, there has been no significant change in mild to moderate disability over the same period (World Health Organization, 2018). If people can experience these extra years of life in good health and if they live in a supportive environment, their ability to do the things they value will be little different from that of a younger person. If these added years are dominated by declines in physical and mental capacity, the implications for older people and for society are more negative. This calls for an elaborate system that will ensure their welfare is well taken of.

But when one thinks of elder care, one typically thinks of it in terms of one's own family or country. Questions of most concern typically center around issues of how to best take care of aging parents or other relatives and how to best plan for one's own future old age and the care that may or may not be needed at that time. Across the globe, individuals grow old and require assistance from family, friends, the government, or charitable organizations to deal with changing mental and physical capabilities and increasing needs for health care or other support to meet the instrumental activities of daily living or even the activities of daily living (Kuh, 2016; World Health Organization,

2018). How such questions are answered and issues resolved often vary widely from country to country, society to society, and culture to culture.

The medical advances witnessed across the developed and developing nations continue to bring about improvements in longevity (Bloom and Luca, 2016). According to the United Nations, there is a continuing trend toward lower birth and death rates around the world. As a result, the proportion of elderly individuals in cultures and societies around the world is on the rise and is projected to continue to rise well into the coming centuries. Further, longevity itself is increasing, with people aged eighty years or older being the fastest growing segment of the global population. The global population of individuals aged one hundred years or more is projected to increase fourteen-fold from 265,000 people in 2005 to 3.7 million by 2050. In addition, the tempo of aging is increasing more rapidly in developing countries than in developed countries, which means that along with the other issues of economic development, these countries will also have to quickly deal with the issue of their aging populations (UN Department of Economic and Social Affairs Population Division, 2017).

Care for the elderly is much more dependent on the culture which varies from one region to another across the world. Africa and South/Southeast Asia are still to a great extent undergoing economic development (Carbonnier, Chakraborty, Mulle & Cartografare, 2018). This allows one to observe the care received by elders in culturally traditional areas as well as the changes in that care and the concomitant attitudes with the incursion of modernization and industrialization. As recognized by the United Nations Assembly on Ageing, it is in such countries that the greatest attention needs to be given to elder care as elders no longer receive the respect and good care afforded them in traditional culture but do not yet have access to the government-funded and institutionalized care infrastructure provided by more developed countries. Similarly, many areas in South and Southeast Asia are still undergoing economic development and are finding it a challenge to switch from a traditional society in which there was intergenerational support and a cultural emphasis on taking care of the elderly to a modern society that does not prioritize these values. As a result of the modernization taking place in some countries in this area, the traditional support systems for elder care are breaking down whereas in other countries they are not.

As with other places around the world, efforts to better provide for the need of the elderly need to be accelerated to meet the rising demand (Teerawichitchainan & Knodel, 2018; World Health Organization, 2018). In traditional African culture, the elderly are given high esteem and social status. Both as part of this traditional culture and as a natural outgrowth of the strong religious roots of the society (in particular, the kinship system, belief in spirits, and certain rites of passage), an expected part of traditional African culture has been to care for the elderly. Traditionally, mistreating the elderly was considered within the culture to be the equivalent of calling down a curse on oneself and the wrath of God and the ancestors on the entire community. However, modernization in many parts of Africa has changed both expectations of status and care for the elderly. The rural to urban migration by the youthful members of the African societies, leave behind elders in rural areas without family support or involvement in their care. Modernity has brought with it new religious attitudes and has changed traditional cultural norms. In much of African society today, traditional values and practices are routinely challenged.

2.2.1 Institutionalized Care for the Elderly

Institutional care refers to the care provided within a congregate living environment designed to meet the functional, medical, personal, social, and housing needs of individuals who have physical, mental, and/or developmental disabilities (Galik, 2013). This is usually provided to vulnerable children, and older adults, individuals with developmental disabilities, mental retardation, chronic mental illness, and physical disabilities are more likely to receive care in institutional settings, such as orphanages, nursing homes, residential facilities, and rehabilitation centers. Care and services may include skilled nursing, supervision/monitoring, assistance with activities of daily living, rehabilitation, adaptive aids and equipment, psychological services, therapies, social activities, and room and board (Russell, Richardson, Bombardier, Dixon, Huston, Rose, & Ullrich, 2016). The cost of institutional care varies by the facility and the services that are required.

Proper care management for older people has seen a steady rise in the population of oldest of the oldest (older people aged 80 years and above) around the world since 1980s. For instance, the population of older people aged 80 years and above in the world rose from 9% in 1980 to 14% in 2014. In 2015, Europe had the most aged population of older persons, with people aged 80 years or over accounting for nearly 20% of older

people in the region. The populations of older people aged 80 years and above in Latin America, Asia and Africa are 15%, 12% and 9% respectively (United Nations, 2015). According to projections, the proportion of the older population aged 80 years or over will surpass 25 per cent by 2040 in Europe, Northern America and Oceania. By 2050, the oldest-old are projected to account for 30%, 29%, 27%, 22%, 20% and 10% in Northern America, Europe, Oceania, Latin America, Asia and Africa respectively (United Nations, 2015).

According to Schatz and Seeley (2015), there are currently about 58 million persons aged 60-plus in sub-Saharan Africa, and their number is growing. And by 2050 there will be an estimated 215 million, an increase from 6% to 10% of the population. In Kenya, the number of the elderly people has been on the increase in the recent past. The population of those aged 60 years and above in the country currently stands at 1.5 million and is projected to rise to 2.2 million by 2020 (Mbabu, 2017). The growth of this group is significant because they are receivers and providers of a vast majority of Africa's informal care. First, these older persons will need care. But, particularly in East and Southern Africa where so many younger kin have been lost to formal employment, HIV and related illnesses, informal care systems are strained (Schatz & Seeley, 2015; Thrush & Hyder, 2014). Importantly however, in the African context, older people help in defining the rights and obligations of members of society and their relations. Older people also play a more formal role as an adjudicatory body whenever disputes occur in society since disputants bring their conflicts before a council of elders, whose decision in many cases is binding (Baer, Bhushan, Taleb, Vasquez & Thomas, 2016). Older people also provide society with moral compass by applying intense social pressure among members of society so as to enforce good mannerism, behaviour and social order. It is therefore for these reasons that they ought to be taken care of by the society (Baer et al., 2016).

Although many approaches have been employed to achieve the goal of taking care of the elderly, proper care management of older people by far remains the most widely used strategy in prolonging the lives of older people. Care management refers to a broad array of behaviors, which aim at reducing a person's suffering or fostering other persons' growth and development (Bowlby, 1982). The goal of care management for older people is to enable older people achieve a healthy and a successful aging. Martin et al. (2014) defines in their paper successful aging as related to "key ideas such as life

satisfaction, longevity, freedom from disability, mastery and growth, active engagement with life, and independence."

2.2.2 Care Management Situation and Strategies towards Older People by Various Governments

Globally, only about 5.6% of older people have access to institutional care homes for older people (World Health Organization, 2015). However, as high as 46% of older people in the developed world have access to institutional care services, even though only half or 23% of them are actually enrolled in institutional care homes for older people (World Health Organization, 2015). The low level of enrollments for institutional care for older people is attributed to low awareness of formal care services Parmar, Williams, Dkhimi, Ndiaye, Asante, Arhinful, & Mladovsky, (2014), elder abuse and neglect in institutional care homes (Roberson, 2015), inadequate social geriatrics among other factors (World Health Organization, 2015). The influence of awareness of institutional care services on the uptake of these services is corroborated by a study by Chen, Gan & How (2018), which found that having more knowledge about elder care institutions and having better impressions on elder care homes enhanced elders' willingness to accept institutional care. There was an estimated 4.5 million social geriatrics in 2015 around the world against 700 million older people, translates to 1 social geriatric to 156 older persons (World Health Organization, 2015). This number is far much inadequate given the diverse and dependency level of older people more so the oldest of the old. Several countries around the world are managing aging populations in different ways.

In India, less than 15% aged Indians are willing to spend their old age life in institutional care homes (Economic and Social Commission for Asia, 2016). In Germany, the government offers a social insurance system to its citizens through income-related contributions paid by both employees and employers (International Reform Monitor (IRM), 2006). The German statutory health insurance system is recognized as one of the prototypes of modern health system configurations (Busse, Blu¨Mel, Knieps, & B€aRnighausen (2017). Since its introduction in 1883 by the German Chancellor Otto von Bismarck, the guiding principle of the German health system has been solidarity among the insured. Solidarity manifests itself both on the income side and the provision side of statutory health insurance: all insured persons, irrespective of health risk, contribute a percentage of their income, and these

contributions entitle the individuals to benefits according to health needs-irrespective of their socioeconomic situation, ability to pay, or geographical location (Busse et al., 2017). In this pooled-risk system, people with high income support people with low income, young people support elderly people, healthy people support people who are sick, and people without children support people with children.

In Australia universal health care coverage is offered to all citizens. It is through the public health insurance system called Medicare that long term care services are offered (IRM, 2006). However, the country established a health system specially designed for older people called Aged Care System to support healthy aging for older Australians and frail people and care providers to older people (Department of Human Services [DHS], 2003). The aged care system delivers residential (high level nursing home care and low level hostel care) and community care (informal care). The scheme helps in the provision of respite services to care providers whether done under formal or informal arrangements. The scheme also offers allowance to care providers who look after older people who need additional attention as a result of a severe disability or advanced age (DHS, 2004). Informal care providers who choose to forego wage employment and instead provide full time care for their older relatives also gain income support from Aged Care system (DHS, 2004).

Studies focusing on the demographic characteristics of older people in institutional homes have reported diverse and interesting findings in China. For example, with regard to marital status, a study by Zhan, Liu & Guan (2013) found that, in China, only 10% of older adults with a spouse were likely to enroll for institutionalized care against over 60% single older adults. Similarly, Qian, Chu, Ge, Zhang, Sun, & Zhou (2017) found that only 5.7% Chinese elderly population were willing to enroll for institutional care. Gender variation has also been identified as an important factor associated with older people's willingness to use institutional care. for instance, in Hong Kong about 21% of women aged over 70% years were enrolled in institutional care homes compared to just 7% of the men (Yangyang, Jie, Dandan, Li, Long & Chengchao, 2017).

In Japan, Annear, Otani & Sun (2016d) states that Japan is a super-ageing society with greater than 20% of its population aged 65 years or older. Due to the declining birth and mortality rates in Japan, there has been growing demand for care services for the elderly provided by both the government and private investors. For the longest time

before formal care, care for the aged in Japan was historically the responsibility of families as mandated in the 1898 Meiji Civil Code, which stipulated that the eldest son was responsible for the care of ageing parents (Annear, Otani & Sun, 2016d). It was not until 1963 with the passing of Elderly Welfare Act in Japan that formal aged care became commonplace. Japan provides universal access to aged care that is funded through a long-term care insurance scheme, with working-age adults making contributions from age 40 and a 10% individual co-payment at the time of accessing services. Older adults who contact the health system after 65 years of age receive a physician-administered needs assessment to determine care requirements.

Hungary offers free access to health care for all citizens, thereby indirectly benefiting the elderly (WHO, 2012). Hungary's health care system is primarily funded through the Health Insurance Fund (HIF), which receives contributions from employers and employees, and deficits are covered by state funds (Goglio, 2005). Hungary also offers a well-developed home health care and home social-assistance system (Burns & Cekota, 2002).

The U.S. offers universal health care coverage to its citizens over the age of 65 and those disabled under the age of 65 through the Medicare program. Under Medicare, a portion of nursing home care is covered for a short period of time followed by either a private insurance or out-of-pocket payment method (IRM, 2006d). Under the Medicaid program, long term nursing home care is available after the recipient has spent down all income and assets thereby allowing them to qualify for Medicaid.

In Sweden, all Swedish citizens are entitled to a national retirement pension after they retire. People can choose to start receiving their pension between the ages of 61 and 67 (Feinberg & Montgomery, 2014). When an elderly person is no longer able to cope with the demands of everyday life, he or she can apply for assistance from municipally funded home-help services. However, the extent of such care is subject to an assessment of need. Elderly people with disabilities can receive assistance around the clock, which means that many are able to remain at home throughout their lives. The severely ill, too, can be provided with health and social care in their own homes. All recipients can choose whether they want their home help or special housing to be provided by public or private operators. Sweden also offers free public transport services for elderly and disabled people. Further, elderly people under informal care can obtain various kinds of

support to make life easier. For example, almost all municipalities in Sweden offer ready-cooked meals that can be home-delivered.

In Africa, Countries such as Zimbabwe and Botswana have been providing formal care services to their elderly populations since late 1990s (World Health Organization, 2015). While the emergence of formal care services was thought to provide relief to elderly persons especially those from dysfunctional extended family and kinship systems, the uptake of these services especially in developing countries has remained extremely low. For instance in Zimbabwe and Botswana only 2.4%, 1.5% and 0.8% respectively of the elderly persons have taken up formal care services (World Health Organization, 2015). However, a study by Neddie (2017), which focused on provision of institutional care for older people in Zimbabwe, found that 4 out of 5 older people in institutional care homes were males. Further, Dhemba & Dhemba (2015) found that most of the older people under institutional care were those without kin or those who could not locate them or with whom there were severed relationships.

Formal care services is still not a very common service in Kenya given that for a long time provision of care to the elderly was done by members of the extended family. It is therefore not clear how much awareness the public has about formal care services in Kenya; not just in terms of their availability but also the kinds of services offered by the formal care institutions. Given its recent development, it is possible that many people are still unaware of these services.

In Kenya, a commitment to social protection is enshrined in Kenya's Constitution, and asserts the right for every person to social security and compels the State to provide appropriate social security (NGEC, 2014). To further this objective, the social protection policy was developed in 2011 and among other issues emphasizes on social protection in old age through contributory benefits that are aimed at maintaining the income of individuals or non-contributory benefits focused on reducing poverty and vulnerability (Mbabu, 2017). According to the NGEC (2014), the government through the Ministry of Labour, Social Security Services implemented cash transfers programs since mid-2000. To this effect, older persons cash transfer program was rolled out on a pilot basis in 2006. It is for this reason that this study endeavoured to establish the level of public awareness about the availability of formal care institutions and the services offered thereof. This study, however, went further to establish whether the level of public

awareness about the formal care institutions has any bearing on the uptake of these services by elderly people as well as the perceived efficacy of these institutions by primary care givers.

2.3 Public Perception of the old people and adoption of formal care

The perceptions the public hold of older people can impact on their health services, and the overall treatment of older adults (UK Essays, 2018). These perceptions are determined and influenced by many different factors such as: modernization and industrialization of society; age; gender; lack of knowledge and misconceptions, as well as the media. The perception of the aged and the society can impact their lives negatively. It may result in stereotypical behaviours and ageism, which further lead to social exclusion and isolation of the elderly, as well as elder abuse (Dionigi, 2015). Ageism can definitely lead to marginalization and degradation of the elderly in our societies today. This section includes the societal perceptions of the elderly people in general and its implications on the uptake of the formal care services for the aged.

2.3.1 Value and Respect for the Elderly

Respect for the elderly which is a process of honoring them by exhibiting care, concern, or consideration for their needs or feelings to a larger extent depends on how much people value the elderly. There are several reasons why people value or disregard the elderly in society. For instance, ageism which refers to discriminatory decisions concerning people because of their age, denies the opportunity of respect for the elderly (Kydd and Fleming, 2015). Ageism as a form of prejudice and discrimination ranks higher than other forms of prejudice such as gender and race (Levy, 2014b). Although other age groups also are subjected to ageism, older people remain by far the greatest victims of ageism around the world (Nelson, 2015). The survey on ageism in Europe found that 35% of older Europeans had experienced unfair treatment directed towards them solely on account of their age. The survey also found that ageism, a form of discrimination was higher than gender (25%) and ethnicity (17%). The country which is mostly concerned about ageism is France, where 68% of the population sees it as an issue. The survey further found that ageism increased as people aged so that older people aged 70 years and above reported significantly higher incidences of discrimination compared to their counterparts aged below 70 years. Ageism according to the survey was manifested through lack of respect, lack of friends, lack of reliable informal support defined as well as neglect or being patronized or ignored (Nelson, 2015).

Stereotypes that healthcare providers and the community at large have towards the elderly may influence the effectiveness of the services rendered to the elderly people (Adams, Buckingham, Arber, McKinlay, Marceau, & Link, 2010). The stereotypes such as physical inactivity, frailty, overdependence and psychological breakdown will have a bearing on the attitudes towards the elderly. Interestingly, Janeckova, Dragomirecka, Holmerova, & Vankova, (2013), investigated the kinds of attitudes staff working in formal care institutions towards older people found that the staffs to have significantly more positive attitude towards the aged and aging. These studies, however, have not established what the public think of the safety of their elderly members in these institutions. The focus of the current study was to extend the understanding of formal care institutions to the public, especially with regard to how the public perceives these institutions to be effective in providing care to the elderly in society.

The kind of perception and respect individuals have towards older people is also influenced by individuals' demographic features such as gender, parenthood and health condition (Janeckova et al., 2013). Although both males and females have negative perception towards the aged and aging, males have been found to have a significantly positive attitude towards aging than females. Adults who are childless have been found to have a significantly negative attitude towards aging and the aged compared to those who have children. Individuals suffering from lifestyle diseases and those undergoing psychological problems such as stress and depression have also been shown to have a significantly negative attitude towards the aged and aging (Janeckova et al., 2013).

Although different people have different reasons for the kind of attitude they have towards old people as already pointed above, a study by Bernhold, Gasiorek, & Giles (2018), reveal that the level of contact individuals have with older people determines whether they are cold or warm toward older people. The authors found that care providers who had greater contact with older people had favourable attitude towards older people and more value and respect for them. Similarly, people who had minimal or no contacts with older people exhibited negative attitude and stereotypes towards older people. Although the above study was done in the context of medical care provision and among healthcare professionals it was nonetheless relevant to this study. The study confirms that contact between people and the elderly significantly determines the kind of relationships and attitudes people develop towards them. Members of the public and care providers in formal care institutions were two sets of individuals that had contacts with

older people. It was therefore necessary to establish whether the kind of contacts they had with older people had any bearing on the ability to take care of older people.

Luckily, studies on intergroup interactions have shown that negative attitudes and prejudice toward older people can be changed through promoting social interactions between older people and those having negative attitudes towards them (Pettigrew & Tropp, 2011). This study generally found that contact leads to a reduction in prejudice through decrease in anxiety and an increase in empathy and knowledge regarding the out-group. The above studies were important to this study since care provision offers care providers the opportunity to interact with older people. However, how the interaction between formal care givers and older people affected the self-efficacy of the former was not immediately clear hence the need for this study.

A study by Geerlings, Twisk & Deeg (2013) importantly reported that some informal care providers (home based carers) felt that their elderly relatives would be much safer in formal care institutions. Geerlings et al., (2013) in their study particularly reported that 67% of the respondents believed that their elderly relatives would lead a safer and quality life in formal care institutions than under informal care system. While it is possible as suggested by Geerlings et al., (2013) that some relatives of elderly people have greater confidence in formal care institutions than informal ones, the study was based in the Scandinavian where formal care systems are well developed. It is such advanced formal care systems that may have led relatives of elderly to have greater confidence that their elderly relatives would not be safe but also receive quality care in the formal care institutions. Formal care especially for the elderly is still at infant stage in developing countries including Kenya. The current knowledge from this study therefore enriches the understanding of the level of confidence relatives of the elderly people have toward formal care in a country such as Kenya and broaden our knowledge about formal care systems especially from regions where these systems are not only emerging but are also largely provided by the private sector.

As observed earlier older people too also have negative attitude towards the aged and aging hence the need in their inclusion in the campaign against ageism. Wolff, Spillman, Freedman, & Kasper (2016), following a series of their studies found that increasing knowledge and information about successful aging was an effective strategy of influencing older people's views of aging in a positive way. The authors particularly

noted that educating older people about the positive aspects of aging and correcting negative misconceptions was a good strategy of improving older people's self-perceptions of aging. This would definitely improve their respect for the fellow older members in the society. Although the above authors' main concern was on self-perception and its influence on ageism, the findings were still relevant to this study. There was need to understand how older people's self-perception affected public perception of their self-efficacy and the eventual uptake of institutional care services for older people.

2.3.2 Elder Role and Adoption of Formal Care for the Elderly

Due to modernization in the global community and Africa particularly, the status and role for the elderly are changing. In a traditional African society, it is believed that the aged has knowledge and skills that the young people have not yet acquired (Dosu, 2014). The above author further states that the aged own land as well and thus play a critical role of custodian of family possessions. They too have control over the decisions of the young.

Beyond the family, older people have crucial economic, social and spiritual roles. In the economic pillar, most sub-Saharan African countries have their older people largely bestowed with the responsibility of giving the necessary labor force, particularly in smallholder agriculture (AGRA, 2018). As a result of selective rural–urban outmigration, incapacity, or uninterested of younger adults in farming, older people constitute a substantial share of smallholders. In Kenya, for example, the average age of a farmer is estimated to be 60 years. Similarly, preliminary analyses of national survey data from Malawi and Kenya show close to 20% of decision makers on smallholder land use in both countries to be aged 60 years and older (African Population and Health Research Center, unpublished). The extent to which older African people can execute their social and economic functions effectively depends heavily on their physical and mental capacity. Conversely, if their health deteriorates to a point at which they themselves need care, the responsibility is likely to fall on female younger kin, whose own health, and employment and education opportunities, can be affected. Impaired health in older age in sub-Saharan Africa thus affects not only older individuals, but families, communities, and prospects for development more broadly. Yet older African people face a large morbidity and disability burden, particularly from chronic disease (Richards, Gauda, Durham, Rodney, Rampatige & Whittaker, 2016).

The elderly people play critical and extensive intergenerational connections to children or adolescents within households and families. The consequent influence on the level or quality of financial or social investments that families make in the education and health of the young is equally magnificent. In a range of the East African countries, around 20 per cent to 30 per cent of all children and adolescents live with an older person, with the share usually higher in poor population groups. They have a significant representation as 'elders' among civic, political and religious leaders at community and national levels, as well as among the business and professional elite. In these roles, older Africans actively and passively shape the conditions for and the attitudes of younger generations toward entrepreneurship, political and societal stability and good governance.

In addition, there are also religious ties and traditional customs that bind the young and the old together (Everton, 2015). In a modern society, young people in Africa have their own income and therefore, command over their lifestyles and thus do not have to consult the aged for anything. Moreover, young people of today are educated to have the knowledge that the aged do not have. Traditional and religious practices and beliefs have become less important and less practiced which as a result have loosened the family and regard for the old (Dosu, 2014). Older people's low social status and their little contribution to the economy are some of the reasons which contribute to people having a negative perception towards older people (Robertson et al., 2015). It is however, important to note that not all people perceive older people negatively. People who hold high regards for the older people usually consider them as wise, experienced and more moral than younger adults. They also consider older people as polite, good at settling disputes and understanding (Sargent-Cox, Anstey & Luszcz, 2014). The above studies although largely done in the developed world where socio cultural setting is different from that of Kenya, the findings were nonetheless important to this study since it informed the study of the reasons behind certain forms of perceptions towards older people. However, the studies were silent on how the kinds of attitude people have towards older people's efficacy to take care of themselves influences their decision to consider institutional care for their older relatives. There was therefore need to understand how individuals' perception of older people's roles and status in the society influences the uptake of institutional care for older people.

2.3.3 Tolerance Level of the Society for Elderly

In traditional societies old age is often highly valued, with the elderly personifying a source of knowledge and experience (Baider & Surbone, 2014). This is especially noticeable in non-Western ones cultures, where relatives continue to provide care and total support. At the most fundamental level, perceptions of aging and care are reflections of religious beliefs, traditional family hierarchies, and patriarchal norms of obedience. The quality of care given depends on the societal fabric that binds together the aged and the younger generation.

Negative views of aging have resulted to among other things elder abuse and neglect (Akpan & Umobong, 2013). In this study, the willingness and ability of the society to accept and live with the opinions, behavior, dislikes and the likes of the older people in the society is analyzed to find out whether it has a bearing on the decision to enroll the elderly in formal care homes. In this line of thought a study of 300 elderly people, Akpan & Umobong (2013) found that 46.7% of elderly people complained of medical neglect and bed sores, 47% experienced physical abuse, 49% lived in uncomfortable living conditions and 35% were being robbed of their little possessions. A negative evaluation of the elderly along discriminatory acts against this group potent harassment. Again the level of tolerance of the society for the elderly differs depending on the cultural context and evaluation of the elderly (Vauclair, Lima, Abramsn, Swift & Bratt, 2016). If older people personally believe that their age group is seen as of lower social status and that others feel pity, contempt and envy towards them and stereotype them negatively, they also report experiencing more age discrimination. The authors found that the fact that different types of emotions, which to some extent could be considered as incompatible (e.g., envy and contempt), were predictive of age discrimination suggested that there may be different subgroups of older people. Although both men and women are routinely abused, a study by Ola & Olalekan (2012) found that more women than men were being abused. While older people are the greatest victims of ageism, individuals who practice ageism during their early adult lives are more twice likely to experience ageism when they grow old (Levy, Slade, Murphy & Gill, 2012). Levy et al. (2012) also found that individuals who had a negative perception of older people during their early adult lives were more likely to suffer from poor health, social isolation, low self-esteem, low optimism, low self-efficacy and old age related physical and psychological problems compared to their counterparts who had a favourable

perception of older people during their pre-old age life. Negative perception and attitudes against the elderly puts them at risk of being mistreated by the society. Unfortunately, many studies highlighted here fail to link directly this societal bias to the uptake of institutionalized care.

This study tries to point to the possibility that older people may face negative profiling and harassment due to the inability of the society to withstand the challenges that these groups of the people in the society suffer. This opens up new research avenues in regard to the analysis of the likely impact of the societal intolerance of the elderly people and its influence on the uptake of the option of formal care of the elderly persons.

The status of the elderly persons and pity the less fortunate elderly persons feel could yet again shape how these people are regarded and treated by the society. For instance, the baby boomer generation is usually portrayed as retiring with good health, having a relatively high education, solid financial resources and as enjoying a comfortable lifestyle. This may lead to a shared perception of older people and retirement which elicits envy, but of a benign type which involves the motivation to improve one's own position and to achieve the same goals as opposed to a malicious type, which is the motivation to cause damage to the target (Abrams & Vasiljevic, 2014). The author further highlights that in a societal context in which older people are seen this way, they may not encounter much age discrimination. On the other hand, older adults who personally believe that others envy their age group may be especially sensitive to any discriminatory practice that they interpret as an expression of a malicious form of envy. This discrepancy in perceptions and its contrasting implications for older people's aging experience is worth exploring in a research for improving intergenerational relations, especially from the perspective of older people. In this study we attempt to determine the influence of tolerance on the uptake on the nature of the care the elderly persons receive.

The societal meta-perceptions of friendliness and status can as well lead to acceptance and humane treatment of the elderly people in their old age (Berger, Keshet, & Gilboa-Schechtman, 2017). This may be because of the shared knowledge that a concomitant of old age is the retirement from professional activities which diminishes the perceived social status of older people (Vauclair, Marques, Lima, Bratt, Swift & Abrams, 2015b). The friendliness may have evolutionary underpinnings and, therefore,

also the same meaning at the individual and societal-level. The Evolutionary theories indicate that older people's physical appearance in terms of baldness in men, and softer voices and specific intellectual attributes such as wisdom signal warmth and friendliness which convey nonthreatening characteristics (Vauclair et al., 2016). Therefore, the older people who portray friendly look and gesture tend to receive nice treatment and are well tolerated in their old age.

The experiences of discrimination can also be associated with older people's personal views and those endorsed by society. It is conceivable that older people have internalized the societal idea that old age is associated with passiveness, neediness, and frailty and, therefore, tend to behave accordingly triggering ageist behavioral responses in others (UK Essays, 2018). However, beyond these subjective perceptions there is also strong evidence that pity has emergent properties when aggregated to the group level. But older people past competence and contempt shape the current experiences of discrimination at the individual level but not at the societal level. The meta-perception of competence is usually related to perceptions of physical and cognitive declines which are frequently explained in terms of inevitable biological outcomes of aging (Robertson, D.A., Savva, King-Kallimanis, & Kenny (2015). Hence, it might be that this specific notion of aging becomes highly self-relevant once individuals enter old age. Furthermore, this self-relevance might lead to self-fulfilling prophecies and therefore heighten the perception of age discrimination. This association does not occur at the societal-level because the self-relevance aspect means that it is an entirely psychological phenomenon that might increase older people's sensitivity for age discrimination (Vauclair et al., 2016). A similar mechanism may apply to contempt, which includes feelings of disgust and possibly general anxieties due to the fact that aging can bring about illness and disability and eventually death. Again, this should become highly self-relevant for older people which in turn may make them more sensitive to any corresponding ageist behaviors. It is against this backdrop that this study needed to find whether societal view of the elderly and tolerance levels which transcends unnecessary discrimination of the elderly could influence the uptake of the formal care. The social norms of intolerance of age prejudice or unprejudiced has been studied extensively at the individual-level by other researcher Kunstman et al. (2013); Vauclair et al. (2016), yet this study is the first to show the predictive power social climate as regards treatment of

the elderly and tolerance at large on the uptake of the institutional care for the elderly people in Kenya.

2.4 Public Perception of Elderly Person's Self Efficacy to take care of themselves

The public perception of the self-efficacy of the elderly people to take of themselves is analyzed in the succeeding sections to lay an understanding of the past literature on this subject. Bandura (1997b) considers self-efficacy as the beliefs in one's capabilities to organize and execute the courses of action required to manage prospective situations. More simply, self-efficacy is what an individual believes he or she can accomplish using his or her skills under certain circumstances. Based on the understanding of what self-efficacy is as given by Bandura (1997b), the focus of the proposed study will be to establish from members of the public whether they believed that their elderly relatives in particular and elderly persons generally have the capacity to live on their own without the presence of their relatives. The term "self-care" includes the notions of self-care agency (capability and power), self-care agent (the older person) and self-care deficits (limitation in self-care agency). Rabie & Klopper (2015) in their article the concept of self-care agency as the capability and power a person has to look after the self. In this study the concept of self-care refers to the capability and power of the older person to engage in self-care activities such as self-living physical, health, financial and psychosocial management.

Self-care for the elderly consists of a variety of care activities deliberately engaged in to promote physical, mental and emotional health in order to maintain life and prevent disease. It is understood that the elderly people can manage self-care when they are equipped with the necessary knowledge, skills and motivation to apply self-care during decision-making and action-taking. It means the older person is empowered to make autonomous decisions. Empowerment enable may enable the older persons maintain health and manage interactions with the healthcare system and self. This study went further to establish whether the perceived self-efficacy of elderly persons can in any way inform the decision by members of the public to either enroll or decline to enroll their elderly relatives in formal care institutions for the elderly. Self-efficacy for the elderly can be assessed in four dimensions which include: physical fitness of the individual, their health status, their financial status and finally their psychosocial status.

2.4.1 Health Status of the Elderly

As people grow old, they are increasingly likely to live with multiple conditions and require support from a range of different health and social care services (Spiers et al., 2019). In most high income countries, welfare systems are attempting to meet rising demands from an ageing population with constrained funding (Harper, 2014). MacLeod et al. (2017), reports that older adults have low financial and health insurance literacy, which pose challenges in making healthcare decisions, due to their declining health and fixed incomes. The frail elderly is a group of the older adult population with potential needs for long-term care services. Poor health care and health care expenditure of the elderly is not well documented. Elderly people are of particular interest because they use more public and private health care services but because of complex financing systems, they delay their treatment at early stages but eventually burdens the health care system during their later stages of life. Provided and received social support for the elderly people may have distinct consequences for individual well-being of the elderly persons (Kroemeke & Gruszczynska, 2016).

The older people's ability to maintain their health care by themselves will definitely have an impact on their decision to enroll for the formal care. Their health status could inform on their ability to take care of themselves or the need for them to be enrolled in care homes. Some of the elderly persons may be fairly strong and as such can seek medical attention on their own, but others may be too physically weak and frail to visit doctors on their own thus requiring their relatives to take them to physicians. Further even elderly persons who can visit physicians on their own may still require the presence of others to occasionally remind them to take their medicine as recommended by the physicians (Stawarz, Rodríguez, Cox & Blandford (2016). This study therefore investigated public perception of elderly persons' self-efficacy with regard to the extent to which the public believe that their elderly relatives are capable of attending to their medical, other psychological and physiological needs on their own as recommended by the physicians.

2.4.2 Financial Status of the Older People

Public perception about elderly persons' self-efficacy may also be investigated in the context of their ability to meet medical costs arising from their deteriorating health conditions. A study by Center on an Aging Society (2012) which investigated the cost of medical care for elderly persons established that elderly persons and their families face

many financial issues in acquiring treatments and resources to support their health and medication. The center particularly noted that financial resources of elderly persons and immediate relatives were quickly drained through payment for multiple prescriptions for chronic conditions affecting elderly relatives. A study by Neddie (2017), which examined among things examined the economic status of older people in Zimbabwe found over 80% of older people lived in abject poverty. The study also reported that most of the elderly people due to poverty could not meet their basic needs.

It is indeed possible as suggested here that for elderly individuals, the cost of medications is a critical financial problem that never goes away since many elderly persons develop several chronic conditions as they age that require costly prescription drugs to manage. The fact that about 30% of elderly persons cannot afford full medication implies that a significant proportion of elderly may waste away and even die without outside help. The number of elderly persons that cannot meet the cost of medication on their own may be even higher in Kenya given the numerous challenges faced by the health sector that makes it even harder for other able age groups to access. The proposed study will therefore investigate the extent to which the public perceives elderly persons' and their close relatives as being able to meet the multiple costs of medications for elderly persons, and how the same influence the decision of whether or not to enroll elderly relatives for formal care services.

According to UNDESA (2015) the inability by older people to meet the cost of medical services is largely compounded by high incidences of poverty among them. Indeed a study by DeNavas-Walt & Proctor (2015) on the incidences of poverty across various age groups found that older persons were afflicted by poverty in greater numbers than younger age groups because of lower skills, lack of savings, ill-health or social prejudices. Whereas on average around 66% of people aged 25 to 59 consider themselves as poor, that share increases to 70.3% for people older than 60.

Although some older people have managed to cater for the cost of their medication through public social security pension scheme, many older people around the world are not covered by this scheme. ILO (2015) report shows that majority of older people are not covered by public social security pension scheme. The report found that it is in North America where a significant proportion of older people are covered by the scheme. In particular North America, Latin America, Asia and Pacific, North Africa,

Middle East and Sub-Saharan Africa 90%, 56%, 47%, 37%, 30% 17% respectively are covered by public social security pension scheme. Although there are no concrete data on the coverage of older people by pension scheme in Kenya, about 1.3 million of Kenyans aged above 70 years in Kenya currently earn a monthly stipend to cater for their primary needs (HSNP, 2019). Since majority of the elderly do not have the capacity to meet their much costly health care, policy makers mapping out efficient funding for older adults should also consider additional funds for caregivers as part of a health care package (Mittal, 2018). Family members are important pillars in caring for the older adults at home, yet they are often neglected.

2.4.3 Psychosocial Status Dimension of Self-Efficacy of the Elderly

Factors relating to the interrelation of the social factors and individual thinking and the behaviour of the elderly may influence how they get treated in the society. While all elderly persons need care and attention from either formal or informal care providers, the oldest of the elderly (those 80 years and above) are thought to require more attention and care than their counterparts who are 80 years and below (Skaff et al., 2010). This perception may have been informed by the fact that elderly persons become more and more dependent as they age. Their bodies weaken, they develop chronic problems and many also suffer from depression and other psychological problems. A combination of physical and psychological problems may overwhelm the elderly persons thus increasing their level of dependency, which further compromises their ability to fend for themselves.

While contributing on the influence or absence relatives or companionship of elderly persons' self-efficacy, Begley et al. (2012) found that feeling of alienation makes elderly persons develop more profound depression, anger, loneliness, and hopelessness. The authors stated in their conclusion that psychological and social problems – depression, anger, loneliness and hopeless, arising from alienation undermines the ability of elderly persons to think positively about life. Being shunned by children and or other relatives can indeed pose great challenge to the elderly especially if they (the elderly) contributed immensely to the development of those who are shunning them. However, it is also possible that some of the elderly persons are alienated because they too neglected their families and relatives at one time in their life. Therefore, some of the children and relatives of the elderly may be alienating their elderly relatives as a way of settling score.

While the authors are assertive that alienation reduces self-efficacy of elderly persons, there is loud silence on the part of the authors on two issues; first the authors have not addressed themselves to the reasons informing the decision by children and relatives to alienate their elderly members. Second it is not clear from the above authors as to whether elderly persons facing alienation had stable families or not. Contributions by Begley et al., (2012) appear to have focused more on the elderly persons without any reference to the public especially with regard to what members consider as contributing to the alienation of elderly persons in society. While still confining itself to the subject of alienation, the proposed study will take a slightly different direction by focusing on the actual or perceived factors contributing to the alienation of elderly persons in society. However, the study ascertained whether perceived alienation of the elderly can in any way influence the public's decision to enroll their elderly relatives to formal care institutions.

Although very few elderly persons are known to abuse alcohol and drugs, it was reported in 2010 that between 6-8 million elderly people abused drugs and alcohol (APA, 2012). The reports, however, noted further that the number of elderly persons abusing drugs and alcohol could be much higher than the ones in their reports if a global survey of the same were to be done. APA (2012) while acknowledging that all alcohol and drug abuse has serious health and social consequences among different age groups, the authors expressed concerns that consequences of drugs abuse are most serious among elderly persons. Drug and alcohol abuse may expose elderly persons to falls, physical injuries and even abuse. Drug and alcohol abuse may also expose them to organ failures and even psychosocial problems.

Older people who perceive higher life satisfaction enjoy living closely with their family, and their family would oppose the idea for them to live in nursing homes (Luo et al., 2016). As a result, the older people who are satisfied with life are unlikely to intend to live in nursing homes. Life satisfaction has mostly been examined as an outcome of living in nursing homes and the findings were mixed. A study showed that placement of residence was not related to older persons' expression of life satisfaction in Japan Xu & Chi (2011). Yet, in the USA, those who lived in nursing homes reported lower life satisfaction than community-dwelling older people. On the contrary, a study in China showed living in a nursing home was associated with increased life satisfaction.

Studies on the relationship between drug and alcohol abuse and self-efficacy have largely focused on the youths and young adults, and more in the context of formal employment (APA, 2012). Studies have shown low self-efficacy among abusers of drug and alcohol. While some studies have reported that drug and alcohol abuse pose serious health and psychological challenges to elderly persons who abuse them as pointed by APA (2012), the extent to which self-efficacy of elderly persons' is affected by drug and alcohol abuse has had very little empirical research, more so from the point of view of members of the public. It is also important to note that studies by APA (2012) were done in the developed world, where strict regulations on the processing and distribution of drugs and alcohol are fairly advanced, which ensures high standards of hygiene.

2.4.4 Physical Dimensions of Self-Efficacy

Frailty which common in all elderly persons is a syndrome that affects biological, psychological, and social processes of a person's life and leads to increased vulnerability and adverse outcomes in old age (Mulasso, Roppolo, Giannotta, & Rabaglietti, (2016). Thus, people tend to decrease from a fit and healthy status to physical weakness and frailty when growing old. Whereas the biological variables for frailty such as weight loss, imbalance, and hand strength are well examined, the literature lacks investigations of the influence of the psychological and social contributors of frailty (Freitag & Schmidt, 2016). Evidence shows that frailty is not only based on biomedical changes and physical deterioration but is also linked to psychological and social variables (Roppolo et al., 2015). The causes of frailty are manifold, and the investigation of its associated contributors is on-going.

Conceptually, physical fitness implies the physical capacity that is needed to undertake the normal everyday activities, independently and without the early onset of fatigue (Milanović, 2013). However, the aging process tends to reduce physical fitness (strength, endurance, agility, and flexibility), and results in difficulties in daily life activities and normal functioning of the elderly. The level of daily activities of elderly person's decreases with aging and physical exercise helps in prevention of chronic health problems and improves the quality of life. If elderly individuals do not take part in physically active lifestyles, they expose themselves to the risk of their muscle mass and joint motion reducing by 40% and 10%-40%, depending on body part, respectively, while loss of muscle strength (30%) is related to a decrease in muscle mass (Milanović, 2013).

Resistance training is generally thought to be a promising intervention for reversing the loss of muscle function and deterioration of muscle structure associated with the aging process. Unfortunately, the elderly fail to achieve a thorough muscle function by themselves which therefore requires that they enroll in an institution that will help them perform guided physical activities. The cardio-respiratory system is also susceptible to change, and significant decreases in aerobic capacity have been found after the age of 40 years, such that at the age of 65 years it has approximately 30% less capacity. This complicates the matter even further and enhances the need for these kinds of guided physical fitness activities for the elderly people.

A study by Jenson, Ferrari & Cavanaugh (2010), which sought to establish whether elderly people understood what they expected from formal care giving institutions, established that elderly people had diverse expectations. However, they were all unanimous that they want quality care that enables them to live a life with physical fitness, dignity and respect. Although this study did not exactly state what elderly people considered as quality care, the study nonetheless shows that elderly people have a fair understanding of what they expect to be provided with formal care institutions which revolved around their physical fitness and general health.

2.5 Perceived Self-efficacy of Primary Care Givers to Take Care of the Elderly

Self-efficacy refers to the belief one has in their own abilities, specifically their ability to meet the challenges ahead of us and complete a task successfully (Akhtar, 2008). General self-efficacy refers to our overall belief in our ability to succeed, but there are many more specific forms of self-efficacy as well (for instance in academics, sports and parenting, sports). Here, literature concerning self-efficacy of the primary care givers as related to the uptake of formal care services for the elderly people is listed and discussed.

2.5.1 Pre-old Age Relationship

The relationship that existed between a member of the public and his/her elderly relative earlier is said to have a significant influence on the self-efficacy of the member of the public providing care to his/her elderly relative(s). Formal and informal caregivers differ both in terms of their relationship to the care receiver and also in the manner in which they embrace and experience the care giving role. That is, caregivers differ in what they do, how they do it, and how long they do it. In general, the closeness of the

familial relationship has been established to influence self-efficacy toward elderly persons (Delgado & Tennstedt, 2007a). Despite many common experiences, caregivers' roles are highly variable across the course of caregiving. The diversity of families, the timing of entry into the caregiving role, the duration of the role in relation to the overall life course of the caregiver, and transitions in care experienced over time all shape the nature of the caregiving role (Schulz & Eden, 2016). The committee conceptualized caregiving over time as "caregiving trajectories" to highlight the dynamic nature of the role and the different directions it can take.

In populations in which the care recipients become increasingly impaired over time, such as with increasing frailty, dementia, Parkinson's disease, or advanced cancer. Thus, the caregiving role expands accordingly and the nature of the relationship between the patient and the care givers matters a lot. In populations in which care recipients experience short-term or episodic periods of disability, such as early-stage cancer and heart failure, the caregiving role may be short term but intense or it may wax and wane over time (Schulz & Eden, 2016). This study observed that it is indeed possible that the kind of rapport that existed between the potential caregiver and elderly relative can influence the attitude of the caregiver toward elderly persons, which may further have a bearing on caregivers' self-efficacy. For example, where a good develop good rapport and mutual concern between the potential caregiver and elderly person prior to old age may make the former have positive attitude toward the elderly relative. This may in turn the caregiver feel more obligated to care for the elderly relative. However, potential caregiver who feels that his/her elderly relative was unsupportive and unconcerned about his/her welfare in the past may find very little incentives to provide care for the elderly relative.

Family relationships and quality of life may also be impacted by caregiving demands, although this topic has received relatively little attention in the caregiving literature. In a large panel study of Health and Retirement Study participants, Amirkhanyan & Wolf (2006) found that adverse psychological effects of caregiving are dispersed throughout the family and not just the active caregivers.

Sigurdardottir et al. (2009) argue that providing care to an older relative as being a challenging task because it is a task that younger relatives do not plan for in advance and are not always expecting to fill. Younger relatives never prepare for the gradual or

sudden decline in the physical and psychological conditions of their older relatives as well as the many tasks that go with care giving. Some of the tasks that go with care giving and in which younger people have to provide to their older relatives include preparing meals, dressing, bathing, going to the bathroom, transportation, medications and laundry. The challenge faced by primary caregivers in providing for their older relatives is well explained by Oyama, Tamiya, Kashiwagi, Sato, Ohwaki, & Yano (2012), in their study. The authors, while basing their arguments on Life course theory posits that unexpected transitions are more stressful than transitions that are expected such as marital and employment roles.

Although most of the care provision for older people is still given by relatives of older people, some families are embracing institutional care for their relatives. In Africa, for instance, countries such as Zimbabwe and Botswana have been providing institutional care services to their elderly populations since late 1990s (El-Badry, 2013). However, only 2.4% and 1.5% of older people are enrolled for institutional care in Zimbabwe and Botswana respectively (El-Badry, 2013). Although the uptake of institutional in Africa as demonstrated by the aforementioned countries, there was need to establish personal factors members of the public consider in their decision whether to enroll their older relatives for institutional care.

This study held that perceived importance and their role in society could act as a source of impetus to primary care givers to provide care to their older relatives and as such consider home based rather than institutional care. However, primary care givers who do not appreciate the importance of older people in society could be less motivated to take care of their older relatives and could thus opt for institutional rather than home based care. This study also held that institutional homes whose existence primary care givers were most aware of and which were also legally operating, had adequate staff whose attitude toward older people was favourable were highly likely to be considered by primary care givers to take care of their older relatives.

Many studies, however, do not say much on the extent to which the pre-old age relationship between the potential caregiver and his/her elderly may influence the former's decision on whether or not to enroll the latter in a formal care institution. There is therefore need to understand the kind of relationship members of the public have with their elderly relatives. This is important so that we can understand how such relationship

is likely to inform their decision to enroll or not enroll their elderly relatives for formal care services in formal care homes for the elderly.

2.5.2 Psychological Strength of the Primary Care Givers

Close family and other informal caregivers provide the vast majority of long-term care to older adults as well as others with chronic illnesses and disabilities (Ennis, Rosenbloom, Canzian, & Topolovec-Vranic, 2013; Viana et al., 2013; Penning and Wu, 2016). Empirical accounts suggest that caregiving is stressful and therefore, likely to have negative implications for the mental health and well-being of caregivers. However, limited research attention has been directed toward the implications of caregiver–care recipient relationships for an understanding of caregiving outcomes as well as the role of gender, age, or other social structural factors in influencing these implications (Litwin, Stoeckel & Roll, 2014; Penning & Wu, 2016). Yet, recent theoretical and empirical developments direct thier attention to their combined importance for an understanding of the experience and consequences of caregiving. This study addresses these gaps in knowledge, examining the psychological strength of the primary care givers and its implications on the uptake of the formal care services by the older people.

It is possible as suggested by Stajduhar & Cohen (2009) that care providers may experience a lot of psychological problems in the course of their work. Therefore, the ideas of Stajduhar & Cohen (2009) are important since it informs the proposed study of the psychological context of care giving and more so that of the caregiver, they however, do not explain how such psychological problems experienced by the caregivers in the course of their work affects their decision on whether or not to take enroll their elderly relatives in formal care institutions for the elderly. The current study not only established the kind of psychological context of care giving for the elderly, but also how such context informs the decision of the public to consider formal care giving institutions to the elderly.

A study by Chipangura, Van Niekerk & Van Der Waldt (2016) found that most of the primary care givers would seek the wishes of their older relatives before deciding on whether to enroll for institutional care. For instance, most of the respondents indicated that their older relatives would wish to be accorded proper burial that is honorable, meaningful and acceptable to their cultures. This expectation made most of the primary care givers to shy away from seeking institutional care out of the concern that the burial

wishes of their older relatives may not be fulfilled under institutional care practices. There is no clear literature linking the psychological strength of the care givers on the adoption of institutionalized care for the elderly. Thus, psychologically people may be obliged to honor the requirements of the elderly when they ate still alive to show respect and regard for them. This study sought to establish the influence of psychological strength of the care givers on the uptake of the institutionalized care.

2.5.3 Financial Capacity of the Primary Care Givers

Self-efficacy entails the confidence in one's own ability to undertake the target behaviour (Luo et al., 2018). People generally have strong motivation towards tasks where self-efficacy is high and thus strongly influences a person's behavioural choice. The self-efficacy of members of the public to care for their older relatives may also be influenced by the financial strength of the primary care givers. A research on filial expectations and responsibilities in the context of societal expectations for women has shown that women often stretch themselves to the breaking point to provide care to their elderly relatives (Coward et al., 2014). Caregiving can be demanding and time consuming, usually without financial compensation. Relatives caring for older adults may have additional responsibilities, such as working or looking after other family members to get the financial strength to foot the bills in the course of the activity. These multiple and potentially conflicting obligations can cause stress, ill health and an increased risk of mortality (Gray, Hahn, Thapsuwan & Thongcharoenchupong, 2016). It is common for caregivers to experience what scholars call 'carer burden', the belief that current and future resources (emotional, physical, social, and financial) cannot meet the role demands of caregiving. Sometimes the care givers may opt for care homes for their older relatives to allow themselves time for working to get the finances to pay for the services instead of committing their entire time to rendering the service.

2.6 Public Perception of Institutional Efficacy to Care for the Elderly

Institutional care homes for older people require a variety of resources in order to offer efficient, quality and effective services to older people. These resources include; personnel, accommodation, equipment for physical exercises, programs for social bonding and the legal framework (World Health Organisation, 2015).

2.6.1 Legal Status and Compliance

Formal care institutions that were more likely to be successful in the provision of care are those that aligned their policies with cultural norms and were respectful of the older adults' rights and wishes. For example, a survey by McDonald & Thomas (2013), which sought to establish from older people the kind of care institutions they would wish to be enrolled in reported that some of the older adults stated that they preferred institutions that allowed them to preserve their independence, and allow relatives to provide assistance. Although formal care institutions operate according to their own policies, it was important for this study to understand whether such policies are accommodative enough to the diverse needs of older people under their care. This study therefore sought to establish whether formal care institutions for older were acceptable in the society and were in compliance with the societal and legal norms.

2.6.2 The Personnel in the Care Homes

Low and inappropriate staffing levels in formal care institutions does not only compromise the quality care services but also leads to increased cases of malpractices such as elder abuse and neglect (Long-Term Care Task Force on Resident Care and Safety, 2013). Similarly, an earlier study by Phillips and Ziminski (2012) found that inappropriate staffing was associated with more neglect. However, appropriate direct-care staffing addresses complex care needs, improves quality of care and is an important approach to reducing abuse and neglect. Regular training of the staff to be equipped with the changing societal needs as well as the needs of the elderly is crucial for the care homes. Studies that have focused on the kinds of skills needed for effective formal care to the elderly have reported that most formal care providers do not have adequate training to provide effective care to elderly people (Rosenfeld et al., 2012). While recognizing that formal carers for the elderly are from diverse professional background, Rosenfeld et al., (2012) noted that nurses provide much of the formal care to the elderly. Rosenfeld et al., (2012), however, established that only 23% of the nurses providing formal care to elderly people had undergone geriatric training. This implied that a huge proportion of nurses and other careers to elderly people had no specialized training in elder care. Further, a study revealed that even nurses with geriatric training only 4% were found to have adequate training and experience in elder care (Kovner et al., 2012). Any inadequacies in the skills of the carers may jeopardize the safety and welfare of the elderly in the care homes. Thus people will be more cautious about enrolling their

relatives in care homes which exhibit such inadequacies. There was need to extend inquiry into institutional care homes for the elderly in Kenya more so with regard to the relationship between level of staffing and public perception of the efficacy of the care institutions.

2.6.3 Physical Facilities of the Care Homes

Physical activities and social interactions for the elderly cannot be downplayed because they are important to older people in frail health and can provide structure and meaningfulness in their daily life (Rowles & Bernard, 2013). The activities can enhance the quality of life as well as the cognitive power of people suffering from dementia. Social interaction in the care home bolsters the health of the elderly since they can share their life stories and make fun. But lack of social relationships can threaten the health and quality of life of older people (Nordin et al., 2016). The authors further highlights that loneliness and higher mortality rates, depression, heart diseases, cognitive decline could result from social isolation. They recommend a free environment with abundant interactions and activity for the elderly. In a different study, Joseph, Choi & Quan (2015) reported in their extensive literature review that a high-quality physical environment can save the elderly from frail health and improve their general well-being. Environmental aspects are essential for supporting person-centered care by facilitating activities, social interactions and creating a sense of home.

According to some researchers the relationship between a persons' functioning and the demands of his or her physical environment can be described in terms of accessibility. With increasing levels of frail health, an accessible physical environment becomes more important and must be adjusted to support the persons' needs. Today, there are demands that decisions about the design of the healthcare architecture should be based on the best available information from credible research and evaluations of existing building projects. Evidence-based design is an established concept as an approach for quality improvements when designing new healthcare environments (Nordin et al., 2016).

Residents in care homes often suffer from one or more chronic conditions (CDC, 2013). Due to illness and aging processes, their functional abilities are reduced, and they experience problems in navigating the environment in which they live. Due to poor vision and frailty, combined with balance and gait problems, many elderly residents fall

and are injured Joseph et al., 2015). Cognitively impaired residents run the risk of hurting themselves in an unsafe environment. A supportive, well-designed environment/physical structure can increase resident safety. Majority of the inhabitants of such place will be concerned about their safety before accepting to be enrolled. Another serious issue about the elderly who enroll in formal care homes is falls. Many falls result in hip fractures and other serious injuries, often leading to hospitalization. Falls are the costliest category of injury among older persons, accounting for nearly 71% of the total costs of injury among persons 60 years of age and older. As a result, many studies focused on fall prevention are multi-factorial and usually include risk assessment and environmental modification.

On the contrary, institutional homes that were perceived by primary care givers as lacking personnel and operating illegally could not be considered by primary care givers as good enough to take care of their older relatives. It was also held by this study that institutional homes with adequate and quality accommodation, social bonding programs and facilities for physical exercises were better placed to be considered by primary care givers to take care of their older relatives. However, institutional homes with inadequate and poor accommodation facilities and without facilities for physical exercises and social bonding could be perceived as less capable of providing quality care and as such may not be considered by primary care givers to take care of their older relatives.

2.7 Theoretical Framework

This study was guided by bio psychosocial and theory of Self-efficacy in understanding of the psychosocial factors that shape the societal perceptions. The uptake of institutionalized care was guided by the Theories of Reasoned Action (TRA) and the Planned Behavior (TPB). Bio psychosocial theory was used to inform the condition that characterize elderly persons and which formal care institutions and relatives of elderly persons must not only be privy to but also deal with if they are to help elderly people under their care lead a dignified life. Theory of Self-efficacy on the other hand was used to inform the range of issues that members of the public and formal care institutions must bear in mind while interrogating the ability of elderly persons, formal care homes and members of the public to provide effective care to elderly people. The following is the detailed discussions of the two theories and how they relate to the proposed study.

2.7.1 Bio Psychosocial Theory

Bio psychosocial theory was developed by Psychiatrist George Engel. Engel (1977) argues that the human wellbeing is a product of biological, psychological and social factors. In the context of the proposed study, Engel (1977) would suggest that a detailed understanding of the wellbeing of an elderly person be done in the context of their biological, psychological, and social environment. The biological component of this theory thus seeks to explain the wellbeing of the elderly persons in the context of their body functioning, and possibly argue their vulnerable situation, which necessitates the need for care provision, stems from their physical inability, which limits their ability to participate in productive engagements. This renders them dependent on others for daily provisions hence the intervention of institutional care homes.

The psychological component of bio psychosocial theory explains the possible precarious condition of elderly people in the context of their inability to comprehend, confront and overcome psychological problems they face due to their advanced age. Elderly people therefore need to be helped to overcome many of the psychological problems they go through if they are to live relatively longer. Although such help was previously provided by their younger relatives, the collapse of the traditional support systems implies that elderly people have to seek for help from formal care homes for the elderly.

The social part of the bio psychosocial theory focuses on how different social factors contribute to the neglect of elderly people, which occasions the need for their admission into formal care homes for the elderly. Elderly persons' family background, economic background, and his/her society's attitude toward the elderly among others constitute the social factors that may inform the uptake of formal care services for elderly people.

The bio psychosocial theory therefore implies that the uptake of formal care services for elderly people may be informed by the biological, psychological and social characteristics of elderly people or care recipients. McLaren (2002) stresses that it is important to handle the three together since elderly persons' perceptions of their vulnerability on account of their age, as well as their socio-cultural background will undermine or enhance care giving being provided to them in the formal care institutions. In a sense therefore, caregivers must have sufficient information on the biological,

psychological and social well-being of elderly people as such information may help them in gauging the efficacy of elderly people to fend for themselves, efficacy of relatives of elderly people to take care of elderly people and the efficacy of formal care institutions to take care for elderly people. Halligan, & Aylward, (2006) further points that the knowledge of the biological, psychological and social contexts of the care giving recipients enables caregivers to have adequate insight of the care recipients.

By insisting that care recipients' wellbeing be understood from three fronts, bio psychosocial theory is in away drawing the attention of caregivers on the need to undertake their care giving role from a multidisciplinary approach (Penney, 2010). This implies that care giving may comprise of several interventions such as medical care, counseling among other approaches. Therefore, this theory is in a sense indirectly suggesting for the integration of professional services through integrated disciplinary teams to provide better care and address the care recipients' concerns at all three levels. Bio psychosocial theory was used to explain the kinds of psychological issues that affect elderly people. This theory was useful to the proposed study especially in explaining social factors that not only compel elderly persons to seek sanctuary in formal care institutions but also how these factors may impede or enhance the uptake of formal care services for elderly people.

2.7.2 Theory of Self-Efficacy

This theory is based on the work of Bandura (1997b), who understands self-efficacy as the beliefs in one's capabilities to organize and execute the courses of action required to manage a particular situation. More simply, self-efficacy is what an individual believes he or she can accomplish using his or her skills under certain circumstances. This basic idea behind this theory is that motivation and performance are determined by how successful people believe they can be (Bandura, 1997b). The basic principle behind self-efficacy is that individuals are more likely to engage in activities they have high self-efficacy and less likely to engage in those they do not. Bandura (1977) outlined four sources of information that individuals employ to judge their efficacy: performance outcomes (performance accomplishments), vicarious experiences, verbal persuasion, and physiological feedback (emotional arousal). These components help individuals to determine if they believe they have the capability to accomplish specific tasks.

In terms of performance outcomes, positive and negative experiences can influence the ability of an individual to perform a given task. If one has performed well at a task previously, he or she is more likely to feel competent and perform well at a similarly associated task (Bandura, 1977). For example, one performed well in his/her previous care provision to an elderly relative they are more likely to feel confident and have high self-efficacy when called upon to provide care to another elderly relative. This may make such individuals encouraged to take care of their elderly relative instead of enrolling them for formal care services. The opposite is also true. If an individual performed poorly in his/her previous care provision role, he/she will feel less confident in his/her care provision role, and such will be less motivated to take care of his/her elderly relative thereby considering formal care services for the elderly relative.

For vicarious experiences, people can develop high or low self-efficacy vicariously through other people's performances. A person can watch another perform and then compare their competence with the other's competence (Bandura, 1977). If a person sees someone similar to them succeed, it can increase their self-efficacy. However, the opposite is also true; seeing someone similar fail can lower self-efficacy. For instance, a member of the public seeing his peers or friends succeed in taking care of their elderly relatives may feel more encouraged and motivated to provide care to elderly people. However, an individual witnesses his/her peers or friends fail in care provision for their elderly relatives, such individual may worry about his/her own chances of success in a similar task leading to low self-efficacy for care provision. Individuals with low self-efficacy in care provision are more likely to consider formal care services for their elderly relatives unlike their counterparts with high self-efficacy in care provision.

With regard to verbal persuasion, self-efficacy is influenced by encouragement and discouragement pertaining to an individual's performance or ability to perform. Using verbal persuasion in a positive light leads individuals to put forth more effort; therefore, they have a greater chance at succeeding. However, a negative verbal persuasion can lead to doubts about one self-resulting in lower chances of success. For instance, an informal caregiver who is appreciated by the care recipient-in this case the elderly relative, may feel more encouraged and motivated and such may put more effort in his/her care provision role. On the other hand, a caregiver who is often bashed or scorned by his elderly relative may feel discouraged and demotivated leading to low self-efficacy in care provision, and may consider formal care services for the elderly relative.

Lastly, for the physiological feedback (emotional arousal), people experience sensations from their body and how they perceive these emotional arousals influences their beliefs of efficacy (Bandura, 1977). Although this source is the least influential of the four, it is important to note that if one is more at ease with the task at hand they will feel more capable and have higher beliefs of self-efficacy. In the context of the current study, Self-efficacy theory suggests that increasing the self-efficacy of care providers and care recipients will boost motivation and performance in care provision to elderly people. Utilizing the sources of self-efficacy (performance outcomes, vicarious experiences, verbal persuasion, and emotional arousal) can improve care providers' and care recipients' effort, persistence, goal setting, and performance on specific care giving tasks.

2.7.3 Theory of Reasoned Action (TRA)

To understand the processes people, undergo before reaching a decision to enroll their relatives or themselves, the study was anchored on two theories, the TRA and TPB. TRA was formulated by Ajzen & Fishbein (1975) in attitude research using Expectancy Value Models, when the authors tried to estimate the discrepancies between attitude and behaviour. The fundamentals of the TRA came from the field of social psychology. The main tenet of the TRA is that an individual's behavioural intention in a specific context depends on intention to change, attitude towards the change, and subjective norms (Ajzen & Fishbein, 1980).

Ajzen & Fishbein (1980) stated that a person's behaviour is determined by their intention to perform that behaviour, and that this intention, in turn, is a function of the person's attitude toward the behaviour and their subjective norms. Thus, one of the potential indicators of a possible behavioural outcome is intention. Intention, which is an indicator behaviour, refers to the cognitive representation of a person's willingness to do a particular function or behaviour. Behavioural intention is the relative strength of a person's likelihood to perform an anticipated behaviour. This is influenced by attitudinal factors that capture how individuals are engaging to perform the intended behaviour, based on their behavioural beliefs and their ability to evaluate the outcomes of their decisions or behaviours (Ajzen, 1991). Behaviour can either be verbal or non-verbal (such as body language), signals, signs, or vocal expressions.

Subjective norms are a combination of the normative beliefs of the relevant individuals, along with the motivation to comply with such beliefs or expectations (Ajzen and Fishbein, 1975). Thus a person's attitude, combined with subjective norms, forms the person's behavioural intention. The TRA can therefore be extended to conceptualise the human behavioural pattern in decision-making regarding utlisation of formal care services by the elderly people. It explains that individual behaviour, such as utilisation of an innovation, is driven by behavioural intention, where behavioural intention is a function of an individual's attitude toward the behaviour, informed by the subjective norms surrounding the performance of the behaviour.

In a study that employed the TRA to understand the uptake of institutionalized care, Liker & Sindi (1997) developed and tested a model based on the TRA, in order to understand the challenges posed by communication systems on the performance of management teams. The model was tested using a cross-sectional design, using a self-administered questionnaire completed by a sample of 94 information system users and non-users from two of the largest accounting firms in the USA. The study measured attitudes toward the system and intention to use the system in the future (or continued use by existing users). The results showed that intention to use the system was influenced by social norms encouraging system use, and by perceptions of the impacts of system use on valued skills, controlling for the effect of attitudes.

Attitudes toward use of the system were affected by the perceived usefulness of the system and its impacts on valued skills. Attitudes were also strongly related to ease of system use, an unanticipated finding. The most surprising result was that general attitudes were not found to predict intention to use the system (Liker & Sindi, 1997).

Similarly, Otieno, Liyala, Odongo, & Abeka, (2016) noted that attitude and subjective norms have been found to be important determinants of peoples' intentions to perform an action, such as uptake and using a new phenomenon. They further stated that attitude has a significant influence on the intention to adopt and continue using a innovation. In another study that employed the TRA to understand the intention to utilize formal care services, Luo et al. (2016) developed and tested a model based on the TRA, in order to understand the processes people, undergo to reach a decision to enroll for care services. The model was tested using a cross-sectional design, using a self-administered questionnaire completed by a sample of 641 while excluding subjects who had hearing,

cognition or communication problems. They found interesting findings that TRA is an acceptable theoretical foundation for the study in line with past research and that attitude was found to be the most powerful predictor of nursing home use.

Although the Theory of Reasoned Action has been extensively utilised in studies evaluating intention to uptake a new idea/innovation, it falls short of explaining the fundamental process that one goes through before they eventually reach a decision to for instance to enroll to a care home which is principally a foreign subject in Africa and Kenya. A key drawback of the theory is that it fails to acknowledge the fact that individual behaviour may be directed by general constraints (Ajzen, 1985). The author provided an additional variable, that of perceived behavioural control, to address the limitations of the TRA when he published the Theory of Planned Behaviour. This theory seeks to address the seeming over-reliance on intentions to predict behaviour. This is why the present research sought to include the theory of Planned Behaviour as it provides a better explanation of uptake intention of by individuals. Figure 1 represents the variables used in the TRA.

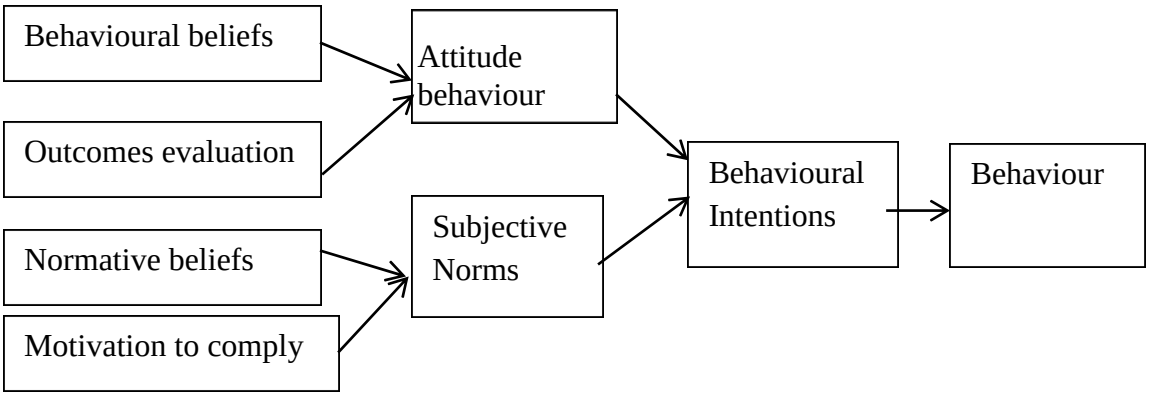

Figure 1: Theory of reasoned action

2.7.4 The Theory of Planned Behaviour (TPB)

Ajzen (1985) provided a useful framework for understanding a recipient's behaviour in the TPB, which explains how different stimuli activate a particular behaviour, such as the intention to enroll for the formal care services by the elderly persons. The TPB provides a useful framework for understanding societal decision-making process according to their attitudes, subjective norms and perceived behavioural control, and the relationship with their intention to utilize a new idea.

Similar to the TRA, the TPB developed by Ajzen (1985) explains that behaviour (such as decision to enroll for institutionalized care) as a function of intention. The individual's behaviour is determined by his or her intention regarding that behaviour. Intention is built upon three components, namely attitude, subjective norms, and perceived behavioural control. The likelihood that a person will engage in certain behaviour is also an indicator of intention, which is determined by the relevant salient beliefs about the behaviour. Attitudes toward formal care homes, for instance, would refer to the individual's evaluation of the existing facilities which can be positive or negative. To measure an individual's attitude towards a particular behaviour, researchers have tried to simplify the understanding of the attitudes of the agents involved. The elements of the theory of planned behaviour are defined as follow:

Subjective norms is defined as the individual's perception of the social pressures to use or not use a particular idea/intervention; it is a belief of an individual about how much others would like him or her to use that particular intervention. Subjective norms are driven by normative beliefs and the motivation to comply with social pressure. According to the Expectancy-Value Framework, subjective norms can also be quantified (Pawlak, Brown, Meyer, Connell, Yadrick, Johnson, & Blackwell, (2008).). Similarly, Wauters, Bielders, Poesen, Govers, & Mathijs, (2010), measured subjective norms by asking the respondents to answer two sets of questions. On the first scale, subjects were asked to indicate whether most people who are important to them would totally disapprove or totally approve of their usage of a new technology. In the second question, farmers were asked to rate the truth of the statement that most people who are important to them think they should apply the new idea. The respondents had to answer on a unipolar seven-point scale with the endpoints: 'Totally not' and 'Totally approve' as the extreme points on either side of the likert. The results suggested that subjective norms are antecedents of a person's intention to perform a particular behaviour.

Perceived behavioural control refers to the way a person regards a particular behaviour as being difficult or easy to undertake, which is related to control belief and the influence of significant others in decision making. Situational and internal factors also restrict or facilitate the bevioural intention. The Expectancy-Value Framework could be used to measure perceived behavioural control quantitatively (Pawlak et al., 2008) using two items. The first item requires subjects to rate the truth of the statement: "Whether I apply this idea or not depends entirely on me, and not on factors facilitating

or inhibiting usage of the idea/innovation". The endpoints of this scale are "Totally not" and "Totally yes". The second question requires subjects to indicate the difficulty of applying the idea/innovation on a scale with endpoints ranging from "Extremely difficult" to "Extremely easy" (Wauters et al., 2010). Because Actual Behavioural Control (ABC) is often difficult to assess, many studies have used perceived behavioural control as a proxy for ABC (Wauters et al., 2010). In cases where respondents are assumed to be capable of adequately estimating their actual control, this can be a good measure. Illustration of the theory of TPB is in Figure

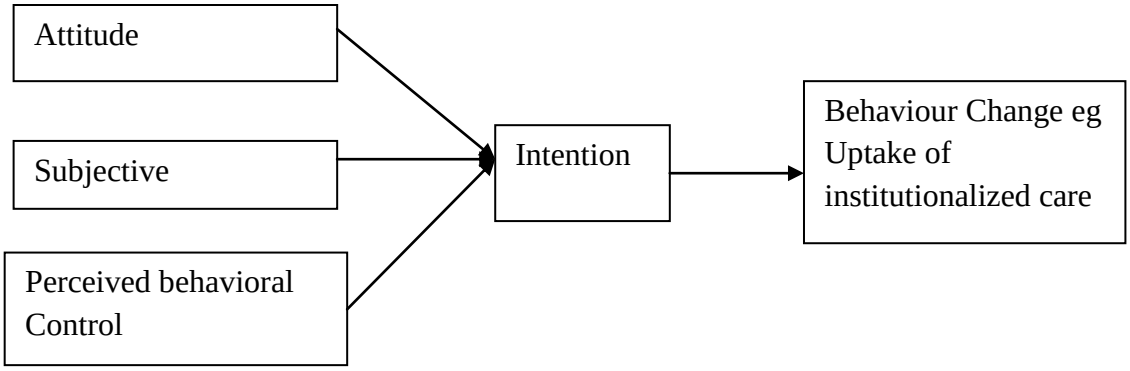

Figure 2: Theory of TPB; Source: Ajzen (2002)

2.7.4.1 Empirical Review of TPB

Sextus Empiricus, a Greek scientist, came up with the idea of generating scientific arguments based on observational data. This precipitated a general diversion from doctrines of the day, which had involved dependence on theoretical support instead of relying on the observation of phenomena as perceived through experience (Hatch, 2018). The term 'empiricism', therefore, is a concept that emphasises the role of experience and observation in acquiring knowledge. This concept focuses on those aspects of scientific knowledge that are closely related to experience, usually formed through experimental arrangements. Mugenda (2008) argued that it is a fundamental requirement of scientific method that all hypotheses and theories be tested against observations of the natural world, rather than relying solely on *a priori* reasoning, intuition, or revelation.

Empirical evidence of the TPB largely supports the fact that other studies have essentially differentiated two dimensions of behavioural intention: goal intentions, which commit people to achieving a certain goal, and implementation

intentions, which enable people to derive usage experience (Sniehotta & Schwarzer, 2005). According to Sniehotta & Schwarzer, people react to a new idea in a particular manner once a situation is encountered and they develop an intention to do so. In some instances, people do not necessarily proceed to form an intention, which develops a gap between intention and the actual behaviour (Sniehotta & Schwarzer, 2005).

An experimental study, for example, showed that among people with similar scores on the TPB variables, individuals who formed implementation intentions were almost twice as likely to proceed to actual behaviour. Additionally, He, Lu and Zhou (2008) noted that "the perceived ease of use of a new idea, its usefulness, vendor competence, introduction and recommendation by a third party (subjective norm), and vendors' attitudes toward customers (attitude), influence the intention to use an innovation". Their results assert that buyer-to-buyer purchase intention is determined by perceptions of the ease of use, perceived usefulness, introduction by a third party, and vendors' attitude. He et al. (2008) recommended further investigation into the influence of external variables such as age, gender, income, cultural background, occupation, family status, and education on behavioural intentions.

2.7.4.2 The Theoretical Sufficiency of the TPB

A lot of research has been done to compare other models with TPB in trying to establish its theoretical sufficiency. Rather than introducing experience as a variable into the model, Taylor & Todd (1995) tested the model twice (once with data from experienced IT users and once with data from inexperienced IT users). The researchers found that their decomposed model provided a fuller understanding of behavioural intention by focusing on the factors that are likely to influence information systems use through the application of design and implementation strategies.

Other researchers preferred meta-analysis studies to determine the theoretical efficiency and sufficiency of the TPB. In some studies, researchers focused solely on the TPB (Armitage & Conner, 2001; Notani, 1998), while others also assessed the TRA (Hausenblas, Carron, & Mack, 1997; Sutton, 1998; Hagger, Chatzisarantis, & Biddle, (2002).). The vast majority of these meta-analysis studies showed robust support for the TPB. Armitage & Conner (2001) analysed 185 independent studies based on the TPB. In their meta-analysis, the scholars found that the TPB worked very well, with a multiple correlation of 0.63 for predicting behaviouaral intention. The model accounted for 27

percent of the variance in actual behaviour and 39 percent of the variance in intention. Perceived behavioural control accounted for significant amounts of variance in intention and actual behaviour, independent of TRA variables (Armitage and Conner, 2001). The researchers sought to establish if indeed each of the previous studies used self-reports. They realised that the TPB had 11 percent positive results in terms of variance in adoption for cases where adoption measures went down.

Overall, Armitage & Conner (2001) noted that subjective norm was a poor predictor of behavioural intention. They also noted that the role of the format of a questionnaire and the level of social desirability had minimal effects on models which applied TPB, which was similar to the findings written in their next paper (Armitage & Conner, 1999). The efficiency and sufficiency of the theory of TPB was also supported in the meta-analysis study conducted by Godin & Kok (1996). The scholars looked at 56 studies that used the theory to study health-related behaviours, and verified the theory's efficiency. Godin & Kok's meta-analysis also found that the TPB explained intention. They noted that two variables, perceived behavioural control and personal attitudes, played an important role in explaining intention. While intention was found to be the most important predictor of behaviour, perceived behavioural control significantly added to the prediction.

According to Notani (1998) studies involving the TPB found similar support for the model, with perceived behavioural control serving as an antecedent to both adoption intention and actual adoption. The findings indicated that perceived behavioural control is a stronger predictor of behaviour when it is operationalised as a global measure, and is conceptualised to reflect control over factors primarily internal to the individual. Other theorists such as Sutton (1998) compared the TPB and the TRA in a meta-analysis. Sutton (1998) found greater support for the TPB by evaluating the performance of these models in predicting and explaining intention and behaviour. The models explained between 40 and 50 percent of the variance in intention, and between 19 and 38 percent of the variance in adoption. Another meta-analysis to determine the usefulness of the TPB against the TRA was also conducted by Hausenblas et al. (1997). While limiting their analysis to intention and behaviour, they found a large effect size for the following relationships: Intention and behaviour, attitude and intention, attitude and behaviour, perceived behavioural control and intention, and perceived behavioural control and actual behaviour. The effect size was moderate between subjective norm and intention

(Notani, 1998). The results of the study by Hausenblas et al. (1997) suggested that the TPB is superior to the TRA in studies involving adoption. Other scholars have found similar results in meta-analytic comparisons of the theories in different research contexts involving adoption intentions. Hagger et al. (2002) examined 72 physical activity studies that used these theories, using meta-analytic techniques to correct the correlations between the TPB and the TRA. They also used path analysis to examine the relationships among variables, and found that the major relationships in both theories were supported, but that the TPB accounted for more variance in physical activity intentions and adoption/uptake. Overall, these meta-analyses overwhelmingly demonstrated the theoretical sufficiency of the TPB, with the majority of these studies demonstrating a strong explanatory power of the TPB in adoption intentions. In summary, the meta-analyses and comparative studies previously discussed justify the selection of the TPB for the present study, which aimed to provide an understanding of what influences societal decisions enroll older persons to formal care homes as alternatives means of taking care of their welfare.

2.7.4.3 Critique of the TPB

In spite of the extensive and successful application of the TPB in adoption behaviour studies, the theory has recently been criticised for insufficient consideration of moral attitudes' influence on adoption (Arvola, Vassallo, Dean, Lampila, Saba, Lähteenmäki, & Shepherd, (2008). According to the TPB, all moral influences on decisions to utilize a particular intervention/service which is perceived to be new were assumed to be mediated via the measures of attitudes, subjective norms, and perceived behavioural control (Ajzen & Fishbein, 1980).

Ajzen (1991) acknowledged the critique that, at least in certain contexts, one needs to consider not only perceived social pressure, but also personal feelings of moral obligation or responsibility to make decisions about usage (whether it is morally right to use such a product/service). The author further stated that this moral duty would definitely impact on intentions, in parallel with attitudes, subjective norms and perceived behavioural control. According to Olsen (2010), the TPB is, in principle, open to the inclusion of additional predictors, if it can be shown that they capture a significant proportion of the variance in intention or adoption after the theory's current variables have been taken into account. It is with this allowance that this theory was found relevant

to explain the uptake behavior of the society and the elderly people in particular to utilize formal care services.

2.8 Conceptual Framework

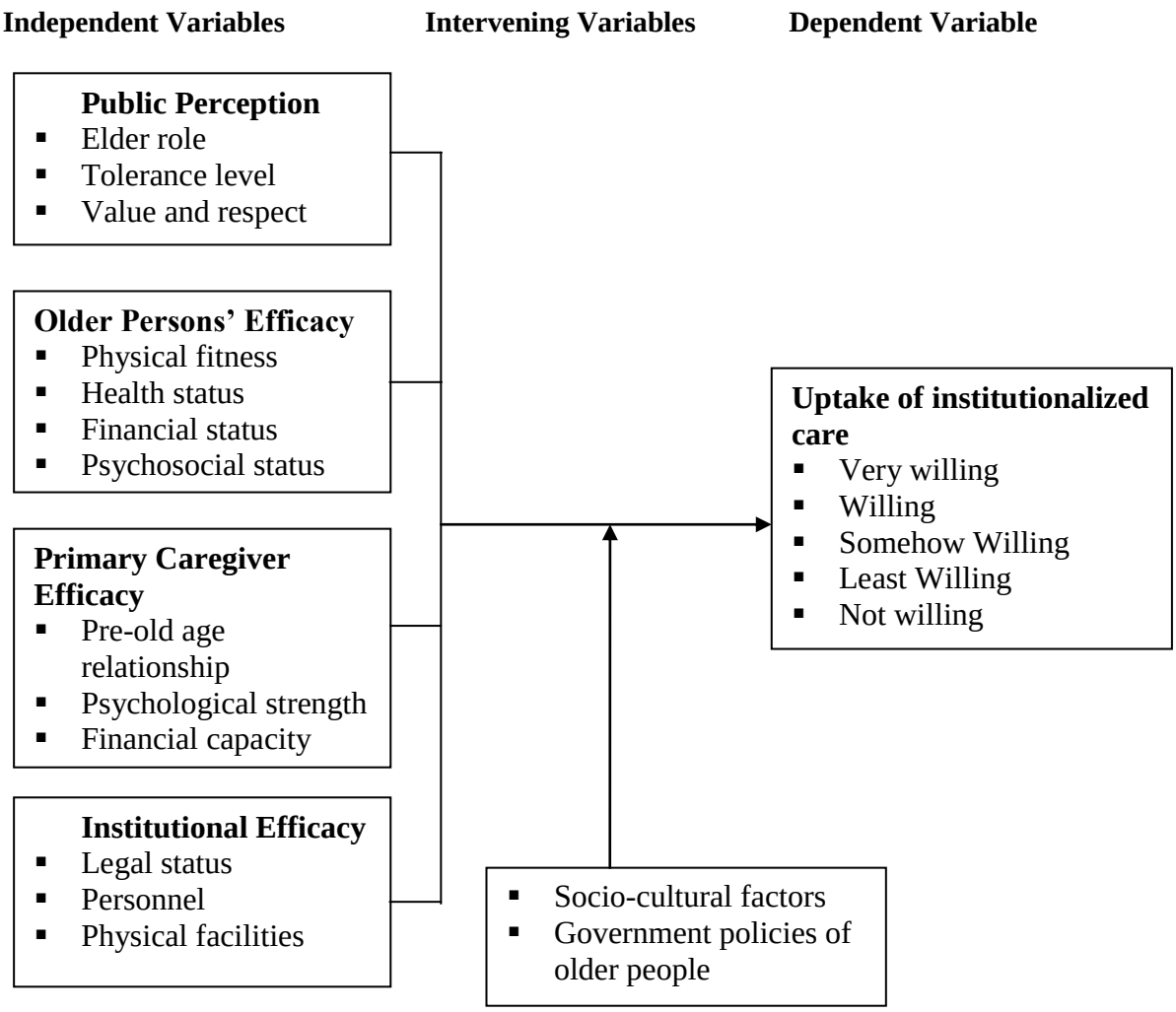

Figure 3: A Conceptual Framework Showing the Interplay between Research Variables

The conceptual framework for this study was modeled along the objectives. It emanated from literature review and theories adopted for the study. This study focused on general perception of elderly people, perceived efficacy of institutional care homes, and perceived efficacy of elderly people and perceived self-efficacy of primary care givers to provide care for older relatives.

Public perception towards the aged was examined in the context of perceived importance of aged in society (elder roles); the tolerance level of the society towards the

challenges faced by the aged. Value and respect for the elderly was also another parameter that was anlysed under this theme.

This study examined institutional efficacy in the context of adequacy of institutional staff/personnel, adequacy and quality of physical facilities such as accommodation facilities, availability and adequacy of facilities for physical exercise and availability of social bonding programs. The legal framework and compliance to the legal requirements was another dimension of institutional efficacy that was analyzed in the conceptual framework

Perceived older people's efficacy of older people to take care of themselves was examined in terms of physical condition of older people, health status of older people, economic condition of older people, psychological status of older people and financial ability to meet their medical and other physiological needs.

The perceived efficacy of primary care givers to take care of older relatives was examined in terms of pre-old age relationship between primary care givers and older relatives, the psychological strength of primary care givers and the financial status of primary care givers.

The above four areas; public perception towards the aged, institutional efficacy, perceived older people's efficacy of older people and the perceived efficacy of primary care givers were the independent variables in the conceptual framework.

Finally, the uptake of institutional care for older people was examined through Likert scale response questions that were posed to the participants. The question had five response categories very willing, willing, somehow willing, least willing and not willing. Participants were asked to state whether they were very willing, willing, somehow willing, least willing and not willing. This was based on their own perception after considering many factors related to the four themes stated above. This part was the dependent variable. The intervening variables were factors related to the general legal regulatory framework and the socio-cultural factors in the external environment. The following Figure 3 shows how the independent variables are conceptualized to influence the dependent variable.

CHAPTER THREE
RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This chapter outlines the methodology that was used in the study. It discusses in detail the location of the study, the research design, sampling procedure and sample size, data collection instruments, data analysis and ethical issues that were observed in the study.

3.2 Research Philosophy

A research philosophy is the foundation of knowledge on which underlying predispositions of any study are based. It constitutes a set of important assumptions about the way the researcher views his/ her world (Saunders, Lewis & Thornhill, 2007). According to Saunders et al. (2009) there are three most important philosophical assumptions in research namely; epistemology, ontology and axiology. Epistemology is concerned with acceptable knowledge in the field of study. It has two core philosophies namely positivist and phenomenological (Collins & Hussey, 2009). Philosophical approach enables the researcher to decide which approach should be adopted and why. Hence before selecting the appropriate research philosophy it is important to know about various types of philosophies in research (Saunders et al., 2009).

The important assumptions in research philosophy explains about the researchers' view regarding the world. These assumptions will determine research strategy and the methods of that strategy. The current study was framed within the positivist research approach which is a mixture of quantitative and qualitative elements. Its main purpose is to describe and explain a phenomenon and empirically establish the relationships between the study variables. It is an approach under which knowledge is based on verification by way of using clear operational definitions, objectives, hypothesis testing and replicability. They view reality as objective and measurable and therefore, develop hypothesis to show associations and through the observed effects, they are verified or refuted. It further suggests that concepts should be operationalized to enable use of quantitative data to test hypotheses drawn from a theoretical framework. In this philosophy, the resources researcher cannot manipulate during data collection procedure as they are independent to the subject of the research. In positivism, the hypotheses are tested and result is confirmed by the researcher to develop a theory. This study therefore, meets these characteristics and as such adopts this approach.

3.3 Research Design

The study design employed in this study an exploratory research design to establish the effect of public perception of the aged people and the institutional efficacy of formal care homes in Nakuru County, Kenya. This was used establish the link between the public perception and the uptake of formal care services for the aged people in Nakuru county. This research design involves conducting a survey of a sample population element or entire population at one point in time (Cooper & Schindler, 2011). This survey design was used because it provides a clear view of what is going on with the variables of interest for the research problem and the need to generalize the results obtained. The design establishes only associations between variables and it is concerned with conditions or relationships that exist, practices that prevail, processes that are ongoing, and attitudes that are developing (Hopkins, 2000). It also enables researchers to study the elements in their natural environment without necessarily manipulating or controlling them. The design was considered relevant in this study because it is concerned with associations that exist between public perception and the uptake of institutionalised care.

3.4 Location of the Study

The study was carried out in Nakuru County. Nakuru County is one of the 47 Counties of the republic of Kenya established in the Constitution of Kenya 2010. The County covers an area of 7,495.1 Km² and lies within the Great Rift Valley bordering eight other counties. Nakuru is located 6,239.69 mi (10,041.81 km) south of the North Pole. Nakuru is 19.34 mi (31.12 km) south of the equator, so it is located in the southern hemisphere. The County headquarter is Nakuru town, one of the fastest growing towns in East African region (Nakuru County Integrated Development Plan, 2013). Nakuru County is divided into 11 administrative Sub-Counties with a total of 31 divisions 55 electoral wards.

3.5 Population of the Study

The County population projection in 2017 is estimated at 2,046,395. The population of Nakuru County is predominantly youthful with about 51.87% aged below 20 years and about 71.63% of the total population aged below 30 years. With a County population growth rate of 3.05% per annum the population is projected to increase further to 2,046,395 in 2017 comprising of 1,026,924 males and 1,019,471 females assuming constant mortality and fertility rates. The County's population is

predominantly youthful with about 51.87% aged below 20 years and about 71.63% of the total population aged below 30 years. The population of elderly people in the county is estimated at 71,340, which is about 3.5% of the total population in the county (Nakuru County Integrated Development Plan, 2013).

Table 1: Population as Per Nakuru Sub-counties

Sub-County	**PP aged 18-59**
Nakuru town	171,536
Naivasha	117,514
Gilgil	65,094
Bahati	69,420
Njoro	82,396
Molo	55,115
Kuresoi North	48,033
Kuresoi South	40,416
Subukia	41,735
Rongai	59,483
Total	**750,742**

Source: Nakuru County Integrated Development Plan, 2013

3.6 Sampling Procedure and Sample Size

In this section, the elaborate procedure of the sampling process is highlighted and the sample size determination analysis provided.

3.6.1 Sampling Procedure

The current study used purposive and stratified sampling methods. Purposive sampling method was used to select the key informants. The choice of key informants was determined by the position and critical role they play in the provision of formal care to elderly people. For this reason, the current study selected county government official in charge of elderly people and formal homes for the elderly people, heads of homes for elderly people, expert in gerontology or associated profession, medical doctor and a professional counselor. Stratified random sampling was used to select the respondents for the questionnaire administration. The main strata for the proposed study were age, gender, occupation, and ethnicity of the respondents. Studies have shown that men and women respond to the plight of vulnerable members of society differently. Age also

defines individual's level of responsibility in society including those that are associated with provision of care to elderly people. One's ethnicity and by extension cultural orientation may influence individual's belief system and attitude toward care provision for their elderly relatives. Occupation may also determine whether or not an individual can be available to their elderly relatives in terms of care provision.

3.6.2 Sample Size

The population of the study entailed people from Nakuru County. Nakuru County has a population 750,742 aged between 18 and 59 years. The proposed study considered individuals aged 18-59 years for sampling and data collection. Using Taro Yamane's formula (Yamane, 1973) for sample size determination, the study had a sample size of 400, which was arrived at as follows:

$$n = \frac{N}{1 + N(e)^2} \quad \text{.....3.1}$$

Where:

n = sample size

N = population

e = error of sampling method = 0.05

$$n = \frac{750{,}742}{1 + (750{,}742 \text{ x } 0.05)2} \quad \text{.....3.2}$$

= 400

The above formula was appropriate since the population of the study was finite and fetched from the county integrated development plan I for the period 2013-2017.

Table 2: Sample Size

Sub-County	PP aged between 18-59	Sample Size
Nakuru town	171,536 (22%)	88
Naivasha	117,514 (16%)	64
Gilgil	65,094 (10%)	40
Bahati	69,420 (10%)	40
Njoro	82,396 (11%)	44
Molo	55,115 (7%)	28
Kuresoi North	48,033 (6%)	24
Kuresoi South	40,416 (5%)	20
Subukia	41,735 (5%)	20
Rongai	59,483 (8%)	32
Total	**750,742**	**400**

3.7 Data Collection Instruments

Research instrument is the general term that researchers use for a measurement device (survey, test and questionnaire. Instruments fall into two broad categories, researcher-completed and subject-completed, distinguished by those instruments that researchers administer versus those that are completed by participants (Zohrabi, 2013). Researchers chose which type of instrument, or instruments, to use based on the research question. Both secondary and primary data were used in this study. The study used a structured questionnaire to collect primary data. The questionnaire was considered the most appropriate research tool for this study as it allows the researcher to collect information from a large sample which is diverse and geographically dispersed (Mugenda & Mugenda, 2003). The study adopted Bass et al. (1985) Multifactor Leadership Questionnaire (MLQ) scale items related to public perception of the formal care services for the elderly people but modified to suit the purpose of the study. Interview schedule and focus group Guide were also used to collect in-depth information. Seven participants were purposively selected for the focus group.

Likert scales were generated and used to collect views about the general public perception on institutional care for the elderly persons. Machuki (2011) asserted that the Likert scale has been used in most fields of scholarly and business research and particularly where the value sought is a belief, opinion, or effect, if it cannot be asked directly and with precision and if it is considered to be of a sensitive nature such that

respondents can only answer categorically in large ranges. The Likert-type scale indicated the extent to which individual questions or statements (items) were operationalized to reflect the intended variables and enable respondents to provide quantifiable information.

3.7.1 Pilot Study

This study undertook a pilot study in Kericho County. Kericho County was chosen for the pilot study because there are greater similarities between its population and that of the population in Nakuru County (Nakuru County Integrated Development Plan, 2013 and Kericho County Integrated Development Plan, 2013). For example, like Nakuru County, Kericho County has a mix of urban and rural populations. A significant proportion of the populations of Kericho and Nakuru Counties derive their incomes from both formal and informal sources.

This pilot study was undertaken so as to test the adequacy of research instruments (validity and reliability) and identify possible logistical problems which the study could face during the actual data collection. Although there is no specific proportion of the study sample size that is specified to be engaged in a pilot study, Nieswiadomy (2002) recommends that 10% of the study's sample is sufficient for a pilot study. Therefore, based on the recommendation of Nieswiadomy (2002), this study administered questionnaires to 40 primary care givers (being 10% of the sample size) in Kericho County. This study used the split-half method to test the validity and reliability of the questionnaire. In split-half reliability test, the researcher divided the study sample into two sets each comprising of 20 respondents. The researcher with the help of two research assistants then administered concurrently the questionnaires to the two sets of respondents who were stationed at different venues.

3.7.2 Validity and Reliability

Reliability and validity are the two most important and fundamental features in the evaluation of any measurement instrument or tool for a good research (Mohajan, 2017). Validity refers to the degree to which a study accurately reflects or assesses the specific concept that the researcher is attempting to measure. In order to test the validity of the evaluation tool, questionnaires were administered to sample respondents using test-retest pilot method. The questionnaires were administered to 40 sampled respondents. The content of the questionnaires were modified based on the assessment of

the responses. The aim of this exercise was to ensure that questions elicited only desired and intended responses.

Reliability refers to the extent to which an instrument is in a position to produce consistent results each time it's administered (Mohajan, 2017). In the study, a reliability co-efficient (alpha value) of more than 0.7 was assumed to reflect the acceptable reliability (Moser & Kalton, 1971). The Alpha value ranges from zero to one and indicates the reliability of an instrument. The more the Alpha value is closer to one, the more reliable the instrument. The results are presented Table 3.

Table 3: Reliability Statistics

1st half Cronbach's Alpha	2nd half Cronbach's Alpha	Cronbach's Alpha Variant	Cronbach's Correlation	N of Items
.836	.848	0.012	.862	34

A total of 41 items (questions) were presented to the respondents. The statistical analysis of data from pilot study yielded a Cronbach's Alpha value of 0.836 and 0.848 for set 1 and set 2 respectively as shown in Table 3.2. The Cronbach's Alpha variance between the two sets of respondents was 0.012 and correlation of 0.862.). A reliability co-efficient (alpha value) of more than 0.7 is considered acceptable reliability (Moser & Kalton, 1971). Therefore, the questionnaire for this study was considered as reliable given reliability co-efficient of 0.862.

Further, analysis of the statistical results showed that out of the 34 items subjected for reliability 27 of them had Cronbach's Alpha value of over 0.7, implying that about 79.4% of the questions were valid and reliable. Items that had Cronbach's Alpha value of less than 0.7 were modified and incorporated into other items as shown in Table 4. The final questionnaire had 27 items.

3.8 Data Collection Procedure

The study employed both qualitative and quantitative procedures of data collection. Semi-structured questionnaires were the main instrument used to collect quantitative data for the study. Questionnaires had both structured and unstructured

questions that enabled collection of standardized responses while simultaneously providing respondents the opportunity to respond without restrictions.

Qualitative data were obtained through the use of in-depth interviews. Interviews were largely used to obtain data from staff of the institutions caring for the elderly. The study employed a semi-structured interview guide as well containing some pre-determined questions for the respondent. This instrument is most preferred especially where semi-literate respondents are involved (Jamshed, 2014). Interviews is also useful in the collection of data that is not directly observable since they, among other things, enquire about feelings, motivation, attitude, accomplishment, opinion as well as an individual's experiences.

Focus Group Discussion is yet another data collection tool that was used to collect qualitative data. A focus group discussion (FGD) was cited as a good way to gather together people from diverse backgrounds and experiences to discuss a specific topic of interest (Kombo & Tromp, 2006). The study brought elderly persons, guardians, county government officials and staff of care institutions to a round table for discussions. The strength of FGD relied on allowing the participants to agree or disagree with each other so that it provided an insight into how a group thinks about an issue, about the range of opinion and ideas, and the inconsistencies and variation that exists in a particular community in terms of beliefs and their experiences and practices (Jackson, 2003). Further, FGD was cited as being useful in providing an insight into different opinions among different parties involved in the change process, thus enabling the process to be managed more smoothly (Kothari, 2004).

Table 4: Cronbach's Alpha Value for Items in the Questionnaire

Items	Cronbach's Alpha
1. Gender of the respondent	0.814
2. Marital status of the respondent	0.821
3. Age of the of the respondent	0.817
4. Main source of income	0.815
5. Monthly income of the of the respondent	0.812
6. Family size	0.819
7. Level of education of the respondent	0.817
8. Older people play important roles	0.833
9. older people are being neglected	0.835
10. older people are leading solidarity lives	0.834
11. Cases of elder abuse in society	0.835
12. Receptive to change	0.832
13. Insight on culture and tradition	0.834
14. Perception toward younger generation	0.732
15. older people are respected and valued	0.832
16. Awareness of formal care institutions	0.831
17. Legal status of formal care institutions	0.830
18. Confidence in management	0.827
19. Personnel training	0.626
20. Personnel Attitude	0.829
21. Personnel Adequacy	0.828
22. Accommodation facilities	0.828
23. Physical exercises facilities	0.826
24. Social bonding programs	0.826
25. Physical conditions	0.832
26. Health Condition	0.839
27. Economic status	0.833
28. Psychological status	0.833
29. Social networks for older people	0.735
30. Alcohol abuse by older people	0.834
31. Pre old age relationship	0.834
32. Current relationship with older relative	0.643
33. Primary care givers' occupation	0.830
34. Primary care givers psychological strength	0.826
35. Free time to attend to older relative	0.428
36. Understanding of older relative	0.627
37. Capacity to take care of my older relatives	0.829
38. Older relative are appreciative	0.733
39. Dependency level of older relatives	0.827
40. Financial Adequacy	0.832
41. Willingness	0.818

3.9 Test for Multicollinearity Using Pearson's Correlation Analysis

Preliminary diagnostics for statistical problems of Multicollinearity and heteroskedasticity were conducted to the variables before actual regression. Multicollinearity, a state of very high inter-correlations or inter-associations among the proposed independent variables Wooldridge (2002) was tested for all variables using the contingent coefficients and results presented in Appendix D Similarly, results confirmed that there was no serious linear relationship among the categorical explanatory variables because contingent coefficients were less than 0.80 in all cases. By rule of thumb, there was no strong association among all hypothesized explanatory variables. Previous studies suggest that the correlation coefficients should not exceed 0.75 (Hair et al., 1998; Tabachnick & Fidell, 1989; Pallant, 2005) while others suggest that it should not exceed 0.80 (Bryman & Cramer, 1990). Therefore, all of the proposed potential explanatory variables were used in regression analysis.

3.10 Data Analysis

Descriptive (frequencies and percentages) analysis and inferential statistics such as chi-square test and multiple regression analyses were used to analyze data after appropriate data coding. Descriptive statistics were used to investigate or explore one variable at a time. To test the hypotheses, multiple regression analysis was conducted for each hypothesis and the results interpreted leading to the rejection or acceptance of the null hypotheses stated earlier. Multiple regression model was used to understand the functional relationships between the dependent and independent variables. This was important to try to see what might be causing the variations in the dependent variables for the four hypotheses of the study (Wooldridge, 2002).

For the first objective, to test its hypothesis which states that, public perception of the elderly does not significantly influence the uptake of institutionalized care in Nakuru, Kenya multiple regression model was used. The explained variable which was the uptake of institutionalised care proxied by the level willingness to pay for the services was regressed against the three dimensions of public perception of the elderly. The average score for each dimension was used in the model. The dimensions included: Elder role, tolerance level and value and respect for the elderly. The intension was to understand the impact of these dimensions on the uptake of institutionalized care.

The composite scores will be computed by taking the average scores of the factors.

$$Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \varepsilon \quad \text{.....3.3}$$

Y =level of willingness to pay for institutionalised care

β_0= intercept or constant

β_1……β_3= regression coefficients or slope of the regression line

X_1= Elder role

X_2 = Tolerance level of the society

X_3 = Value and respect for the elderly

ε= Regression error term (unobserved factors)

$\beta_1 - \beta_3$ Slopes coefficients representing the influences of the association of independent and the dependent Variable. The results were interpreted based on the value of the regression coefficient and the R-squared. The independent variables were interpreted for significant p values only. This interpretation is applicable is applicable to all the coefficients of the other objectives.

In the second objective, the hypothesis which stated that, perceived self-efficacy of primary care givers does not significantly influence the decision to enroll for institutional care in Nakuru, Kenya, multiple regression model was used as well. The dependent variable remained the same as in the first objective and the independent variables were the average scores for each dimension of perceived self-efficacy of the primary care givers. The dimensions included: Pre-old age relationship, psychological strength and financial capacity. The intension was to understand the impact of these dimensions on the uptake of institutionalized care.

The composite scores were computed by taking the average scores of the factors.

$$Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \varepsilon \quad \text{.....3.4}$$

Y =level of willingness to pay for institutionalised care

β_0= intercept or constant

β_1……β_3= regression coefficients or slope of the regression line

X_1= pre old relationship with the elderly

X_2 = psychological strength of the care givers

X_3 = financial capacity of the care givers

ε= Regression error term (unobserved factors)

$\beta_1 - \beta_3$ Slopes coefficients representing the influences of the association of independent and the dependent variable. The results were interpreted based on the value of the regression coefficient and the R-squared. The independent variables were interpreted for significant p values only.

For the third objective, the hypothesis was that Public perception of the elderly dependent's self-efficacy does not significantly influence the public's uptake of institutionalized care in Nakuru, Kenya. Multiple regression model was used as well to establish the influence of the public perception of the elderly peoples self-efficacy on the uptake of institutionalised care. The dependent variable remained the same as in the first objective and the independent variables were the average scores for each factor of perceived self-efficacy of the elderly people to take care of themselves. The factors included: Physical fitness, health status, financial status and psychosocial status of the elderly people. The intension was to understand the impact of these factors on the uptake of institutionalized care.

The composite scores were be computed by taking the average scores of the factors.

$$Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \varepsilon \quad \text{.....3.5}$$

Y =level of willingness to pay for institutionalised care

β_0= intercept or constant

β_1……β_4= regression coefficients or slope of the regression line

X_1= physical fitness

X_2 = health status

X_3 = financial status

X_4= psychosocial status

ε= Regression error term (unobserved factors)

$\beta_1 - \beta_4$ Slopes coefficients representing the influences of the association of independent and the dependent variable. The results were interpreted based on the value of the regression coefficient and the R-squared.

For the last objective, the hypothesis was that Public perception of institutional efficacy to care for the elderly does not significantly influence the uptake of institutionalized care in Nakuru, Kenya. Similarly, multiple regression analysis was done

to establish the influence of the public perception of institutional self-efficacy on the uptake of institutionalised care. The dependent variable remained the level of willingness to pay for institutionalised care and the independent variables were the average scores for each factor of public's perceived self-efficacy of care homes. The factors included: legal status, personnel and physical facilities of the care homes. The intension was to understand the impact of these factors on the uptake of institutionalized care.

The composite scores were be computed by taking the average scores of the factors.

$$Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \varepsilon \quad \text{.....3.6}$$

Y =level of willingness to pay for institutionalised care

β_0= intercept or constant

$\beta_1 \ldots\ldots\ldots \beta_3$= regression coefficients or slope of the regression line

X_1= legal status of the care homes

X_2 = personnel

X_3 = physical facilities of the care homes

ε= Regression error term (unobserved factors)

$\beta_1 - \beta_3$ Slopes coefficients representing the influences of the association of independent and the dependent variable. The results were interpreted based on the value of the regression coefficient and the R-squared. Table 5 presents the analysis matrix for all the four objectives.

Table 5: Data Analysis Matrix

Objectives	Independent Variable	Dependent Variable	Statistical tools
To establish the public perception of ageing and its influence on uptake of institutionalized care in Nakuru County, Kenya.	**Public Perception** ▪ Elder role ▪ Tolerance level ▪ Value and respect	**Willingness to enroll for formal care services** ▪ Very willing ▪ Willing ▪ Somehow Willing ▪ Least Willing ▪ Not willing	Chi-Square Multiple regression
To explore how perceived self-efficacy of elderly people influence enrollment for institutionalized care in Nakuru County, Kenya.	**Older Persons' Efficacy** ▪ Physical fitness ▪ Health status ▪ Financial status ▪ Psychosocial status		
To find out perceived self-efficacy of primary care giver influence uptake of institutionalized care for the elderly in Nakuru County, Kenya.	**Primary Caregiver Efficacy** ▪ Pre-old age relationship ▪ Psychological strength ▪ Financial capacity ▪ Reciprocity		
To find out public perception of institutional efficacy to care for the elderly and its influence on the uptake of institutionalized care in Nakuru County, Kenya.	**Institutional Efficacy** ▪ Legal status ▪ Personnel ▪ Physical facilities		

3.11 Ethical Considerations

Barker, Pistrang & Elliott (2002) define research ethics as principles that are concerned with protection of the rights, dignity, and welfare of research participants. Research ethics that were observed in this study include informed consent, confidentiality, honesty and data handling and storage. The following is an illustration of how each of the aforementioned research ethics was observed. There are multiple reasons why it is necessary to adhere to the basic norms of scientific conduct during academic research. The credibility of the scientific community and the perception of the public to judge and accept new results strongly depends on the authenticity of the results that have been published. It is particularly important to have a clear distinction between acceptable and unacceptable conduct especially when human beings or animals are involved in a study. Given the competitive nature of research, it has become increasingly challenging for scientists to report unique and pioneering research. Nevertheless, the

practice of misreporting data and scientific results continues to be followed by some members of the research community. In this study, the research maintained high standards of ethics by seeking informed consent, marinating confidentiality and honesty.

3.11.1 Informed Consent

The principle of Informed consent requires that participants in the research are fully aware that they are taking part in the research and what the research requires of them. This study explained to the participants the purpose of the study, the methods of data collection for the study and the possible outcome of the study as a way of making them aware of what the study is about and seeking their permission for participation in the study. The principle of informed consent also requires that participants take part in the study without coercion, deception or inducement. All the participants took part in this study out of their free without any coercion, inducement or deception. The type of informed consent obtained for this study was a general consent. A general consent gives general permission to the researcher to use data and information obtained from the participants for the purpose of the study as well as sharing with others researchers **(**Barker, Pistrang & Elliott, 2002). A general informed consent was appropriate for this study since information obtained from the participants has been used for the development of thesis for academic award and sharing with other researchers through publication of journals articles.

3.11.2 Confidentiality

This is an ethical principle that demands of researchers to keep some types of information confidential or secret. In research, confidential information typically includes private data pertaining to human subjects, papers or research proposals submitted for peer review, personnel records, proceedings from misconduct inquiries or investigations, and proprietary data (APA, 2002). This study assured participants that the information obtained from will not be used for any purpose other than an academic one. The researcher also assured participants of their right to remain anonymous. The researcher has ensured that identity of the respondents is not revealed to other parties. The researcher has also used pseudo names in the qualitative data to conceal the identity of the participants who gave their views during interviews. The participants were also accorded the discretion and freedom to choose how much information about themselves and the issues under inquiry they will reveal and under what circumstances.

3.11.3 Honesty

This is the ethical principle that requires researchers to tell the truth and avoid deception (Sales & Folkman, 2000). Researchers are thus required this principle to honestly report data, results, methods and procedures, and publication status. Data should never be fabricated, falsified, or obtained from sources disguised as authentic. The researcher observed honesty as an ethical requirement throughout the study. All the data and information were obtained from the authentic sources and with the necessary approval and consent of the respondents for both primary and secondary data. All the data from primary respondents have been reported as they were without any fabrication or manipulation by the researcher. The researcher has also acknowledged the original authors of literature review through appropriate citations and referencing. This thesis was also subjected to anti-plagiarism testing and found to have met the standards.

3.11.4 Data Handling and Storage

Barker, Pistrang and Elliott (2002) understand the ethical principle relating to data storage and handling as the practices and policies related to recording, storing, auditing, archiving, analyzing, interpreting, sharing, and publishing data. Ethical handling of research data requires not only acting according to ethical principles but also learning about the policies, resources, procedures, and practices that contribute to the collecting, analysis, sharing, and preservation of data. All data was treated as confidential, in the sense that the raw information collected was securely stored, not to be published and also was to be accessed only by the researcher. The study findings were accurately reported and analyzed from the data gathered without alteration or plagiarism.

CHAPTER FOUR
DATA ANALYSIS, PRESENTATION AND DISCUSSION

4.1 Introduction

This study presents the findings of the analysis of Public Perceptions of Elderly People and Elderly Care Institutions and Willingness to enroll for Institutionalized Care for the Aged in Nakuru County, Kenya. The study was guided by the following objectives namely: first, was to establish the influence of public perception of old people on the willingness to enroll for institutionalized care in Nakuru County, Kenya. Second was to explore the influence of perceived self-efficacy of elderly people on the decision to enroll for institutionalized care in Nakuru County, Kenya. Third was to determine the influence of perceived self-efficacy of primary care givers on the willingness to enroll for institutionalized care for the elderly in Nakuru County, Kenya. Fourth and final objective was to determine the influence of public perception of institutional efficacy to provide care for the elderly on the willingness to enroll for institutionalized care in Nakuru County, Kenya.

4.2 Demographic Characteristics of the Respondents

The demographic characteristics that were considered were gender, marital status, age, source of income, and level of education.

As indicated in Table 6, 56% of the respondents were females while 44% were males. Provision of care to older people is largely within female gender domain (Jayachandran, 2015). It is for this reason that majority of the respondents were women. Further, the population of females generally in Kenya is slightly higher than that of men (KNBS, 2017). Therefore, the high number of females in the study sample was reflective of their numerical advantage over the male gender in the general population. In the African context, gender ascribes certain roles that are instituted by society and sanctioned by customs. For instance, women provide care for the sick, children, frail and the elderly (Sharma et al., 2016). However, men also play an important role in provision of physical security and financial support to vulnerable members such as women, children and the elderly. The role played by different gender in society made gender an important consideration in this study hence its coverage as one of the profile of the respondents. Table 5 represents gender of the respondents.

Table 6: Demographic characteristics of the respondents

Variable	Frequency	Percentage
Gender of the respondents		
Female	217	56.07
Male	170	43.93
Total	**387**	**100.00**
Marital Status		
Single	111	31.8
Married	83	23.8
Widowed	84	24.1
Separated	41	11.7
Divorced	30	8.6
Total	**349**	**100.0**
Age distribution of the respondents		
18-26 Years	49	12.7
27-32 Years	86	22.2
33-38 Years	152	39.3
39-44 Years	79	20.4
45-51 Years	11	2.8
52-59 Years	10	2.6
Total	**387**	**100.0**
Education Level of the respondents		
No Formal Education	6	2.2
Primary	158	40.9
Secondary	166	43.0
College	38	9.7
University	19	4.3
Total	**387**	**100.0**

The results for marital status presented in Table 6 indicate that about 32% of the respondents were single. This was followed by widows and married individuals who constituted 24% and 23.8% respectively of the respondents. Further, examination of the results in Table 6 shows that 11.7% and 8.6% of the respondents were separated and divorced respectively. Individual's marital status may accord him/her respect, status, and added obligations and responsibilities in society, which may further shape his/her perception of people, events and issues affecting society (Jayachandran, 2015. Older people are related to individuals in any form of a marital relationship as parents, parents in law, or other forms of kinship connections. It is this significance of marriage that made marital status one of demographic profiles of the respondents considered in this

study. The study engaged respondents from diverse marital background as shown in Table 6.

In terms of age of the respondents, it was revealed that majority of the respondents were aged between 33-38, 27-32 and 39-44 years. In particular, persons aged 33-38, 27-32 and 39-44 years accounting for 39.3%, 22.2% and 20.4% of the respondents respectively. Another important age, the current study surveyed was those aged 18-26 years, which accounted for 12.7% of the respondents. Persons aged 45-51 and 52-59 years constituted 2.8% and 2.6% of the respondents respectively as shown Table 5. Although society expects everyone to be mindful of each other, the moral obligation on care provision to vulnerable populations such as the elderly was placed on adults (Moses, 2015). In most communities, one graduated into adulthood upon initiation (Ginsberg et al., 2014). Most African communities initiate their children around the age of 18 years. Conventionally, a person is considered an adult after attaining the age of 18 years.

Therefore, at the age of 18 years a person is considered an adult both traditionally and conventionally and as such is required to be fairly responsible to society. It is for this reason that this study considered individuals aged 18 years and above as its respondents. The fact that old age begins at 60 years meant that it was only individuals below the age of 60 years that could be considered as respondents as possible care providers to the elderly. This explains why this study considered individuals aged 18-59 years as its respondents. Age determines one's perception and responsibility towards members of society including vulnerable populations including older people (Moses, 2015).

Education level of an individual may influence how individuals perceive different phenomena in society including the perception on aging. Further, education as one of the profiles of a population provides insights, social status and shapes the standard of living of people (Luo et al., 2018). The level of formal education of the respondents was analyzed and results were presented as shown in Table 6. From the results, it is evident that the respondents with secondary education constituted 43% of the respondents. This was closely followed by respondents with primary education, which accounted for 40.9% of the respondents. Individuals with college and university level of education formed 9.7 and 4.3% of the respondents respectively.

Finally, in terms of source of income for the respondents, the results presented in Figure 4 indicates that business was the most common source of income that supported up to 46% of the respondents.

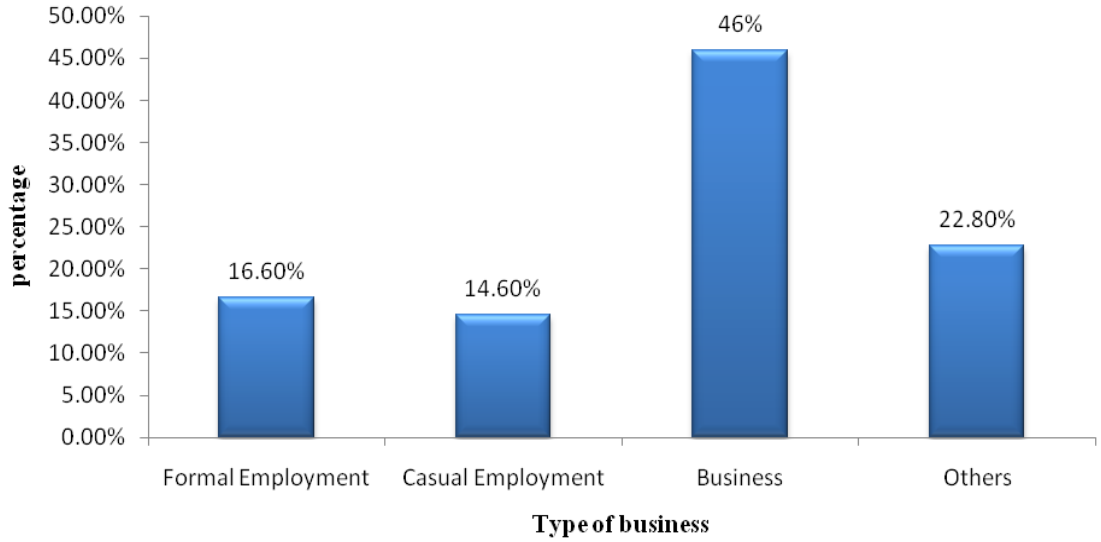

Figure 4: Main Source of Incomes of the Respondents

Formal employment was a source of livelihood to about 16.6% of the respondents. Casual employment was source of livelihood to 14.6% of the respondents. This made it the least source of income to the respondents who participated in this study as Figure 2 shows. Another 22% of the farmers were engaged in other means of livelihood other than the three mentioned categories of sources of income. They included, small scale farming, motorcycle transport (popularly known as bodaboda), and conductors at the bus stops among others. It was important to analyse the source of income since it could influence the amount of income as well as the time available to provide care for the elderly people or enroll them to formal care giving institutions. Ordinarily, a formal engagement in employment which consumes much time of the care giver would necessitate the enrollment of the elderly to care homes to allow the supposed care giver an opportunity to eke out a living through the formal jobs.

4.3 Public Perception of Older People and Aging, and Uptake of Institutional Care for Older People

The first objective of this study was to examine public perception toward the aged and aging and how such perception influenced the uptake of institutional care services for older people in Nakuru County, Kenya. To achieve this objective the following issues were analyzed and discussed; respondents' willingness to enroll their

older relatives in institutional care homes, perceived importance of older people in society, the neglect of older people by their dependents, whether older people were leading solitary lives, existence of cases of elder abuse in society, the receptivity of older people to younger generation, older people's insight on culture and traditions, older people's tolerance toward social change and perceived respect and value society has toward older people in society. The following is therefore the results and discussions of the study on public perception toward aged and aging, on the one hand and its influence on the uptake of institutional care for older people in Nakuru County, Kenya.

4.3.1 The Willingness of Members of the Public to Enroll Older Relatives for Formal Care

The uptake of institutional care services for older people was examined in the context of the willingness of members of public to enroll their older relatives into these institutions. Using Likert scale response format, this study asked sampled respondents to state whether they were very willing, willing, somehow willing, least willing and not willing to enroll their older relatives into institutions offering care services for older people with a view to providing formal care for their older relatives. The result of the study on this question is shown in Table 7 .

Table 7*:* Willingness of Members of the Public to Enroll Older Relatives for Formal Care

Willingness	Frequency	Percent
Not willing	114	30.0
Least willing	140	36.9
somehow willing	58	15.2
willing	46	12.1
Very willing	22	5.9
Total	**380**	**100.0**

The result of the study on this question is shown in table 5. Although, 70% of members of the public who participated in this study had generally indicated their willingness to enroll their older relatives in these institutions, greater or decisive willingness was reported by just about 18% (very willing, 5.9% and willing 12.1%) of the respondents. However, 30% of the respondents asserted that they were not willing to enroll their older relatives in these institutions for purposes of formal care provision.

Although about a half (least willing 36.9%, and somehow willing 15.2%) of the respondents expressed their willingness and readiness to admit their older relatives into formal care services, the nature of their response on this question, is not only reflective of their ambivalence on this issue but also their reluctance to embrace institutional care services for older people in society.

The results of the present study, which found that majority of the respondents were not willing to enroll their older relatives for institutional care are in many respects similar to a study by El-Badry (2013), which found that many African countries to have low uptake of institutional care services. A study by El-Badry (2013), for instance found that only 2.4%, 1.5% and 0.8% of older people had been enrolled for institutional care in Reunion, Zimbabwe and Botswana respectively.

4.3.2 Older People Play Important Role in Society

An examination of public perception toward older people and aging began with seeking from the respondents whether they considered older people to have an important role to play in society. When asked to state whether they agreed or disagreed that older people play an important role in society, the following results were their responses.

Table 8: Older People Play Important Role in Society

Nature of Response	Frequency	Percent
Strong Disagree	21	5.4
Disagree	21	5.4
Somehow Agree	47	12.0
Agree	98	25.1
Strongly Agree	204	52.2
Total	**391**	**100.0**

From the results in Table 8, 89.2% of the respondents generally agreed against 10.8% who disagreed that older people played an important role in society. Respondents who strongly agreed that older people were important in society accounted for 52.2% of the respondents engaged in the study. It is also clear from Table 6 that 25.1% and 12% of the respondents agreed and somehow agreed respectively that older people play an important role in society. However, 5.4% and 5.4% of the respondents disagreed and strongly disagreed respectively that older people play an important role in society.

Older people together with traditional leaders such as chiefs and medicine men ensured harmony and sustained peace in society. They also helped in defining the rights and obligations of members of society and their relations. Older people also play a more formal role as an adjudicatory body whenever disputes occur in society. Disputants often bring their conflicts before a council of elders, whose decision in many cases is binding. Elders also applied intense social pressure among members of society so as to enforce good mannerism, behaviour and social order. The authority of the elders is hugely respected by all members and the violation of such authority is unthinkable.

However, whether members of society consider older people as playing important role in society depends on the character of individual older person in question. This implies that the respect and value members of society accord older people are not absolute as it is contingent upon the older person observing certain principles befitting his/her age and responsibilities in life. In qualifying the seniority principle, Cox and Mberia (1977) noted that the African ideology of old age is accompanied by certain roles and responsibilities that are bound to the elder's life experience and accumulated wisdom. Thus, the respect and honour attached to being old continues as long as an older person is responsive to traditional expectations.

4.3.3 The Relationship between Perceived Importance of Older People in Society and Uptake of Formal Care Services

As noted earlier, 89.2% of the respondents agreed that indeed older people were playing important roles in society (Table 9). There was therefore need to establish whether the strong positive attitude of the public toward older people had any significant bearing on their decision to enroll their older relatives for institutional care services in Nakuru County. Using Chi-Square, this study measured the relationship between perceived importance of older people in society and willingness of members of the public to enroll their older relatives for institutional care services.

Table 9: Perceived Importance of Older People and Uptake of Formal Care Services

Willingness	Older People Play Important Role in Society					Total
	SD	D	SA	A	SA	
NW	5(4.1%)	3(2.4%)	15(12.2%)	36(29.3%)	64(52%)	123(100%)
LW	9(6.9%)	6(4.3%)	20(14.5%)	31(22.5%)	72(52.2%)	138(100%)
SW	2(3.5%)	6(10.5%)	5(8.8%)	12(21.1%)	32(56.1%)	57(100%)
W	4(8.2%)	5(10.2%)	4(8.2%)	11(22.4%)	25(51.0%)	49(100%)
VW	1(4.2%)	1(4.2%)	3(12.5%)	8(33.3%)	11(45.8%)	24(100%)
Total	**21(5.4%)**	**21(5.4%)**	**47(12.0%)**	**98(25.1%**	**204(52.2%**	**391(100%)**

χ^2=17.729, df=16, P=0.040, Cramer's V=0.124

The Relationship between perceived importance of older people in society and uptake of formal care services was significant (P = 0.04). However, the Relationship between perceived importance of older people in society and uptake of formal care services was weak (Cramer's V=0.124). Analysis of the statistical results in table 9 above shows that 6.5% and 93.5% of the respondents who were not willing to enroll their older relatives for institutional care disagreed and agreed respectively that older people were playing important roles in society. This meant that respondents who considered older people as being important in society due to their significant roles in society were either unwilling or reluctant to enroll their older relatives for institutional care services. Therefore, the greater the appreciation of older people and their important roles in society the lower the uptake of institutional care services for older people.

Members of the public who considered older people as being important in society were reluctant to consider institutional care provision for their older relatives. As noted earlier older people are custodians of society's morals and are thus needed from time to time to guide society. Older people are also responsible for dispute resolutions within and outside the family unit. Enrolling older relatives in institutional homes was perhaps considered by some members of the public as not being appreciative of the unique roles and positions held by older people in society. Further, enrolling older people in the institutional homes meant that members of the public had to travel to these homes to consult their older relatives on various issues.

It would be difficult for members of the public to travel to the institutional homes each time they needed their counsel. Further, institutional homes being under the management of a different regime may also pose restrictions as to who, when and how older people are visited and consulted. The fact that older people must submit to the authority of institutional homes may also undermine the authority of elders enrolled in the institutions thereby rendering them ineffective in discharging their traditional roles.

4.3.4 The Neglect of Older People by their Dependents

Public perception of the aged and aging was also examined with regard to the extent to which older people were cared for or neglected in society. The result of study on the neglect of older people is as presented in Figure 5.

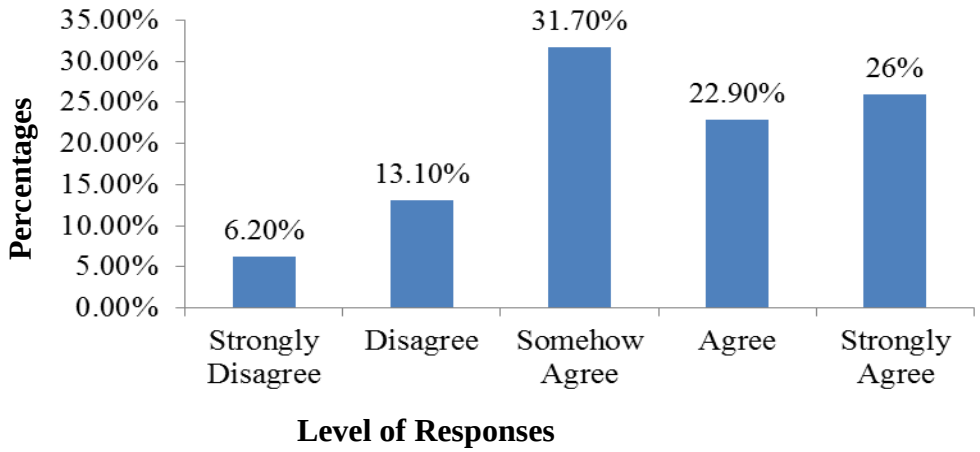

Figure 5: The Neglect of older people by their dependents

When asked about the neglect of older people in society, 81.1% and 19.3.9% of the respondents generally agreed and disagreed respectively that older people were neglected by their dependents. In particular, 31.7% of the respondents reported that they somehow agreed that there was neglect of older people in society. The position that older people were neglected by their dependents was, however, not supported by all the respondents. As shown in Figure 5, 13.1% and 6.2% of the respondents disagreed and strongly disagreed respectively that older people were neglected.

Through observations and in-depth interviews, this study established that indeed some of the older people were leading lives of neglect. In some of the homes we visited, we came across elderly men and women who were living in very degrading conditions. Some of them had torn mattresses, very dirty, torn and dusty blankets, with most of the

beddings infected by bedbugs and lice. Some of the elderly people were too old and physically weak to fend for themselves, yet there was no one on standby to help them walk to the latrines, bathe and even enjoy the sun.

A female informant Chebet (not her real name) a neighbour to one of the neglected old men remarked;

> "I really feel for this old man. His children never bother whether he has eaten or bathed. At times he urinates and helps himself in his beddings because he is too weak to walk to the latrines. He goes several days without bathing because there is no one to bring him water and help him bathe. Those wounds that you see on his feet are due to jigger infestation. Look at his bedding; they have never been washed for several months. He has four children (one daughter and three sons). One of the sons lives and work in Eldoret. The other two are just within but are total alcoholics. The daughter, who is married wanted to take the old man to her matrimonial home but was told that it was culturally not right. It is so unfortunate to have children yet being neglected by the very children that you spent your entire active life raising" lamented Chebet.

The assertion by the informant is supported by some of the literature on the dynamic between family care provision on one hand and urbanization and wage labour on the other hand. For example, Penning (2008) argues that the central place of the family and extended kinship networks in delivering support to older and disabled people is a consistent theme across all societies around the globe. Penning (2008), however, observed that the number of people who can provide care to dependent family members such as older persons has drastically reduced over the years due to the fragmentation of the traditional large family groups into small family units in an urbanized context. Vlasblom and Schippers (2009) has also attributed much of the unavailability of informal care providers to the rising female labour market participation, which has placed greater emphasis on paid work and enhancement of career opportunities for women.

4.3.5 Older People Are Leading Solitary Lives

One of the ways in which this study sought to understand public perception toward older people and aging was an examination into whether older people were leading solitary lives. A significant proportion of the respondents generally affirmed-

albeit with varying degree- that older people were leading solitary lives as shown in Figure 6.

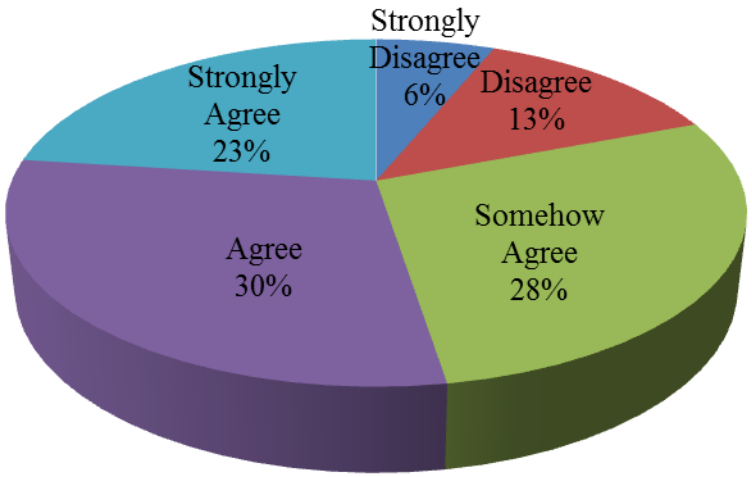

Figure 6: Older People Are Leading Solitary Lives

An examination of the study results presented in Figure 6 shows that 81% and 19% of the respondents agreed and disagreed respectively that older people were leading solitary lives. Further, respondents who somehow agreed that older people were leading solitary lives constituted 28% of the respondents thus leaving just about 19% of the respondents with divergent opinion on the issue of solitary life among older people. It is clearly evident in Figure 6 that 13% and 6% of disagreed and strongly disagreed that older people were leading a solitary life.

Care provision to older people in society has relied historically on the family, with extended family members and kinship networks being pivotal. However, recent years has witnessed the increased number of people moving to urban areas in search of formal employment. Children who previously complemented care provision to older people are spending significant amount of their time in formal schools. Therefore, the unavailability of traditional care providers such as children and women due to formal education and wage labour respectively have resulted in a huge proportion of older people to lead solitary lives.

The results of this study are in many respects similar to survey done by World Bank (2014) which found considerable evidence from around the world that indeed the elderly are leading solitary lives. The survey found that about 14% of the elderly are

leading solitary lives globally, with Americas having the highest number (17%). Europe, Asia, Africa and Australia have 9%, 9%, 8% and 9% of their elderly populations living alone respectively. At national level, Denmark has the highest (39.1%) proportion of its elderly population living alone. This is followed by Germany, Netherlands and United Kingdom, which has 34.7%, 34.5% and 33.9% respectively. In Africa, Ghana has the highest (21.6%) proportion of the elderly population living alone. This is followed by Kenya, which has 17.3% of its elderly population living alone. In terms of gender, the average proportion of older women living alone (19%) is more than double the proportion for older men (8%), worldwide.

4.3.6 Existence of Cases of Elder Abuse in Society

The extent to which older people are perceived favourable or unfavourable may be manifested in the existence of elder abuse in society. It is for this reason that this study sought to establish whether elder abuse existed in society. There were widespread incidences of elder abuse based on the respondents' accounts as documented in Figure 7.

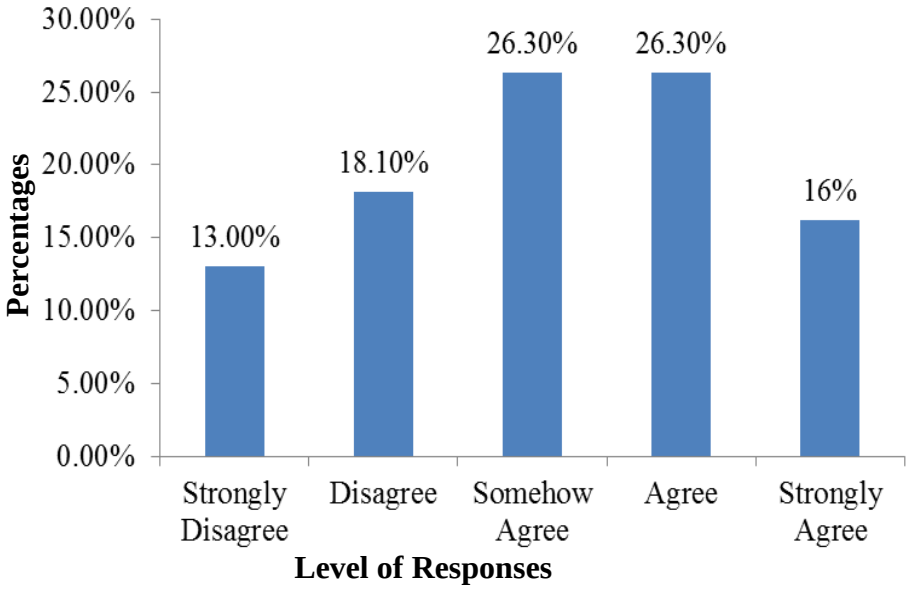

Figure 7: Existence of Cases of Elder Abuse in Society

When asked to whether they agreed or disagreed that older people were being abused in society, 69.9% and 31.1% of the respondents agreed and disagreed that older people were being abused in society. Specifically, 16%, 26.3% and 26.3% of the respondents strongly agreed, agreed and somehow agreed respectively that there were incidences of elder abuse in the society. An examination of study results in Figure 7 shows that less that just about a third of the respondents denied the existence of elder

abuse in the society. This position was taken by 18.1% and 13% of members of the public engaged in this study who disagreed and strongly disagreed that there was elder abuse in society.

Although solitary living is becoming a common practice in several parts of the world, this living arrangement has exposed a substantial number of older people to danger and harm. Elder abuse remains one of the foremost harm that elders who live alone are exposed to. Although all elders face both physical and psychosocial abuse regardless of their living arrangements, research shows that there are more incidences of abuse among elders living alone than their counterparts living with relatives. For instance while only 4-6% of the elders who live with their relatives are abused, cases of elder abuse is as high as 18% among elders living alone (Help Age International, 2015). Although there are no coherent statistics on elder abuse in Kenya; cases of rape being meted on elderly women have been reported in the media on several occasions. While such reports can be treated as isolated cases of elder abuse, they nonetheless confirm that elder abuse is a real societal problem that needs urgent attention.

4.3.7 The Relationship between Perceived Cases of Elder Abuse in Society and Uptake of Formal Care Services

This study thus found it necessary to establish if there was any significant relationship between public acknowledgement of cases of abuse of older people and the uptake of institutional care services in Nakuru County. The statistical analysis (Table 10) on the relationship between perceived cases of elder abuse and uptake of institutional care services for older people showed that there was significant relationship between the two (P = 0.089). The relationship between perceived cases of elder abuse and uptake of institutional care services for older people showed that there was not only non-significant but also weak (Cramer's V=0.093).

Table 10: Perceived Cases of Elder Abuse and Uptake of Formal Care Services

Willingness	Elder Abuse					Total
	SD	D	SA	A	SD	
NW	14(11.9%)	19(16.1%)	34(28.8%)	31(26.3%)	20(16.9%)	118(100%)
LW	18(13.5%)	28(21.1%)	33(24.8%)	31(23.3%)	23(17.3%)	133(100%)
SW	12(21.4%)	9(16.1%)	12(21.4%)	16(28.6%)	7(12.5%)	56(100%)
W	3(6.4%)	6(12.8%)	13(27.7%)	17(36.2%)	8(17.0%)	47(100%)
VW	2(9.1%)	6(27.3%)	7(31.8%)	4(18.2%)	3(13.6%)	22(100%)
Total	**49(13.0%)**	**68(18.1%)**	**99(26.3%)**	**99(26.3%)**	**61(16.2%)**	**376(100%)**

χ^2=9.52, df=16, P=0.089, Cramer's V=0.093

Closer examination of results in Table 10 reveals that 28% and 34.6% of the respondents who denied that there were cases of elder abuse in society were both willing and least willing respectively to enroll their older relatives for institutional care services. Similarly, 19.2% and 36.4% of the respondents who were willing and very willing to enroll their older relatives for institutional care services denied the existence of abuse of older people in society. Therefore, affirmation of the existence of elder abuse in society was neither a motivation nor a hindrance toward the uptake of institutional care services in the county. This confirms that indeed there was no significant relationship between perceived existence of elder abuse in society and uptake of institutional care services for older people as revealed by the results of the inferential analysis in Table 10.

4.3.9 Older People's Insight on Culture and Traditions

This study held that whether older people are perceived favourably or unfavourably depended on among others, older people's knowledge of their community's cultural practices and traditions. This study sought to establish whether or not members of the public held that older people had great insight of the cultural practices as well as traditions of their communities and the results were as shown in Figure 8.

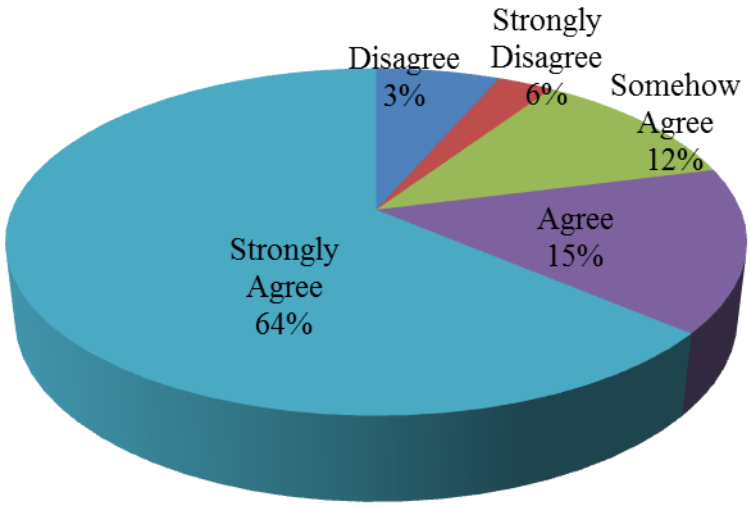

Figure 8: Older People's Insight on Culture and Traditions

A huge proportion or 91% of members of the public engaged in this study agreed that older people had great insight on culture and traditions of their communities. This assertion was confirmed by 64% of the respondents who strongly agreed that older people had great insight into the culture and traditions of their communities. This position was also supported by 15% and 12% of members of the public engaged in the study who agreed and somehow agreed that older were knowledgeable about the culture and traditions of their communities. However, 3% and 6% of the respondents disagreed and strongly disagreed that older people had great insight on the culture and traditions of their communities.

It should be observed that one does not become an elder just by mere attainment of a particular age, but rather his/her deep knowledge of community's culture and traditions in addition to the ability to pass the same to subsequent generations. While everyone born eventually become elderly on account of chronological aging, eldership is largely seen in the prism of social aging. Social aging simply implies the changes in a person's roles and relationships, both within their networks of relatives and friends and informal organizations such as the families. Although social aging can differ from one individual to another, it is also profoundly influenced by the perception of aging that is part of a society's culture. If a society views aging positively, the social aging experienced by individuals in that society will be more positive and enjoyable than in a society that views aging negatively. In many African communities, social aging is

perceived positively, thereby making members of society receiving even greater recognition as they age.

It is also important to note that eldership in the society is a product of the sum total of life experiences. Through the process of accumulating knowledge and experience, some individuals begin to show an aptitude for talking to people and helping them in ways that contribute to a better life. This aptitude is acknowledged by the community in seeking them out, for discussions, for teaching, for public lectures among other important activities. This in itself is a process that takes many years such that by the time a person reaches old age, members of society begin to "recognize" their unique position and roles in society.

4.3.11 Older People Are Respected and Valued In Society

When asked to state directly whether in their individual capacity respected and valued older people, majority responded in the affirmative as shown in Figure 9.

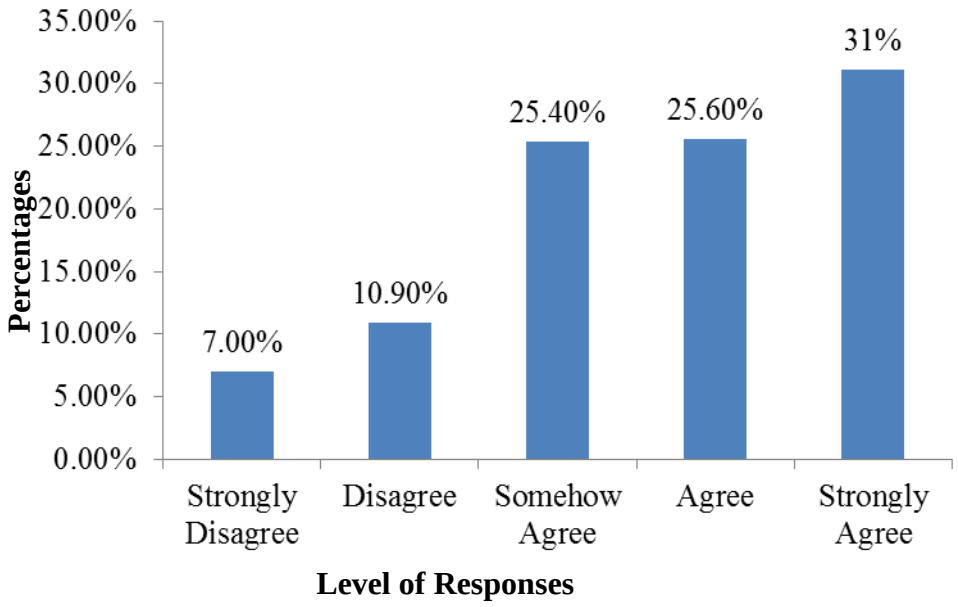

Figure 9: Older People are Respected and Valued in Society

As shown in Figure 9, 86.1% of the respondents agreed that they respected and valued older people in society. It also clear from the study results hereunder that 25.6% and 25.4% of the respondents agreed and somehow agreed respectively that they respected and valued older people. However, 10.9% and 7% of the respondents disagreed and strongly disagreed that they respected and valued the elders. The results in Figure 9 confirm that older people are still largely respected and valued in society.

It is, however, important to note here that some respondents stated that they had little regard for older people in society. There is increasing concern that most elders have retreated to personal and sectarian interests rather than communal or societal issues. Some elders no longer observe virtues such as selflessness, objectivity and impartiality on issues affecting society. Some older people also know very little about their community's traditions since they spent most of their prime time outside the community in civil service, as expatriates, and academicians or in the military. Further, some of the older people were accused by the respondents as having very little regard to community affairs, which made them unpopular among members of the community during their prime time.

> Some of these old people held very powerful positions in government, military and even in the academia. But there is no single person-other than their children and close relatives- that they helped to even pay school fees or secure a job. They did nothing during their active years that can inspire respect from us" remarked Njuguna (not his real name) one of the key informants.

According to one key informant it was difficult for them to respect and value individuals who had no regard to community when they held influential positions in their prime time. Key informants assertion above resonates with Ralston's (2017) observation, when he stated that the kinds of perception people have towards the elderly hinged on their personal contribution to the family and society during their younger ages. For instance, people who were influential and supported community projects were highly respected and value at their old age. In qualifying the seniority principle, Cox and Mberia (1977) noted that the African ideology of old age is accompanied by certain roles and responsibilities that are bound to the elder's life experience and accumulated wisdom. Thus, the respect and honour attached to being old continues as long as an older person is responsive to traditional expectations.

4.3.12 The Relationship between Perceived Society's Respect toward Older People and uptake of Formal Care Services

It was confirmed by over 86.1% of members of the public engaged in this study that elders are still respected and valued in society (Table 11). The inferential analysis on the relationship between perceived society's respect for older people and the uptake of

institutional care services for older people showed that there was a significant relationship between perceived respect for older people and uptake of institutional care services (P = 0.010).

Table 11: Perceived Society's Respect of Older People and Uptake of Care Services

Willingness	Respect and Value					Total
	SD	D	SA	A	SA	
NW	10(8.2%)	14(11.5%)	32(26.2%)	27(22.1%)	39(32.0%)	122(100%)
LW	7(5.1%)	16(11.8%)	34(25.0%)	36(25.5%)	43(31.6%)	136(100%)
SW	4(7.1%)	5(8.9%)	13(23.2%)	13(23.2%)	21(37.5%)	56(100%)
W	3(6.1%)	4(8.2%)	14(28.6%)	16(32.7%)	12(24.5)	49(100%)
VW	3(13.0%)	3(13.0%)	5(21.7%)	7(30.4%)	5(21.7%)	23(100%)
Total	**27(7.0%)**	**42(10.9%)**	**98(25.4%)**	**99(25.6%)**	**120(31.1%)**	**386(100%)**

χ^2=9.928, df=16, P=0.010, Cramer's V=0.093

It is discernible from results in Table 11 that 80.3% who generally agreed that older people were still respected and valued in society were not willing to enroll their older relatives for institutional care services. However, 19.7% of the respondents who generally disagreed that older people were still respected and valued in society were willing to enroll their older relatives into institutional care homes for older people. The findings of the study suggest that greater respect toward older people adversely affected the uptake of institutional care services for older people. In fact one of the informants Onyango (not his real name) informed this study that enrolling his older parents in institutional homes amounts not only to lack of respect but also sign of lack of appreciation for the sacrifice his parents went through to educate him and prepare him for the challenges of adult life.

> "My father had to sell livestock at the beginning of each year to raise fees for my secondary education. This is not to mention the menial and degrading work that my mother had to do in order to get something for my pocket money. Imagine they were doing this at a time when the education of the girl child was never considered by most parents as a worthwhile undertaking. My parents believed that through education I would get a good job and lead a good life. How then can I turn against them after investing their entire wealth in securing my future? It is now my turn to reciprocate. Am not sure whether these homes can accord my parents the

respect they deserve. It may be hard but am sure they too had a hard time raising me. There is no way I can through my parents to some NGOs who want to use the plight of my parents to solicit funds from some donors".

Based on the informant's observations, it is clear that whether an older person is respected and valued depended on the role they played in the lives of their younger relatives. People who were well taken care of by their older relatives had a lot of respect for their older relatives. Individuals who had great respect and valued their older relatives felt greater obligation to take care of their older relatives. Members of the public who believed that they had greater obligation to provide for their older relatives were reluctant to consider institutional care for their older relatives.

The informant's assertion that she could not allow her older relatives to be used as bait by NGOs (read institutional homes) for donor funding demonstrates the extent to which members of the public perceived institutional care homes as being dishonest and may not be safe enough for their older relatives. This assertion and perception of institutional homes as not being conducive for care provision for older people resonates with a similar study done in Australia among the Aborigines (Brascoupé & Waters, 2009). While focusing on the uptake of institutional health care services by Aboriginal people, Brascoupé and Waters (2009) noted that most of the Aboriginal people tended to prefer institutions that provided care services within their cultural values and norms or what they called the cultural safety. Cultural safety refers to the extent to which care provision respects the cultural values and norms of the care recipient (Brascoupé and Waters, 2009). Although a study by Brascoupé and Waters (2009) was done in the context of health care, the findings of the study are in many ways similar to that of the current study.

4.4 Perceived older People's Efficacy on Care Provision for Themselves and Uptake of Institutional Care

The second objective of this study was to examine the influence of perceived older people's efficacy on the uptake of institutional care services for older people in Nakuru County. Issues examine in this objective were physical condition of older people, health status of older people, economic condition of older people, psychological status of older people and alcohol and substance abuse by older people on the one hand and their influence on the uptake of institutional care services for older people. The following is

therefore the results and discussions on the influence of perceived older people's efficacy on the uptake of institutional care services in Nakuru County.

4.4.1 Older Relative Can Provide Own Care Due To Physical Weaknesses

Whether a particular service is consumed or not depends on among others the extent to which potential consumers are aware of its existence. Similarly whether members of the public were willing to enroll their older relatives into formal care institutions for older people depended on among others whether they were aware that these institutions existed in Nakuru Country. It is for this reason that this study began its inquiry into the perceived institutional efficacy of care provision for older people by establishing the extent to which members of the public were aware of the existence of these institutions in Nakuru County. When asked whether the older relative can provide own care, the respondents' views were captured in Table 12.

Table 12: Physical Weaknesses of Older People

Response	Frequency	Percent
Strong Disagree	57	15.0%
Disagree	65	17.1%
Somehow Agree	64	16.8%
Agree	89	23.4%
Strongly Agree	106	27.8%
Total	**381**	**100.0%**

Results of the study in Table 12 show that 67.9% and 32.1% of the respondents agreed and disagreed respectively that older people were physically weak to cater for themselves. Closer examination of the results reveals that 27.8% of the respondents strongly agreed that their older relatives were physically too weak to fend for themselves. Further, 23.4% and 16.8% of the respondents agreed and somehow agreed respectively that their older relatives could not take care of themselves due to their weak physical conditions. However, the assertion that older people were too weak to take care of themselves was not supported by all the results as shown in table 12. In fact 15% of the respondents strongly disagreed that older people were too weak to fend for themselves. This position was also held by 17.1% of respondents who disagreed that older people were unable to take care of themselves on account of their weak physical conditions.

4.4.2 The Relationship between Physical Condition of older Person and uptake of Formal Care services

It was necessary to establish whether the physical condition of older people had any significant influence on members of the public decision to enroll their older relatives for institutional care services. This study thus tested the relationship between physical condition of older person and uptake of institutional care services as shown in Table 13.

Table 13: Physical Condition of older Person and uptake of Formal Care services

	Physical Weakness					Total
	SD	**D**	**SA**	**A**	**SA**	
NW	21(17.8%)	22(18.6%)	20(16.9%)	19(16.1%)	36(30.5%)	118(100%)
LW	20(14.6%)	30(21.9%)	22(16.1%)	34(24.8%)	31(22.6%)	137(100%)
SW	7(13.0%)	4(7.4%)	6(11.1%)	16(29.6%)	21(38.9%	54(100%)
W	9(18.8%)	8(16.7%)	8(16.7%)	13(27.1%)	10(20.8%)	48(100%)
VW	-	1(4.2%)	8(33.3%)	7(29.2%)	8(33.3%)	24(100%)
Total	**57(15.0%)**	**65(17.1%)**	**64(16.8%)**	**89(23.4%)**	**106(27.8%)**	**381(100%)**

χ^2= 21.238, df=16, P=0.017, Cramer's V=0.138

The relationship between physical condition of older person and uptake of institutional care services was statistically significant (P = 0.017). However, the relationship between physical condition of older people and uptake of institutional care services was weak (Cramer's V=0.138). Results in Table 13 show that majority of the respondents who were generally willing to enroll their older relatives for institutional care services were those who agreed that their relatives were physically weak. For example, out of 137 respondents who were least willing to enroll their relatives for institutional care services, 63.1% of them were respondents who generally agreed that their relatives were generally physical weak against 36.9% of their counterparts who disagreed that their older relatives were physically weak. Further, out of 54 members of the public who participated in this study and who were somehow willing to enroll their older relatives for institutional care, 79.6% of them were those who generally agreed that their older relatives were generally physically weak. As can be observed in Table 13 above, 64.6% of the respondents who were willing to enroll their older relatives for institutional care were those who agreed that their older relatives were physically weak against just 35.4% who disagreed. The same trend obtained for respondents who stated that they were very willing to enroll their older relatives for institutional care.

The extent to which some of the older people had become dependent because of their poor physical condition was narrated by one of the informants Sarah (not her real name).

> "My mother in-law has gradually become crippled on both legs due to arthritis attack. I have to wheel her to the toilet and assist her in other activities. I am the only daughter in-law who is unemployed and since my husband is the last born, he is obliged by culture to take care of his parents during old age. Clearing her toilet is a nightmare for me. She does not accept using diapers, saying she would rather die rather than use things meant for children. Taking care of her is more challenging than taking care of a child. I would readily consider taking her to homes for older people, but his son (my husband) cannot entertain such a suggestion. So I have no otherwise but to persevere".

4.4.3 Older Relative Cannot Provide Own Care Due To Health Problems

As to the view that older relatives cannot provide own care due to health problems, the participants expressed their feelings as shown in Figure 10.

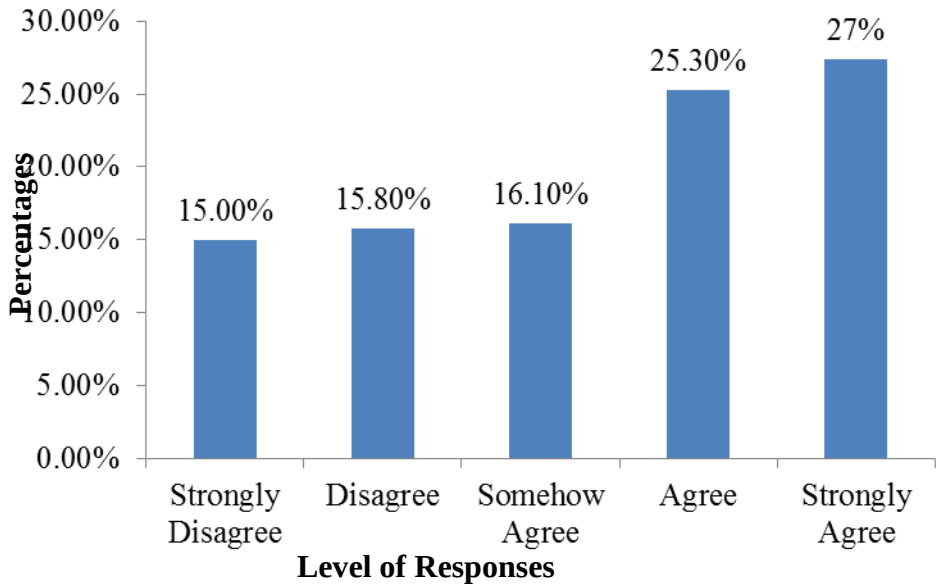

Figure 10: Health Problems and self-efficacy

This study established that 69.2% of the respondents agreed that that their older relatives could not take care of themselves due to their ill health against 30.8% who held a contrary opinion. When asked to whether or not they agreed that their older relatives

could not take care of themselves because of their poor health conditions, 27% and 25.3% of the respondents strongly agreed and agreed respectively that indeed it was impossible for their old relatives to fend for themselves due to poor health. Further, 16.1% of the respondents somehow agreed that their older relatives could not take care of themselves due to ill health. On the contrary, 15% and 15.8% of the respondents strongly disagreed and disagreed respectively that their older relatives could not take care of themselves because of poor health as shown in figure 10 above.

An interview this study held with Dr. John (not his real name), a consultant physician based in Nakuru town revealed the diverse health problems that affect older people. The doctor stated that older people by virtue of their age have weak immune system. Accounts of the doctor as enumerated above are similar to the findings of a survey done by Merck Institute (2012) on the health needs of elderly persons. A survey by Merck Institute (2012), which compared the health needs of elderly persons with that of younger adults, reported that elderly persons visited physicians more often than younger adults do, averaging 15 physician visits per year compared to 7.2 visits by younger adults. It is clear from this survey that elderly persons need monthly medical attention.

In an FGD discussion, it emerged that diverse health problems affected older people. Older people by virtue of their age have weak immune system. This observation is similar to that of Frese et al., (2016) who notated that people aged 65 years and older visited the hospitals more frequently than the younger persons. The authors further stated that such persons visited the hospitals for procedural than for nonprocedural reasons. Although the discussants agreed that it was normal for people to develop certain health problems as they age, they reiterated the need for institutions and society in general to have health care systems that respond to these problems effectively. A medical doctor among the discussants noted that unlike the developed countries, Kenya has fewer medical gerontologists.

4.4.4 Older Relative Cannot Provide Own Care Due To economic Problems

As to the view that older relatives cannot provide own care due to economic problems, the participants expressed their feelings as shown in Figure 11.

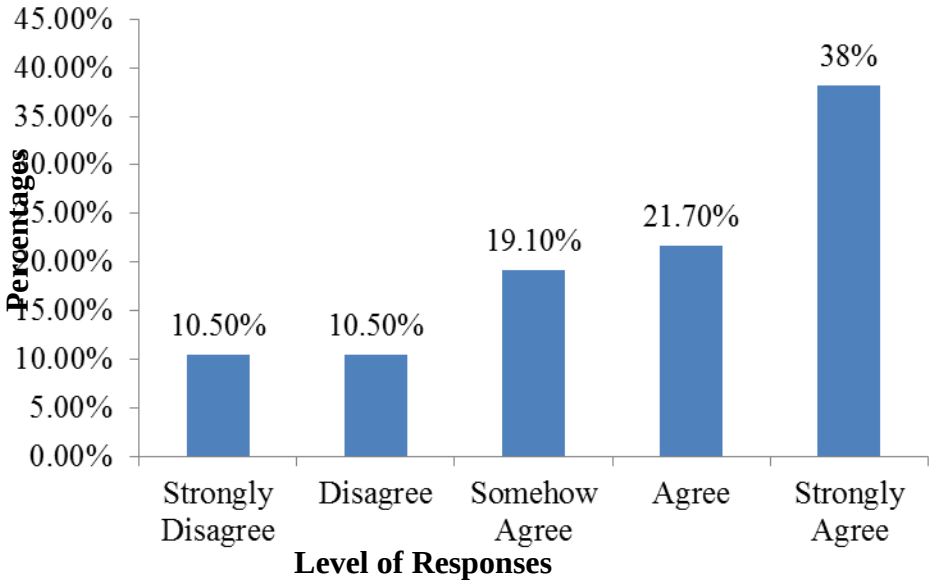

Figure 11: Economic Problems and self-efficacy

As shown in Figure 11, 89% and 21% of the respondents generally agreed and disagreed respectively that older people could not take care of themselves due to economic hardships. In particular, 38%, 21.7% and 19.1% of the respondents strongly agreed, agreed and somehow agreed respectively that indeed older people could not take care of themselves due to their poor economic conditions. However, 10.5% and another 10.5% of the respondents strongly disagreed and disagreed respectively that poor economic conditions of older people was undermining their ability to fend for themselves as shown in figure 19 above.

The above results, which shows that majority of the respondents conceded that majority of older people were experiencing problems are in support of past studies. For instance, a study by Center on an Aging Society (2012) which examined the cost of medical care for elderly persons established that elderly persons and their families face many financial issues in acquiring treatments and resources to support their health and medication. The centre particularly noted that financial resources of elderly persons and immediate relatives were quickly drained through payment for multiple prescriptions for chronic conditions affecting elderly relatives. A similar study by Merck Institute (2012) found that nearly 30% of elderly persons either took less medication than prescribed or were completely unable to afford prescriptions.

In the same vein, while analyzing the issues of financing institutional long-term care for the elderly in China, Yang et al. (2016) highlighted that lack of financial muscles

by the older people and their relatives was the greatest impediment to the willingness to enroll for the formal care of the elderly people in the Chinese societies. They however suggest that long term care insurance model assessed in the paper which had taken place in wealthier coastal regions where stronger fiscal capacity could just be a policy intervention by government to mitigate upon the financial limitations of the these vulnerable people in the society.

4.5.5 The Relationship between Economic Condition of older Person and uptake of Formal Care services

This study sought to establish whether the decision of members of the public to consider institutional care for their older relatives was in a significant way informed by the economic conditions of their older relatives. The relationship between economic condition of older person and uptake of formal care services was statistically significant (P = 0.041) as shown in Table 14.

Table 14: Economic Condition of older Person and uptake of Formal Care services

	Economic Conditions					Total
	SD	**D**	**SA**	**A**	**SA**	
NW	12(10.0%)	16(13.3%)	19(15.8%)	28(23.3%)	45(37.5%)	120(100%)
LW	14(10.1%)	13(9.4%)	30(21.7%)	27(19.6%)	54(39.1%)	138(100%)
SW	7(13.0%)	6(11.1%)	7(13.05)	9(16.7%)	25(46.3%)	54(100%)
W	7(14.9%)	1(2.1%)	10(21.3%)	14(29.8%)	15(31.9%)	47(100%)
VW	-	4(17.4%)	7(30.7%)	5(21.7%)	7(30.4%)	23(100%)
Total	**40(10.5%)**	**40(10.5%)**	**73(19.1%)**	**83(21.7%)**	**146(38.2%)**	**382(100%)**

χ^2= 16.616, df=16, P=0.041, Cramer's V=0.122

Closer examination of statistical results in Table 14 shows that willingness to embrace institutional care for older people was more evident among respondents who generally agreed that older people's economic condition could not allow them to take care of themselves. For instance, of the 138 respondents who stated that they were least willing to consider institutional care for their older relatives, 19.5% and 80.5% generally disagreed and agreed respectively that older people's economic condition could not allow them to fend for themselves. Further, of the 54 respondents who reported that they were somehow willing to enroll their older relatives for institutional care, 24.1% and 75.9% of them generally disagreed and agreed respectively older people's economic condition could not allow them to take care of themselves. Similarly, of the 47 members

of the public engaged in this study, and who expressed that they were willing to enroll their older relatives for institutional care, 83% of them had earlier conceded that indeed their older relatives could not take care of themselves due to their precarious economic condition. Similarly, of the 138 respondents who stated that they were least willing to consider institutional care for their older relatives, 19.5% and 79.5% generally disagreed and agreed respectively that older people's economic condition could not allow them to fend for themselves.

One of the older people who was extensively interviewed by this study disclosed that inability to support himself economically was the primary reason for seeking institutional care in one of the homes for older people in Nakuru County. This is an excerpt of the interview this study held with Mr. Munyao (not his real name).

> "I came to this home in 2014. I came here by myself after having been abandoned by my wife who left me and got married to someone else. I used to stay in Kamba land. I was admitted in hospital for three years after developing swellings on my left leg. When I was discharged from the hospital I found that my wife had left our matrimonial with our children and got married to another man. I came to Nakuru County so that I could live my sister who stays in Njoro town. However, my sister accepted to stay with me for only a few weeks. One day he told me that I needed to leave and go back to Kamba Land. I decided to come to this home having spent four nights in the streets of Nakuru Town. A member of the public informed me that there is a home for older people in Bondeni Estate. I came to this home and having my situation, the management of the home admitted me. I have no intention of leaving this home. Even if I die it will be upon the management of this home to decide where to bury me".

It was interesting to learn that some of the homes allowed older people to engage in income generating activities. For instance, one of the elderly people in the institutional home informed this study that he makes cooking stick (Mwiko), which he hawks around the estate. The incomes derived are used by the elderly to buy clothing, personal effects among other items.

> "I make *Mwiko*, which I sell to people in Bundeni, Kivumbini, Pangani and even Race Course estates. I sell each Mwiko at Ksh. 100. In a good month I can sell up to between 70 and 80 Mwikos. I get materials from the local timber yards. The owners of these timber yards know and many times they give me the wooden materials free. It only sand paper that I buy, which I use to smoothen the Mwikos".

Although a significant number (4 out 5) of older people who were interviewed were poor and could not meet their their basic needs and medication among other needs on their own, it was, disheartening to learn that poverty cases among some older people was caused by their immediate relatives. This study established that some members of the public had disinherited their older relatives of property such as land leading to the precarious economic condition of older people. An informant Mrs Keringet (not her real name) emotionally narrated how his brothers dispossessed their mother of her land, sold the land and then used the proceeds to indulge in alcohol consumption.

> "My mother has suffered a lot in the hands of my brothers who became alcohol addicts. They sold my mother's land and property and spent it in drinking. They bore many children and did not educate them. My two brothers have died due to alcoholism leaving behind nephews who are also alcohol addicts. My mother is often physically abused by my nephews (grandsons). I am the only daughter, I am married but I defied culture to bring mother to live with me. But my husband and in-laws could hear none of it. My husband has since gone to live with concubine. Despite the difficulties am facing in taking care of my mother, I cannot hand her over to an institution. If she could be mistreated by her own sons and grandsons how about strangers in these institutions for older people? I cannot under whatever circumstance consider taking my mother to these homes. No way".

4.4.6 Older Relative Cannot Provide Own Care Due To Psychological Problems

As to whether the older relative cannot provide own care due to psychological problems, participants expressed their feelings as shown in Figure 12.

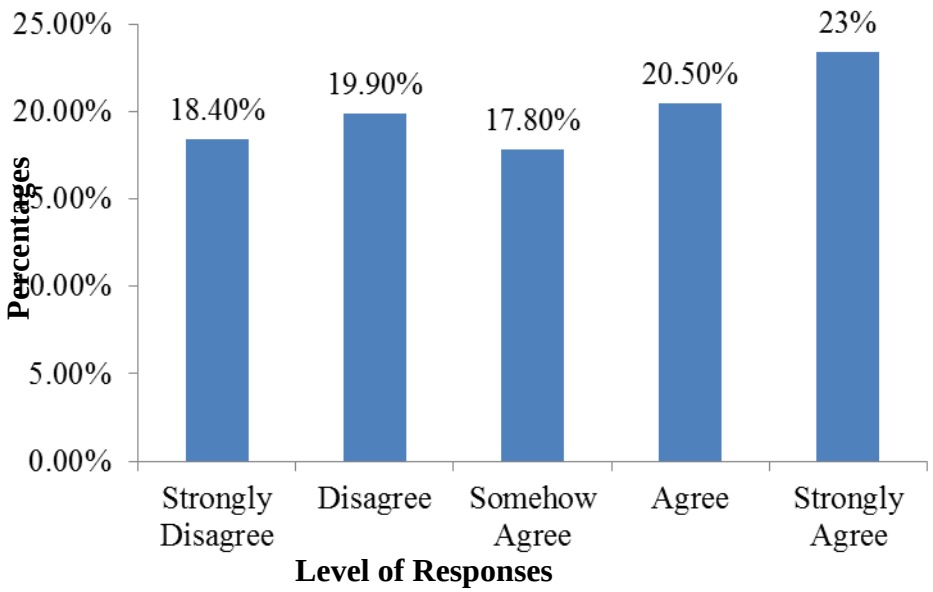

Figure 12: Psychological Problems and self efficacy

A significant proportion or 60.3% of members of the public engaged in this study agreed that their older relatives were unable to take care of themselves due to their poor state of psychological health. As shown in Figure 12, 23% and 20.5% of the respondents strongly agreed and agreed that indeed their older relatives could not fend for themselves due to psychological problems. Similarly, 17.8% of the respondents somehow agreed that their older relatives could not take care of themselves due to poor psychological health. While taking a contrary view, 18.4% and 19.9% of the respondents strongly disagreed and disagreed that their older relatives were unable to take care of themselves on account of their poor psychological health.

Although there are no global statistics on the prevalence of psychological problems experienced by older people, it was estimated about a decade ago that insomnia affects about 60% of older people in the United States (McCurry, 2007). It is prevalent among older adults; 30-60 percent of all older persons have one or more sleep complaints such as difficulty falling and staying asleep, early morning awakenings, excessive daytime sleepiness and daytime fatigue (APA, 2011). It is estimated that about 21% of adults aged 65 and older experience some form of mental disorder (WHO, 2013). Although older adults suffer from various forms of mental disorder, the most common one is depression (Karel*et al.*, 2012). While a significant proportion of older adults suffer from depression, studies show that the prevalence of depressive symptoms increases with age (Kennedy, 1996).

4.4.7 The Relationship between Psychological Condition of older Person and uptake of Formal Care services

It was generally held by majority (61.3%) that older people could not care of themselves due to their psychological problems (Figure 13). it was important to establish whether public perceived psychological condition influenced the decision of members to consider institutional care for their older relatives. To ascertain this, this study carried out inferential analysis on the relationship between psychological condition of older people and uptake of institutional care for older people as depicted in Table 15. In Table 15, there was no significant relationship between psychological condition of older people and uptake of institutional care for older people (P = 0.850). The relationship between psychological condition of older person and uptake of institutional care for older people was also none significant given a weak value of Cramer's V (Cramer's V=0.096).

Table 15: Psychological Condition of older Person and uptake of Formal Care services

	Psychological Problems					Total
	SD	**D**	**SA**	**A**	**SA**	
NW	20(16.7%)	22(18.3%)	20(16.7%)	29(24.2%)	29(24.2%)	120(100%)
LW	23(16.8%)	34(24.8%)	22(16.1%)	2316.8%)	35(25.5%)	137(100%)
SW	10(18.5%)	8(14.8%)	7(13.0%)	16(29.6%)	13(24.1%)	54(100%)
W	12(25.5%)	7(14.9%)	12(25.5%)	8(17.0%)	8(17.0%)	47(100%)
VW	5(21.7%)	5(21.7%)	7(30.4%)	2(8.7%)	4(17.4%)	23(100%)
Total	**70(18.4%)**	**76(19.9%)**	**68(17.8%)**	**78(20.5%)**	**89(23.4%)**	**381(100%)**

χ^2= 10.31, df=16, P=0.850, Cramer's V=0.096

Closer examination of the results in Table 15 shows no marked difference between respondents who disagreed or agreed that older people could not take care of their themselves due to psychological problems and their desire to partake of institutional care for older people. Consider for instance out of 23 respondents who were very willing to enroll their older relatives for institutional care, 43.4% of them generally disagreed and 56.6% agreed that older people could not take care of themselves due to their psychological conditions. Additionally, out of 47 of the respondents who stated that they were willing to consider institutional care for their older relatives, 40.4% and 59.6% of them generally disagreed and agreed respectively that older people were unable to take

care of themselves because of their psychological conditions. Similarly, out of 54 respondents who were somehow willing to enroll their older relatives for institutional care, 33.3% of them disagreed while 66.7% agreed that older people could not take care of themselves due to psychological problems. Whereas there were differences in the examples provided herein, the differences were insignificant thus confirming the statistical results, which found no statistically significant relationship between psychological condition of older people and uptake of institutional care for older people.

An interview this study held with a social worker further confirmed that indeed older people suffer from numerous psychological problems. The social worker observed that during her visits to homes for older people she found that a lot of older people suffered from depression, stress and insomnia. Others suffered from dementia while others experienced anxiety. Loneliness and abandonment made some of elderly wonder where they will be laid to rest and how their families would know when they die since some of them have no trace of the whereabout of their immediate members of the family.

The psychological problems being experienced by older people was also affecting the efficacy of their younger relatives in their care provision. One of the informants reported that her mother in law who was in her mid-eighties was unappreciative of the care she was extending to her. This she noted was adversely affecting her in her care provision role.

> "I only have two sons without a daughter and I cannot afford to employ a house help. My Mother in law is very choosy on food. She does not appreciate the help given but instead complains a lot. I am totally confined around the home. At times she calls me as if she has anything special to tell me, but on reaching her there is nothing she says. I am physically and mentally tired that at times I don't care much about kind and quality of care I give to my mother in-law since nobody appreciates after all. In fact to be honest I pray that God rests her sooner but when she becomes critically ill I panic a lot.If there could be a place where she could be taken care of so that we just go visiting, I would really appreciate". Remarks Jackline (not her real name).

4.5.8 Older Relative Cannot Provide Own Care Due To Alcohol and Substance Abuse

Alcohol and substance abuse was not a major problem affecting the ability of older people to take care of themselves. This is according to the study results shown in Figure 13.

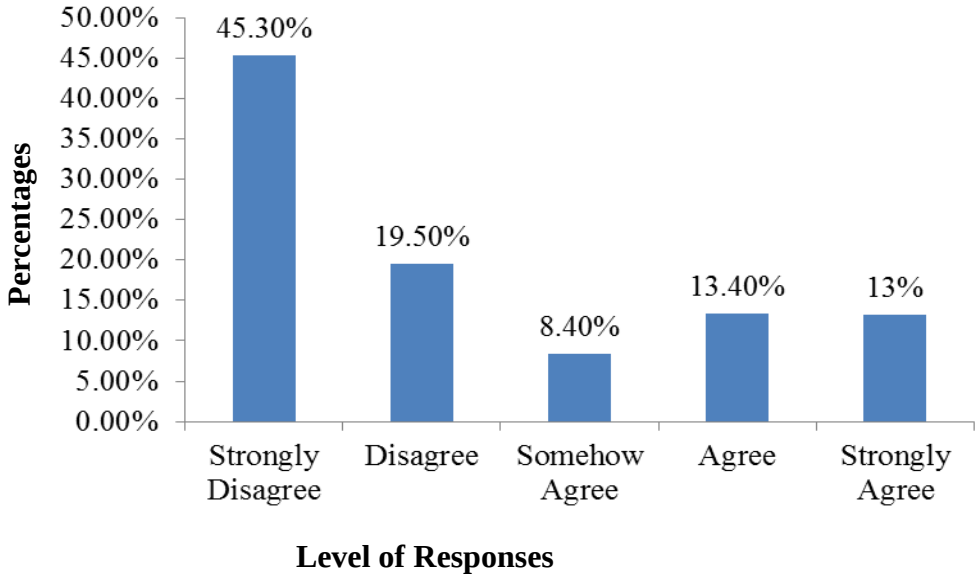

Figure 13: Alcohol and Substance Abuse and self-efficacy

As can be discerned from the results of the study in Figure 13, 64.8% of the respondents disagreed that alcohol and substance abuse was undermining the ability of older people to take care of themselves. Further examination of the results shows that 45.3% and 19.5% strongly disagreed and disagreed respectively that their older relatives could not take care of themselves due to alcohol and substance abuse. However, about a third of the respondents reported that alcohol and substance abuse was undermining the ability of their older relatives to take care of themselves. This position affirmed by 13%, 13.4% and 8.4% of the respondents who strongly agreed, agreed and somehow agreed that indeed alcohol and substance abuse was making it difficult for their older relatives to fend for themselves.

The findings of the current study differ with earlier studies done by Gfroerer et al., (2011) and APA (2011), which found alcohol and substance as not only being prevalent among older people but also undermining their ability to take care of themselves. Although very few elderly persons are known to abuse alcohol and drugs, it was reported in 2010 that between 6-8 million older people abused drugs and alcohol

(Gfroereret al., 2011; APA, 2011). The reports, however, noted further that the number of elderly persons abusing drugs and alcohol could be much higher than the ones in their reports if a global survey of the same were to be done. Gfroerer et al. (2011) while acknowledging that all alcohol and drug abuse has serious health and social consequences among different age groups, the authors expressed concerns that consequences of drugs abuse are most serious among elderly persons.

4.5 Perceived Efficacy of Primary Care givers of the Public to Take of Older Relatives

The third objective of this study was to examine perceived efficacy of primary care givers of the public to take of older relatives examine the influence of perceived older people's efficacy on the uptake of institutional care services for older people in Nakuru County. Issues examined in this objective the relationship primary care givers and their older relative prior to his/her old age, the occupation of the primary care givers, the psychological strength of primary care givers and uptake of institutional care for older people, whether primary care givers can take care of my older relative without major assistance from other people or organizations, whether primary care givers can take care of my older relative(s) notwithstanding their dependency level and whether primary care givers' financial status allow them to attend to their older relative(s)on the one hand and their influence on the uptake of institutional care services for older people. The following is therefore the results and discussions examine perceived efficacy of primary care givers of the public to take of older relatives examine the influence of perceived older people's efficacy on the uptake of institutional care services for older people in Nakuru County.

4.5.1 My relationship with my older relative was very good prior to his/her old age

A greater percentage of members of the public who participated in this study reported that they had a cordial relationship their older relatives prior to their old age status according to results of the study in Table 16.

Table 16: Pre-old Age Relationship

Response	Frequency	Percent
Strong Disagree	41	10.7%
Disagree	26	6.8%
Somehow Agree	59	15.4%
Agree	114	29.8%
Strongly Agree	143	37.3%
Total	**383**	**100.0%**

Table 16 reveals that 82.5% and 17.5% of the respondents generally agreed and disagreed respectively that the relationship between them and their older relatives was very good prior to their old age. Closer scrutiny of the results shows that 37.3% and 29.8% of the respondents strongly agreed and agreed respectively that the relationship between them and their older relatives was very good prior to their old age. A similar position was taken by 15.4%, who somehow agreed that the relationship between them and their older relatives was very good prior to their old age. However, some members of the public engaged in this study reported that they had a strained relationship with their older relatives prior to their old age. This position was held by 10.7% and 6.8% of the respondents who strongly disagreed and disagreed that their relationship with their older relatives was good at pre-old age stage.

The character and attitude of the elderly person toward potential care provider prior to old age affects the quality and efficacy of the care provider to the elderly person as supported by Irurita (2009) whose study found that care providers who were well treated and handled by their elderly relatives (when the elderly persons was still a young adult) provided better quality care compared to their counterparts who were neglected or mistreated by their elderly relatives (when the elderly persons was still a young adult). The author concluded that caregivers' self-efficacy toward elderly relatives was influenced by the pre-old age relationship.

4.5.2 The Relationship between pre-old age relationship with older person and uptake of Formal Care services

The study sought to establish the relationship between pre-age relationship with older person and uptake of formal care services and the results as shown in Table 17.

Table 17: Pre-Old Age Relationship and Uptake of Formal Care Services

	Pre-old Age Relationship					Total
	SD	**D**	**SA**	**A**	**SA**	
NW	15(12.4%)	6(5.0%)	12(9.9%)	41(33.9%)	47(38.8%)	121(100%)
LW	13(9.7%)	12(9.0%)	24(17.9%)	29(21.6%)	56(41.8%)	134(100%)
SW	6(10.9%)	5(9.1%)	8(14.5%)	17(30.9%)	19(34.5%)	55(100%)
W	5(10.2%)	2(4.1%)	8(16.3%)	20(40.8%)	14(28.6%)	49(100%)
VW	2(8.3%)	1(4.2%)	7(29.2%)	7(29.2%)	7(29.2%)	24(100%)
Total	**41(10.7%)**	**26(6.8%)**	**59(15.4%)**	**114(29.8%)**	**143(37.3%**	**383(100%)**

χ^2= 22.216, df=16, P=0.013, Cramer's V=0.142

The Relationship between pre-old age relationship with older people and uptake of institutional care was significant but weak (P = 0.013; Cramer's V=0.142). For instance out of 121 of the respondents who were not willing to consider institutional care for their older relatives, 86.6% of them confirmed to this study that there was cordial relationship between them and their older relatives prior-to old age. Further, out of 134 of the respondents who were least willing to partake institutional 81.3% of the respondents who were least willing at enrolling their older relatives for institutional care had generally agreed that there was cordial pre-old relationship between them and their older relatives. Based on the examination of the statistical results, it is clear that the more cordial the pre-old age relationship between the respondents and their older relatives, the less the consideration for institutional care for older people.

This study concurs that the kind of relationship that existed between a person and his/her older relative may influence individual's self-efficacy toward older relative. The influence of pre-old age relationship between and individual and his/her older relative on the uptake of institutional care are well captured by the assertion of the following informant:

> "I will never under any circumstance enroll my parents in homes for the elderly. I can feed my parents, take care of their medication and other essential things they need. The worst I can go if they become so dependent is to hire a private nurse to help me take care of them at home. They would rather suffer under my custody rather than somebody else", remarked Wanjiru (not her real name).

However, when asked whether she would extend the same care to her parents' in-law, Wanjiru had this to say:

> "It is not easy for me to stay with my parents in law. If her daughters can't take care of them then I will be left with no alternative but to take them to homes for the elderly. My mother in-law told me that I was not the right woman for her son. In fact she is the cause of some of the conflicts and instability we had in the past in our marriage. I would not feel motivated at all to have her live with me. So if her daughters- whom she collaborated with to cause troubles in my marriage- can't take care of her then straight away I will take her to the homes for the elderly. For my father in-law, I have no issues with him. In fact if it were not for him, I could not have coped with the hostility I was getting from other members of my husband's family".

The informant's reluctance to enroll her older parents for institutional care is purely born out the cordial and supportive relationship that existed between her and her older parents prior to old age. On the other hand the ease with which she embraces institutional care for her parents' in-law is largely motivated by the kind of adversarial relationship between her and them more so her mother in-law. From these illustrations, it is evident that consideration of institutional care for older people is significantly influenced by the nature of relationship that existed between the individual and his/her older relatives prior to old age.

The findings of this study are in many respects similar to that of Austin and McClelland (1996), which found the relationship that exists between a member of the public and his/her elderly relative to have a significant influence on the self-efficacy of the member of the public providing care to his/her elderly relative(s). While noting that the overall goal of both formal and informal care giving is provision of psychosocial support to the needy, Austin and McClelland (1996) argued that formal and informal caregivers differ both in terms of their relationship to the care receiver and also in the manner in which they embrace and experience the care giving role. That is, caregivers differ in what they do, how they do it, and how long they do it. Further, a study by Delgado and Tennstedt (2007) also found that the closeness of the familial relationship between an individual and her older relative had a significance influence on the self-efficacy toward elderly persons. This suggests that members of the public who feel

closer to their elderly relatives are more likely to spare more time in care provision and as such may be reluctant at enrolling their older relatives for institutional care.

Similarly Luo et al., (2018) explains that in cases where pre-old relationship was not solid and intimate, the elderly people were more likely to face neglect and abuse in the old age. They are more likely to feel lonely mostly because it is hard for them to establish intimate relationships with their family members, friends or relatives. But their feeling of loneliness is unlikely to decrease if they move into a nursing home. Even worse, living in a nursing home can further separate them from their family and friends.

4.5.4 My Occupation Allows Me to Attend to Older Relative(s)

This study established that a significant proportion of the members of the public could get some time to attend to their older relatives despite time constraints posed by their occupations as expressed by the respondents in Figure 14.

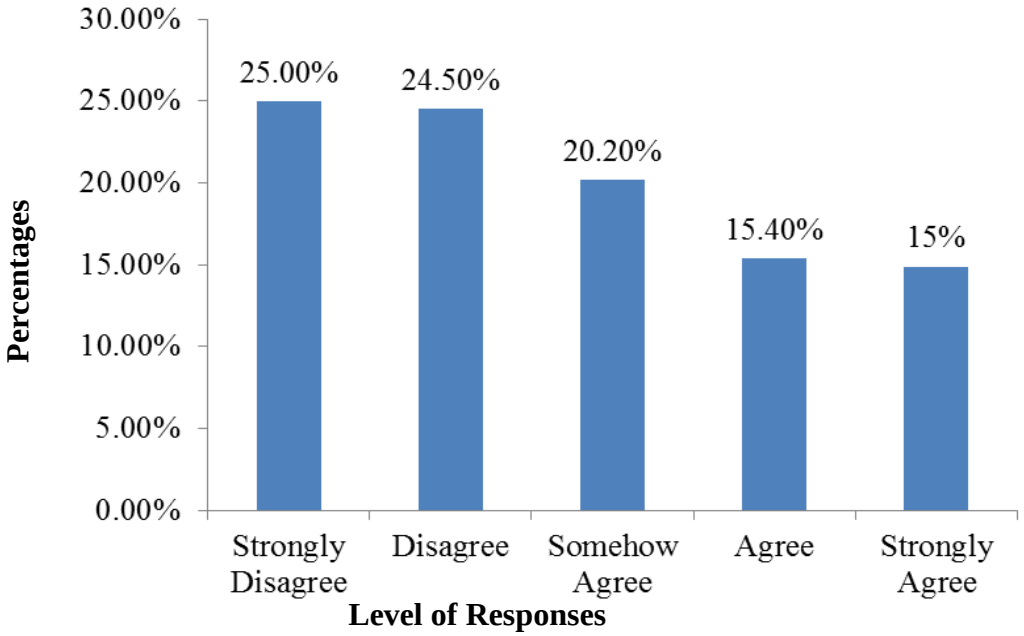

Figure 14: Occupation and Public Efficacy

The results of the study in Figure 14 show that 50.6% of the respondents agreed that could get some time to attend to their older relatives despite time constraints posed by their occupations, unlike 49.4% who stated otherwise. In particular, 15%, 15.4% and 20.2% of the respondents strongly agreed, agreed and somehow agreed respectively that their occupation could permit them to attend to their older relatives. Some members of the public engaged in this study pointed that their heavy work schedules could not permit them to attend to their older relatives. This view was supported by 25% and 24.5% of the

respondents who strongly disagreed and agreed that their occupation allow them to attend to their older relatives as shown in Figure 14.

Most of the respondents were small scale business operators and casual employees working as security guards, cleaners, hotel attendants, messengers and gardeners in various organizations in the county. Some of these occupations generated very little returns that forced individuals to diversify and pursue incomes from more than one occupation. Therefore, respondents who stated that they were unable to take care of their older relatives due to the nature of their occupations, were those whose occupations were too engaging and hardly had free time to attend to other things such as attending to their older relatives. Although some of the occupations were so much engaging, respondents could still spare time to attend to their older relatives.

4.5.5 The Relationship between Nature of Occupation of Relative of Older Person and Uptake of Formal Care Services

On the relationship between nature of occupation of relative of older person and uptake of institutional care the results are in Table 18.

Table 18: Occupation and Uptake of Formal Care Services

	Occupation					Total
	SD	D	SA	A	SA	
NW	26(22.2%)	28(23.9%)	22(18.8%)	17(14.5%)	24(20.5%)	117(100%)
LW	39(29.3%)	37(27.8%)	23(17.3%)	21(15.8%)	13(9.8%)	133(100%)
SW	9(16.7%)	10(18.5%)	13(24.1%)	10(18.5%)	12(22.2%)	54(100%)
W	16(33.3%)	10(20.8%)	11(22.9%)	8(16.7%)	3(6.3%)	48(100%)
VW	4(16.7%)	7(29.2%)	7(29.2%)	2(8.3%)	4(16.7%)	24(100%)
Total	**94(25.0%)**	**92(24.5%)**	**76(20.2%)**	**58(15.4%)**	**56(14.9%)**	**376(100%)**

χ^2= 14.564, df=16, P=0.557, Cramer's V=0.115

Although more respondents who stated that their occupation could afford them time to attend to their older relatives than their counterparts who disagreed, the numerical difference is very minimal. For example, out of 117 of the respondents who were not willing to consider institutional care for their older relatives, 46.1% and 53.9% of the respondents generally disagreed and agreed respectively that their occupation could afford them time to attend to their older relatives. Among 133 of the respondents who stated that they were least willing to enroll their older relatives for institutional care,

57.1% and 42.9% of them disagreed and agreed respectively their occupation could afford them time to attend to their older relatives. Similarly, out of 48 of the respondents who were willing to consider institutional care for their older relatives 54.1% disagreed against 45.9% who agreed that their occupation could afford them time to attend to their older relatives. Further, of the 24 respondents who were very willing to enroll their older relatives for institutional care, 45.9% and 54.1% disagreed and agreed respectively that their occupation could afford them time to attend to their older relatives.

4.5.6 I Can Take Care of My Older Relative Due To My Psychological Strength

As to whether the respondents can take care of their older relative due to their psychological strength, they gave their feelings as depicted in Figure 15 below.

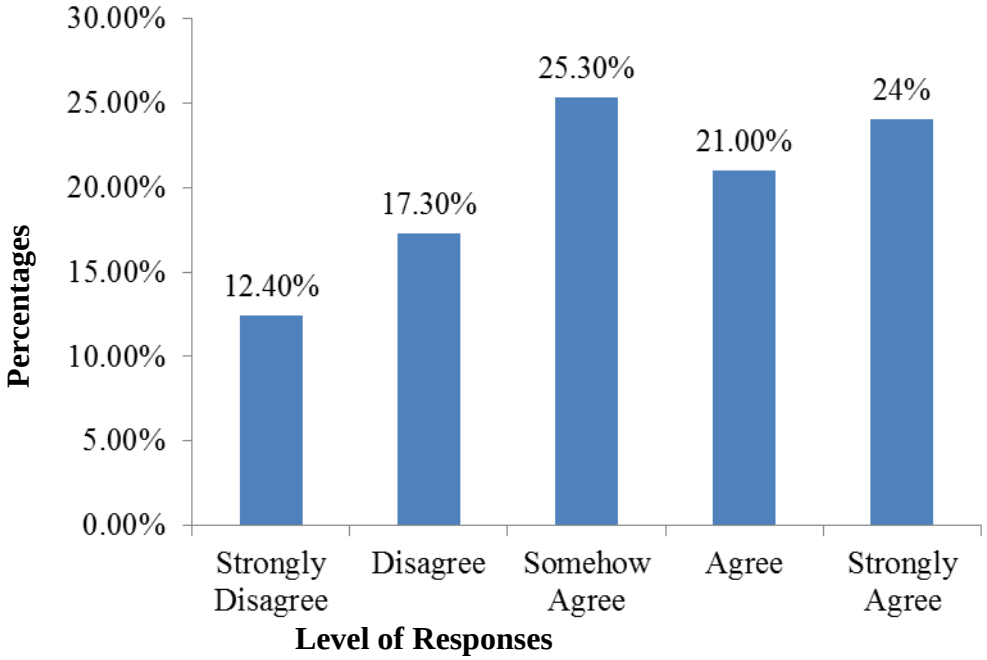

Figure 15: Psychological Strength and Public Efficacy

From the results of the study in Figure 15, 70.3% and 29.7% of the respondents agreed and disagreed respectively that they were psychologically strong to handle the needs of their older relatives. Closer examination of the study results presented in Figure 15 above shows that 24% and 21% of members of the public engaged in this study strongly agreed and agreed respectively that they were physiologically strong and as such could attend to their older relatives. Additionally, 25.3% of the respondents somehow agreed that they strong psychologically to attend to their older relatives. Some respondents believed that they were not well prepared psychologically to attend to their older relatives. Respondents who subscribed to this position accounted for 12.4% and

17.3% of the respondents who strongly disagreed and disagreed that they were psychologically strong to attend to the needs of their older relatives.

The ability of the care provider to cope with the social and psychological consequences of care giving has been found to influence self-efficacy toward care giving (Stajduhar and Cohen, 2009; Blieszner and Alley, 1990). Stajduhar and Cohen (2009) describe the entire landscape of care giving services as one that poses great challenges to the caregivers. Stajduhar and Cohen (2009) further observe that the responsibilities of the caregivers to the elderly persons as being emotionally and physically complex, which may result in fatigue, sleep problems, depression, anxiety and burnout on the part of the caregiver. Extending the discussion on the consequences of care giving to the caregivers, Blieszner and Alley (1990) argued that care giving has an intense impact on the caregiver's lifestyle, which includes increased stress due to confinement and changing work schedule. Similarly, Wolf *et al*., (2016) acknowledge the responsibility of the caregivers to the elderly persons as being emotionally and physically complex, which may result in fatigue, anxiety and burnout on the part of the caregiver. There is no doubt that such a complex task requires caregivers to be emotionally strong. There was, however, need to understand whether caregivers' psychological strength had any significant influence on the decision of the caregiver in considering institutional care for their older relatives.

4.5.7 The Relationship between Psychological Condition of Relative of Older Person and uptake of Formal Care Services

Concerning the relationship between psychological condition of relative of older person and uptake of formal care services, the participants expressed their feelings as shown in Table 18. As shown in Table 19, there was no statistically significant relationship between psychological condition of relatives of older people and uptake of institutional care for older people ($P = 0.142$).

Table 19: Psychological Condition and Uptake of Formal Care Services

Willingness	Psychological Strength					Total
	SD	D	SA	A	SA	
NW	10(8.5%)	21(17.9%)	29(24.8%)	22(18.8%)	35(29.9%)	117(100%)
LW	18(14.0%)	25(19.4%)	36(27.9%)	24(18.6%)	26(20.2%)	129(100%)
SW	8(14.8%)	6(11.1%)	13(24.1%)	12(22.2%)	15(27.8%)	54(100%)
W	8(17.0%)	8(17.0%)	10(21.3%)	15(31.9%)	6(12.8%)	47(100%)
VW	2((8.3%)	4(16.7%)	6(25.0%)	5(20.8%)	7(29.2%)	24(100%)
Total	**46(12.4%)**	**64(17.3%)**	**94(25.3%)**	**78(21.0%)**	**89(24.0%)**	**371(100%)**

χ^2= 22.037, df=16, P=0.142, Cramer's V=0.142

An examination of table statistical results in Table 19 above shows that both respondents who agreed and disagreed that they were psychologically strong to take care of their older relatives were either bother willing or unwilling to enroll their older relatives for institutional care. For example, whereas some respondents who stated that they psychologically strong to take care of their older relatives, they were still unwilling to consider institutional care for their older relatives. It is also important to note that willingness to enroll older relatives for institutional care was also expressed by respondents who stated that they were psychologically strong to take care of their older relatives. For example, of the 24 respondents who reported that they were very willing to consider institutional care for their older relatives, 25% and 75% had generally disagreed and agreed that they were psychologically strong to take care of their older relatives. This trend obtains for respondents who were willing, somehow willing and even least to enroll their older relatives for institutional care. Therefore, there was no peculiar difference among respondents who expressed willing or unwillingness to consider institutional care for their older relatives based on their psychological strength. This confirms that indeed there was statistically significant relationship between respondents' psychological strength and the uptake of institutional care for older people in Nakuru County, Kenya.

4.5.8 I Can Take Care of My Older Relative without Major Assistance

As to whether the participants could take care of their older relative without major assistance, they expressed their feelings as shown in Table 20.

Table 20: Respite Services

Nature of Response	Frequency	Percent
Strong Disagree	108	28.4
Disagree	126	33.2
Somehow Agree	68	17.9
Agree	37	9.7
Strongly Agree	41	10.8
Total	**380**	**100.0**

Majority of the respondents affirmed to this study they could not take care of their relatives on their own without much assistance. It is evident from results in Table 20 that 51.6% and 48.4% of the respondents disagreed and agreed that they were able to attend to their older relatives without much assistance. Further examination of the results shows 33.2% of members of the public who participated in this study disagreed that they could attend to their older relatives without outside assistance. A small proportion of the respondents, however, conceded that it was possible for them to take care of their relatives without outside assistance. As shown in Table 20, 10.8%, 9.7% and 17.9% of the respondents strongly agreed, agreed and somehow agreed respectively that they could take care of their older relatives without outside assistance.

It has been pointed out earlier that some older people especially oldest of the old do suffer from numerous health and psychological problems that require constant attention from care providers. It has also been noted earlier that a significant number of care providers experience psychological problems due to the burden posed by care provision. Therefore, the availability of external support can go a long way in relieving care providers some burden and stress associated with care provision.

Traditionally external assistance in care provision to older people was provided by children, women and members of the extended family. Recent years has seen an increasingly high number of children being absorbed into formal education system, with women joining wage employment. Formal education and paid employment have thus robbed many families a substantial number of informal care providers. Further, while many families still have ties with members of their extended families and kinship systems, these ties are not as strong and reliable as they were in the past. The extended family also played a significant role in supporting its members take care of vulnerable

members including older relatives. Members of the extended families provided valuable source of both material and psychosocial support to the immediate families of older relatives thereby lessening the burden of care provision in a significant way to the immediate relatives of older people. However, the absence of such strong kinship ties means that immediate relatives of older people have to bear the burden of care provision alone, which may not be only challenging financially but also emotionally draining. Faced with this situation, some families may prefer institutional care for their older relatives. This therefore explains why most of the respondents reported that it was difficult for them to effectively take care of their older relatives without external support.

4.5.9 I Can Take Care of My Older Relative(s) notwithstanding their Dependency Level

Members of the public who participated in this appeared divided almost evenly on whether they were able to take care of their relatives due to the dependency level of their older relatives. When asked whether they could take care of their older relatives notwithstanding their dependency level, the participants expressed their views as shown in Figure 16.

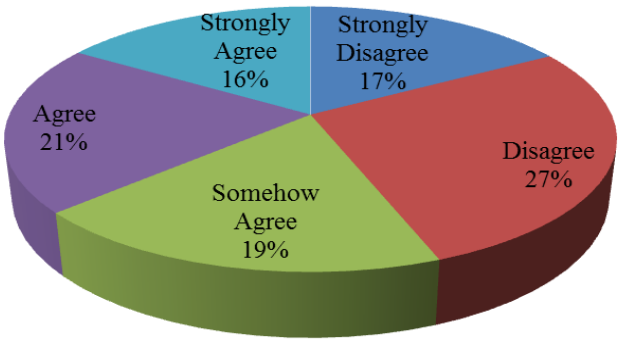

Figure 16: Dependency Level and Public Efficacy

Accounts of the respondents revealed that 54% of the respondents generally agreed that they could take care of their older relatives despite the high level of dependency against 46% of their counterparts who had a contrary view. In terms of individual accounts, 16%, 21% and 19% of the respondents strongly agreed, agreed and somehow agreed respectively that they were able to take care of their relatives despite the latter's level of dependence. On the other hand, 17% and 27% of the respondents strongly disagreed and disagreed with the assertion that they were able to take care of

their older relatives notwithstanding their high levels of dependency as shown in Figure 16.

The dependency level of the care recipient has also been established to influence self-efficacy of the care provider (Mui, 1995). The author observed in a study of care provision among elderly persons with multiple chronic illnesses that an over dependent elderly person may bear a lot of strain to the care giver. Noelker and Townsend (1987) also observed that that negative perceptions of care giving to elderly persons were more likely to occur when the caregiver felt distressed and overwhelmed and when the care recipient was more impaired. The ideas of (Mui, 1995) and Noelker and Townsend (1987) find much relevance in the proposed study since some older people especially the oldest of the old may need more care and attention than their 'younger' counterparts. While all elderly persons need care and attention from either formal or informal care providers, the oldest of the elderly (those 80 years and above) are thought to require more attention and care than their counterparts who are 80 years and below (Skaffet al., 2010). This perception may have been informed by the fact that elderly persons become more and more dependent as they age. Their bodies weaken, they develop chronic problems and many also suffer from depression and other psychological problems.

4.5.10 My Financial Status Allows Me to Attend to Older Relative(s)

When asked whether their financial status allowed them to attend to older relatives, the respondent expressed their views as depicted in Figure 17.

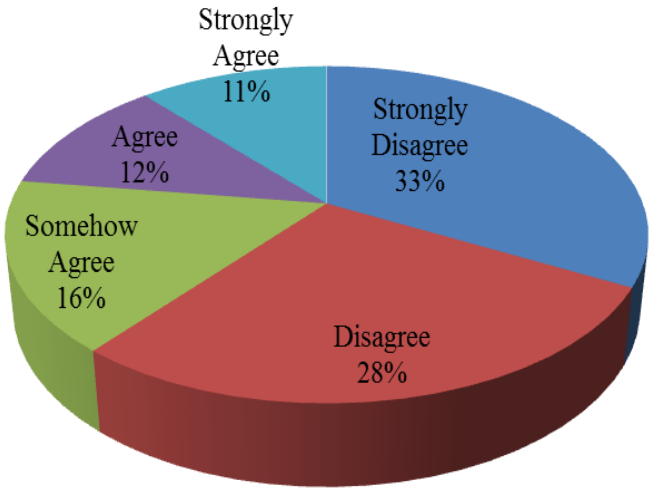

Figure 17: Financial Status and Public Efficacy

From the study results 61% of the respondents indicated that they were unable to take care of their relatives due to financial constraints. However, 39% of the respondents agreed that their financial status allowed them to take care of their older relatives as shown in Figure 17. From the study results, 33% and 28% of the respondents indicated that they were unable to take care of their relatives due to financial constraints. However, 16%, 12% and 11% of the respondents somehow agreed, agreed and strongly agreed respectively that their financial status allowed them to take care of their older relatives.

As noted earlier, most of the respondents stated that they derived their livelihoods from business, formal and casual employment. A huge proportion of members of the public who participated in this study engaged in small scale businesses, which earned very small profits that could barely enable them meet their essential needs. Further, even the respondents who stated that they were in formal employment, majority of them were teachers in basic education institutions. Most of the casual employees were from the agricultural farms in Naivasha, Rongai, Bahati and Molo sub-Counties. Some of the casual employees were seasonal and as such were not in full time employment. Other than the few respondents who were employed in banks and other established corporations, the rest complained of poor wages that could hardly afford them even basic needs.

Just like in this study, about 78% of the family caregivers in a study in Ghana carried out in 2016 reported a high level of caregiving burden with females reporting a relatively higher level than males. Further, about 87% of the family caregivers reported a high level of financial stress as a result of caregiving for their elderly relative (Tettey, Cecilia, Moses, Djesika, and Justice, 2017).

4.5.11The Relationship between Economic Status of Relative of Older Person and Uptake of Formal Care Services

Majority of the respondents conceded that they were unable to take care of their older relatives due to their financial status. It was important to establish whether respondents' economic status had any significant bearing on their decision to enroll their older relatives for institutional care. Inferential analysis on the relationship between economic status of relative of older person and uptake of institutional care for older people was statistically significant (P=0.034). However, the relationship between economic status of relatives of older people and uptake of institutional care for older people was weak (Cramer's V=0.090) as shown in Table 21.

Table 21: Economic Status and uptake of Formal Care services

Willingness	Financial Stability					Total
	SD	D	SA	A	SA	
NW	35(30.2%)	29(25.0%)	21(18.1%)	13(11.2%)	18(15.5%)	116(100%)
LW	49(36.3%)	40(29.6%)	19(14.1%)	14(10.4%)	13(9.6%)	135(100%)
SW	19(35.2%)	17(31.5%)	6(11.1%)	6(11.1%)	6(11.1%)	54(100%)
W	13(27.1%)	14(29.2%)	11(22.9%)	7(14.6%)	3(6.3%)	48(100%)
VW	8(33.3%)	6(25.0%)	5(20.8%)	2(8.3%)	3(12.5%)	24(100%)
Total	**124(32.9%)**	**106(28.1%)**	**62(16.4%)**	**42(11.1%)**	**43(11.4%)**	**377(100%)**

χ^2= 8.994, df=16, P=0.034, Cramer's V=0.090

It is evident from the statistical results in Table 21 that majority of the respondents who conceded that their economic status limited their ability to take care of their older relatives were more willing to consider institutional care for their older relatives. For example, of the 135 respondents who stated that they least willing to enroll their older relatives for institutional care, 34.1% of them generally conceded that their financial status could not allow them to cater for their older relatives. Further, of the 54 respondents who reported that they were somehow willing to consider institutional care for their older relatives, 66.7% of them also stated that their economic situation could not allow them to take care of their older relatives. Similarly, 56.3% of respondents who stated that they willing to enroll their older relatives for institutional care were those who indicated that their economic status could not permit to take care of their older relatives. Lastly, of the 24 respondents who stated that they were very willing to consider institutional care for their older relatives, 58.3% of them held that they were unable to take care of their older relatives due to their economic condition. In general, the uptake of institutional was influenced more by the respondents' poor economic situation, which compromised their ability to care for their older relatives.

Unlike in the past when children were regarded as a source of wealth and social security against old age, today children are increasingly seen as economic burden given the many demands in form of care that they have to be accorded. Children are not only required to be provided by decent shelter, adequate food/nutrition and sufficient clothing but also medical care and education. This implies that a substantial amount of families incomes go into provision of children's basic necessities. Families with inadequate and unreliable sources incomes such as some of those engaged in this study, may be left with virtually no savings to direct toward care provision for their older relatives. Such

families would easily embrace institutional care for their older relatives since it relieves it of the economic costs associated with care provision toward their older relatives.

One of the informants Kones (not his real name) who was a casual employee in one the flower farms in Molo Sub-County made this observation when asked whether his economic status could allow him to take care of his older relatives.

> "Am just a casual employee and you know what people like us earn in a farm like the one am working in. what I get at the end of the month is far too inadequate to even enable me support my family. I have two wives and seven children. One of my children dropped out of school at form three. Now tell if a person who cannot even afford school fees for his children take care of an elderly relative. The income is not adequate for both your needs and that of the elderly person? Life is so difficult and I would consider it a godsend if there are organizations that are willing to take care of older relatives".

Advanced age may mean increased vulnerability to chronic infections, depression and insomnia among other problems. This may make them more dependent on the caregivers unlike their younger counterparts some of who may not need so much support. Therefore older people due to their physical and psychological condition may require special diet, frequent medication and even counseling from time to time as part of their care. Medication offered to older people may be very expensive and specialized in nature given that some of the older people may suffer from multiple infections and organ failure due to their advanced age. Ferrying older people to hospitals for medication may also require ambulances and other specially designed vehicles. Given all these, there is no doubt that care provision especially to the oldest of old is very expensive and beyond the means of ordinary members of the public with meager and unreliable incomes. It was therefore not surprising that majority of members of the public who participated in this study asserted that they could not afford to cater for their older relatives.

4.6 Perceived Institutional Efficacy on Care Provision for Older People

The fourth objective of this study was to assess the relationship between perceived institutional efficacy on the uptake of formal care for older people in Nakuru County, Kenya. issues covered in this objective were public awareness of the existence of formal care institutions in Nakuru county, whether formal care institutions for older

people had adequate staff to respond to the needs of older people admitted in their institutions, confidence in the management of care institutions for older people, the attitude of personnel of care institutions towards older people, whether formal care institutions had adequate staffs to respond to the needs of older people, whether care institutions had quality accommodation facilities for older people, whether formal care institutions had adequate facilities for physical exercise and whether these institutions had comprehensive programs for social bonding. The following is therefore the results and discussions of the study on the perceived efficacy of the institutions to take care of older people and its influence on the uptake of formal care for older people in Nakuru county, Kenya.

4.6.1 Awareness of the Existence of Formal Care Institutions in Nakuru County

Whether a particular service is consumed or not depends on among others the extent to which potential consumers are aware of its existence. Similarly whether members of the public were willing to enroll their older relatives into formal care institutions for older people depended on among others whether they were aware that these institutions existed in Nakuru Country. It is for this reason that this study began its inquiry into the perceived institutional efficacy of care provision for older people by establishing the extent to which members of the public were aware of the existence of these institutions in Nakuru County.

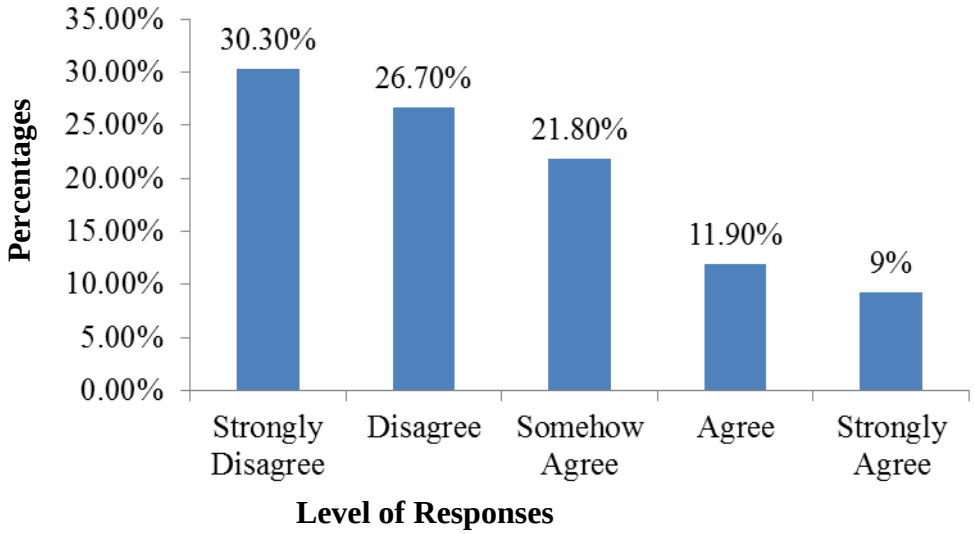

Figure 18: Aware of the existence of formal care institutions

When asked to state whether they were aware of the existence of formal care institutions for older people in Nakuru County, 57% of the respondents generally stated that they were unaware of the existence of these formal care institutions. However, further examination of the results in figure below shows that 9% and 11.9% strongly agreed and agreed that they were aware of the existence of these institutions in the county. It is evident from the results in figure 18 below that 21.8% somehow agreed that they were aware of these institutions in Nakuru County.

The results of the current study are similar to that of Gilmour (1998), which also found that majority of members of the public were unaware of the existence of formal care institutions for older people. While examining the level of public awareness about the availability of formal care institutions, Gilmour (1998) found that majority of the respondents were unaware of the existence of the formal care services but even those who were aware of the availability of the formal care institutions knew very little about the kinds of services offered by the institutions to the elderly people.

Although awareness of services offered by organizations is important for all organizations, Kotleret al., (2009) observe that it is even more critical for organizations that are seeking to penetrate new markets and make more or new customers. Institutional care services for older people in Kenya is still relatively a new phenomenal, thus making public awareness of the existence of these services a critical factor in their uptake. Indeed awareness of services offered by organizations has been empirically established to influence various aspects of consumer purchase decisions (Nijset al., 2001). In particular these authors established that service awareness influenced consumer's purchase decisions such as brand choice, purchase time, quantity and brand switching. Further, a study by Nagar (2009) found that awareness of services offered by an organization to have a positive influence on customer commitment, and retention.

Although many indicated that they were unaware of the existence of institutional care homes for older people, these homes have been in existence in Nakuru since 1945. There are currently four such homes in the country namely County Government home for the elderly-Bondeni Estate, Catholic Diocese of Nakuru home for the elderly-Pipeline Estate, Dolly Care Rehabilitation and Elderly Home- Egerton, Njoro and Ngure International Help Age (Home-based)-Dundori. County Government home for the elderly-Bondeni Estate was the first one to be established in the county. It was built by

the colonialists to take care of the aging workers who could only work for half a day. After independence it became under the jurisdiction of Municipal Council of Nakuru and later by the County Government of Nakuru in 2013.

It is important to note here that other than County Government home for the elderly-Bondeni Estate, the rest of the homes are privately owned. Although most of the respondents were unwilling to enroll their older relatives in these homes, the few who expressed their willingness to consider these homes for their older relatives preferred private rather than government run homes. When asked to justify their preference for private, Sarah (not her real name), one of the key informants stated that she prefers private homes because they have superior facilities, better trained personnel and general care services. Indeed one the private homes that the researcher had far much better facilities compared with the government run home at Bondeni estate.

The fact that majority of the respondents were not aware of the existence and location of homes for the elderly in Nakuru County prompted this study to establish from the management of one the homes how they got older people enrolled in her institution. The manager informed this study some of elderly people enrolled in her home were just dumped at the gate of her institution presumably by family members. This study also learnt that some of elderly people were brought to the home by the police after they (elderly) reported to the police station and stated that they had nowhere to live. While in some cases elderly people just report to the institution by themselves. In other cases they are guided by media reports of elderly people who are living in poor conditions. For example, the manager informed this study that one of the elderly people under their care was taken after media report that he was living under a tree in a place called MailiSita in Bahati Sub-County. Others are also brought to them social workers after picking from the streets where they employ beggary as a means of earning a livelihood.

4.6.2 The Relationship between Public Awareness of Formal Care Institutions for Older People and Uptake of the Services

When asked about the relationship between public awareness of formal care institutions for older people and uptake of the services, majority (60%) of the respondents reported that they were unaware of the existence of institutional care homes for older people in Nakuru County (Table 22).

Table 22: Awareness of Formal Care Institutions and uptake of the services

Willingness	Awareness Of Formal Care Institutions					Total
	SD	D	SA	A	SA	
NW	33(27.0%)	34(27.9%)	33(27.0%)	10(8.2%)	12(9.8%)	122(100%)
LW	48(35.0%)	37(27.0%)	25(18.2%)	17(12.4%)	10(7.3%)	137(100%)
SW	18(33.3%)	14(25.9%)	9(16.7%)	10(18.5%)	3(5.6%)	54(100%)
W	10(20.4%)	15(30.6%)	10(20.4%)	7(14.3%)	7(14.3%)	49(100%)
VW	8(33.3%)	3(12.5%)	7(29.2%)	2(8.3%)	4(16.7%)	24(100%)
Total	**117(30.3%**	**103(26.7%)**	**84(21.8%)**	**46(11.9%)**	**36(9.3%)**	**386(100%)**

χ^2= 21.636, df=16, P=0.155, Cramer's V=0.138

As shown in Table 22, there was no significant relationship between public awareness of formal care institutions for older people and uptake of the services (P = 0.155).The relationship between public awareness of formal care institutions for older people and uptake of the services was not only none significant but also weak (Cramer's V=0.138). It is evident from the results in Table 22 above that out of the 122 respondents who were not willing to enroll their older relatives into formal care institutions for older people, 54.9% and 45.1% of them generally disagreed and agreed respectively that they were unaware of the existence of formal care institutional homes for older people in society. It also clear from the results that out of the 24 respondents who were very willing to enroll their older relatives for formal care services, 45.8% and 54.2% of them were unaware and aware respectively of the existence of formal care institutions for older people in Nakuru County. Therefore, there was no major numerical difference between those who aware or unaware about the existence of institutional care homes for older people, and were willing or unwilling to enroll their older relatives in the homes. This therefore confirms the findings of the study, which found that there was no statistically significant relationship between public awareness of the existence of institutional care homes for older people and the uptake of the services.

All the homes for the elderly visited by the researcher in Nakuru County had no awareness campaign programs. Other than the homes themselves, the other place where members of the public could obtain information about homes for older people in Nakuru County was the office of Director of County services. It also important to note that of the four homes for older people in the county, only three was well known to the general public. Catholic Diocese of Nakuru home for the elderly was exclusively for the retired Catholic Nuns, and no admission could be granted to other members of the public. Dolly

Care Rehabilitation and Elderly Home and Ngure International Help Age were private and as such had restricted access policy. The only public institutional care home was County Government home for the elderly. This home was open to all members of the public. The home had a capacity of 12 but at the time of this study had only 7 elderly people admitted, which represented just about 58% of the enrolment. Although the management of other homes did not provide the actual number of older people enrolled in their institutions, majority of them indicated that their current enrolment was between 40% and 70%. Low level awareness of homes for elderly in Nakuru County was also indicated by the inability of huge proportion of members of the public who could neither mention names of these homes neither cite their exact locations in the County. Even though there were four homes for the elderly in Nakuru County, very few members of the public engaged in this study were aware of them. Nine out of ten respondents in this study could only mention the Bondeni-based home for the elderly when asked to mention some of the homes of the elderly they were aware of in Nakuru County.

4.6.3 Perceived Conformity of Care Institutions for Older People to Formal Regulations

Although it was important to establish the extent to which members of the public were aware of the existence of formal care institutions for older people, it was even more necessary to understand whether members of the public perceived these institutions to be existing and being managed legally. When asked to state whether they agreed or disagreed that formal care institutions were existing legally, the respondents stated as presented in Figure 19.

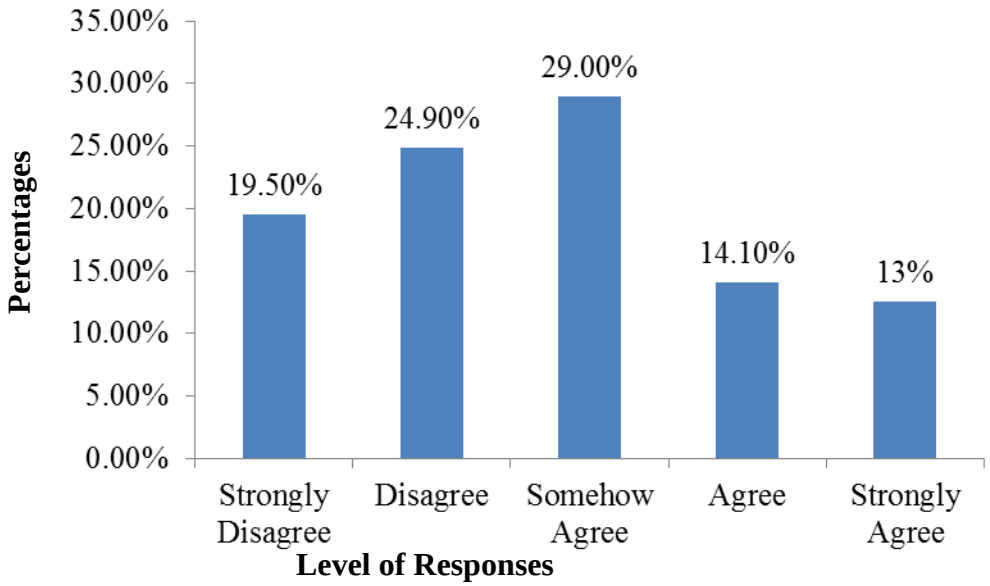

Figure 19: Perceived Conformity of Care Institutions

Figure 19 above shows that 56.1% agreed that formal care institutions for older people in Nakuru County were being run legally against 43.1% who disagreed. The results also reveal that 29% of the respondents somehow agreed that these institutions were being run legally. Some of the respondents, however, considered formal care institutions for older people in Nakuru County as being operated illegally. Specially, 19.5% and 24.9% strongly disagreed and disagreed of the respondents considered these institutions as being run legally.

An interview this study held with two respondents revealed the eagerness of member's to establish whether an institution was licensed by the government as the most important way of determining the conformity status of the institution. The two informants both agreed that they would consider if the home was licensed before taking any decision to enroll their older relatives. There were a number of requirements that a proposed facility for institutional care home for the elderly had to meet before it is registered and permitted to operate. They include land, standards, security, capability, professionalism and accessibility. Land for the proposed home for older people must be in the right place and topography. The facility must also meet the standards set out by the physical planning act and must be approved by the physical planning department. The area must be secure, safe with perimeter wall. The facility must be accessible not only to the visitors but also for emergency evacuations.

The registration and regulation of the operations of institutional is a function of county government through the County director of social services (MoLSSS, 2014). As pointed out earlier a facility proposed to serve as an institutional care home must meet certain conditions. A license issued to individuals and organizations to run an institutional care home may be revoked if certain improprieties are detected. There are, however, continuous inspections of licensed homes by a team of director of social services, physical planner, nutritionist and public health officer to ensure continuous compliance.

4.6.4 The Relationship between Legal Status of Formal Care Institutions for older people and uptake of the services

A slightly higher (56.1%) proportion of the respondents held that institutional care homes for older people in Nakuru County were registered by the relevant authorities and were operating according to established rules and regulations (Figure 19). It was necessary for this study to test if there was any statistically significant relationship between public perceptions of the legal status of institutional care homes for older people and the uptake of the services offered by the homes. Table 23 illustrates this.

Table 23: Legal Status of Formal Care Institutions and uptake of the services

Willingness	**Personnel Attitude**					**Total**
	SD	**D**	**SA**	**A**	**SA**	
NW	23(20.0%)	33(28.7%)	30(26.1%)	12(10.4%)	17(14.8%)	115(100%)
LW	26(20.2%)	30(23.3%)	36(27.9%)	22(17.1%)	15(11.6%)	129(100%)
SW	13(24.1%)	16(29.6%)	13(24.1%)	7(13.0%)	5(9.3%)	54(100%)
W	7(14.9%)	10(21.3%)	17(36.2%)	8(17.0%)	5(10.6%)	47(100%)
VW	3(12.5%)	3(12.5%)	11(45.8%)	3(12.5%)	4(16.7%)	24(100%)
Total	**72(24.9%)**	**92(24.9%)**	**107(29.0%)**	**52(14.1%)**	**46(12.5%)**	**369(100%)**

χ^2= 8.228, df=16, P=0.042, Cramer's V=0.088

The relationship between public perceptions of the legal status of institutional care homes for older people and the uptake of the services was significant though weak(P=0.042, Cramer's V=0.088). It is discernible from Table 23 that willingness by members of the public to enroll their older relatives for institutional care services was expressed more by respondents who agreed that these homes were legally registered. For instance, out of 47 respondents who were willing to enroll their older relatives for institutional care services, 63.3% of them were respondents who generally agreed that

these homes were legally registered. Further, out of 115 respondents who were unwilling to enroll their older relatives in institutional care homes for older people 48.8% of them disagreed that the homes were legally registered. From the foregoing, it is clear that the uptake of institutional care services for older people was influenced more by public perception about the legal existence of the homes.

The registration and regulation of the operations of institutional is a function of county government through the County director of social services. As pointed out earlier a facility proposed to serve as an institutional care home must meet certain conditions. A license issued to individuals and organizations to run an institutional care home may be revoked if certain improprieties are detected. There are, however, continuous inspections of licensed homes by a team of director of social services, physical planner, nutritionist and public health officer to ensure continuous compliance.

4.6.5 Confidence in the Management of Formal care institutions for older people

The management of any organization is a critical player in the implementation of organizational goals. It is this critical role of the management of institution of formal care institutions for the elderly that prompted this study to establish from the respondents whether they were confidence in the management of these institutions. When respondents were asked to state whether they had confidence in the management of formal care institutions for older people in Nakuru County, their response were as shown in Figure 20.

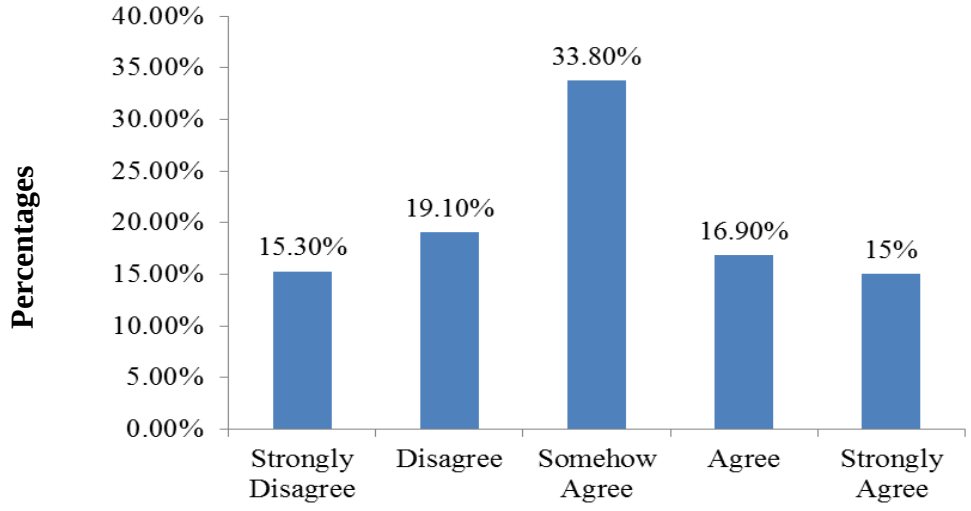

Figure 20: Confidence in the Management of Formal care institutions

The results of the study on public confidence in formal care institutions reveal that 65.6% of the respondents agreed that they indeed had confidence in the management of the institutions. It is also evident from the results in figure 20 above that 33.8% of the respondents somehow agreed that they had confidence in the management of formal care institutions for older people in Nakuru County. Respondents who disagreed on the ability of the management of formal care institutions to run the institutions effectively accounted for 34.4% of the respondents respectively.

It was important also to establish whether elderly people too had confidence in the institutions. An interview this study held by two elderly people enrolled in different institutions confirmed that indeed they had confidence in the care institutions. One of the elderly people Mr. Njau (not his real name) stated that he had confidence in the management of the institution where he was enrolled in. When probed further to state why he had confidence in the institution he stated the following;

> "People were mean to me outside there. My biological sister even told me on my face that I was a burden to him. In this place (institution) I feel loved and cared for. We eat well, bath and sleep well. Our beddings are washed regularly. We are also allowed to walk outside the home. As you can see we have cleaners who take care of our toilets, dormitory and compound. The staffs here respect us, listen to us and consider us as their parents. I find their attitude better than those of some of my close relatives".

4.6.6 Personnel of Care Institutions Have Positive Attitude towards Older People

On the attitude of personnel of care institutions toward elderly people, respondents were almost evenly divided as to whether they believed that personnel of formal care institutions had favorable attitude toward older people as shown in Table 24.

Table 24: Attitude towards Older People

Response	Frequency	Percent
Strong Disagree	48	13.3
Disagree	66	18.3
Somehow Agree	130	36.1
Agree	66	18.3
Strongly Agree	50	13.9
Total	**360**	**100.0**

Results in Table 24 reveal that 69.4% and 31.6% agreed and disagreed that personnel in formal care institutions for older people had positive attitude toward older people in the county. However, further examination of the results show that 13.9% and 18.3% of the respondents strongly agreed and agreed respectively that personnel in formal care institutions for older people had positive attitude toward older people in the county. Respondents who somehow agreed that personnel of formal care institutions for older people had positive attitude toward older people accounted for 36.1% of the respondents. It is also evident from the results that 13.3% and 18.3% of the respondents strongly disagreed and disagreed respectively that personnel in formal care institutions for older people had positive attitude toward older people in the county.

Unlike the results of the current study, Adams *et al.,* (2010) found that that majority of personnel of formal care institutions for older people had unfavourable attitude toward the elderly. Further, the results of the current study differ with that of Levy (2009), which found a significant proportion of care service providers in formal care institutions for the elderly had internalized stereotypes toward the elderly. The results of the current study also depart from that of Billings (2009), which found care providers to be overcritical and insensitive to elderly patients seeking clinical and psychosocial treatment from formal care institutions for the elderly. While examining some of the social barriers in accessing health care services for the elderly, McGibbon and Etowa (2009) found institutional racism and other forms of discriminatory practices as being greatest stumbling block to access to institutional care services. The authors reported that experiences of institutional racism had left patients from some communities over-stressed and distraught when accessing care services outside of their communities, producing risks to their already vulnerable health. Patients who faced discriminations expressed concerns over their neglect, delayed service provision and even verbal abuses.

4.6.7 The Relationship between Attitude of Personnel of Formal Care Institutions toward older people and uptake of the services

On the relationship between attitude of personnel of formal care institutions toward older people and uptake of the services, the responses were as depicted in Table 24. Inferential analysis results on the relationship between Attitude of Personnel of Formal Care Institutions toward older people and uptake of the services confirmed that the relationship between the two were statistically significant though weak (P=0.037, Cramer's V=0.131).

Table 25: Personnel Attitude toward older people and uptake of the services

Willingness	Personnel Attitude					Total
	SD	D	SA	A	SA	
NW	17(15.3%)	18(16.2%)	43(38.7%)	18(16.2%)	15(13.5%)	111(100%)
LW	15(11.6%)	26(20.2%)	43(33.3%)	27(20.9%)	18(14.0%)	129(100%)
SW	9(17.3%)	7(13.5%)	15(28.8%)	10(19.2%)	11(21.2%)	52(100%)
W	5(10.9%)	10(21.7%)	23(50.0%)	5(10.9%)	3(6.5%)	46(100%)
VW	2(9.1%)	5(22.7%)	6(27.3%)	6(27.3%)	3(13.6%)	22(100%)
Total	**48(13.3%)**	**66(18.3%)**	**130(36.1%)**	**66(18.3%)**	**50(13.9%)**	**360(100%)**

χ^2= 17.777, df=16, P=0.037, Cramer's V=0.131

Analysis of the results in Table 25 above shows that more respondents who expressed willingness to enroll their older relatives into institutions providing care to older people were those who generally agreed that personnel of these institutions had positive attitude toward older people. For example, of the 22 respondents who reported that they were very willing to enroll their relatives into these institutions, 68.2% of them generally agreed that personnel of the institutions had positive attitude toward older people. Similarly, of the 46 respondents who indicated that they were willing to consider taking their older relatives to institutional homes for the elderly, 67.4% of them generally agreed that personnel of the institutions had positive attitude toward older people. The same trend obtains for respondents who reported that they somehow willing and least willing to consider formal care services for their older relatives. Overall, willingness to partake of institutional care services for older people was more among members of the public who believed that personnel of these institutions had positive attitude toward older people.

An interview that this study held with an elderly person and one of the staff at Nakuru County home for the elderly, revealed that the existence of a harmonious relationship between the staffs of the home and the elderly people in their custody. Nancy (not her real) an employee of the home had this to say asked to explain the kind of relationship that exist between the staff and elderly in their home.

> "The relationship between us (staffs) and elderly people is every cordial. We understand each other very well. They (elderly people) appreciate and value our work. We also appreciate and value their presence. Although some of them have mood changes, but we understand that it is because of

> their age and not their negative attitude toward us. In this home we live us a family. We sit, discuss and resolve dispute as and when it arises together just like any family in the society".

It was also necessary to establish from the elderly people enrolled in the home what they thought of the staffs of the institution with regard to how they were treated. An interview this study held with Joseph (not his real name) one of the elderly people enrolled in the home on this subject also confirmed that indeed there was a cordial relationship between elderly people and staffs in the institution as demonstrated by the following excerpt.

> "We are seven elderly people enrolled in this home. I was the second one to be admitted in this home. I have been in this home since early 2000s. We used to have a few problems in the past but things are now better these days. We talk freely with our staff. They encourage us to freely present our problems to them. They talk to us in a friendly way even when we make mistakes. They treat us like their seniors in life. We generally feel good here".

Although this interview was confined to on one institution, it nonetheless conforms that the attitude staffs of institutional homes for older people toward older people was positive. The change of ownership of public home for the elderly from the Municipal Council of Nakuru to now County government of Nakuru has seen a significant improvement in service delivery. As confirmed by the one of senior staffs at the home, there is increased funding to the home, prompt payment of salaries to the staffs and timely acquisition of essential items needed in the home. The facility was also renovated, lighting systems improved, dormitory refurbished among other infrastructure. These interventions have served as a huge motivation to staff, which has enabled them to value and appreciate their work. Further, regular inspections and visits by the staffs of department of social services at the county to the home has ensured provision of quality services, which among others is indicated by the cordial relationship that exists between the service providers (staffs) and services recipients (elderly people).

4.6.8 Care institutions have adequate staffs to respond to the needs of older people

The respondents were asked whether the care institutions have adequate staffs to respond to the needs of the older people. Their responses were as shown in Figure 21:

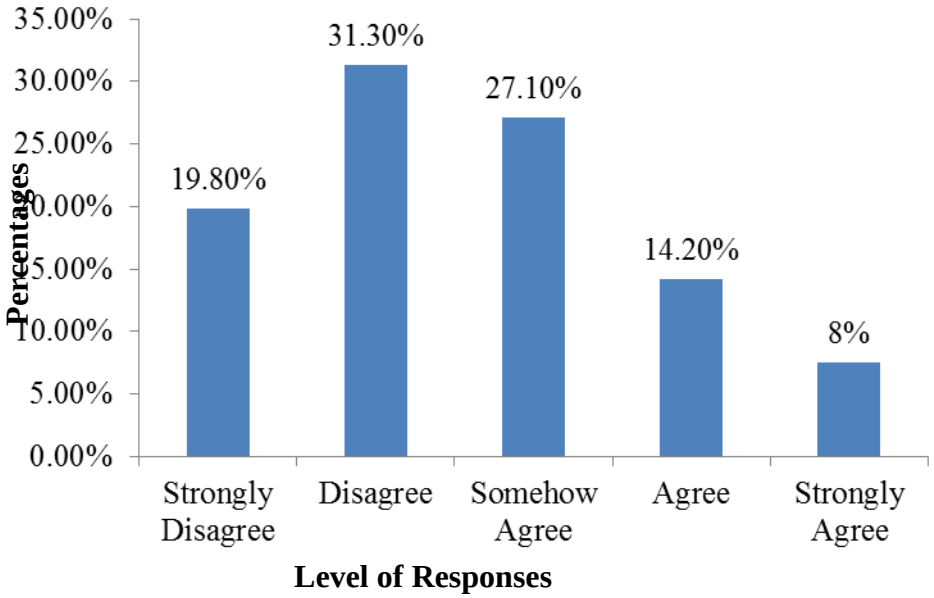

Figure 21: Care institutions have adequate staffs

A significant proportion or 51.1% of members of the public engaged in this study held that formal care institutions for older people had inadequate personnel to take care of older people enrolled in their programs. Analysis of the results of the study in Figure 21 shows that 19.8% and 31.3% of the respondents strongly disagreed and disagreed that formal care institutions for older people in Nakuru County had adequate staff to respond to the needs of older people admitted in their institutions. This is against 8% and 14.2% of the respondents who strongly agreed and agreed that these institutions had adequate staff to respond to the needs of older people admitted in their institutions. However, 27.1% of the respondents somehow agreed that formal care institutions for older people had adequate staff to take care of older people enrolled in their institutions.

Institutional leadership has also been cited a critical factor in the delivery of services in the institution. Wilson (2004) argues that leadership is critical for the success and survival of all forms of organizations. Wilson (2004) argues that the role of leadership in organizations is to put structure and order. However, to achieve this, Basham (2012) observes that leaders must exhibit certain traits, which are grouped into group and individual traits. Group traits include collaboration, shared purpose, disagreements with respect, division of labor and a learning environment. Individual traits include self-knowledge, authenticity/ integrity, commitment, empathy and competence. Institutional leadership as has been pointed by Hughes et al. (2012) and buttressed by Basham (2012) is indeed important in the establishment and growth of

organizations. Institutions such as those providing care to older people too may face challenges, some of which can only be overcome through effective leadership.

4.6.9 Care Institutions Have Quality Accommodation Facilities for Older People

Accommodation facilities are essential facilities in institutions that offer residential services. The centrality of accommodation facilities to the wellbeing of older people admitted for institutional care is what prompted this study to establish issues relating to quality of accommodation as understood by members of the public who participated in this study. When respondents were asked to state whether they agreed with the assertion that formal care institutions for older people had quality accommodation facilities for older people, their responses were as presented in Figure 22.

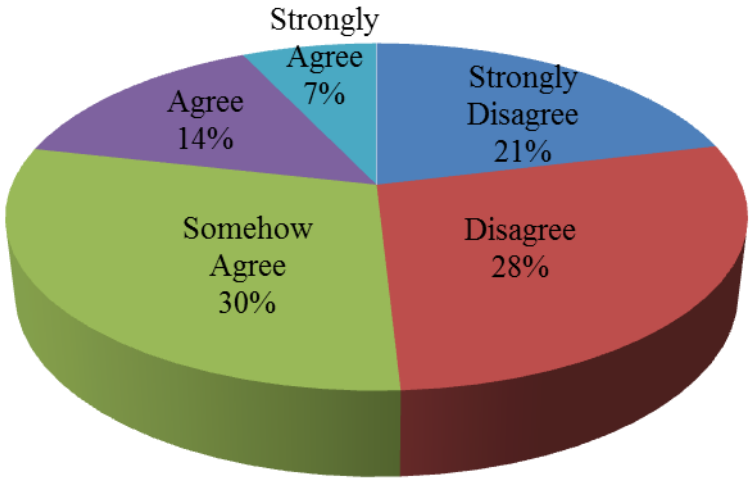

Figure 22: Quality Accommodation Facilities for Older People

As shown in Figure 22 above, 51% and 49% of the respondents generally agreed and disagreed respectively that formal care institutions for older people had quality accommodation. However, 21% of the respondents registered strong disagreement that these institutions had quality accommodation for older people. It is also clear from the results that 28% of the respondents disagreed that formal care institutions in Nakuru County had quality accommodation for older people. The idea that these institutions had poor quality accommodation facilities for older was not supported by all since 7% and 14% of the respondents strongly agreed and agreed respectively that these institutions had quality accommodation facilities for older people in their custody. Further examination of the results in figure 4.13 below indicate that 30% of the respondents

somehow agreed that formal care institutions in Nakuru County had quality accommodation for older people.

It was important for this study to establish from members of the public what they considered to constitute quality accommodation facility. When asked to describe what they considered as quality accommodation, Nekesa (not her real name) stated as follows:

> "A good accommodation is one which is spacious, clean, well ventilated and lit. The bedding should be warm, clean and adequate. There should be toilets and bathrooms, which are not only clean but also located near. There should be proper drainage. There should be a clinic within the facility or an arrangement between the facility and a nearby clinic. The facility should have a perimeter fence and security".

A visit to various homes for older people in the county and through the administration of an observation checklist, this study established that homes had most of the basic and essential requirements listed above by the informant. Most of the requirements as noted earlier relate to accommodation, health, hygiene and security of elderly people. It was therefore not surprising that most of the homes had most of the things that members of the public considered to constitute quality accommodation.

4.6.10 The Relationship between Availability of Quality Accommodation in Formal Care Institutions toward older people and uptake of the services

The relationship between perceived quality accommodation in formal care institutions for the elderly and uptake of services in these institutions was both insignificant and weak as shown in Table 26(P=0.597, Cramer's V=0.117).

Table 26: Accommodation Facilities and uptake of the services

Willingness	Accommodation					Total
	SD	D	SA	A	SA	SD
NW	23(20.7%)	35(31.5%)	29(26.1%)	16(14.4%)	8(7.2%)	111(100%)
LW	25(20.0%)	31(24.8%)	40(32.0%)	22(17.6%)	7(5.6%)	125(100%)
SW	13(25.5%)	10(19.6%)	15(29.4%)	7(13.7%)	6(11.8%)	51(100%)
W	9(19.6%)	17(37.0%)	15(32.6%)	3(6.5%)	2(4.3%)	46(100%)
VW	7(30.4%)	6(26.1%)	5(21.7%)	3(13.0%)	2(8.7%)	23(100%)
Total	**77(21.6%)**	**99(27.8%)**	**104(29.2%)**	**51(14.3%)**	**25(7.0%)**	**356(100%**

χ^2= 14.03, df=16, P=0.597, Cramer's V=0.117

Although the number of respondents who were not willing to enroll their older relatives for formal care services was higher among those who generally disagreed that these institutions had quality accommodation, the difference was negligible as shown in Table 26. For instance, the number of respondents who were not willing to partake of these services for their older relatives was 52.2% and 47.8% of those who generally disagreed and agreed respectively that these homes had quality accommodation. Further examination of the statistics in Table 26, reveals that respondents who were willing to enroll their older relatives for institutional care services was 53.6% who disagreed that these institutions had quality accommodation against 46.4% who generally agreed that the institutions had quality accommodation. It is also evident from the results that 56.5% and 43.5% of the respondents who generally disagreed and agreed respectively that institutions homes had quality accommodation were very willing to consider institutional care services for their older relatives. In all these cases the numerical differences are very negligible between those who disagreed and agreed that there were quality accommodation in the institutional homes for older people thereby buttressing the findings of the study on the relationship between quality accommodation and uptake of formal care services in Nakuru County.

Institutional care for older people is still a relatively new phenomenon in Kenya and as such has not been subjected to greater scrutiny by society. Most of the institutions that offer care to older people do so free of charge and as such members of the public whose older relatives are accommodated in these facilities might have deem it unkind to question issues to do with quality of services in the institutions since they have not paid for them. Otherwise, the public would have given service quality an important consideration had payment for the services been made a requirement prior to their access. As noted earlier, majority of the respondents also believed that these institutional care homes for older people were registered and regulated by relevant government agencies (Figure 22). Further, majority of the respondents also had confidence both in the management and staff of these homes to offer quality services to their older relatives (Figures 20 and 22, and Table 14), all of which may have made accommodation a minor consideration in the uptake of institutional care for older people.

Although institutional homes for the elderly covered in this study generally had enough accommodation facilities, there was need to improve the quality of facilities as noted by one of the managers of the homes. According to one of the managers (name

withheld), accommodation of special populations such as the elderly goes beyond mere availability of dormitories. The manager noted that elderly people require regular medical checkups, special diets, entertainments, physical exercises and heaters among other things for their well-being. To this extent, the manager pointed that a dispensary, a gym, TV room, ambulance and a hall should be included as part of the accommodation facilities in homes for elderly people. The manger further noted that the inappropriateness of the current arrangement where homes are forced to ferry their sick clients to the nearby dispensaries owing to the frail and fragile condition of the elderly people in their custody.

Unlike the current study, which found no statistically significant relationship between perceived quality of accommodation services and uptake of services offered, a study by Johnson & Sirikit (2012) found significant relationship between perceived quality of accommodation in the hospitality industry and consumption of such services. The study particularly noted that organizations that offered high quality services attracted more customers than their competitors even if such services were being offered at prices that are higher than those of their competitors.

4.6.11 Care Institutions Have Adequate Facilities for Physical Exercise

The participants were asked to state whether the care institutions have adequate facilities for physical exercises. Their responses are summarized in Figure 23.

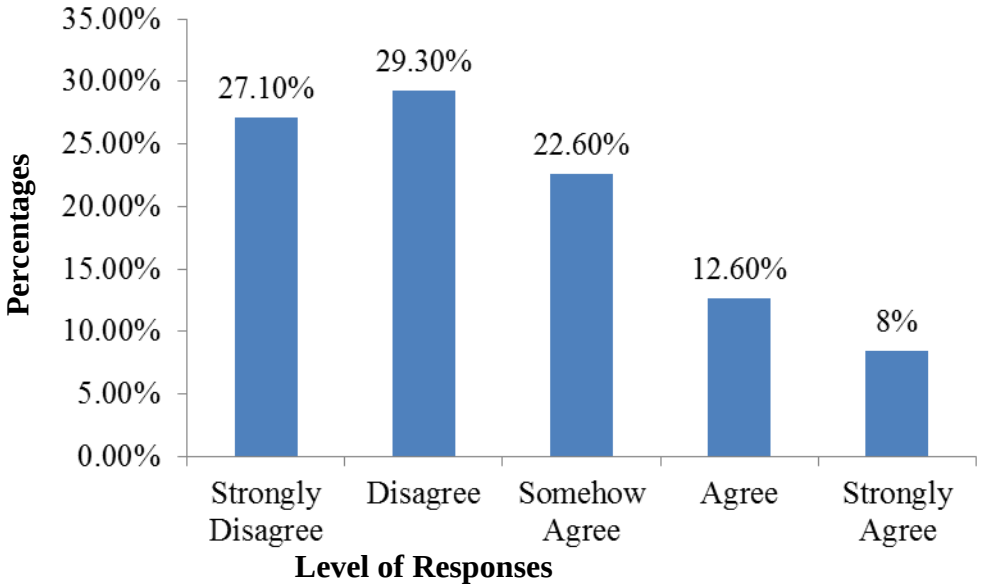

Figure 23: Adequacy of Facilities for Physical Exercise

It was held by 55.4% of the respondents that formal care institutions for older people in Nakuru County did not have adequate facilities that could be used by older people for physical exercises. Specifically 27.1% and 29.3% of the respondents strongly disagreed and disagreed that these institutions had adequate physical exercises facilities for older people. However, 8% and 12.6% of the respondents strongly agreed and agreed that these institutions had adequate facilities for physical exercises. Further, 22.6% of the respondents somehow agreed that there were adequate facilities to be used by older people for physical exercises as shown in Figure 23.

Whether or not formal care institutions can provide effective services to the elderly has also been examined in the context of the kinds of physical facilities they have (Mosadeghrad, 2012). The author indeed asserted that formal care institution's physical environment can be either a hindrance or an impetus to the provision of formal care services to the elderly. (Mosadeghrad, 2012) reported that institutional factors such as availability of supplies and equipment and allocation of time were to affect the quality of care provided to the elderly. The author concluded that quality of formal care to the elderly was grossly undermined by lack of resources. There is no doubt as suggested here that lack of resources can surely undermine delivery of quality formal care to the elderly as pointed out by (Mosadeghrad, 2012).Although Mosadeghrad's (2012) has shown that physical facilities contribute positively to quality care provision, the author has not elaborated on the specific kinds of physical facilities that were lacking in the formal care institutions covered in the study, which their absence undermined provision of quality care services.

4.4.12 Care Institutions Have Comprehensive Programs for Social Bonding

Whether the care institutions have comprehensive programs for social bonding, the respondent gave their views as depicted in Figure 24.

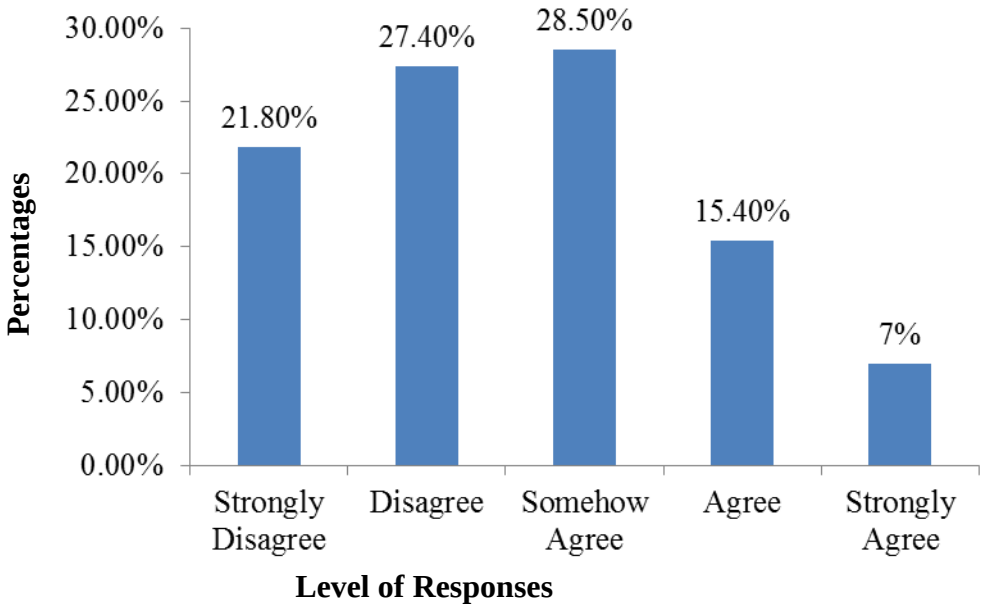

Figure 24: Comprehensiveness of Social Bonding Programs

A significant proportion or 49.2% of the respondents disagreed that formal care institutions for older people in Nakuru County had comprehensive programs for social bonding against 51.8% who held contrary opinion. The results of the study in Figure 24 above indicate that 21.8% and 27.4% of the respondents strongly disagreed and disagreed respectively when asked to confirm that formal care institutions had comprehensive programs that older people can exploit for social bonding. This position was, however, repudiated by 7%, 15.4% and 28.5% of the respondents who strongly agreed, agreed and somehow agreed that these institutions had comprehensive programs for social bonding.

A visit to one the homes older people in Nakuru County by the researcher and her assistant revealed that only one out the four homes had structures for social bonding. The home had a TV room, social hall and designated visiting days. The home also on specific days organized social meetings between elderly people in their custody and younger people and even their peers from informal homes. The manager of the home informed this study that they even bring artists to entertain older people in their home. When asked to state what informed their decision to incorporate these programs in their care provision services, the manager stated that they learnt that most of their clients appeared withdrawn and loneliness. It was the social worker who advised them they could help fight these psychosocial problems through social bonding programs.

4.6.13 The Relationship between Availability of Social bonding programs in Formal Care Institutions and uptake of the services

Programs that enable older people to bond have been found to help the elderly overcome health problems such as depression which results from loneliness (George (1996). It was therefore important for this study establish whether availability of social bonding programs in institutional care homes for the elderly has any significant influence on the decision of members of the public to enroll their older relatives into these homes. The relationship between availability of social bonding programs in formal care institutions and uptake of the services was not only statistically significant but also strong (P = 0.000, Cramer's V=0.836). Closer examination of statistical results is shown in Table 27.

Table 27: Social Bonding Programs and Uptake of the Services

Willingness	**Social Bonding Programs**					**Total**
	SD	**D**	**SA**	**A**	**SA**	
NW	20(18.0%)	33(29.7%)	37(33.3%)	15(13.5%)	6(5.4%)	111(100%)
LW	28(22.4%)	31(24.8%)	34(27.2%)	21(16.8%)	11(8.8%)	125(100%)
SW	16(30.2%)	15(28.3%)	8(15.1%)	10(18.9%)	4(7.5%0	53(100%)
W	12(26.1%)	13(28.3%)	16(34.8%)	4(8.7%)	1(2.2%)	46(100%)
VW	2(8.7%)	6(26.1%)	7(30.4%)	5(21.7%)	3(13.0%)	23(100%)
Total	**78(21.8%)**	**98(27.4%)**	**102(28.5%)**	**55(15.4%)**	**25(7.0%)**	**358(100%)**

χ^2= 18.878, df=16, P=0.000, Cramer's V=0.836

Closer examination of statistical results in Table 26 shows that more respondents who reported that they were very willing to enroll their older relatives for institutional care service were those who generally agreed that these homes had social bonding programs for older people. For example of the 23 respondents who stated that they were very willing to partake of these services 65.1% of them generally agreed that social bonding programs were available in these homes. This showed that the availability of social bonding programs was a significant consideration that members of the public made before deciding on whether to enroll their older relatives for institutional care services.

The advice of the social worker on the importance of social bonding in the fight against withdrawal and loneliness as highlighted in part 4.3.12 is in agreement with several accounts of other specialists. For instance, psychologists have argued that the

best way to prevent depression and associated psychological problems faced by older people is to address their loneliness, which has been identified as the main cause of depression in old age. Consequently, George (1996) a psychologist has advocated for sociability of the older people. Sociability according to George (1996) plays an important role in protecting people from the experience of psychological distress and in enhancing well-being. George (1996) observed that loneliness in old age occasioned by loss of important relationships can lead to feelings of emptiness and depression. Hanson and Carpenter (1994) also concurs that older people without relationships often become isolated, ignored and depressed; and tend to develop and maintain negative perceptions of self, find life less satisfying and often lack the motivation to change. In view of these, proponents of sociability stress the need for older people to spend time with relatives, friends and even peers.

4.7 Hypothesis Testing

In this section, an in depth analysis to test the hypotheses was done and results presented. Multiple regression model was used for the four objectives.

4.7.1 The Influence of Public Perception of Old People on the Willingness to Enroll for Institutionalized Care for the Elderly in Nakuru County, Kenya.

The first hypothesis was H_O1: Public perception of the elderly people does not significantly influence the willingness to enroll for institutionalized care in Nakuru, Kenya. To test this hypothesis, multiple regression analysis was done. The results for the influence of public perception of the elderly people on the willingness to enrol for institutionalized care in Nakuru are presented in Table 28. Multiple regression model was used with willingness to pay for institutionalised care used as the proxy for the willingness to enroll for institutionalised care and was the dependent variable. The explained variable (dependent variable) was regressed against the three dimensions of public perception of the elderly people. The independent variables included public perceived role of the elderly people in society (Elder role), Society's intolerance of the elderly peoples' weaknesses (Tolerance), and the society's value and respect for the elderly people. The model is significant as indicated by the F statistics of 72.243 being significant at 1% significance level (Sig=0.000). Further, the results of the model summary of the multiple regression analysis in Table 27 shows that the three independent variables included in the model accounted for 37.5% of the variance in the willingness to enroll for institutionalised care (R Square=0.375). This shows that the

public perception of the elderly people influenced 37.5% of the public's desire to enroll their elderly relatives in the institutionalised care homes. Thus, the null hypothesis which states that public perception of the elderly people does not significantly influence the willingness to enroll for institutionalized care in Nakuru, Kenya was rejected and the alternative hypotheses adopted. The collinearity results also indicated that there was no serious multicollinearity between the three independent variables used in the model since the VIF values were all less than 5 (De Jongh et al., 2015).

A further scrutiny of the results in Table 28 indicates that the willingness to enroll for institutionalised care was specifically influenced by Elder role (β=-0.115, p=0.028) negative and significant at 5% and tolerance (β=0.607, p=0.000) positive and significant at 1%. These two variables were the only predictors of willingness to pay for institutionalised care services.

Table 28: Influence of Public Perception of the Elderly on Willingness to Enroll for Institutionalised Care

Model Summary

Model	R	R Square	Adjusted R Square	F(ANOVA)	Sig
1	.612[a]	.375	.370	72.243	0.000

a. Predictors: (Constant), Value and respect, Tolerance, Elder role

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			Collinearity Statistics	
		B	Std. Error	Beta	T	Sig.	Tolerance	VIF
1	(Constant)	1.025	.250		4.096	.000		
	Elder role	-.141	.064	-.115	-2.204	.028	.638	1.566
	Tolerance	.626	.043	.607	14.526	.000	.993	1.007
	Value and respect	.063	.062	.053	1.014	.311	.635	1.574

a. Dependent Variable: WTP SCORES

Elder role meant the perceived importance of the elderly people in society and was a significant factor that reduced the willingness to pay for institutionalized care by the people interviewed in this study. This implies that the respondents who recognized the important roles and the wisdom that the elderly people have were less willing to enroll their elderly relatives in the formal care homes. Clearly, people who appreciate the roles of their older relatives in society expressed unwillingness to seclude them from society by enrolling them in the care homes. In the same breadth, Dosu (2014), supported

the above argument and stated that elderly people in society play critical roles of custodial of family possessions such as land and may not be allowed to be secluded from their family members since chaos would arise with regard to the sharing of these possessions. Additionally, Robertson et al., (2015) noted that people who perceive older people negatively are the most likely to enrol them in the care homes since they are viewed as burdens in the society.

Tolerance was measured by the level of intolerance of the society towards the older people. Specifically, the study sought to determine whether older people were neglected by their relatives, whether they were leading solitary lives and whether they were facing elder abuse which jointly formed the tolerance variable. The regression results indicates that relatives who were intolerant to the weaknesses of the older people were the most likely to send them to care homes. This implies that such relatives were more willing to pay for the services and avoid the burden of taking care of the older people. This issues were also raised in a focus group discussion held where the panel members confirmed this result where by older people were facing problems such as: Discrimination by their own family members because of old age as they are seen as a burden by their family members. Some of them are accused of committing witchcraft by the members of the society hence face the challenge of being burned to death by the neighbours. Due to these problems they lack or have inadequate care and social support from their own family members hence most of them live miserable lives in their homesteads. They thus face the risk of lacking proper medical care by the people they ought to look up to for the vital support.

The discussants however pointed out that the solutions to these problems would definitely be to enrol the members of the society to the formal care homes. They viewed this as the best option since the relatives would perhaps visit their older members once in a while when they miss them rather than being left in the society unattended to. This would restore their dignity and pride, which is overly eroded. According to Akpan & Umobong (2013), people who held negative views about the elderly would orchestrate elder abuse and neglect which would condemn them to solitary lives. This is a clear impetus for enrolment of the elderly to the care homes by the relatives who can afford to pay otherwise such older people could easily lead a solitary life on their own without any attention from the relatives.

4.7.2 The Influence of Perceived Self-efficacy of Elderly People on the Willingness to Enroll for Institutionalized Care for the Elderly in Nakuru County, Kenya.

The hypothesis for the second objective was HO2: public perception of the elderly person's self-efficacy does not significantly influence the public's willingness to enroll for institutionalized care in Nakuru, Kenya. Multiple regression model was used as well to establish the influence of the public perception of the elderly peoples self-efficacy on the willingness to enroll for institutionalised care. The dependent variable was willingness to pay for institutionalised care while the independent variables were the average scores physical fitness, health status, financial status and psychosocial status of the elderly people which were the independent variables. The intension was to understand the impact of these factors on the willingness to enroll for institutionalized care. The model results were presented in Table 29.

The results presented in Table 29 indicate that the model was significant (F-statistic of 20.159 was significant at 1% significance level (Sig=0.000)) and independent variables explained 17.9% of the changes in the dependent. Thus, the remainder, 82.1% can be explained by other factors other than the four independent variables included in this model. The null hypothesis which stated that public perception of the elderly dependent's self-efficacy does not significantly influence the public's willingness to enroll for institutionalized care in Nakuru, Kenya is thus rejected at 1% significance level and the alternative hypothesis accepted. The results further indicate that there was no serious multicollinearity problem among the independent variables used in the model since all the VIFs were less than five. Hence, the model results are reliable and the beta coefficients can be adopted.

The results in Table 29 also indicate that specific factors related to public perception of the elderly peoples' self-efficacy which influence the changes in the willingness to pay for institutionalised care services were; health and psychological statuses of the elder people. The variable for the perception on health status of the older people was measured by the statement "My older relative suffers from serious health problems that require regular medical check-ups." This variable was negative and significant at 10% which implies that respondents who agreed with this statement were less willing to enroll their relatives in the care homes. This could be because they had little trust in the care homes' ability to provide the necessary care needed by such older relatives. They otherwise preferred to provide the care themselves other than engaging

the institutions which they had less trust in. In the African context, the best time to show love and care to relatives is when they are sick and needed close attention. This could further explain why most people who thought that their older relatives were experiencing health problems were less willing to enroll them for the institutionalised care. The FGD panel confirmed that there was quite a number of the elderly people that are physically challenged and lack some aid equipment such as hearing aids, walking sticks and even wheelchairs to assist them in their day to day normal living making life unbearable for them. Provision of proper medical care was also lacking the local communities and suggested that it would be wise for the relatives of the older persons to provide their elders with health insurance covers such as National Health Insurance Fund covers so as to ensure they get proper medical care especially even as they think about other formal care service provision for the elderly people.

Since result contradicts that of Green et al. (2017) who noted that people admitted to formal care homes had an increased number of health conditions and functional deficits, and were increasingly likely to report memory-related diagnoses, arthritis and heart disease. Thus, they were enrolled to the care homes to be monitored and treated by the institutions. This implies that such people had trust in the ability of the care homes to provide the needed care by the older people. The contradiction however could arise from the cultural differences and the difference in the efficacy of the care homes in the UK and Kenya.

The public perception on the psychosocial status of the elder people was measured by the statement “My older relative does not have enough friends to give him/her company.” The result for the variable indicates that people who agreed with this statement were more willing to pay for the institutionalised care services. Hence, respondents who felt that their relatives did not have enough friends to give them company were willing to enroll their relatives in the care homes so that perhaps they can get the company from their fellow comrades or the care providers. Indeed it would be prudent for such respondents to enroll their relatives in these institutions since they are the institutions with the speciality of providing care for older people. Among the challenges faced by the elderly people in the society was Psycho-social disabilities such as depression and stress caused by old age or as a result of illness leading them to be taken advantage of by the society where old women are even raped. Some are even just waiting for their own death due to the feeling of loneliness. Some of the suggestions to

the solutions included the relatives naming their children after their elderly persons so that it could give the elderly people a sense of pride that even after passing away they could still be felt present through this new generation. Again they identified good neighborliness could help keep tabs with the elderly people to cure their loneliness and reduce their psycho-social problems. If the above conditions are not met then the last option would be to enroll the older people to the care homes where their welfare could be professionally taken care of.

Young-Hyman et al. (2016) while studying the psychosocial conditions of the people with diabetes who are mostly elderly, reports that psychosocial condition of the older people can largely be enhanced through communications and interactions, problem identification, psychosocial screening, diagnostic evaluation, and intervention services. The psychosocial services can be provided in formal care homes for the older people. Addressing psychosocial problems upon identification is recommended. For patients with psychosocial challenges at home, interventions can be initiated through visits by specialists (qualified behavioural health care providers) or may just be recommended for enrolment in the care homes for close attention. Thus, the authors recommend enrolment in formal care homes for people with psychosocial challenges so that they can be well attended to by specialists.

Table 29: Perceived Self-efficacy of the Elderly People to take Care of Themselves

Model Summary

Model	R	R Square	Adjusted R Square	F(ANOVA)	Sig
1	.423[a]	.179	.170	20.159	.000[b]

a. Predictors: (Constant), psychosocial status, health status, physical fitness, financial fitness

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			Collinearity statistics	
		B	Std. Error	Beta	t	Sig.	Tolerance	VIF
1	(Constant)	1.354	.184		7.371	.000		
	Physical fitness	.009	.044	.011	.202	.840	0.810	1.235
	Health status	-.062	.035	-.089	-1.740	.083	0.854	1.171
	Financial status	.013	.045	.016	.296	.768	0.768	1.315
	Psychosocial status	.402	.050	.421	8.058	.000	0.811	1.233

a. Dependent Variable: WTP SCORES

4.7.3 The Influence of Perceived Self-efficacy of Primary Care givers on the Willingness to Enroll for Institutionalized Care for the Elderly in Nakuru County, Kenya.

In the third objective, the hypothesis was HO3: Perceived self-efficacy of the primary care givers does not significantly influence the decision to enroll for institutional care in Nakuru, Kenya. Multiple regression model was used as well. The dependent variable remained the same as in the first objective and the independent variables were the average scores for each dimension of perceived self-efficacy of the primary care givers. The dimensions included: Pre-old age relationship, psychological strength and financial capacity of the primary care givers. The intension was to understand the impact of these dimensions on the willingness to enroll for institutionalized care.

The results as presented in Table 30 indicate that the model was not significant and the therefore pre-old age relationship, psychological strength and financial capacity of the primary care givers did not significantly influence the willingness to enroll for institutionalised care. The F statistics of 1.415 was no significant (Sig=0.238) and thus the null hypothesis which stated that perceived self-efficacy of primary care givers does not significantly influence the decision to enroll older people in institutional care in Nakuru, Kenya was supported. This result implies that the conditions of the primary care givers in terms the pre-old age relationship with the older relatives, their psychological strength and financial capacity of do not matter in their decision to pay for the institutionalised care services for their older relatives. Further, the willingness to enroll for the institutionalised care services is therefore influenced by other factors but not the perceived self-efficacy of the primary care givers.

Table 30: Perceived Self-efficacy of the Primary Care Givers

Model Summary					
Model	R	R Square	Adjusted R Square	F(ANOVA)	Sig
1	.112[a]	.012	.004	1.415	0.238[b]

a. Predictors: (Constant), Psychological strength, Pre old relationship, Financial capacity

Coefficients[a]								
		Unstandardized Coefficients		Standardized Coefficients			Collinearity Statistics	
Model		B	Std. Error	Beta	t	Sig.	Tolerance	VIF
1	(Constant)	2.823	.293		9.638	.000		
	Pre old relationship	-.045	.044	-.057	-1.016	.311	.936	1.069
	Financial capacity	-.057	.083	-.048	-.689	.491	.600	1.668
	Psychological strength	-.073	.115	-.045	-.634	.527	.573	1.745

a. Dependent Variable: WTP SCORES

4.7.4 The Influence of Public Perception of Institutional Efficacy to Provide Care for the Elderly on the Willingness to Enroll for Institutionalized Care for the Elderly in Nakuru County, Kenya.

In the last objective, the hypothesis was HO4: The public perception of institutional efficacy to care for the elderly does not significantly influence the willingness to enroll for institutionalized care in Nakuru, Kenya was the hypothesis for the last objective. Similarly, multiple regression analysis was done to establish the influence of the public perception of institutional self-efficacy on the willingness to enroll for institutionalised care. The results for the test for this hypothesis are presented in Table 31. The dependent variable was the level of willingness to pay for institutionalised care and the independent variables were the average scores for the three factors of public's perceived self-efficacy of care homes. The factors included: legal status of the care homes, personnel and physical facilities of the care homes.

From the results, it is clear that the three independent variables increased the willingness to pay for institutionalised care services by 40.1%. That is, 59.9% of the willingness to pay for institutionalised care services can be explained be by other factors other the three used in the multiple regression model. The model results further indicate

that the model is significant as shown by an F statistic of 75.283 significant at 1% significance level (Sig=0.000). Hence, the null hypothesis which states that public perception of institutional efficacy to care for the elderly does not significantly influence the willingness to enroll for institutionalized care in Nakuru, Kenya is hereby rejected and the alternative hypothesis accepted. It will be therefore true to say that the public perception of institutional efficacy to care for the elderly people has an influence on the willingness to pay for the care services.

When the scrutiny is narrowed down to specific institutional factors, it is observed that two factors; personnel and physical facilities of the care homes have the influence on the willingness to pay for the service. Personnel has a negative and significant effect on the willingness to pay for the services (β=-0.167, p=0.004). This implies that the respondents, who had confidence that the formal care homes for the elderly had adequate staffs to respond to the needs of their older relatives, the staffs had a positive attitude toward older people in society and that the staffs were well trained, were less willing to enrol their relatives in the formal care homes. This is quite contrary to the expectations and can be explained by the general reluctance of Kenyan people to enrol their relatives in these facilities given the close knit nature of many households. Interestingly, Rabie & Klopper (2015) observed that factors that negatively affect the care of older persons in the formal care facilities were staff shortages, high staff workloads and overcrowding of the older people in South Africa. These factors hampered the legibility and efficacy of such institutions and were and thus a turn off for many people who would want to enrol for formal care services of the older people. This is however contrary to the findings in this study due to perhaps the differences in socialisation in South Africa and Kenya. The South African society is more dominated with white mentality compared to Kenya which is dominated by African social cultural orientation.

The variable for physical facilities was measured by three items; availability of the facilities, good accommodation facilities and enough facilities that older people could use for physical exercises. This factor (physical facility) was positive and significant at 1% significant level (β=-0.659, p=0.000). This means that respondents who had the view that these facilities were available with good accommodation facilities and enough facilities that their older relatives could use for physical exercises were more willing to pay for the formal services for their older relatives. Availability of these facilities as well

as their conditions are a great stimulant to any consumer of care homes since it is the first and important means of verifying the adequacy of such facilities before looking at the softer issues. Hence, the interviewed respondents seem to be keen on assessing the physical infrastructure before embarking on other issues such as the legal framework under which they operate.

Indeed this was a major consideration even in the FGD where the public members clearly noting these facilities should be structured in a way that the health facilities should be within reach with doctor or nurse present, dispensary available and medicines available. Sanitation facilities, for example; with proper drainage systems for waste disposal, enough clean and hygienic toilets and bathrooms. Proper ventilations in the room for fresh air, proper lighting in the rooms for easy visibility, serene environment where trees are present for the elderly to sit under during the day, clean and hygienic kitchen, hall and dorms with proper beddings and a mosquito nets and a permanent home with ceiling and sub floors effective for the elderly persons. A care facility which meets these conditions is what will promote the welfare of the kinsmen away from home.

Table 31: Perceived Institutional Efficacy to Provide Care for the Elderly People

Model Summary

Model	R	R Square	Adjusted R Square	F(ANOVA)	Sig
1	.633[a]	.401	.396	75.283	0.000[b]

a. Predictors: (Constant), Legal status, Physical facility, Personnel

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			Collinearity statistics	
		B	Std. Error	Beta	t	Sig.	Tolerance	VIF
1	(Constant)	1.152	.177		6.498	.000		
	Personnel	-.208	.072	-.167	-2.873	.004	.0528	1.894
	Physical facility	.732	.049	.659	14.972	.000	0.918	1.089
	Legal status	-.002	.068	-.002	-.028	.978	0.536	1.865

a. Dependent Variable: WTP SCORES

CHAPTER FIVE
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This study focused on public perception of age and aging and its influence of the uptake of institutionalized care in Nakuru County, Kenya. The study was guided by the following objectives namely a) public perception of older people, b) perceived older people's efficacy on care provision for themselves and, c) perceived efficacy of members of the public to take care of their older relatives, d) perceived institutional efficacy of care provision for older people. Therefore, the summary, conclusions and recommendations presented in this chapter focuses on public perception of age and aging and its influence on the uptake of institutional care in Nakuru County, Kenya.

5.2 Summary of Findings

The summary of the following study findings are based on the objectives of the study, data collection and data analysis. The quantitative data was collected using self-administered questionnaires, which were analyzed using descriptive and inferential statistics. The descriptive statistics were frequencies and percentages. Chi-Square and Multiple Regression were used to test if there was any significant relationship between public perception of older people, perceived institutional efficacy, perceived older people's efficacy and perceived efficacy of members of the public on the one hand and uptake of institutional care services for older people on the other hand. The following are the summary of the findings of the study, which have been presented according to the objectives of the study.

There was a significant relationship between public perception of the elderly people and uptake of institutional care. A combination of Chi Square and multiple regression analysis revealed that perceived importance of elder role, elders' tolerance towards younger generation and respect towards older people were the main predictors of the uptake of institutional care (Tables, 8, 11 and 28). It is evident from the study findings in Table 8 that of the 123 respondents who were not willing to enroll their older relatives for institutional care 93.5% of them agreed that older people were playing important roles in society. Additionally, 80.3% of the respondents who generally agreed that older people were still respected and valued in society were not willing to enroll their older relatives for institutional care services (Table 11). Therefore, reluctance

toward the uptake of institutional care for older people was more conspicuous among primary care givers who considered older people as being important in society and those who had tremendous respect for older people in society. However, the independent variables under public perception of elderly people in society that influenced the uptake of institutional care for older people accounted for 37.5% of all the variables under public perception towards older people (Table 28

There was a significant relationship between public perception of elder people's self-efficacy and uptake of institutional care (Tables 13, 14 and 29). The results of Chi Square and multiple regression analysis show that the aspects of older person's self-efficacy, which influenced the uptake of institutional care were, physical condition, health condition, economic condition and psychological condition of older people. Majority (63.1%) of the respondents who were willing to enroll their older relatives for institutional care were those who agreed that their relatives were physically weak (Table 13). Further, willingness to embrace institutional care for older people was supported by 83% of the respondents who generally agreed that older people's economic condition could not allow them to take care of themselves (Table 14). Although Chi Square analysis showed that there was no significant relationship between older people's psychological condition and the uptake of institutional care, Multiple regression analysis found that there was a significant relationship between the two (Table 29). It is, however, important to note that independent variables on older people's self-efficacy that influenced the uptake of institutional care accounted for just 17.9% of all the variables under older people's self-efficacy (Table 29).

There was no significant relationship between efficacy of primary care givers and uptake of institutional care for older people (Tables 18, 19, 30). Chi Square and Multiple Regression analysis revealed that psychological status and nature of occupation of primary care givers had no significant influence on the uptake of institutional care for older people. Although more (53.9% of the respondents who stated that their occupation could afford them time to attend to their older relatives than their counterparts who disagreed (46.1%), the numerical difference was very minimal (Table 18). Both sets of respondents who agreed (75%) and disagreed (25%) that they were psychologically strong to take care of their older relatives were either willing or unwilling to enroll their older relatives for institutional care (Table 19). Pre-old age relationship and economic status of primary care givers had significant influence on the uptake of institutional care

according to Chi Square Analysis (Tables 17 and 21). Majority or (66.7% of primary care givers who agreed that their economic status limited their ability to take care of their older relatives were more willing to consider institutional care for their older relatives (Table 21). A higher proportion or 86.6% of primary care givers who generally agreed that their pre-old age relationship with their older relatives was cordial were reluctant to embrace institutional care (Table 17). However, further analysis using Multiple Regression found no significant relationship between Pre-old age relationship and economic status of primary care givers on one hand and the uptake of institutional care on the other hand (Table 30).

There was a significant relationship between perceived institutional efficacy and the uptake of institutional care for older people. A combination of Chi Square and multiple regression analysis revealed that personnel attitude, availability of physical facilities and social bonding programs were the main predictors of the uptake of institutional care for older people (Tables 25, 28 and 31). More members or 68.2% of the respondents who expressed their willingness to enroll their older relatives into institutional homes were those who generally agreed that personnel of these institutions had positive attitude toward older people. More members of the public who reported that they were very willing to enroll their older relatives for institutional care were those who generally agreed (65.1%) that these homes had social bonding programs for older people. Further analysis of the results using Chi Square showed that perceived institutional conformity to legal requirements had also significant influence on the uptake of institutional care (Table 23). Willingness by members of the public to enroll their older relatives for institutional care services were expressed more (63.3%) by respondents who believed that institutional homes for older people were legally registered. However, perceived institutional conformity to legal requirements had no significant influence on the uptake of institutional care according to the results of Multiple Regression (Table 31). Independent variables on institutional efficacy that influenced the uptake of institutional care accounted for just 40.1% of all the variables under institutional efficacy (Table 31).

5.3 Conclusions

5.3.1 Empirical Conclusions

In general, the results of the study indicate that there was a very low level of awareness about existence of the institutionalised acre homes as well as the uptake of these services in Nakuru County.

Aspects of public perception that had the greatest influence on the uptake of institutional care were perceived elder role, elder's tolerance towards younger generation and respect for elders. This implied that the uptake of institutional care for older people was undermined by perceived significance of older people in society and society's high regard for the elderly. On the other hand, the uptake of institutional care for older people was enhanced by negative perception of elder role, elder's intolerance towards younger generation as well as disregard or disrespect for older people in society.

Personal factors of older people that were accorded greatest consideration in the uptake of institutional care for older people were physical, health and economic status of older people. The results of the study suggest that older people who were physically weak, experienced poor health and economically poor were likely to be enrolled in institutional homes for older people. Therefore, the uptake of institutional care for older people was enhanced by older people' poor health, poor economic status and physical weakness. On the contrary, good health, physical strength and economic stability in old age undermined the uptake of institutional care in the County.

Pre-old age relationship between primary care givers and their elderly relatives was the most outstanding primary care givers' characteristics that influenced the uptake of institutional care for older people in Nakuru County. Primary care givers' whose pre-old age relationship with their elderly relatives was cordial expressed were reluctant to enroll their older relatives for institutional care. This was unlike their counterparts whose pre-old age relationship with their elderly relatives was adversarial. Therefore, the uptake of institutional care for older people was enhanced and undermined by cordial and adversarial pre-old age relationship between primary care givers and their older relatives respectively.

Institutional factors that had significant influence on the uptake of institutional care for older people in Nakuru County were the legal status of institutional care homes, attitude of personnel of institutional care homes and availability of social bonding

programs in institutional care homes. The uptake of institutional care for older people was enhanced conformity to legal requirements, personnel's positive attitude towards older people and availability of social bonding programs. However, the uptake of institutional care for older people was undermined by non-conformity of institutional care homes to legal requirements, personnel's negative attitude towards older people and inadequacy or unavailability of social bonding programs in institutional care homes.

5.4 Recommendations

This study wishes to make the following general and policy recommendations that need to be considered so as to improve the uptake of institutional care and enhance the provision of quality institutional care by homes for the elderly. This study has also made recommendations on areas which may require further research.

5.4.1 General Recommendations

This study established that very few people in Nakuru County care givers were aware of the existence of institutional care homes. The study also established that institutional care homes had no coherent strategies of creating awareness about their existence. This study holds that lack of clear awareness on the existence of institutional care homes may have undermined elderly people's access to institutional care services. This is regrettable given that some elderly people were leading solitary lives with others being subjected to numerous forms of abuse. Institutional care homes can serve as important rescue centres for elderly people faced with abandonment and abuse. In view of this, this study recommends for the development and execution of a comprehensive and coherent awareness creation strategies by institutional care homes about their existence so as to reach not only the aforementioned category of older people but also other primary care givers whose elderly relatives may be in need of institutional care.

5.4.2 Recommendation for Policy

This study recommend that policy implementers to develop programs that will assure the society of the availability of the elderly to them to serve their roles in the society. Once they are convinced that these people will still play their roles in the society while at the care homes, they would probably be willing to accept the formal services. Societal tolerance of the elderly people should be understood by policy makers for them to rescue those who face abuse. The policy makers and development agencies need to

sensitize the society about the possibilities of the elderly people being accommodated in the care homes instead of assaulting them in the society.

Although institutional care homes were generally providing satisfactory services to the elderly people enrolled in the various institutions, it was clear that they were doing so under serious resource constraints. Currently, government support is only limited to public institutions, yet majority of the elderly people under institutional care are found in private institutions. There is need for the government to extend its support to private institutional care homes given that majority of the elderly people under institutional care homes are under their care. The Government may consider extending cash transfers to elderly people to also elderly people in institutional care homes.

When setting up the institutions in future, the government, private and development partners need to consider key factors such as the public perception of the of the institutions in regards to the personnel and the physical infrastructure so that they lure more people into the care homes. While creating the awareness, they should showcase the competence of the staff and the standards of the facilities which are meant to provide the highest level of comfort for the people who are held in high esteem by the society.

Primary care givers may be willing to enroll their relatives in the care homes but the decision to do so may be outside their purview. Thus, deeper understanding of the societal evaluation of such decisions is important

5.4.3 Areas for Further Research

This research contributes to a broad understanding of the current perception of the society about aging and institutionalised care, a study scene that was yet to be exploited in the country. Further, the study found out that majority of the people in the study area were not aware of the existence of the care institutions even though some available were more than 70 years old. This calls for more awareness on the existence of these services as a way of boosting the welfare of the elderly people who could be facing abuse in the hands of the brutal relatives. Above all, the study finds that majority of the people in the society still hold a negative attitude about the formal care provision as they wouldn’t imagine sending their older folks away into solitude (which is actually not the case as there is a whole community in the care homes).

Despite these discoveries, the study still finds that although most of the care providers in these institutions indicated that they enjoyed their work. Care providers also reported that care provision role was physically and psychologically tasking owing to the diverse psychological, social and physical problems faced by elderly people enrolled in their institutions. Despite care provision being a challenging task, most of the care providers indicated that they were coping well in their care provision work. In view of this, it is necessary for a clear documentation of the experiences of formal care providers as well as the mechanisms employed by the care providers to cope with the challenging task of care provision. This study therefore recommends for an examination into the coping mechanisms of care providers in their adaptation to the challenging role of care provision in institutional care homes.

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APPENDICES

Appendix I: Questionnaire

This questionnaire is intended to collect data on Public Perceptions of Elderly People and Elderly Care Institutions and Uptake of Institutionalized Care for the Aged in Nakuru County, Kenya. All responses will be treated with utmost confidentiality and used only for study purposes. Any additional information may be recorded in a separate paper, if the spaces provided are not adequate. Where applicable please mark with an x as shown in this box [X]

PART A: Demographic Data

1. State your gender
   - □ Male
   - □ Female
2. State your marital status
   - □ Single
   - □ Married
   - □ Widowed
   - □ Single parent
3. State your age bracket
   - □ 18-26 Yrs
   - □ 27-32Yrs
   - □ 33-38 Yrs
   - □ 39-44 Yrs
   - □ 45-51 Yrs
   - □ 52-59 Yrs
4. State your main source of income
   - □ Formal employment
   - □ Casual employment
   - □ Business
   - □ Others. Specify

5. State your cumulative monthly income range
    - Below 5000
    - 5000-10,000
    - 11000-15,000
    - 16000-20000
    - 21000-25000
    - 26000-30000
    - 31000 and above
6. What is the size of your household
    - 2-5
    - 6-9
    - 10-12
    - 13-15
    - More than 15
7. State your highest level of formal education
    - No formal education
    - Primary
    - Secondary
    - College
    - University
8. To what extent are you willing to consider institutional care for your older relative?
    - Very willing
    - Willing
    - Somehow willing
    - Least willing
    - Not willing

PART B: Public Perception of Older People

KEY: 5- Strongly Agree, 4- Agree, 3-Somehow Agree, 2- Disagree, 1-, Strongly Disagree

Statement	**1**	**2**	**3**	**4**	**5**
Elder role					
9. Older people play important roles in our society					
10. Older people are wise and knowledgeable about the traditions of their society					
Tolerance level					
11. Older people are less tolerated and received to changes in society					
12. Older people are being neglected by their dependants in many families					
13. Older people are leading solitary lives in many families					
14. There are many cases of elder abuse in society					
Value and respect					
15. Older people are respected and valued in society					
16. Older people are warm and welcoming to younger generation					

PART C: Perceived Institutional Efficacy on Care Provision for older people

To what extent would you agree with following statements about institutional care homes for older people?

KEY: 5-Strongly Agree, 4- Agree, 3- Somehow Agree, 2- Disagree, 1-, Strongly Disagree

Statement	1	2	3	4	5
Availability of physical facilities					
17. Am very much aware of the existence of formal care institutions in Nakuru County					
18. Formal care institutions have good accommodation facilities to take care of my older relatives					
19. Formal care institutions have enough facilities that my older relative can use for physical exercises					
Legal status					
20. Formal care institutions for older people are operating according to government regulations					
21. Formal care institutions have sufficient and acceptable programs and activities that my older relative can use for social bonding					

Personnel					
22. I have confidence in the individuals/organizations that have established formal care institutions for older people					
23. Formal care institutions have well trained personnel that can take care of my older relatives					
24. Staffs of formal care institutions have positive attitude toward older people in society					
25. Formal care institutions have adequate staffs to respond to the needs of my older relatives					

PART D: Perceived older People's Efficacy on Care Provision for themselves

KEY: 5-Strongly Agree, 4- Agree, 3- Somehow Agree, 2- Disagree, 1-, Strongly Disagree

Statement	**1**	**2**	**3**	**4**	**5**
26. My older relative is **physically** weak and cannot fend for him/herself					
27. My older relative suffers from serious **health problems** that require regular medical checkups					
28. My older relative is **economically unstable** and cannot meet the cost of his/her medical needs (**financial capacity**)					
29. My older relative does not have enough friends to give him/her company (**psychosocial status**)					

PART E: Perceived efficacy of members of the public (care givers) to take Care of their older relatives

KEY: 5-Strongly Agree, 4- Agree, 3- Somehow Agree, 2- Disagree, 1-, Strongly Disagree

Statement	**1**	**2**	**3**	**4**	**5**
Pre old age relationship					
30. My relationship with my older relative was very good prior-to his/her old age					
31. My current relationship with older relative is very good and cordial					
Financial capacity					
32. The nature of my occupation permits me to dedicate enough time to take care of my older relative					

33. I have the financial capacity to take care of my older relative given his/her level of dependency					
34. I have adequate financial resources to cater for the medical needs of my older relative					
Psychological strength					
35. Am strong enough psychologically to take care of my older relative					
36. I have enough free time that allows me to take care of my older relative without major assistance from other people					
37. I understand my older relative very well, so it is easy for me take care of him/her					
38. My older relative appreciates every help or support that I offer him/her					
39. I have the capacity to take care of my older given his/her mental/psychological state					
40. My older relative suffers from **psychological problems** that requires my regular presence					

Thank you

Appendix II: Interview Guide

This is an interview on how public perception of ageing influence uptake of institutionalized care for the aged.

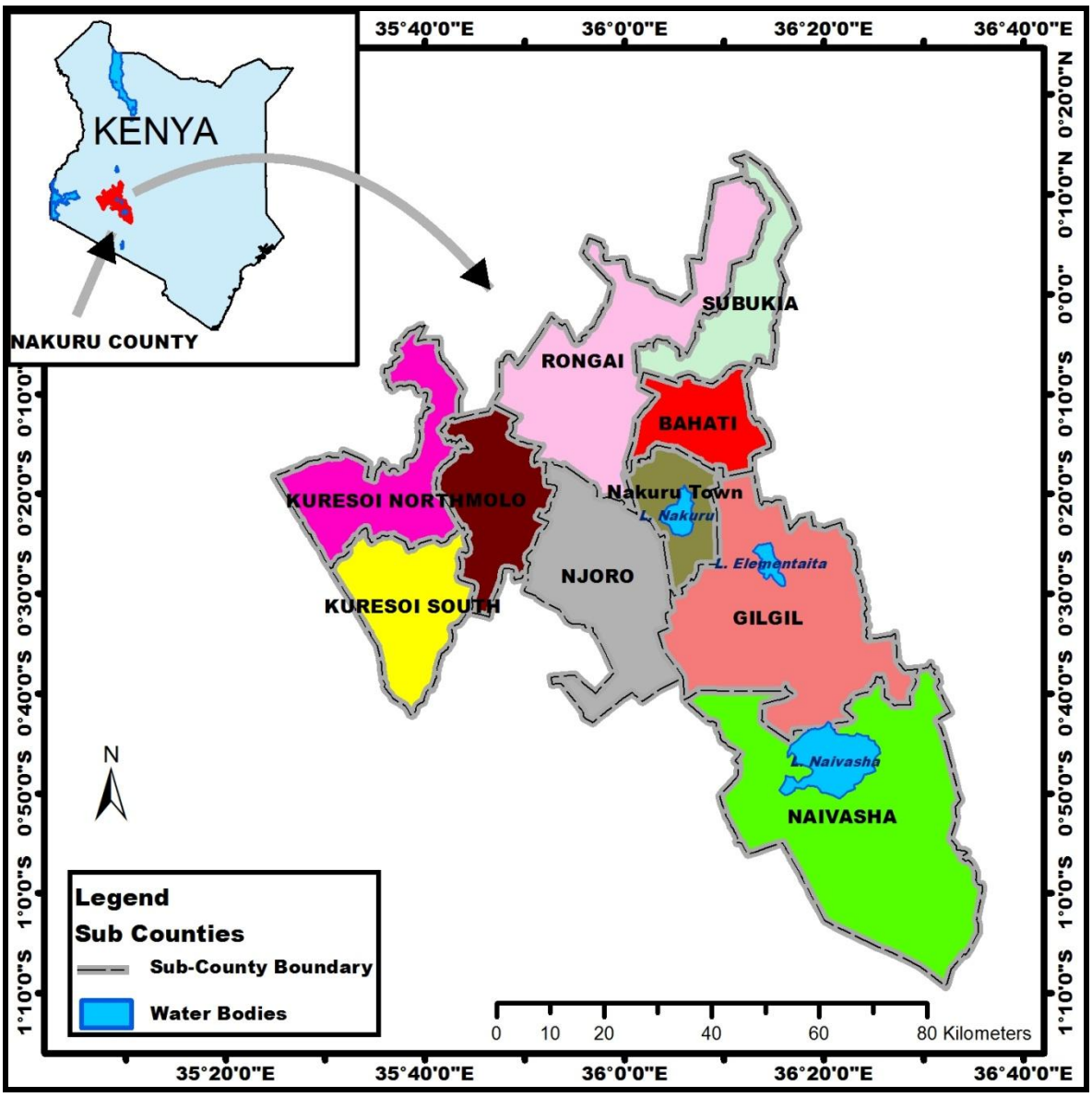
1. Explain some of the problems older people face in society today
2. What do you think relatives of older people should do to help alleviate some of the problems being faced by older people in society
3. How receptive would you say the public is towards institutional caregiving for elderly people?
4. What are some of the things members of the public may consider if they choose to enroll their older relatives for institutional care services?
5. What challenges would you say are being experienced by formal care institution in the provision of care to older people?
6. Explain some of the external support services that may be essential for effective provision of Institutional care services to elderly people?

Appendix III: Focus Group Guide

This is discussion on how public perception of ageing influence uptake of institutionalized care for the aged. I would like to request you to be as open and free as possible to discuss issues related to elder people's care at home and in the formal care institutions. All responses will be treated with utmost confidentiality, group views and will be used only for study purposes.

1) What are some of the problems older people face in society today?
2) What do you think relatives of older people should do to help alleviate some of the problems being faced by older people in society?
3) How receptive would you say the public is towards institutional caregiving for elderly people?
4) What are some of the things members of the public may consider if they choose to enroll their older relatives for institutional care services?
5) What challenges would you say are being experienced by formal care institutions in the provision of care to older people?
6) What are some of the external support services that may be essential for effective provision of Institutional care services to elderly people?

Appendix IV: Map of Kenya Showing Nakuru County



Appendix V: Test for Multicollinearity Suing Contingent Coefficients

	A	B	C	D	E	F	G	H	I	J	K	L
A	-											
B	0.1851	-										
C	0.6026	0.0928	-									
D	0.0513	0.2595	-0.0417	-								
E	0.0289	0.2294	-0.0778	0.3465	-							
F	0.0799	0.242	0.0361	0.4099	0.3858	-						
G	-0.0243	0.1993	-0.1223	0.3561	0.2939	0.4357	-					
H	0.1517	0.1254	0.1922	0.1503	0.1202	0.0598	0.025	-				
I	0.135	0.0539	0.2189	-0.0036	-0.0834	-0.1199	-0.0085	0.1416	-			
J	0.1912	0.2016	0.2782	0.2524	0.164	0.2119	0.2205	0.2528	0.4328	-		
K	0.0657	0.1468	0.1844	0.0747	-0.0106	0.0423	-0.0114	0.1687	0.2399	0.2811	-	
L	0.133	0.1932	0.2681	0.0466	-0.0513	0.0459	0.0607	0.1387	0.348	0.3492	0.0777	-
M	0.0936	0.1484	0.1912	0.064	-0.0306	0.0557	0.0316	0.0969	0.3389	0.3228	0.0404	0.0039

Note: A=Elder roles, B=Tolerance level, C=Value and respect, D=Physical fitness, E=Health status, F=Financial status of the old persons, G=Psychosocial status, H=Pre-old relationship, I= Financial capacity of the primary care givers, J=Psychological strength of the care givers, K=Legal status of the care homes, L=Personnel, M=Physical facilities

Appendix VI: Journal Publications and Conference Presentations

The influence of public perception of old people on the uptake of institutionalized care for the elderly in Nakuru County, Kenya

Sellah Jerop Chepkwony[1], Prof. Gladys[2], Dr. James Kay[3]
[1] Assistant lecturer, Department of Psychology and Foundations, University of Kabianga
[2]*Associate Professor, Department of Education, Kabarak University, P.O. Box-Kabarak Kenya Senior Lecturer, Department of Education, Kabarak University, P.O. Box - Kabarak, Kenya*

Corresponding Author: Sellah Jerop Chepkwony, Email: sellahchepkwony@gmail.com, Tel.: +254724793881

ABSTRACT

We examine the perceived public efficacy to address the needs of aged dependants, the public perception of the elderly dependants' self-efficacy, and public perception of institutional efficacy in taking care of the aged and socio-cultural factors on the one hand and their influence on the uptake of institutional care for the elderly. A pilot study was carried at Kericho County to determine validity and reliability of the study. The reliability coefficient of 0.862 and validity of 79.4% were attained hence the tool was both reliable and valid. The study was guided by exploratory research design. The study engaged 400 respondents, who were selected through purposive and stratified random sampling. Data for the study was collected through the use of questionnaires and in-depth interviews. The results vividly reveal that older people are respected and valued and also play a crucial role in the society. Unfortunately, the result loosely indicate that some older people face older abuse and are less tolerated. The regression results also indicate that willingness to accept formal care services is influenced negatively by elder role but negatively influenced by tolerance (measured as the intolerance level of the society against the elderly people). Thus, it is important to consider the roles actual significance of the elderly people in the society and their societal regards before marketing the services.

Key words: Public perception, Old people, Institutionalized care

The influence of public perception of primary care givers on the uptake of institutionalized care in Nakuru County, Kenya

Sellah Jerop Chepkwony[1], Prof. Gladys[2], Dr. James Kay[3]

[1] Assistant lecturer, Department of Psychology and Foundations, University of Kabianga

[2]*Associate Professor, Department of Education, Kabarak University, P.O. Box-Kabarak Kenya*

[3] *Senior Lecturer, Department of Education, Kabarak University, P.O. Box – Kabarak, Kenya*

Corresponding Author: Sellah Jerop Chepkwony, Email: sellahchepkwony@gmail.com, Tel.: +254724793881

ABSTRACT

Globally, few of the older people have access to institutional care homes for older people and African lags behinds. Nearly half of the population of the elderly people in the developed world have access to these services but actual percentage of African older people who have access to the services is not clearly documented. It is however believed to be below 5%. This study sought to determine whether primary care givers have an influence on the decision to enroll the elderly people in formal care homes. The study engaged 400 respondents from Nakuru County, who were selected through purposive and stratified random sampling. Data for the study was collected through the use of questionnaires and in-depth interviews. The results reveal that actually, the decision to enroll the elderly persons to care homes lies outside the purview of the primary care givers. It could be a societal issue beyond the sole decision of a primary care giver. The paper therefore recommends that deeper societal understanding be made on the perception on this subject rather than narrowing the scope to primary care givers' attributes.

Key words: Public perception, Elderly people, Self-efficacy, Care giver, Institutionalized care

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Chepkwony, S. J., et al., Editon Cons. J. Psychol. Guid. Couns. Double –Blind Peer Reviewed Journal

The Influence of Public Perception of Institutional Efficacy to Provide Care for the Elderly on the Uptake of Institutionalized Care for the Elderly in Nakuru County, Kenya

*Sellah Jerop Chepkwony[1], Gladys Kiptiony[2]

[1]Department of Psychology and Foundations, University of Kabianga, Kenya
[2]Department of Education, Kabarak University, Kenya
Author: Email: sellahchepkwony@gmail.com

ABSTRACT:

This study's purpose was to investigate the public perception of institutional efficacy to provide specialized care for elderly people and its influence on the uptake of institutional care in Nakuru County, Kenya. Specifically, the study examined perceived institutional efficacy in taking care of the aged and socio-cultural factors on the one hand and their influence on the uptake of institutional care for the elderly. A pilot study was carried at Kericho County to determine the validity and reliability of the study. The study engaged 400 respondents, who were selected through purposive and stratified random sampling. Data for the study was collected with questionnaires and in-depth interviews. The results indicate that uptake of care homes is positively influenced by physical facilities and negatively affected by staff. Thus, the availability of proper physical facilities for accommodation and physical exercise was a positive factor. It was, however, unexpected to find that the availability of competent staff negatively influenced the uptake of institutionalized care. The legality of the care homes was not a non-issue for the society in terms of influencing their decision to enroll their relative to the care homes. It is, therefore, necessary to sensitize the society about the efficacy of staff in the care homes as well as the importance of the legal status of the care homes.

Key Terms: Public perception, Old people, Institutionalized care, Uptake of institutional care

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The Nexus between Public Perception of the Elderly Person's Self-Efficacy and the Uptake of Institutionalised Care for the Elderly in Nakuru County, Kenya

Sellah Jerop Chepkwony[1], James Kay[2]
[1]Department of Psychology and Foundations, University of Kabianga, Kenya
[2]Department of Education, Kabarak University, Kenya
Author: Email: sellahchepkwony@gmail.com

Abstract

This study sought to determine the public perception of self-efficacy of the older people to take care of themselves. It was also intended to determine the factors influencing the uptake of formal care services in Kenya. The study engaged 400 respondents from Nakuru County, who were selected through purposive and stratified random sampling. Data was collected using questionnaires and in-depth interviews. The results reveal that indeed the level of awareness of the existence of the formal care services in Kenya is very low and that majority of the interviewed respondents were reluctant to enrol their relatives to the formal care homes. The result further indicates that health and the psychosocial status of the older people influence the decision of the members of the community interviewed to enrol the older relatives in formal care homes. It emerged from the results that the majority of the people declined the use of the services despite agreeing that their older relatives faced challenges that would warrant their enrolment for the services. We, therefore, recommend that a marketing plan for the services to be designed with an inherent system societal perception re-engineering so that a positive attitude towards services be formed. Psychosocial therapy provision should also be a key service of the care services since it emerged that older people suffering neglect and abuse were the most likely to be enrolled where there's the availability of services.

Key Terms: Public perception, Elderly people, Self-efficacy, Institutionalised care

Appendix VII: Letter of Research Authorization from the Ministry

THE PRESIDENCY
Ministry of Interior and Coordination of National Government

Telegram: "DISTRICTER" Nakuru
Telephone: Nakuru 051-2212515
When replying please quote

COUNTY COMMISSIONER
NAKURU COUNTY
P.O. BOX 81
NAKURU

Ref No CC.SR.EDU 12/1/2 VOL.11/182

9th, June 2017

TO WHOM IT MAY CONCERN

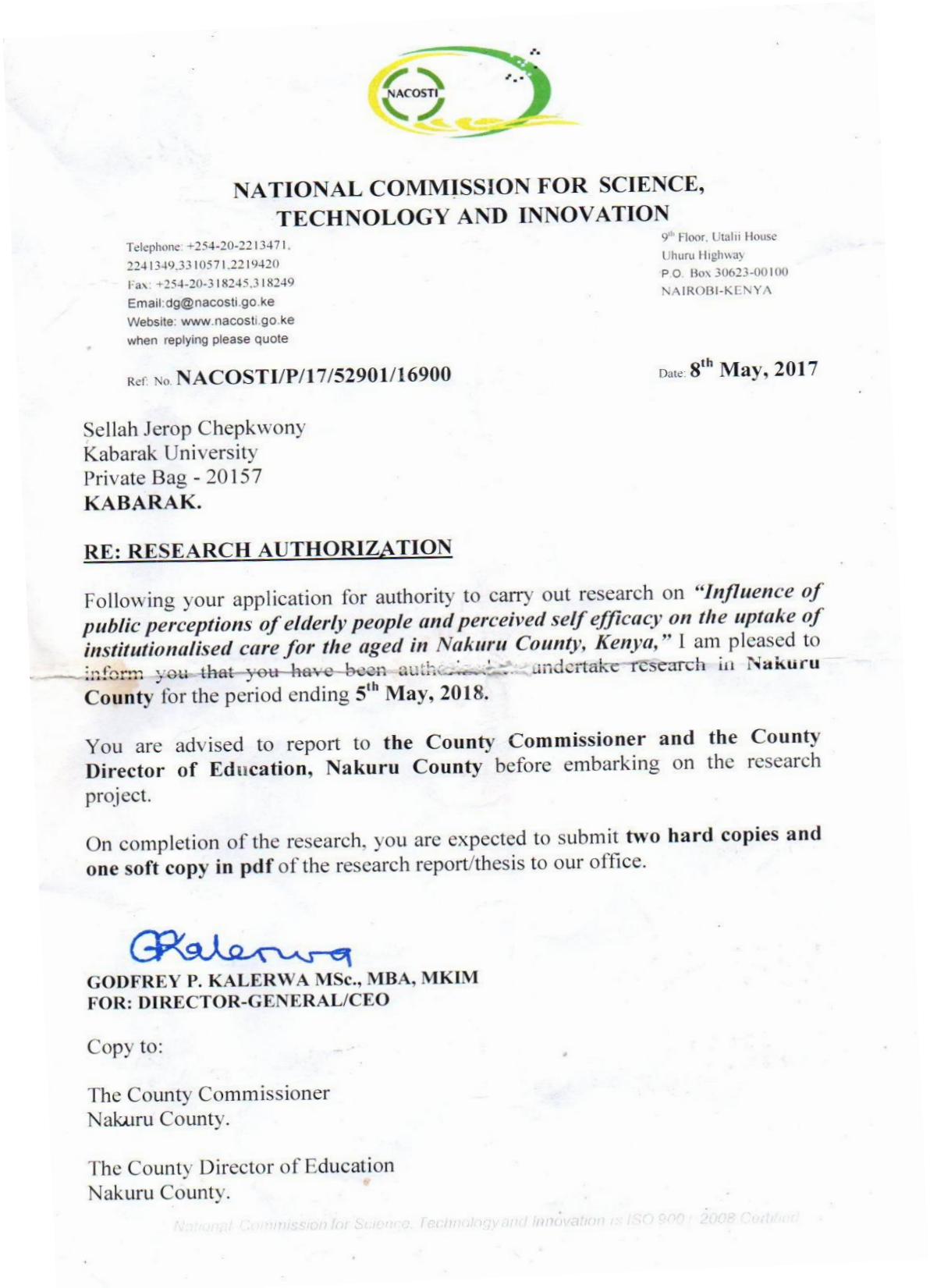
RE:- RESEARCH AUTHORIZATION
SELLAH JEROP CHEPKWONY

The above named student from Kabarak University, Nakuru has been authorized to carry out research on ***"Influence of public perceptions of elderly people and perceived self efficacy on the uptake of institutionalized care for the aged in Nakuru County,"*** for the period ending 5th May, 2018.

Please accord her all the necessary support to facilitate the success of her research

EDITH KOECH
FOR: COUNTY COMMISSIONER
NAKURU COUNTY

Appendix VIII: Letter of Research Authorization



NACOSTI

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone: +254-20-2213471, 2241349,3310571,2219420
Fax: +254-20-318245,318249
Email:dg@nacosti.go.ke
Website: www.nacosti.go.ke
when replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No. **NACOSTI/P/17/52901/16900**

Date: **8th May, 2017**

Sellah Jerop Chepkwony
Kabarak University
Private Bag - 20157
KABARAK.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Influence of public perceptions of elderly people and perceived self efficacy on the uptake of institutionalised care for the aged in Nakuru County, Kenya,"*** I am pleased to inform you that you have been authorized to undertake research in **Nakuru County** for the period ending **5th May, 2018.**

You are advised to report to **the County Commissioner and the County Director of Education, Nakuru County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

GODFREY P. KALERWA MSc., MBA, MKIM
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Nakuru County.

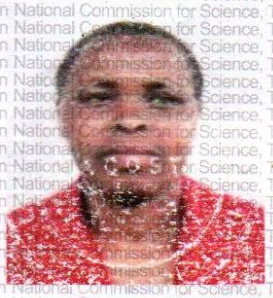
The County Director of Education
Nakuru County.

National Commission for Science, Technology and Innovation is ISO 9001: 2008 Certified

Appendix IX: Research Permit

THIS IS TO CERTIFY THAT:
MS. SELLAH JEROP CHEPKWONY
of KABARAK UNIVERSITY, 0-20117
egerton,has been permitted to conduct
research in *Nakuru County*

Permit No : NACOSTI/P/17/52901/16900
Date Of Issue : 8th May,2017
Fee Recieved :Ksh 2000



on the topic: *INFLUENCE OF PUBLIC PERCEPTIONS OF ELDERLY PEOPLE AND PERCEIVED SELF EFFICACY ON THE UPTAKE OF INSTITUTIONALISED CARE FOR THE AGED IN NAKURU COUNTY, KENYA*

for the period ending:
5th May,2018

.....
Applicant's Signature

.....
Director General
National Commission for Science, Technology & Innovation

CONDITIONS

1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit.
2. Government Officer will not be interviewed without prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two(2) hard copies and one (1) soft copy of your final report.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice

REPUBLIC OF KENYA

NACOSTI

National Commission for Science, Technology and Innovation

RESEACH CLEARANCE PERMIT

Serial No.A 13994

CONDITIONS: see back page