OPINION ARTICLE

Understanding influences on mental health among over 70-year-olds in Kenya using a life course theory [version 1; peer review: awaiting peer review]

Adelaide M Lusambili1, Robert Nyakundi2, Christine Ngaruiya3, Kizito L Muchanga4, Ahaya L Ochieng4, Laurie M Vusolo5, Newton Joseph Guni2

1Environmental Governance, Africa International University, Nairobi, Nairobi County, Kenya  
2The Aga Khan University, Nairobi County, Kenya  
3Yale University, New Haven, Connecticut, USA  
4Masinde Muliro University of Science and Technology, Kakamega, Kakamega County, Kenya  
5Westminister University, London, UK

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Abstract

World Health Organization (WHO) estimates that by 2050 “older adults” (OAs)—denoting those over 70 years old in this article—will constitute 21% of the global population, with over half living in low or middle-income countries (LMICs). Old age is associated with increased multiple chronic conditions (MCCs) such as cancer, hypertension, arthritis, diabetes and mental health. According to WHO, 20% of older adults in Africa are affected by mental health – and dementia and Alzheimer’s diseases are likely to increase, adding expenditure on public services. Knowledge and understanding of OAs experiences and histories and how they contribute to mental health are critical to informing measures and strategies to safeguard older adults. Like many sub-Saharan African (SSA), these experiences have not been documented in Kenya. In this article, we use a life course theory (LCT) to reflect on the intersection between historical and current environmental and socioeconomic factors and their effects on the mental health of OAs. We hope to enrich future researchers by providing core yet overlooked historicities to guide research and policies in an understudied population in sub-Saharan Africa. We conclude with policy and research recommendations on ageing and health.

Keywords

Older people, elderly, ageing, mental health, life course theory, Kenya and Africa.
Introduction

While half of the “older adults” (OAs) population is projected to live in low or middle-income countries such as Kenya by 2050, there is limited research to inform mental health interventions and policies. According to WHO (2013), mental health is an essential part of health and well-being, and it encompasses not only individual characteristics but also social, cultural, economic, political and environmental factors. An increase in life expectancy is linked to chronic conditions ingrained in ageing, such as dementia and psychological and behavioural disorders. Factors predisposing OAs to mental health are contextual, and understanding the ageing process and mental health by examining individual historicities within their environment is critical to prevention, early diagnosis, treatment and interventions. This paper uses a life course theory (LCT) to map out historical and environmental intersectionalities and their contributions to OAs mental health in Kenya.

The LCT is an interdisciplinary perspective or framework that seeks to understand the multiple factors that shape people’s lives from birth to death. It emerged in the 1960s and encompasses ideas and observations from an array of disciplines. The basic concept of LCT includes cohorts, trajectories, transitions, turning points and life events within which the study of family life and social change can ensue.

The life course theory views each person as a product of their environment as well as their genetics, which consequently act as a determinant for their health and healthcare. Emphasis is not placed on single steps in a life’s path but an integrated continuum of exposures, experiences and interactions. In studying gerontology, with a central focus on ageing, LCT has the potential to help practitioners understand complex interacting factors affecting the overall health of a population both at the individual level and as it affects generations.

In understanding and mapping the life course of older adults (OAs) in Figure 1 below, we highlight individual episodes of stress, or isolated life experiences, and their impact on an individual’s trajectory. Moreover, according to LCT, the cumulative effect of multiple negative experiences over time may have an inimical impact on health and development.

By way of example, in Figure 1, we demonstrate a LCT schematic with various effects that contribute to the trajectory of mental health among OAs in the context of Kenya. We present this model for consideration of contexts similar to Kenya, including other countries in SSA. Across the lifespan, populations are connected to social structures which may link to historical events such as urbanization and globalization. This, in turn, shapes opportunities such as those involving access to care; these factors act as determinants for the availability of care and ultimately affect health outcomes. By incorporating historical influences and recognizing the cumulative effects of multiple factors, this framework is valuable for understanding mental health among OAs and guiding effective policies and programs.

Intersection between urbanization, globalization and disintegration of traditional social fabrics

In Kenya, most OAs live in rural areas. Historically, rural areas were held together by tight-knit socio-cultural mores, which provided pathways for social protection and care in advanced age. However, rapid urbanisation after Kenya’s attainment of independence in the 1960s ushered in rural-urban migration and a move towards a primary focus on the nuclear family. This process weakened the traditional social fabrics of integration and interdependence that had typically supported care for OAs (extended family members).

Globalisation and urbanisation specifically began intensifying in SSA after the second world war (1939–1945). After the war, many returning African soldiers had attained a mindset that associated nationalism with urbanization. Hence, the rural-urban dichotomy disintegrated the traditional ties. The process of globalisation further contributed to the severing of traditional ties. While providing complex interconnectedness, linkages and cultural interactions that had not existed previously left OAs feeling isolated in terms of their ethnic identities.
Furthermore, age related social inequalities—with regards to access to the available resources—worsened as technological advances increased. Many OAs in Sub-Saharan Africa have no access to modern technological platforms such as smartphones, social media and games; hence having little to no contact with family members who are domiciled in urban areas. Children raised in urban cities that have been most rapidly influenced by globalization have become less grounded in traditional mores that conventionally provided pathways for the care of older adults. Such inaccessibility exacerbates loneliness that contributes towards worsening mental health.

Structural adjustment program (SAPS)
The majority of living OAs in Kenya were subject to the destructive effects of the World Bank Structural Adjustment Programs (WB-SAPs) - implemented in the 1980s and developed through the 1990s. The SAPs had far reaching consequences for people in these communities, and particularly the current OAs population. The WB-SAPs policies lowered the living standards as many Kenyan government employees were retrenched through a government approach that encouraged them to take a ‘handshake’ and leave their jobs; the majority being men.

A ‘handshake’ was a lump sum of money that was given to all those opting to retire early as a way for governments to contain wages. These individuals were primarily in their forties and early fifties at the time, constituting the demographic cohort coined “baby boomers” and the majority of current living OAs. The SAPs retrenchment program although lauded for decreasing wages and salaries on the government payroll in the initial stages, however, it increased poverty characterized with inequalities in education and accessing healthcare particularly for vulnerable populations. The implications were that many people who took the handshake plunged into poverty after a few years as it was inadequately
the abject poverty brought on by SAPs, women were forced to engage in risky behaviours, such as prostitution, in order to
isolate OAs. Fleming

Moreover, the SAPs were associated with budget cuts and privatization, both weakening the health system, and limiting
access to its services.20 Consequently, urban and rural inequalities increased as the number of public hospitals decreased,
and care provided by private hospitals was rendered too expensive for the majority of the population.31–32

Finally, spending cuts in the education ministries—as guided by the SAP driven policies—saw the reduction of student
enrollment into schools and the consequent drop out of trainees.33,34 The addition of school dropouts put further stress on
OAs who also took on the burden of these uneducated children; this resulted in increased financial demands for already
strained OAs. In sum, the SAPs are widely blamed for a short-changing of the country’s capacity for local investment,
autonomous prioritization of government spending by sovereign nations, and a downward quality in social services and
other priorities available to its citizens.35

Human immunodeficiency virus infection and acquired immunodeficiency syndrome (HIV/AIDS)
During the era of SAPs, HIV/AIDS ravaged communities in Sub-Saharan Africa and other low or middle income
countries (LMICs). In fact, evidence supports the link between SAPs and the increase in the HIV/AIDS burden.26 Due to
the abject poverty brought on by SAPs, women were forced to engage in risky behaviours, such as prostitution, in order to
make a living leading to HIV infections.7–9,43 At the same time, HIV/AIDS related mortality and morbidity rates among
young men increased, leaving behind a generation of orphaned children.44 Consequently, the generation that constitutes
OAs in Kenya today took on the responsibility of raising children whose parents had died by providing social and material
support.42 A survey within one of Kenya’s largest tribes, found the mean age of caretakers was 63.5 and in around a
quarter of the studied households (23.2%, n=108/465), at least one orphan was sheltered.43 Inadequate access to funds for
food and schooling are cited as prominent issues and this economic burden on OAs, alongside the shift in care-giving
responsibility, fell concomitant with the already ongoing, negative economic toll in the country caused by SAPs.45

The intersection between SAPs and the HIV/AIDS pandemic imply that OAs in Africa have a distinct history and experience
compared to other generations who are not in this age bracket. However, the effects these experiences have had on their
mental health have been poorly described. Furthermore, interventions to recuperate or remunerate their loss have gone
unaddressed.

Technological advancement and marginalization
More recently, the advent of computers and information technology has widened the gap between generations and further
isolated OAs. Fleming et al. (2018),43 highlights the predominant lack of consideration for OAs in the development and
implementation of technological interventions despite its promise to conversely advance equity of access in many sectors.
However, by excluding the behaviours of OAs, potential patterns of use, and daily practices in the inherent design of
digital technology, it has instead marginalized this population from its use.44

Firstly, the majority of OAs live in rural areas where access to computers and smart phones are less likely. Secondly, the
vast majority of OAs in Kenya are illiterate, which further alienates them from computer or even smart phone literacy
despite potentially having access.45 The latter (smart phones) of note, are unfortunately required for the delivery of most
digital mental health tools or interventions that have been developed.46 Meanwhile, urbanization and globalization have
led to the reliance of younger populations on these and other technologies. While technology has enormous benefits, it has
disconnected OAs from younger generations as communication is limited, particularly for those who are illiterate. The
social fabrics that held communities together have now been disrupted by technology leaving OA especially in those in
remote or rural communities, subject to increased marginalization, isolation and loneliness.7,27

The advent of ‘mobile-money’ has created new avenues for interaction and the provision of basic sustenance that did
not exist previously for city-dwelling family members and their elderly relatives in rural settings. By way of background,
a mobile money system called ‘Mpesa’ was designed and implemented in 2007 in Kenya. ‘Mpesa’ is used by the vast
majority of Kenyans to transfer funds, including the sending of remittances from bread-winning family members to other
family members, such as OAs in remote locations.45–50 However, the effects of successful money transactions with
family members, albeit beneficial at face value, is not solvent in addressing the significant changes in social interactions that have well-established negative consequences for mental health.\textsuperscript{51–53} Moreover, these changes have taken place at such an expedient rate leaving OAs little time to adapt, and for their family and friends to accommodate. Additionally, government investments in their benefits, health care, mental health and well-being have not kept up.

Another pronounced impact of technology on OAs is their access to cash transfer programs (CTPs) through mobile phones. Kenya has implemented CTPs as part of the social protection program to identify and promote immediate relief from poverty among poor and vulnerable OAs. However, not all vulnerable OAs can access the CTPs, especially those living in remote areas. The program has been fraught with delays and unfavourable payment modes. For example, paying through banks and post offices that may not be accessible to illiterate OAs and those without access to phones or transportation. Thus, this approach has increased inequalities and poverty among older people who lack consistent income.

Climate change and its impact on older peoples' mental health

Africa today, like the rest of the world, suffers from unpredictable weather and climate changes that have resulted in whole regions becoming drier, wetter, hotter, or colder than before—vicissitudes that have drastic negative effects on human health and wellbeing.\textsuperscript{34} Similarly, in Kenya, there has been abnormally heavy rainfall, strong winds, cyclones, ice storms, extended periods of drought, and fatal heat waves in recent years.\textsuperscript{55–57} During periods of extreme cold in Kenya, snow has fallen in places where this has never occurred before. The new weather extremes adversely affect food production and limit access to basic needs, including water, and services, such as health care. All of this disproportionately affects populations already vulnerable to these afflictions, such as individuals living in drought-ridden areas, having consequently been exposed to further harsh climates and increased drought. Evidence suggests that climate is likely to have especially strong negative effects on OAs, many of whom have reduced mobility and cognitive abilities.\textsuperscript{58–61}

The impact of extreme weather such as flooding, disruption of infrastructure, lack of water, displacements due to flooding and a lack of proper pathway to care for older people can cause anxiety, stress and trauma.\textsuperscript{52–65} As discussed, effects of climate change are altering social, communal and familial structures. Climate change can enable environmental degradation and loss of profitable social-cultural networks that can improve mental health, particularly for the older adults who remain isolated in rural areas in Kenya and similar contexts. The stressors emanating from both extreme heat and heavy rainfall are further augmented by the already eroding traditional family support and social-cultural networks (as discussed earlier in the paper), necessitated by urbanization and technological changes. Increased emotional and physical insecurity, due to heavy rainfall associated with flooding and destruction of rural infrastructure, has led to increased poverty, homelessness and a loss of profitable social networks.

COVID-19

The older populations in Kenya have been particularly vulnerable in the era of Coronavirus disease 2019 (COVID-19). As the population that suffered the highest morbidity and mortality rates among other sub-groups globally, older populations were disproportionately affected by the direct effects of the disease.\textsuperscript{66} However, negative indirect effects also prevailed. Kenya has undergone extended periods of lockdowns where older people, many of whom reside in previously discussed rural and remote villages, went without seeing their families or attending community functions such as church services, funerals and weddings. These gatherings constitute routine sociocultural practices, and often are the only form of social contact they may have. Extended periods of lockdown have then, unsurprisingly, increased the prevalence of loneliness.\textsuperscript{57,68} The majority who are frail, and who suffer from underlying conditions, have experienced difficulties in accessing medical care in addition to having lost loved ones. Further, economic deprivation has increased, as family remittance has dwindled due to exacerbated unemployment caused by retrenchment and reduced commercial activities due to lockdowns. In the context of COVID-19, there is also the fear of living alone, increasing anxiety due to poverty have increased as OAs are made redundant and remittance from relatives reduced.\textsuperscript{69} COVID-19 found an already fragile population of OAs plagued by effects of climate change, technology, poverty, globalisation and historical experiences of HIV/AIDS and SAPS and augmented their difficulties.

Future research recommendations and approaches

In order to tackle the rising burden of mental health issues in OAs in Kenya, we propose intentional, versatile and intersectional research that particularly focuses on this population. There are several approaches we would recommend based on our thesis and additional existing literature outside of the scope of our article.

Firstly, we propose that literature reviews, content analyses, and needs assessments are conducted in order to identify existing data on mental health in the older Kenyan community. We recommend that these analyses address the historical and sociocultural effects on resultant mental health decline. We anticipate that such reviews would be exploring the work
of non-conventional social research methods, as well as reviews of policy documents that may provide important historical context on these changes – such as in the case of the effects of SAPs that are as yet to be fully explored.

Secondly, while strategies targeting mental health on the continent has continued to progress in Africa over the past decade, we have found that the majority of this work is exclusive of older adults. This is specifically with regards to effective treatment approaches, currently available modalities and their access, as well as coping strategies that have otherwise been effective in this population. Community-based and rural studies (CBRS) may need to be pursued in this case, because this population may not routinely access healthcare in hospital-based settings, as we have presented. Ethnographies provide an appropriate strategy to assess traditional and cultural biases or practices that may otherwise be missed by more conventional research methods.

Finally, when considering sampling strategies for mental health studies on the continent, older adults should be sampled for equitably, such as through the use of stratified sampling, or targeted follow-ups that are anticipated in the design given a high likelihood of non-response or loss to follow up of this group. Additionally, community sensitization and consent approaches need to be carefully considered during study design in order to help optimize inclusion and voluntary participation while also securing this important data. Intersectionality approaches to assess the direct and indirect health impact vulnerabilities brought by climate change, technology and COVID-19 on the ageing population in sub-Saharan Africa should be considered.

Conclusion
We conclude that the LCT theory offers an invaluable framework to better understand both the ageing process and the mental health issues associated with it. While great strides have been made to understand mental health among the OAs in Kenya, much work is yet to be done to understand the different age groups in the ageing cycle, as well as the intersectionalities and linkages of different life dynamics as contributing factors to mental health. As we have shown in our discussions, mental health problems among OAs do not occur in isolation; rather a plethora of outcomes and factors throughout the lives of people significantly contribute to the same. This also has to be viewed as the gradual and incremental accrual of coping scenarios to different socio-economic and physical challenges that occur throughout the lifetime.

Authors’ contributions
Adelaide M Lusambili: Conceptualization, Supervision, Validation, Visualization, Writing – Original Draft Preparation, Writing – Review & Editing

Robert Nyakundi: Data Curation, Methodology, Project Administration, Writing – Review & Editing

Christine Ngaruiya: Validation, Visualization, Writing – Review & Editing

Kizito L Muchanga: Validation, Visualization, Writing – Review & Editing

Ahaya L Ochieng: Validation, Visualization, Writing – Review & Editing

Laurie M Vusolo: Validation, Visualization, Writing – Review & Editing

Newton Joseph Guni: Supervision, Validation, Visualization, Writing – Review & Editing

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