FACILITATORS AND BARRIERS TO SEEKING MENTAL HEALTH SERVICES AMONG OLDER ADULTS IN HURUMA ESTATE, ELDORET

BY

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A RESEARCH THESIS SUBMITTED TO THE SCHOOL OF MEDICINE, DEPARTMENT OF BEHAVIORAL SCIENCES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF SCIENCE CLINICAL PSYCHOLOGY OF MOI UNIVERSITY

DECLARATION

Declaration by the Student

I, the undersigned, certify that this work is mine and has not been submitted for credit at any other educational establishment than Moi University.

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This Thesis has been presented for examination with my approval to the appointed supervisor.

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DEDICATION

I dedicate this research project to my supportive loved ones, who have been there for me throughout my academic pursuits and helped inspire me to do my best.

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Because of God's grace, I was able to put together my research project. Moreover, I would want to thank everyone who contributed in any way to the development of this research project. My supervisors at Moi University, Dr. Irene Chesire and Dr. Juddy Wachira, worked tirelessly to help me finish this study. Thirdly, I thank the librarians at Moi University Library, who were invaluable to me throughout my study. And last but not least, I must give gratitude to my loved ones. My mum and dad, who brought me into this world and raised me to be a responsible adult. A particular thanks goes out to my great husband, who has been so supportive during my studies, and to my children, who have been so kind and patient. I pray that God showers his abundant blessings upon all of them.

LIST OF ABBREVIATIONS

ACT	Acceptance and Commitment Therapy
AIDS	Acquired Immunodeficiency Syndrome
CHW	Community Health Workers
COVID 19	Coronavirus disease
CPT	Cognitive Processing Therapy
HIV	Human Immunodeficiency Virus
IREC	Moi University Research and Ethics Committee
KM	Kilometres
MTRH	Moi Teaching and Referral Hospital
NACOSTI	National Commission on Science, Technology and Innovation
PE	Prolonged Exposure
PTSD	Post Traumatic Stress Disorder
SEM	Social Ecological Model
USA	United States of America
WHO	World Health Organisation

DEFINITION OF TERMS

Peri Urban - It is an area on the outcasts of town that is a transitional zone between rural and urban centers where people have erected homes and businesses.

Older adults – Individuals who have the chronological age of between 50-80 years.

Mental Health Services - Encompass healthcare interventions and assistance for those with mental illness such as diagnosis, treatment, counselling, and rehabilitation.

Mental Health: refers to our emotional, psychological, and social well-being. It influences how we think, feel, and act, and it plays a crucial role in how we handle stress, relate to others, and make choices. Good mental health is more than just the absence of a mental illness; it encompasses a positive sense of well-being and the ability to cope with life's challenges.

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ABSTRACT

Background: Psychological disorders like anxiety and depression have become more frequent among older adults (50-80 years) as a result of the changes occurring in society. Some older adults have reported having trouble readjusting to life after retirement. Among older adults in Kenya, living in areas with limited resources little is known regarding the factors that encourage or discourage them to seek mental health services.

Objectives: The study had specific objectives which were; to explore the perceptions about mental health, to identify the facilitators and the barriers to seeking mental health services among older adults in Huruma estate, Eldoret.

Methods: This study utilized qualitative research design. Respondents totaling 30 both male and female aged 50-80 years, were selected purposively using snowball sampling method. In-depth interviews were conducted utilizing semi-structured questions. The data was analyzed thematically where initially, transcripts were coded, and then, using the coded data, preliminary themes were established to collect information pertinent to the study's objectives. The results were presented in tables and narrations. Permission was sought from the Moi University and Moi Teaching and Referral Hospital, Institutional Research and Ethics Committee (IREC) and the National Commission on Science, Technology, and Innovation (NACOSTI).

Results: Age ranges of the participants were 50-59 years 50%, 60-69 years 40%, 70-80 years 10%. Marital status: single 10%, married 63.3%, divorced 20%, widowed 6.7%. Income sources varied among the respondents: 28% receiving a pension, 22% being employed, 35% engaging in business activities, 11% receiving support from family, and 4% having other sources of income. Majority of respondents 80% (24) rated their mental health as "good," indicating a positive self-perception of their mental well-being. Thematic analysis revealed various facilitators which included awareness of mental health services, confidentiality, availability of support networks and positive past experiences with mental health services. Barriers described by the participants included stigma associated with mental health, fear of being judged, lack of information, financial constraints, limited access to mental health services, cultural or religious beliefs and lack of social support.

Conclusion: The findings reveal that older adults often perceive mental health through a lens influenced by stigma, cultural beliefs, and personal experiences, which either impede or encourage their willingness to seek help. The findings also highlight the crucial role of social support systems: family, friends, and religious leaders, in motivating older adults to seek help.

Recommendations: There is need for psychoeducation on mental health to be implemented among older adults and their communities to create awareness. In order to make their services more culturally relevant, mental health professionals can tailor the ones they now give to better meet the needs of their elderly patients. Policy makers should provide government subsidies, expand insurance coverage for mental health services, and introduce financial assistance programs.

CHAPTER ONE

1.0 INTRODUCTION TO THE STUDY

1.1 Background of the Study

To be healthy is to enjoy a state of physical, mental, emotional, and social well-being (Manwell et al., 2015). Having control over one's own life, being able to bounce back from setbacks, doing work that one enjoys, and making a positive impact on one's community are all factors that contribute to one's mental health, as recognized by the World Health Organization (Sorkin et al., 2016). Furthermore, there are two ways to define a person's mental health: the absence of mental illness, or as a condition of being that takes into consideration the physiological, cognitive, and social factors that are related to a human's psychiatric condition and capability to thrive in their surroundings (Manwell et al., 2015). One of the leading causes of death and disability in the United States is mental illness (Murray et al., 2013). Regardless of this, providing and expanding access to mental healthcare in rural and peri urban areas is a pressing matter of public importance. People in rural and peri urban locations are less likely to seek and complete mental health therapy than those in urban ones (Brenes et al., 2015). Additionally, compared to their urban counterparts, people being treated for mental health issues in rural and peri urban areas have fewer visits overall and are less likely to see a specialist. Common obstacles to providing mental health treatment to rural people include stigma, a scarcity of mental healthcare specialists, and an inadequate healthcare workforce (Moy a et al., 2017).

Older adults are the wisest and most seasoned members of any society (Yuan et al., 2018). They are an invaluable asset to any country because of the ways in which their knowledge, understanding, and insight may contribute to its growth and improvement.

The population of people aged 60 years and up is rising rapidly. One billion persons in the world were 60 years or older in 2019. By the year 2030, that figure will rise to 1.4 billion, and by 2050, it will reach 2.1 billion. By 2050, the majority of the world's geriatric population will be found in low and middle-income nations (Zenebe et al., 2021). This growth is attributed to progress in lowering infant mortality rates and life expectancy is rising steadily due to falling rates of death among the elderly. An increasing elderly population means an increasing older adults mental health crisis. Due to the increased prevalence of undiagnosed and improperly treated mental illness, particularly among at-risk populations, it is becoming increasingly difficult for mental health practitioners to address the demands of this growing demographic (Guzman et al., 2015).

The aged as a group suffer several difficulties because of the natural aging process's effects on the body and mind. One of the obstacles to healthy aging is the prevalence of psychiatric diseases and cognitive decline. Mental and neurological disorders, excluding headaches, affect about 20% of those over 60, accounting for 6.6% of total disability among this age group (Petrova & Khvostikova, 2021). There is a great deal of variance in the data on the prevalence of mental problems in older adults.

According to the World Health Organization, between 10 and 20% of the world's elderly population suffers from major depression (Zenebe et al., 2021). Furthermore, the prevalence estimates for anxiety disorders and depression in older adults in the U.S range from 4.9% to 11.6% over the course of a year (Brenes et al., 2015). In China, 2.8% of the aged population suffers from Major depressive disorder (Giri et al., 2016). The most prevalent mental illnesses in the Korean population, according to

a recent survey, are depression (17.8%) and anxiety disorders (15%) (Kim & Ko, 2018).

Mental illness is extremely common among the elderly population in nursing homes. For instance, approximately 4.7 million Americans reside in nursing facilities, with 80% being 65 or older and 40% having mental illness. Depression affects 28.2% of the population and anxiety disorders affect 18.9% (Petrova & Khvostikova, 2021). Iraqi researchers found that 55.8% of older adults in nursing homes and 21.5% of them living with their family suffered from a mental disorder (Ibrahim et al., 2019). The most common disorders were depression, anxiety, and dementia. Depression is more common among the older adults in long-term care facilities, with an estimated prevalence of 10% (Giri et al., 2016). Older adults receiving home care are more likely to experience a more severe course of mental disorder, and depression is more likely to be accompanied by suicide ideation, than the healthy population. The onset of physical sickness, significant functional abnormalities that hinder independent living, and the impact of stressors like the loss of a home, spouse, social connections, and companionship can all lead to this (Zhang et al., 2019).

In sub-Saharan Africa, the prevalence of depression in the older population varies widely among different epidemiological research. For instance, in a community-based cross-sectional research of 800 senior Ethiopians 41.8% were found to be suffering from depression (Mirkena et al., 2018). On the other hand, only 4% of senior South Africans reported experiencing depression in the previous year, according to a nationwide community-based cross-sectional survey (Peltzer & Phaswana-mafuya, 2013).

Although widespread among older adults, mood and anxiety disorders in later life are often poorly treated. Stigma around mental health care and a lack of care coordination are often cited as reasons for its low uptake (Byers et al., 2012). According to literature, some common hurdles that older adults experience while trying to seek mental health services include loss of a spouse, retirement, a drop in income, a shift in social circles, or a move to a rural area (Pywell et al., 2020). Furthermore, stigma, low mental health literacy, lack of specialized therapists, limited mobility, and the mistaken belief that mental health disorders are an inevitable aspect of getting older are all obstacles (Brenes et al., 2015). Many Africans with mental health problems do not get medical help because they either do not recognize their condition as a treatable issue or they mistakenly believe that they will get well without treatment. In low-resource communities, where local culture and religion have a significant impact on people's daily lives, stigma and false beliefs about the nature and severity of mental illness are significant obstacles (Andersson et al., 2013).

Treatments for mental problems exist, and they have been shown to be effective namely: pharmacotherapy, psychotherapy, group therapy, rehabilitation services and social support (Whealin et al., 2014). Psychological treatments including Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) have been shown to reduce PTSD symptoms and use the same essential ingredients for treatment. They both expose and cognitively process thoughts, feelings, and memories connected to the trauma (Vujanovic et al., 2011). Another useful psychotherapy is Acceptance and Commitment Therapy (ACT). This form of treatment encourages its patients to stop avoiding uncomfortable feelings and ideas in favor of a more determined pursuit of their stated goals (Vujanovic et al., 2011). In addition, client-centered motivational

interviewing promotes motivation for treatment attendance and drug use reduction or cessation in persons with substance used disorders (Teeters et al., 2017).

1.2 Problem Statement

Mental health is a crucial and an important part of an individual's well-being. The older adults are the ideal mentors and from all the experiences they have accumulated over the years, they possess great wisdom and knowledge which makes it important to preserve their mental health. A number of older persons experience a decline in health and wellbeing due to the myriad social, mental, and physical changes that come with age. The vast majority of seniors are able to adapt to these changes without experiencing any mental health issues, but a sizable minority of seniors have severe mental health demands that are not inherent to aging. Poor health outcomes, increased utilization of healthcare and costs, a more complicated course and prognosis for many mental and physical illnesses, functional disability and cognitive impairment, a diminished quality of life, and an increased risk of death (including suicide) are all associated with untreated mental health problems in the older adults (Sorkin et al., 2016). Therefore, mental health service providers face a significant problem in reaching out to, engaging, and retaining older persons in mental health care.

Despite these effects, older adults who have mental health needs underutilize the available services. About 70% of elderly population suffering from anxiety or depression do not receive treatment (Byers et al., 2012). Han et al., (2011), mentions that the percentage of adults in the USA who have seen a mental health professional in the past year is lower among those aged 50 and up compared to those aged 18 to 49. Older adults in need of mental health care do not get them, even when they are covered by insurance. Stigma around mental health and a lack of treatment

coordination are often cited as reasons for low utilization. Further obstacles include lack of affordable care, a shortage of mental health professionals, poverty and difficulty getting to healthcare facilities (Brenes et al., 2015). On the other hand, resilience, spirituality, and social support have all been linked to lower rates of mental illness (Mwangala et al., 2022).

Depression, anxiety, and social isolation are all risk factors for substance misuse in older adults, as there are physical health difficulties such chronic pain, sleeplessness, dementia, and loss of independence (Satre et al., 2020). Substance abuse is a leading cause of hospitalization, nursing home placement, and mortality among the older adults, and is linked to a wide range of other health and social issues (Kuerbis et al., 2014).

However, Substance Use Disorder (SUD) is often misdiagnosed or untreated among the elderly. Health care providers sometimes fail to recognize SUD in the older adults, mislabeling the symptoms as those of more frequent conditions such as depression or dementia. In addition, older adults are less likely to admit they have a problem with substance abuse and more reluctant to seek assistance. Furthermore, there is lack of widespread access to drug and alcohol treatment programs tailored to the needs of senior citizens (Wu & Blazer, 2014). Older adults' substance abuse is indicative of the rising interest in SUD treatment options.

Older adults may handle pressure better if they undergo timely diagnosis and treatment and this may contribute to a societal shift in which getting help for psychological disturbance is viewed as beneficial rather than embarrassing. In a culture that stigmatizes getting treatment, research could help assess if this would be an effective, proactive way to improving older adult's well-being. For these reasons it

is of great importance to understand the reasons why the older adults might or might not seek psychiatric services provided. These factors that either promote or discourage them to seek mental health practitioners remain poorly understood in the Kenyan context especially, being a hard-to-reach population. Furthermore, few studies have been done to ascertain how older adults seek out psychological services. The current study will address these deficiencies.

In Kenya, research studies have primarily been concerned with how Human Immunodeficiency Virus (HIV) has affected the older adult's mental health (Mwangala et al., 2022). Due to the focus on H.I.V, there is minimal focus on the barriers and factors that impede or promote older adults to seek mental health care in cases of emotional imbalances or mental disorders.

1.3 Justification

The study will engage serious research work of great importance to society because it will look into the needs for mental health care of old people living in low-income areas in Kenya. This study stands as a meeting point of social science, public health and old-age studies. It will try to understand the connections between ageism, changes in social culture and problems with mental health that older people face. Besides, this research has a strong method because it uses both careful interviewing and community-involved research ways. This way of doing research tries to completely understand the feelings, thoughts and problems faced by older people. It gives a real reason to study those things.

Moreover, it is very important for learning, and it goes way beyond how it will be done. Its connection with the Kenyan Policy for older people and aging, makes it very important not just for policy importance but also to help things based on

evidence. This matching supports the study's key role in shaping policy plans and actions aimed at improving mental health beliefs among older people. This study also aims to expose more about old people's minds in a deep and broad way. It aims to create understanding that changes how we teach, make rules, and take action about mental health care for seniors. This research will change how we study mental health in old people who do not have much money. It does this by looking closely at their families, communities and cultural norms. This new way of thinking will guide policy makers, researchers and interdisciplinary discussions.

Guided by fairness and social justice principles, this research will make the older people heard. It also wants better health care rules that help everyone in a meaningful way. It tries to explain how discrimination, neglect and vulnerability can have deep effects on old people's mental health. This is done with the goal of making society and institutions change their views on how elderly people should be treated in terms of mental health care. Lastly, it aims to give a deep understanding of mental health problems faced by older people in poor areas. It bridges the gap between school books and real-world information. This helps make future studies and talks between different subjects about older people's mental health care stronger.

1.4 Significance

This research will be important because it talks about something often missed in discussions on old people's mental health. This specific area looks at how both the elderly with mental problems and those who help take care of them can have their own difficulties. This study brings out the different ways caregivers face discrimination. It wants to show how these problems can harm their careers, what they think of themselves, and their mental health by looking deep into this area. By

digging into these details, the research wants to make a big change. It shows the need for fair treatment and help for those who look after old people with mental health problems.

Apart from taking care of the elderly, it also talks about the experiences of the older people and those who care about them when they intend to get help from mental health professionals. The study will show how stigma and discrimination stop older adults from getting needed mental health help. It hopes to create a more understanding way to help elderly people with their minds that respects them better. It wants to line up with worldwide plans like the Decade of Healthy Aging from 2021-2030. It will encourage care, kindness and fairness while fighting age discrimination and elder abuse in healthcare systems.

This study shows how mental illness and physical health are linked in older people. Further, the study looks at the changes in mind and body tied to conditions like depression. It investigates their effects on our actions related to health, aiming to discover important steps we can take to stop bad health results. The planned short, based on research, prevention treatments in health care places and community centers could help elderly people get better care. It will make them more whole and healthier overall.

This research also helps us understand what factors affect how much older people and their caregivers use mental health services. The study gives useful information about where and how to get mental health care. This helps those who need help as well as people who provide it. It guides them towards taking smart steps for dealing with mental health problems in older people. As a main part of the National Policy on Older People and Aging, it provides new ideas for making policies. It is important to

make sure that policies are not only helpful but also change with the needs of older people as they improve too.

1.5 Research Questions

The below questions were developed to assist in achieving the objectives:

i. What are the perceptions about mental health among older adults in Huruma estate, Eldoret.
ii. What are the facilitators to seeking mental health services by older adults in Huruma estate, Eldoret.
iii. What are the barriers to seeking mental health services by older adults in Huruma estate, Eldoret.

1.6 Objectives of the Study

1.6.1 Broad Objective

To identify facilitators and barriers that influence older adults in Huruma Estate, Eldoret to seek mental health services.

1.6.2 Specific Objectives

i. To explore the perceptions about mental health among older adults in Huruma estate, Eldoret.
ii. To identify the facilitators to seeking mental health services among older adults in Huruma estate, Eldoret.
iii. To gain insight into the barriers to seeking mental health services among older adults in Huruma estate, Eldoret.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

Understanding the context of a research issue, the evolution of related studies and the practical significance of results can all be facilitated by reading and understanding the relevant literature. One of the main objectives of this literature review is to stay away from rehashing old information. This chapter discusses mental health of older adults, the risk factors for mental disorders, the effects of mental disorders on older adults and the reasons that motivate some to seek help and discourages others. The last section of the chapter entails the theoretical framework for understanding these phenomena.

2.2 Mental health of older persons

There are two basic categories of mental disease in geriatric mental health services: organic and functional mental illness. Degenerative alterations in brain tissue, such as those seen in dementia, are considered to be the root cause of organic mental disorder. Depression, bipolar disorder, schizophrenia, and anxiety disorders are all part of functional mental illness; however, they are not progressive in nature (Wells et al., 2020). Most people who have diagnosable mental health disorders do not get care, and older adults are more reluctant to do so. In most parts of the world, spouses, family members, and friends are the primary caregivers for the aged with mental illnesses (Mackenzie et al., 2011). For the following reasons, it is deeply concerning that older adults so drastically under-use mental health care. Firstly, the population of the elderly is rising with 20-25% of the population predicted to be 65 or older by 2030 (Zenebe et al., 2021). Second, there is reason to believe that the rates of mental health issues among the elderly will rise more rapidly than those among the young within

this time period (Petrova & Khvostikova, 2021).Third, there is a lot of success with talking therapy and medication for treating mental health issues in the seniors (Ellin, 2013).

There is a correlation between aging and the onset of physical sickness in those who suffer from functional mental illness (Sanchez-Carro et al., 2021). Some older adults with functional mental illness may have a lower life expectancy because of their history of economic hardship, poor diet, excessive alcohol consumption, and heavy smoking, all of which increase the likelihood that they will develop diabetes, cardiovascular disease, and vascular disease (Wells et al., 2020). Some of the manifestations of deteriorating physical health among them include pain, fragility, sensory impairment and polypharmacy. Because of the complexities involved, it may be difficult for an older adult to find the help they need.

2.3 Risk factors for mental disorders in the elderly

Some of the risk factors for mental illness in the elderly population include living alone, being female, drinking excessively, not finishing education, being poor, having a family history of mental illness and having a serious physical illness (Petrova & Khvostikova, 2021). In a study involving 12,000 Americans aged 55 and up, there were statistically significant variances based on a person's sex, race, marital status, and income. Females disproportionately suffer from mood and anxiety disorders, while males tend to have issues with psychoactive substance use and personality disorders (Reynolds et al., 2015). Similarly, independent positive associations were discovered in an Indian study between the incidence of depression and factors such as not being consulted for significant family choices, chronic illness, idle daytime hours, and the loss of a close member (Pilania et al., 2017).

Another risk factor is the development of an economic crises. There is a larger lifetime frequency of mental disorders among older adults of Iraq (38.7%) compared to Europe (23.3%), and this can be attributed to the country's history of economic and social disasters (Ibrahim et al., 2019). There is a parallel between this and the situation in Kenya. Those who are retired or otherwise unable to work are particularly vulnerable to the effects of inflation and rising cost of living (Lusambili et al., 2023).

The geographic location of a person's home also has a role in their likelihood of developing a mental condition. Several studies show that urban dwellers, as opposed to those living in rural areas, are more likely to suffer from mental health issues (Sengupta & Benjamin, 2015). As a result, it stands to reason that the danger of psychiatric disorders is lower in small communities with a more tranquil pace of life. Furthermore, constant urbanization and population aging contributes to an increase in senior people experiencing mental health issues, which in turn places a heavier demand on medical services (Giri et al., 2016). However, the Chinese experience shows that pre-senile persons living in rural settings are disproportionately affected by mental health problems Older adults in rural areas have a higher than average prevalence of mental disorders (20.11%) and severe depression (9.2%) (Jin et al., 2020). Poor financial status, chronic physical sickness, and the relocation of children to large cities, especially an only child, can all increase the probability that a person will develop a mental health issue.

Multiple reports from different locations of Kenya confirm a widespread problem with elder abuse (Kabole et al., 2013). They go hungry, have no one to talk to, have no money, cannot find work, and have trouble getting medical treatment and other necessities. Typically, abusive interactions occur within the context of a position of

authority. As a result, individuals are vulnerable to emotional abuse, which can lead to prolonged feelings of despair, trauma, low self-esteem, and even death.

2.4 Factors affecting mental health service seeking

2.4.1 Illness severity

In cases where degree of severity is considered mild, sufferers often treat themselves with over-the-counter medications and home cures. Other older adults seek spiritual remedies. An example is the use of church water in the management of epilepsy in Uganda (Rutebemberwa et al., 2020). When the illness is severe medical attention is sought. Severe mental illness is considered to be attempted suicide or having suicidal thoughts (Koly et al., 2022). Family members of older adults consider where to take the individual, who will accompany them and the cost of treatment. Many older adults in Sub Saharan Africa prefer to seek mental health services in government hospitals because of subsidized cost of treatment (Semo & Frissa, 2020).

2.4.2 Financing treatment

Consideration must also be given to how the elderly person will pay for their medical care. Savings, assistance from grown children, the sale of livestock and poultry, and formal or informal loans from friends and family are all viable options for covering the costs of medical care (Teo et al., 2022). It is not uncommon for neighbors to chip in financially. Older adults may find themselves in a more precarious financial position after an illness, shifting from the security of having savings to the pressure of carrying debt. Most low-income families accept their unfortunate circumstances rather than take on more commitments and have to put up with their condition (Lee et al., 2020).

2.4.3 Accessibility to mental health professionals

The ease of travel for the elderly is also essential. Especially in rural locations, it might be difficult for elderly people to go to a place where they can get aid due to a lack of transportation options (Fischer et al., 2016). Visiting a male doctor who is not a close relative has a social stigma, especially among older women. Other women were urged not to talk about their feelings with anybody but close friends and relatives (Koly et al., 2022).

2.4.4. Marital strife

Marriage problems have been identified as a significant contributor to emotional suffering and the need for professional mental health care. Women are burdened by their husbands' lack of emotional support, which manifests itself in a variety of ways, including insufficient attention, poor communication, a lack of commitment, and a lack of mutual understanding. They also suffer emotionally because their spouses do not provide for their health and education, or for that of their children (Koly et al., 2022). Additionally, women have had to deal with infidelity form their male partners.

2.5 Mental health in the elderly people and COVID 19 pandemic

Both immediate and subsequent economic costs and psychosocial suffering, as well as major restrictions on access to treatment for persons with health difficulties, were all a result of the COVID-19 pandemic and had a negative impact on people's mental health around the world Isolation and social withdrawal are stressful in themselves (Brooks et al., 2020). During the COVID-19 pandemic, the importance of social interaction for older adults' mental health became especially apparent as stay-at-home orders and personal distancing contributed to a breakout of depressive symptoms among them, more so those who reside in solitude without children (Marroquín et al.,

2020). Isolation is associated with a sedentary life, which especially adversely affects the older adults. The lack of exercising causes functional disturbances and permanent need for physical assistance, which in turn poorly influence emotional and psychological wellbeing of the older adults (Goethals et al., 2020). Other factors contributing to strain include the stagnation of the economy and the worsening of the financial situation. This makes the older adults vulnerable financially. Older adult's mental health is exacerbated by the unfamiliar, uncertain environment. Between March and July of 2020, the proportion of Americans over the age of 65 who said the COVID-19 pandemic had an adverse effect on their mental health rose from 27% to 47% (Marroquín et al., 2020). Furthermore, isolation caused by the quarantine led to a rise in Post-Traumatic Stress Disorder cases, anxiety and agitation of the older adults (Chong et al., 2020).

Depression, anxiety, and dependency on psychoactive substances all raise suicide risk, as do social isolation, fear of contamination, uncertainty, ongoing stress, and financial troubles. Loneliness and social isolation are both risk factors for thinking about and attempting suicide. Suicide risk can be mitigated by a number of factors, including regular social interaction, access to technology, good nutrition and physical activity. Suicide is more common among older adults, and is especially dangerous for those who are already suffering from a mental illness (Sher, 2020). Limiting exposure to television programs that could contain inaccuracies and increase psychological and emotional suffering is advised. However, the television was the only source of entertainment during the pandemic.

There have been long periods of lockdown in Kenya, during which the older adults, many of whom live in the distant and rural communities, were unable to see their

family or participate in communal events like church services, funerals, and weddings. Oftentimes, these get-togethers are the only means of social interaction these people have. The majority of frail people have lost loved ones, and many often have trouble getting medical care for chronic diseases. And as unemployment rises owing to cutbacks and business slows because of lockdowns, economic hardship rise as family remittances fell. As older adults are made redundant and remittances from relatives are diminished, the fear of living by oneself and the anxiety caused by poverty have intensified in the setting of COVID-19 (Lusambili et al., 2023).

2.6 Perceptions of older adults about mental health

Decreased mental wellness, such as more depressed symptoms, has been found to predict more negative self-perceptions of aging (Schönstein et al., 2021). There could be a number of causes for this correlation. Depressive symptoms, for instance, can have a detrimental effect on daily functioning which may contribute to the impression that aging is a negative experience (Sabatini et al., 2022). The negative self- and world-views typical of depressive people may also prevent them from focusing on the benefits that come with becoming older. Furthermore, research suggests that aging people with higher levels of depression may be more vulnerable to ageism and less able to resist negative self-stereotyping (Schönstein et al., 2021).

Another study found that older people with more pessimistic outlooks on life were more likely to agree that depression is a natural and acceptable part of aging, and that this view may contribute to a sense of hopelessness that prevents older people from seeking help for their depression (Bryant et al., 2012). In addition, older adults had negative views about medication, indicating a desire to limit or forego its use. Adverse effects and the risk of addiction were the primary sources of worry. Overprescribing and a lack of efficacy were also causes for alarm. It was also feared

that the effects of mood-altering drugs would be temporary and that the original problems would return once the medication was no longer being taken (Pettigrew et al., 2010).

2.7 Facilitators to receiving mental health care

2.7.1 Affordability of services

For healthcare to be affordable, several funding mechanisms, such as insurance policies that guarantee access for mental health services, must be in place. Older adults would use mental health services more often if there were more low-cost, community-based programs available to those who need them but cannot afford them (Pass et al., 2019).

2.7.2 Prompt communication

Communicating through phone calls and reminding patients of their impending appointments is very much appreciated. Patients felt that they were cared for by their doctors. Additionally, patients can benefit greatly from screening and routine monitoring of their symptoms.

2.7.3 Good relationship

There was a strong desire on the part of patients to keep their current doctors for they had a good rapport with them. Positive long-term relationships between patients and providers were associated with higher quality mental health care, as patients believed that their providers were better able to read their emotions. Furthermore, patients reported being receptive to doctors' suggestions, and they saw doctors' willingness to debate treatment plans to find the best fit as evidence that their doctors cared about them. Positive doctor-patient interactions and increased treatment adherence may be

facilitated by clinical organization and collaborative decision making, according to another study (Ward et al., 2014).

2.7.4 Awareness of mental health services

An important factor in patients' ability to gain access to mental health care is their level of education about such options. Older adults are unaware of mental health services existence, who they are meant for, what they do, why and how they would put the services to use, or how to find others who could also benefit from the services. A research study suggests that public advertising of mental health services in clinics or the community, as well as social networks, may be effective means of increasing service utilization (Saurman, 2016). Individuals' expectations regarding clinical results were influenced by their familiarity with available mental health services and their familiarity with how to access mental healthcare.

2.7.5 Taking ownership of one's decision to seek assistance

In an Australian study, older adults' willingness to accept responsibility was evident in their pursuit of a formal diagnosis and participation in the official help-seeking procedure. They did not want to merely receive care; rather, they wanted to actively participate in shaping their own care by applying what they had learned and gaining access to the tools they needed to do so. From this vantage point, they discussed how they stopped blaming others and started taking accountability for their situation. Older adults sought counseling because they wanted to take charge of their own decisions and actions related to depression management, and this was motivated by their willingness to accept personal responsibility (Polacsek et al., 2019).

2.7.6 Accessing information about mental health

According to a study by Polacsek et al, (2019) the majority of the older persons reported feeling positive and assured about the informational tools they had at their disposal. Information about depression's diagnosis and therapy was sought frequently from online sources. Participants were cautious when using such resources, however they were able to tell the difference between reliable and fraudulent sites. A higher level of mental health literacy correlates with increased likelihood of seeking professional help, treatment adherence, and positive lifestyle choices (Polacsek et al., 2019).

2.7.7 Enhancing Non-formal Assistance

Older adults discussed how their efforts to seek professional assistance were bolstered by the informal support of spouses, family members, and/or close friends. Encouragement to seek care, increased adherence to treatment plans, and consistent exercise are all examples of informal support that can supplement professional support (Sorkin et al., 2016). Some research suggests that older adults who report a strong social support system are more likely to be open to the idea of seeking help from and having faith in mental health specialists (Kessler et al., 2015).

2.7.8 Use of peer educators

Peer educators can serve as a model for positive change because of their reputation, accessibility, familiarity with the local language, and extensive network of contacts. Peer educators provided a welcoming space for depressed seniors, prompted them to take the initial step toward managing their emotions, prompted them to engage in social activities, and raised their interest in finding resources (Conner et al., 2016).

2.8 Barriers to receiving mental health care

2.8.1 Stigma

One of the most common hindrances identified to receiving mental health treatment was the individual's own stigma. In one study conducted in the United States it was found that 80% of the population sample agreed that they did not need help while 40% also mentioned feelings of stigma and embarrassment, a lack of trust in mental health experts, and the assumption that treatment would be ineffective (Brenes et al., 2015). Although these seniors acknowledged a need for assistance and showed some openness to the idea of psychotherapy by inquiring about the research, they supported negative personal attitudes that impeded their ability to seek the treatment they required. Some people were even scared they might get a diagnosis of mental illness. Therefore, realizing you need assistance is a starting point, but it is not the whole story. Similarly, older adults with severe anxiety or depression are less likely to seek treatment because they do not believe in the treatment's efficacy and they fear stigma (Byers et al., 2012).

2.8.2 Limited resources

Insufficient availability of trained professionals in the field of mental health care was considered to be a barrier. As could be expected, older adults in remote locations reported a scarcity of mental health workers qualified to treat them. One respondent in a rural region stated that even in more populous areas, waiting times to see a new psychiatrist or therapist are often between 6-8 weeks (Colligan et al., 2020). In another study, patients had a harder time getting to their psychiatrists, therapists, and support groups. Many patients said that they would need at least 45 minutes to reach the next major city with access to specialized care (Pass et al., 2019). A paucity of

psychiatrists and therapists, might make it difficult to treat or refer patients who have been diagnosed with a mental illness.

Despite the fact that some older adult may have never been treated at a mental health unit, several persons brought up the topic of state-run mental health facilities and psychiatric units closing as an indicator of declining resources or options for seeking mental healthcare. Some older persons may have gotten the impression from these shutdowns that mental health care options were few in general. In addition to a lack of infrastructure, patients frequently cited a dearth of clinicians, especially those with specialized training. Current recipients of specialized mental healthcare said that their physicians' caseloads were too heavy and that it was tough to schedule an appointment with a psychiatrist (Pass et al., 2019)

The inability to afford mental health professionals was also mentioned as a hindrance (Byers et al., 2012). Unfortunately, some seniors lack financial security, which prevents them from receiving necessary mental health care. Cost was cited by more than half of the rural elderly surveyed by Bocker and colleagues as a reason for not seeking mental health care (Bocker et al., 2012). In an additional study, patients typically reported expensive cost payments for clinic visits and drugs while seeing a specialist. Copayments were a problem for several patients since they were retired or had low incomes. Patients seeking therapy often encountered difficulties related to insurance coverage. Access was constrained since only a small fraction of mental health practitioners accepted government-funded insurance (Moroz et al., 2020).

2.8.3 Worry

Consistent with the literature suggesting a link between symptom intensity and barriers, it was found that worry was related with greater obstacles (Brenes et al.,

2015). More hurdles were reported overall when worry was of a higher severity. Those who worry more than average may sense greater obstacles to care because they are more prone to see the world through a negative or frightening lens.

2.8.4 Communication to the patient

Maintaining regular appointments and patient adherence were both impacted by open lines of communication. Appointment reminders and critical care updates were occasionally missed because clinics did not always contact with patients via their preferred methods. The breakdown of patient-provider communication has the potential to negatively impact the delivery of mental health services (Zahran et al., 2016). One person's life was shattered when her clinic failed to inform her that her mental health provider was departing. She experienced the loss of a trusted professional connection. When therapists leave their practices, patients sometimes have to start the search for new doctors from scratch. As a result, they may have to go without mental health care for a period of weeks or months.

2.8.5 Processes of initiating and changing treatment

Many people do not know where to go for specialized care. It is difficult for some patients to get referrals to other doctors or other services. When patients have needs that go beyond what their primary care physician can give, this can constitute a major roadblock. However, other patients still experience difficulty in beginning services with new providers, even after locating specialized care. Some clinics do not take in new patients or do not accommodate patients' requests to switch therapists within the clinic. As a result, patients may stop seeing that doctor and start looking for one who could better meet their needs (Colligan et al., 2020).

2.8.6 Patient provider relationship

Older adults' interaction with any mental healthcare professional is a major factor in determining whether or not they would keep receiving treatment. A patient's refusal to return for further treatment due to a bad first experience with their mental health practitioner is understandable. Sometimes this can cause further delays of months or even years before patients finally seek treatment from other providers. Effective interpersonal communication among mental health professionals is essential. Pass et al, (2019) sought out patient feedback regarding ideal characteristics of mental health professionals. Patients said their ideal physician is reliable, someone who is not afraid to talk about tough topics like mental illness and their own personal histories, who respects their opinions and actively listens to them. Patients appreciated having a safe space to share their stories without concern for reprisal. Patients viewed being heard and comprehended as critical to their own healing processes (Pass et al., 2019).

Furthermore, older adults respect their clinicians' willingness to incorporate their input into treatment plans. Some patients stopped seeing their previous physicians because they thought their requests for treatment or therapy modifications were not being taken seriously. This seems to be the case in particular for patients who wanted to stop taking drugs known to cause undesirable side effects (Levesque et al., 2013).

2.9 Theoretical Framework

2.9.1 Social Ecological Model

This strategy recognizes the need of taking into account the impact that one's surroundings have on one's health. The environment influences and shapes an individual's behavior along with many other variables. Most public health concerns are too complicated to be fully recognized and managed by single-level analysis, which is why the Social Ecological Model (SEM) places such great emphasis on the interrelations of elements within and across different stages of health behavior. In

doing so, it emphasizes the need to build environments that support and encourage successful and long-lasting behavior change by requiring that people not be seen in isolation from the wider social units in which they live (Townsend & Foster, 2013). This theory has been used to better understand the many factors and barriers that influence dietary behaviors, such as healthy eating and pediatric obesity (Townsend & Foster, 2013).

This theoretical framework for older adults is grounded in social ecology and combines the ideas of personal biology, psychology and health behavior to those of environment activities and the significance to older persons. Using SEM, doctors are urged to look at their patients' health problems in the broader context of their social and environmental settings. Healthcare providers can utilize this SEM to zero in on the specific social and ecological factors that affect a patient's health, as well as specific health behaviors that either exacerbate or alleviate a health problem. Each layer of the system is emphasized for its effect on the person as a whole. This concept puts the emphasis on the individual by having them take in information from all levels of their own social ecological system. While alterations in behavior may play a role in determining health outcomes, other systemic levers may cause shifts that improve an individual's health in other ways. By connecting health results to the many tiers of the social ecological system, it will be possible to pinpoint entry sites for reform at each level (Trego & Wilson, 2021).

Due to the unique constraints placed on the entire social ecological system by older persons culture, SEMs work exceptionally effectively with the elderly community. The use of Social Ecological Model (SEM) can be helpful in researching older persons’ health because it can be used to assess the situation from various perspectives, establish links between health outcomes and environmental factors at

various levels, find possible change drivers, and direct the creation of actions at different tiers of impact. Applying SEMs to the elderly has the ability to affect changes in policy and practice that safeguard the from harm and promote healthier lifestyles (Trego & Wilson, 2021).

2.10 Conceptual Framework

The Social-Ecological Model served as our overarching conceptual framework throughout this investigation. This approach took into account both the facilitators and the barriers that the older adults face when trying to access mental health care.

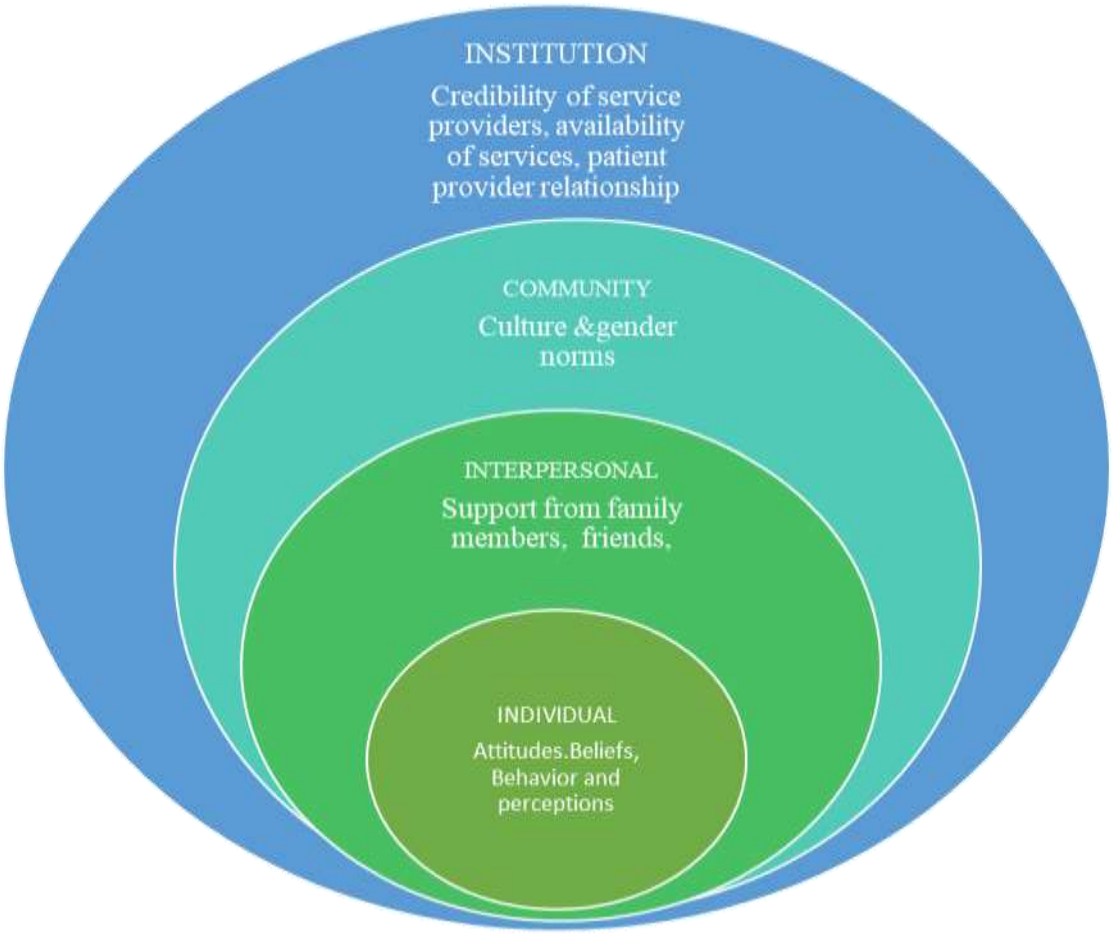

Figure 2.1 Social Ecological Model for older persons' Mental Health

2.10.1 Individual Domain

An individual's knowledge, attitude, belief, and self-concept are all examples of intrapersonal elements that influence health-related behavior (Humphrey et al., 2021). Individuals are taught certain ideals that will guide them throughout their lives. Thus, as individuals age their value system and experiences shape their attitudes, which in turn can affect their health-related behaviors. Age and gender also affect how people seek mental health care.

2.10.2 Interpersonal Domain

Interpersonal relationships with close friends, family, and neighbors make up this domain. Social support has been demonstrated to positively correlate with both physical and mental health outcomes. An individual's social network is a valuable asset since it gives them reassurance and the feeling of being cared for in times of need. Beneficial effects on health are seen when older persons both receive and give social assistance (Tkatch et al., 2017). For instance, family support, laughter clubs, religious programs, social interaction, prayer, continuing education, pursuing many hobbies were all mentioned as helpful interventions against mental illness (Hunt et al., 2019).

2.10.3 Community Domain

Community based support creates a structure for well-being and develops a network for referrals. Referrals help connect older people to appropriate services. In order to best serve their clients, mental health providers should be familiar with local, national, and international organizations that provide services for the older people. Inclusion should be at the heart of all community outreach efforts. Depending on the needs of the client, it may be necessary to add an additional component of intervention in the form of familiarity with community resources that aid older adults and families and

also dissemination of information about mental health. In its broadest sense, society encompasses the shared values, customs, and social conventions within which people older persons find themselves living. The treatment-seeking behavior of the elderly is affected by gender and cultural norms. It is possible that older people face social stigma that prevents them from seeking treatment (Devooght et al., 2023).

2.10.4 Institution Domain

Social support programs help individuals overcome stigma and discrimination associated with obtaining mental health services. Furthermore, having access to culturally sensitive treatment, aids in reducing blind spots. Moreover, providers of mental health services can pave the way toward more equitable treatment by using language that is less exclusive (Devooght et al., 2023).

2.11 Conceptual framework Diagram

The diagram below shows an interrelation between different various factors.

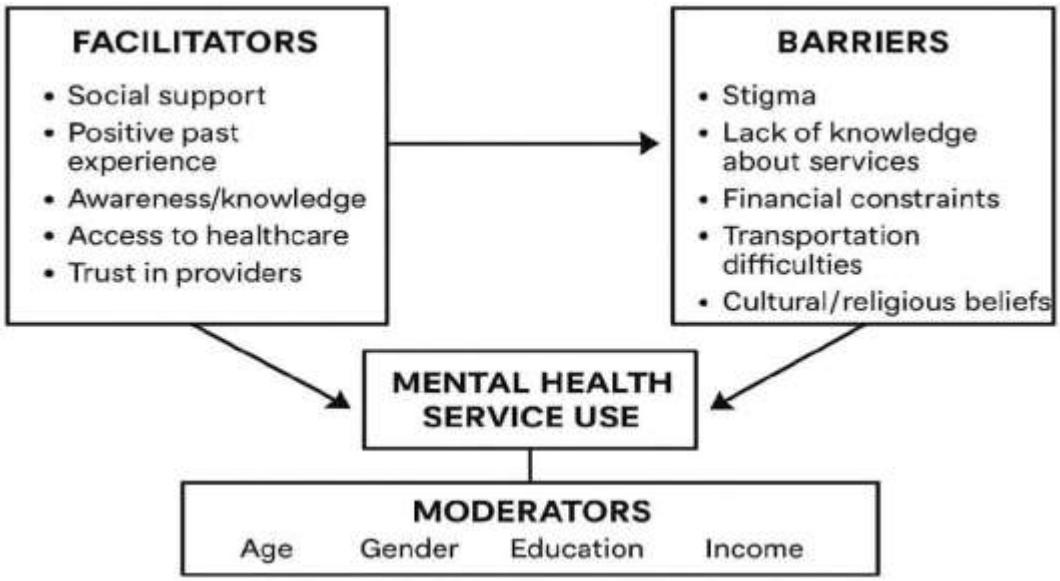

Figure 2.2 Conceptual framework showing interrelation between different factors

CHAPTER ONE

3.0 RESEARCH METHODOLOGY

3.1 Introduction

As stated in the introductory chapter, this research aims to understand the factors that help and hinder older adults' use of mental health services. In-depth interviews with older adults were the main source of data used to understand their perspectives on mental health. Beginning with a description of the study's setting and the demographic from which 30-person sample was chosen, the proposed methodology lays out the parameters of the research. After that, it looks at how the data was gathered and the sampling procedure that was used. Following that, it explains the methods of analysis that was used to decipher the information and finally, the study's major ethical considerations are discussed.

3.2 Study Site and Setting

The research took place at one of Eldoret North's wards in Uasin Gishu County. Huruma ward is found in Turbo Sub County which has a population of 167,016 as per the 2019 census which showed how suitable it was for research because of its metropolitan nature.

In addition, Huruma's mix of cultures from tribes like the Luo, Luhya, Kikuyu, Kalenjin, Kamba and Kisii gave a strong social foundation. This mix of people, combined with the estate's popularity for those moving to different areas, gave a special place that shows many types of social groups. This made it possible to learn more about mental health problems from different levels of wealth and culture.

Also, being only 5 kilometres from Eldoret's financial area was a big advantage. It brings together all kinds of people, like workers in factories to middle class to jobs and business owners. This coming together did not just make experiences more

different, but it also highlighted the range of problems that older people face across various jobs and money levels.

The services and products in Huruma are of a good quality but face big problems because there is not enough housing, health care, water and sewage. This moving side-by-side of growth and shortcomings gave a good chance to check how bad infrastructures affect the mental health of older people. The growing amount of people puts pressure on important services. This gave us a chance to look at how not having enough resources can affect the mental health of elderly citizens.

Finally, the presence of both government and private hospitals in Huruma made it a good place for study. This difference in healthcare helped not only to tell us about the ease and use of services, but also showed the gaps in care given to old people with mental health issues. The property's appeal to older people with fixed incomes, giving them cheap homes and jobs was a factor. The way this group moves and their ability to do well in Huruma showed it might be a good place for the elderly.

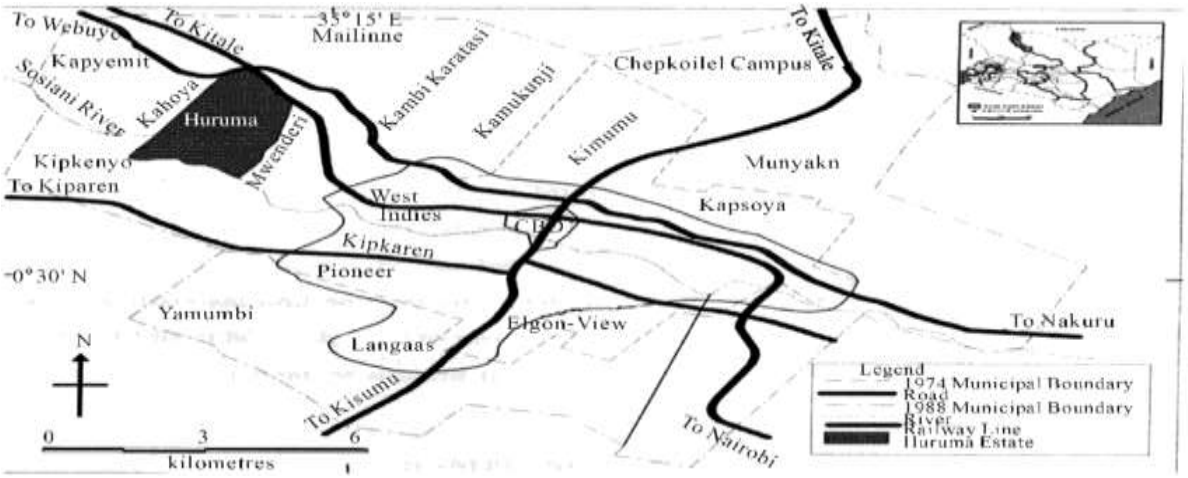

Figure 3.1: A Map of Eldoret Municipality (in Uasin-Gishu County) showing the study area (Huruma Estate). Source: Department of Geography Moi University.

3.3 Research Design

The study utilized a cross-sectional method that sought to understand the factors that encourage and discourage older persons from seeking psychiatric care; it was preferred because participants were surveyed at the same time, thus lowering the cost of time and money. Since the researcher's primary goal was to comprehend the factors that influence the elderly populations' decisions to seek or avoid mental health services, this design was appropriate. Due to the comparatively open-ended nature of the interview schedule, qualitative research methods were the most appropriate.

Bhattacherjee (2012), stated that qualitative research is inherently exploratory and is typically conducted in uncharted areas of study to better grasp the full scope of a phenomenon, initiate ideas about a phenomenon or to check whether undertaking a more extensive study is feasible (Bhattacherjee, 2012). In addition, its emphasis is at examining variables in their natural setting as emphasized in qualitative research. More so, qualitative approach provides a stage for identifying and recording study data from the inside, via a process of profound attentiveness, thus dispelling the researcher's assumptions (Khan, 2014). This study utilised the phenomenological design. This is because the study sought to explore and understand the lived experiences of older adults. The study further captured the subjective meanings and emotions attached to the barriers and facilitators to seeking mental health services. Finally, the study used in-depth interviews with a small sample which was purposefully selected.

3.4 Target Population

Target population refers to people, who make up the study population and are well-defined and specifically targeted. This research focused on older persons from a peri urban area in Eldoret town who are 60-80 years. This range was chosen because the United Nations defines older adults as individuals who are above 60 years of age (UNHCR, 2018). A variety of ethnic groups made up the majority of the responses. Another striking aspect of this demographic is that they were mostly jobless, which impacted their ability to seek mental health resources.

3.5 Sampling Size and Technique

Sampling is the choosing of a subset of a larger population to serve as a representation of the larger population as a whole. In this investigation, a representative sample was selected by a combination of purposive and convenience sampling methods. By definition, purposive sampling selects respondents who are more likely to deliver informative responses that advance the study's goals (Guest et al., 2013). Convenience sampling is a type of non-random way to pick people for a study. It is when the people who take part in the study are picked by the researcher because they can get to them with ease. To avoid bias in this case we worked with people residing in the area to identify possible participants within Huruma. To find older people who meet the study's inclusion and exclusion criteria, the researcher enlisted the aid of a research assistant who resides at the area of study. Furthermore, the previous cooperating participants helped in identifying other possible participants that wanted to take part in the research with their consent. In addition, purposive sampling involves non-random picking of respondents on purpose. Non-probabilistic and convenience sampling relies on existing relationships between researchers and potential participants. It is a non-probability method in which participants in the study find new

participants from among their social circles. As the number of people in the sample grows, researchers will have enough information to draw conclusions. Researchers frequently employ this method when trying to obtain representative samples from groups that are otherwise inaccessible (Khan, 2014).

Thirty older adults; 15 males and 15 females, aged between 50-80 years, were selected from Huruma in Eldoret. Within this sample, saturation was achieved. After interviewing 30 individuals, no new themes or notable variances in responses were noticed throughout data collection. This meant that all themes had been covered. Furthermore, the study's participants were a diverse group with a range of marital statuses, educational backgrounds, income levels, and housing arrangements, which allowed us to capture a wide range of perspectives in a small sample and increase the data richness. Additionally, for studies with homogeneous populations and narrowly focused topics, sample sizes between 20 and 30 participants are typically recommended in qualitative research literature to ensure saturation (Guest et al., 2013). Thirty was an appropriate and justified sample size because participants were sufficiently similar in terms of life stage and social-cultural context.

This sample size represented different views on the problems faced by old people in Huruma Eldoret. These challenges included getting healthcare, finding social help, worrying about money issues and facing abuse. Purposefully choosing ensured a better understanding of thoughts about mental health. While looking at Huruma, this specific group showed a bigger pattern among older people in Eldoret. This helped us understand their life experiences more deeply and clearly. This shows how important older adults are and we must care for their whole well-being in all areas. The participants did not require permission to share their perceptions about mental health

and were free to do so based on their own knowledge. Saturation of data was used as a threshold for further gathering of information.

3.6 Eligibility Criteria

3.6.1 Inclusion Criteria

People living in Huruma estate, ranging in age from 50 to 80 years, participated in the study. As much as older adults constitutionally in Kenya are those 60 years and above, the average life expectancy in Kenya is 62 years (World Bank, 2025) and many developing countries still consider those from 50 years as older adults hence the use of respondents 50-80 years.

3.6.2 Exclusion Criteria

The study excluded participants who were deaf, dumb or blind because of communication difficulties and their input could be unreliable. Also, individuals who did not understand English or Kiswahili language. Finally, it excluded participants who were unavailable during the time of the study, either they had travelled or were engaged in other community activities.

3.7 Data Collection Methods

There are numerous ways to collect data. An instrument or tool's selection is largely dictated by the characteristics of the subjects being studied, the research question being asked, the objectives being sought, the design being used, and the expected outcomes being obtained (Andrews et al., 2012). The research instrument was arranged based on study goals.

The purpose of the in-depth interviewing that will be employed is to get insight into a topic of interest by having in-depth conversations with a select group of people. When the researcher needs specifics on an individual's or group's outlook or when they wish

to go deeply into an uncharted topic. If a respondents does not feel comfortable speaking freely in a group setting, or if the researcher wishes to separate an individual's viewpoint from that of the group, individual interviews can be utilized in place of focus groups (Guest et al., 2013). The main benefit of conducting in-depth interviews is that they can lead to more thorough information while simultaneously creating a more calm and pleasant atmosphere where the respondent feels at ease enough to open up and share their thoughts and feelings. More research shows that interviews are a great tool for getting to the heart of people's thoughts and feelings (Kang & Hwang, 2021).

The precise goals of the study shaped the development of the interview guide's questions, which were used to learn about the elderly population's views on mental health and the factors that may influence their decision to seek or not seek treatment for psychological disturbances. The purpose of the interview guide was to help the researcher collect reliable and meaningful qualitative data. The interview guide was developed focusing on various factors that influence mental health seeking behavior in the different social ecological domains: individual domain which includes the beliefs, behaviors, attitudes and knowledge, the interpersonal domain which includes social interactions between family members and peers, the community and society domain which involves cultural norms, gender norms and organization domain that deals with credibility of service providers, provide patient relationship and availability of services as seen in Appendix 2.

The interviews were given in both English and Kiswahili, Kenya's official languages. The English-language interview guide was translated into Kiswahili as seen in Appendix 3. The reverse translation method, was used to determine how accurate the

translated interview guide was. The purpose was to check for inconsistencies and judge the quality of the translation.

To ensure the validity of the interview guide, assessment of responsiveness and applicability was undertaken using two female and two male older persons from Langas, Eldoret. This site is different from where the original study was undertaken; in Huruma Estate. The four individuals were interviewed to ascertain that the questions were easy to answer and identify those that were difficult. The researcher then made changes to the interview guide by reframing and rewording the questions according to the views of the four individuals.

The study was inductive in nature because it sought to explore and understand the lived experiences, beliefs and perceptions of older adults regarding mental health services. The study collected open ended data utilising an interview schedule and letting themes emerge from the data itself. The researcher was not testing a predefined hypothesis but rather trying to understand how and why older adults seek or do not seek mental health services which aligns with an exploratory inductive approach.

3.8 Research Procedures

A total of 30 one-on-one interview questions each lasting between 30 minutes to 1 hour, were conducted. Details were collected till there was an abundance of them. To find older people who met the study's inclusion and exclusion criteria, the researcher enlisted the aid of a research assistant who resides at the area of study. This is because she is in regular contact with many different people in Huruma through her role as a church leader in the area. The research assistant introduced the researcher to the first respondent. When interviewing the first elderly participant, the researcher introduced themselves, explained the study's purpose, and asked for the participant's written consent, and obtained verbal permission to record the interview. After that, the

interviewee suggested another person for the researcher to talk to and the same procedure was administered for every other participant.

The in-depth interviews began after each participant had filled out a demographic survey form, which provided a detailed profile of each participant. The researcher maintained a nonjudgmental stance during the interview to encourage candid responses from the respondents. The interview questions and their order were fluid, depending on the participants' responses. Data was collected using a variety of methods, including the notation of personal thoughts and observations in the form of field notes. The interviews were conducted in either English or Kiswahili (the local language), giving the respondents a greater range of options for expressing themselves. The assistant who accompanied the researcher during interviews was briefed beforehand on the study's overarching goals, specific objectives, and interview methodology. The ethics of conducting interviews were observed with each respondent. Since the interviewees were opening up about their life experiences, it was important to conduct the interview somewhere they felt at ease. Due to the nature of the research, majority of the participants preferred to have in-home, one-on-one interviews. However, some respondents preferred the in-person interviews held at the church because of transportation and family concerns. Because of this, not only was the researcher and respondents able to take use of it in regards to availability, but the respondents were also able to feel very comfortable expressing themselves.

3.9 Data Analysis

The term qualitative data analysis refers to a set of procedures including the organization and interpretation of textual qualitative data gathered from various sources such as interviews, field notes and recordings (Spencer et al., 2021). The study used theme analysis, which entails analyzing interview transcripts and

organizing the content, for evaluating the data. Following data transcription, a thematic analysis identified and catalogued recurring themes based on direct quotations or shared concepts (Rodriguez-Dorans & Jacobs, 2020). The Kiswahili audio-recorded interviews were transcribed verbatim from Kiswahili to the English language by the researcher. To ensure that the audio files were transcribed exactly, the research assistant listened to them. After the research assistant had checked the internal reliability, the researcher then consumed the material in its entirety to acquaint herself with it. Additionally, she reread the full dataset before beginning to code, classify, and discover any trends. After the data was coded and compiled, the researcher made a lengthy inventory of all the codes found in the dataset.

Moving beyond codes, this stage redirected the investigation to more general subjects. As part of this procedure, the codes were categorized into possible themes and then compile all of the pertinent coded data extracts inside each topic. A collection of themes was formulated by the researcher, and these were subsequently honed. At this stage, certain themes merged into others, while others were kept distinct. The operational definitions that accompanied the coded themes helped the researcher understand what each topic represented and ensured that the thematic map of her data was satisfactory. In order to guarantee that the data's tale is succinct, clear, logical, non-repetitive, and correct, the article included enough proof of the data's topics. The researcher used NVivo 14 software to finish a second round of coding and by checking every code to make sure it was consistent with the category that we used to form the conclusions.

3.10 Trustworthiness of data

The researcher employed member verification, which involved restating the participants' statements to verify their accuracy, to guarantee the data's credibility (Stahl & King, 2020). The researcher coded and recoded the data multiple times to make sure it was consistent and reliable. In order to guarantee transferability, the researcher selected individuals who were rich in information and could provide pertinent answers to the research questions.

3.11 Dissemination of Research Findings

The complete thesis will be uploaded to Moi University repository so that it can be accessed for future reference and research. Seminars will be held in the medical facilities in Huruma Estate, the study area, to share the findings of the research and help them develop actionable recommendations with the goal of maximizing the benefit to older adults. A manuscript will be developed for publication in peer reviewed journals. Finally, the findings will be presented in various scientific conferences.

3.12 Limitations of the Study

The sample size and method of sampling are the primary drawbacks of this research. Older persons who are not part of the researcher's networks are often left out of the sample. The sample may not accurately reflect the elderly population in Huruma estate because of the tiny sample size that was selected due to time restrictions. This sample solely reflects the viewpoints of individuals residing in that particular region. Views expressed here do not reflect those of the region or the people at large. This suggests that the data may be skewed in favor of the Huruma estate community's viewpoints. In addition, it is difficult to draw broad conclusions from this study because of the tiny sample size and the fact that the respondents were all from

Huruma estate. Furthermore, this study's sample just reflected one racial group since it only included African respondents. Because of this, we cannot say anything about the results in terms of other races.

The data collection was cross-sectional and there was no follow-up interview with the respondents to see if their views had changed. Also, because the study only included participants aged 50 and up, the researcher had to exercise caution when conducting in-depth interviews with these participants and actively steer the conversation away from irrelevant topics whenever they veered off course. Finally, many respondents addressed the researcher as "daughter," suggesting that age is a factor in how older adults responded and expressed themselves. This could be because of cultural beliefs that discourage older people from discussing sensitive family matters with younger generations.

3.13 Ethical Considerations

Ethical clearance was obtained for the study before it began. According to appendix 4, the researcher was given ethical authorization to proceed with the study by the Institutional Research and Ethics Committee (IREC) of Moi University and Moi Teaching and Referral Hospital (MTRH). A license to conduct research was issued by the National Commission for Science, Technology, and Innovation (NACOSTI) as seen in Appendix 5. The researcher took all necessary precautions to ensure the safety of the elderly. The participants in each interview were provided with a consent form and given a thorough explanation of the study's purpose before they were asked to sign it. Just before starting the interviews, the researcher made sure the responder knew what the study was all about. Participation in the study was entirely voluntary, and the participants were made aware that they would not receive any compensation for their time. Additionally, the researcher informed the participants that the final

report may include some or all of the interview snippets. The interviews were conducted in a way that ensured participant anonymity, and no names were included in the final report. Furthermore, the researcher had exclusive access to a password-protected computer where all materials, including transcripts, were stored. Participants were given the option to postpone, reschedule, or end the interview at any point if they felt the need to do so, considering the potentially stressful nature of mental health. Lastly, following the completion of the study, all interview instruments will be disposed of.

CHAPTER FOUR

4.0 DATA ANALYSIS AND FINDINGS

4.1 Introduction

This chapter presents the results of the data analysis, providing insights into the patterns and trends identified through the research. The analysis is structured around the research objectives and questions, utilizing various statistical tools and techniques to interpret the data. The findings are discussed in relation to the literature reviewed, highlighting significant correlations, relationships, and deviations that emerge from the data. This chapter serves as the foundation for the subsequent discussion, where these results are further interpreted and contextualized.

4.2 Demographic Analysis

The demographic profile of the 30 participants in the study on facilitators and barriers to seeking mental health services among older adults in Huruma Estate, Eldoret, reveals a diverse group primarily aged between 50 and 80 years.

Table 4.1 Demographic Analysis of Participants

Variable	N=30
Age	
50-59 years	15
60-69 years	12
70-80 years	3
Sex	
Male	15
Female	15
Marital status	
Single	3
Married	19
Divorced/separated	6
Widowed	2
Level of Education	
No formal Education	9
Primary Education	9
Secondary Education	6
Tertiary/University Education	6
Source of Income	
Pension	8
Employment	7
Business	11

Support from Family	3
Other	1
Employment status	
Employed	7
Self employed	11
Unemployed	12
Religion	
Christian	27
Atheist	3
Living status	
Alone	8
With family member	22

The study included 30 participants, representing a diverse group of older adults aged between 50 and 80 years. The majority of participants were in the range of 50–59 years (50%) being the most common. There were fewer individuals in the 60–69 years (40%) age range, and a smaller proportion of participants were aged 70–80 years (10%). The gender distribution was balanced, with 50% of the participants being male and 50% female, ensuring a comprehensive gender perspective on the issues being studied.

Marital status data indicated that a significant portion of the participants were married (63.3%), while others were divorced or separated (20%), single (10%), or widowed (6.7%). This variety in marital status could influence the participants' mental health needs and their willingness or ability to seek mental health services. The data reveals that education levels varied, with 29% of participants having no formal education, 31% having completed primary education, 19% having secondary education, and 21% holding tertiary or university education. This diversity in educational attainment may influence awareness and understanding of mental health issues, as well as the ability to navigate the healthcare system to access services.

In terms of income sources, the participants relied on a range of means, with 28% receiving a pension, 22% being employed, 35% engaging in business activities, 11% receiving support from family, and 4% having other sources of income. These income sources likely impact the financial accessibility of mental health services, where those with stable income from employment or business may find it easier to afford care, while those dependent on family support or pensions might face financial barriers.

Employment status showed a fairly even distribution among employed (23.3%), self-employed (36.7%), and unemployed (40%) participants, potentially reflecting different levels of financial independence and access to health services. Religiously, the majority identified as Christians (90%), with a small minority being Atheist (10%). Religious beliefs may play a role in how these individuals perceive and approach mental health issues. Additionally, most participants lived with a family member (73.3%), while 26.7% lived alone. Living arrangements are significant as those living alone may face greater barriers in accessing mental health services due to isolation or lack of support.

Religion played a role in the lives of most participants with a large majority (90%) identifying as Christian. A smaller group identified as atheist (10%). These religious affiliations influence how participants perceive mental health and their openness to seeking support.

Finally, most participants lived with family members (73.3%), which suggest the availability of immediate social support. However, some lived alone (26.7%), a factor that contributes to isolation and potential barriers to accessing mental health care.

4.3 Perceptions about Mental Health among Older Adults

The perceptions about mental health among older adults are shaped by a complex interplay of cultural, social, and individual factors. The perceptions of mental health among older adults in Huruma Estate revealed several prominent themes. These themes were derived from the narratives shared by participants during in-depth interviews, highlighting cultural beliefs, personal experiences, and societal attitudes toward mental health.

On Cultural Beliefs About Mental Health many participants expressed that mental health issues are often misunderstood or attributed to supernatural causes within their cultural context. Some older adults viewed mental health problems as a result of curses, witchcraft, or spiritual punishment. This cultural interpretation led some to seek traditional healers or spiritual interventions instead of professional mental health services.

> Illustrative Quote: "*In our culture, when someone starts behaving strangely, it is believed that they might have been bewitched or angered the spirits.*" (KP,58 years).

Some older adults demonstrated knowledge about mental illness while others maintained the belief that mental illness is a result of being bewitched.

> Illustrative Quote *"My nephew was caught stealing maize from the neighbours. Then the next day he went mad. Nafikiri neighbour wetu alimwendea kwa mganga." (I think our neighbor sought the services of a witch doctor), (WY, 57 years).*

On Fear surrounding mental health older adults were afraid of being judged or ostracized emerged as a significant barrier to seeking mental health services. Participants noted that a diagnosis of mental illness often results in societal exclusion,

with older adults being treated differently or viewed as incapable of contributing to their families or communities.

> Illustrative Quote: "*Once people know you have a mental illness, they no longer respect you. They treat you like you are no longer a person*." (MR, 50 years)

Majority of the respondents shared that stigma leads to fear of being viewed negatively by others. For instance, one respondent mentioned,

> *"I am old and in old age I am considered a life consultant (while laughing). Young people come to me for advice about their marital issues. Now if they ever know that I am being treated for depression they will never come to me for advice. I will be seen as a useless person. I cannot share my sickness" (MG, 56 years).*

Participants reported that older adults diagnosed with mental illness often experience discrimination or neglect within their families and communities. This difference in treatment sometimes leads to isolation, further exacerbating their mental health challenges. Additionally, some participants expressed frustration with the lack of understanding and empathy from healthcare providers.

> Illustrative Quote: "*Even in the family, once they hear you have a mental issue, they ignore you. They think you are no longer important*." (OT, 60 years).

Furthering on this, on the question on how does being diagnosed with a mental illness impact an older adult's quality of life, the qualitative data shows that the results in increased reliance on family and social isolation. One participant noted,

> Illustrative Quote: *"Also, he now has to rely a lot on the help of family members and friend…and yet when our children were young, we took care of*

them. Now we are old they do not want to do the same when we need help" (WA, 55 years).

Another emerging recurring theme was the belief in personal responsibility for managing mental health. Some participants described the need to take ownership of their emotional and psychological well-being, often emphasizing resilience and self-reliance. This perspective motivated some older adults to seek counseling or engage in community activities as coping strategies.

Illustrative Quote: "*I believe it is up to me to take care of my mind. No one else can help if I don't start by helping myself*." (AN,53 years).

Illustrative Quote: *"I am really serious. When it comes to the health of my head, I ensure to take care of myself" (KB, 58 years)*

The other them was unwillingness to communicate about mental health. Many older adults were hesitant to talk openly about mental health, both within their families and in public. This reluctance was often linked to generational norms, where discussing personal issues, especially those related to mental health, was considered taboo or a sign of weakness.

Illustrative Quote: "*In our time, we didn't talk about these things. You just endured and moved on.*" (KR, 60 years).

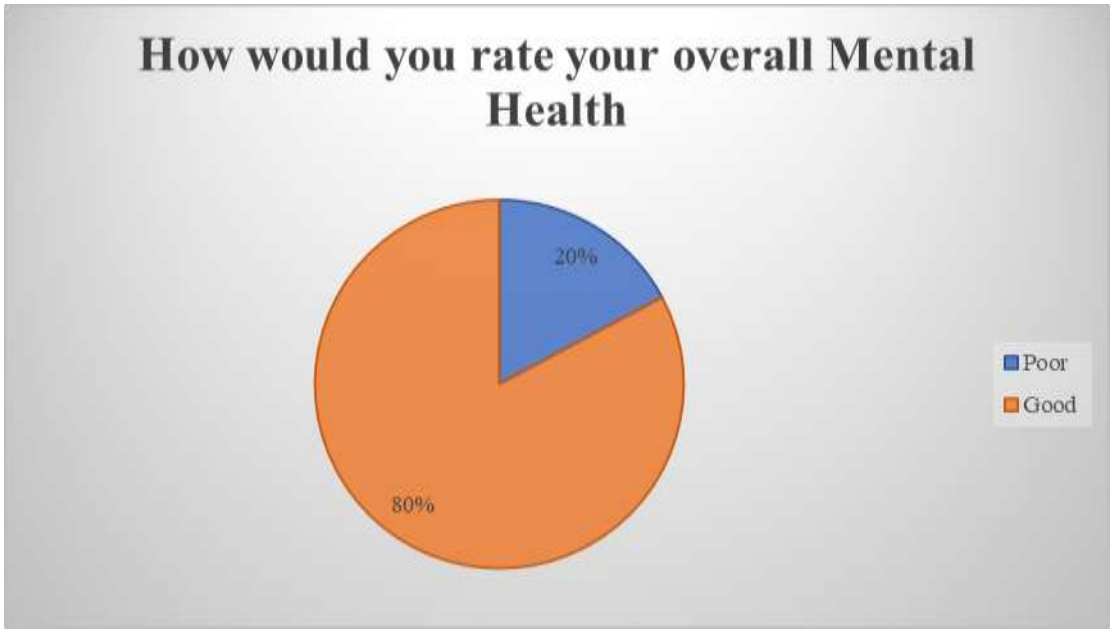

Figure 4.1 Mental Health Rating of older adults. Source: Author

The majority of participants, 80% (24) reported a positive perception of their overall mental health, with many acknowledging that while they felt relatively well, there may be room for improvement in their emotional or psychological well-being. This reflects a general sense of good mental health among the older adults in the study, suggesting that most participants feel mentally stable and healthy.

However, a significant number of participants expressed concerns about their mental health. A portion of respondents described their mental health as poor 20% (6), reflecting an awareness of difficulties such as anxiety, stress, or other emotional struggles that could affect their quality of life.

These findings highlight the variability in mental health perceptions among older adults, with most participants feeling positive about their mental well-being. Nevertheless, the presence of a considerable number of individuals who report poor mental health underlines the need for targeted mental health interventions to address these issues and improve overall well-being.

On examining on whether the respondents understand the term mental health, generally, respondents showed a limited understanding of mental health terms and the resources accessible to those living with mental illness. The viewpoints about mental health are caused by cultural variations and misconceptions. For example, one participant mentioned,

> Illustrative Quote *"I think mental illness is drifting of a person's mind. If I was to experience confused thoughts I do not know where to go for help" (NJ, 69 years)*

On the question on the social circle who might discourage the older adults from using mental services, majority emphasizes the respondent's family as the group that discourages them from using the services. For example, one participant shared,

> Illustrative Quote *"My mother told me not to ever share my home troubles with other people especially in hospitals" (AC, 70 years).*

On the question on what ways are older adults treated differently when diagnosed with mental illness it was indicated that they face discrimination and decreased social standing. Negative societal attitudes can lead to social isolation. One respondent mentioned,

> Illustrative Quote "*Even though people think mental health is an individual problem I think it involves society too. When an older person is diagnosed with madness, his position in society decreases and he faces discrimination, (WA, 55 years).*

On the changes on daily life that the older adults face after a mental health diagnosis, the output indicates that they may experience abandonment and increased reliance on family. Another respondent shared,

Illustrative Quote *“Sometimes family members agree to help. Other times we are abandoned and people just wish for our death because we are a burden, (WA, 55 years).*

On what kind of support do older adults receive from family members and friends, it is indicated that support from family and friends is crucial. For example, one participant noted,

Illustrative Quote *"The majority of support people get when battling a mental health disorder is from loved ones and family members" (NO, 57 years).*

On further probe, on how do support systems impact the mental health of older adults, it is illustrated that support systems are crucial, but when lacking, it can worsen the mental health condition. For instance, one respondent mentioned,

Illustrative Quote *"The messy behavior of family members can really turn against the mental health of the patients if they cannot help at any point” (AN, 53 years).*

A question on What interpersonal challenges do older adults face in their relationships with family, friends, or partners, where the Interpersonal challenges include discouragement from using mental health services by family members, as noted by AC (70 years):

Illustrative Quote *“My daughter, in my earlier years of marriage I was going through a lot of depression. My husband was very abusive. When my mother discouraged me from sharing my problems I felt so alone” (AC, 70 years).*

The participants were asked to describe the challenges they faced after being diagnosed with a mental health condition, particularly in your relationships and support systems. One of the participants stated that,

> Illustrative Quote *"I experienced a lot of challenges when I was diagnosed with depression. There was a lot of miscommunications between me and my husband because of the mood changes. At some point he left and went to live with his younger brother who had just began teaching practice. I found solace in my "Jumuia" (*small group of people in church who meet once a month for devotions) *and the doctor who was treating me" (RB, 61 years).*

On how has your faith or religious community supported you during times of stress or mental health challenges, one of the respondents stated that,

> Illustrative Quote *"My daughter, are you born again? I am a staunch Christian and Jesus is my Lord and Savior. I hope the music is not too loud. Church has really held me. When I lost my job and had a lot of stress, my pastor talked to me, visited me and even some church members brought some food items to sustain me. To me church is very important and if you do not go look for a good church to attend. I even invite this Sunday to our service" (KM, 61years).*

The older adults shared that they mainly sought help and support from the clergy and chaplains.

Information was collected from a mental health expert where they were asked to share an experience where they encountered someone struggling with mental health issues and how their emotional, psychological, and social balance was affected.

> Illustrative Quote *"I think emotional, psychological, and social balance is a means of attaining mental wellbeing. I had a client who also had a mood problem. She was very hypersexual. The husband just thought that she was cheating. But as I continued to interact with the patient, she was mentally*

unwell. Her husband disowned her and family members stayed away from her because she was HIV positive and had a mood problem, (KM, 61Years).

On further probe on what challenges, they faced in seeking support, and how the mental health expert did assist them, the response was;

Illustrative Quote *"She only got the necessary assistance after I referred her to MTRH and she was properly diagnosed and treated. She is still under treatment but lacks social support from family members" (KM, 61 years).*

4.4 Facilitators to seeking mental health services

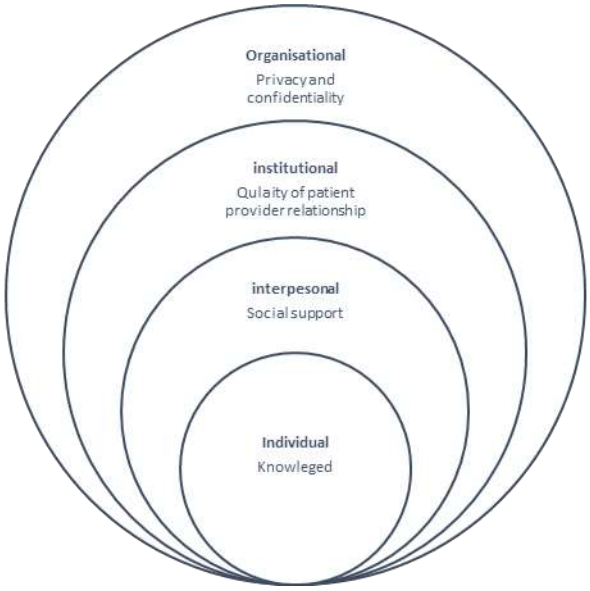

Figure 4.2 A Socio-Ecological Model of the facilitators to seeking mental health services among older adults. Source: Author

As the understanding of mental health issues continues to evolve, older adults are increasingly encouraged to seek the help they need to address their mental health concerns. Despite the barriers they face, various factors facilitate access to mental health services for this population. These facilitators include supportive social networks, improved access to healthcare services, awareness and education about mental health, and the role of community and religious organizations. Together, these elements create a more conducive environment for older adults to seek and receive the

mental health care they need, ultimately contributing to their overall well-being and quality of life.

In this section the factors that make it easier for older adults to seek out mental health care are presented thematically. The respondents were asked on where they commonly seek mental health care and why they choose those places. One of the respondent's statements was that,

> Illustrative Quote *"When I was going through divorce, I experienced period of low moods and could not eat. Later I was told I was going through depression due to the stress of the divorce. I remember my brother telling me to go and visit a counsellor at Moi Teaching and Referral hospital and even organized who was to help me. I felt cared for and was not afraid" (MR, 50years).*

On further probing the older adults were asked why they prefer seeking care from medical doctors, chaplains, religious or spiritual leaders or mental health clinics. One of the respondents stated that,

> Illustrative Quote *"My wife and I lost our second born child at birth. It was a very difficult time for us. As a husband I had to be strong for my wife. I did not know how to grieve. My wife had church friends supporting her. After the burial I felt I needed to talk out my feelings. I went to our pastor and we had a very long conversation. He even allowed me to cry and did not judge me. I felt relieved after that. I had mourned our child" (KP, 58 years).*

4.4.1 Knowledge and Awareness

On the key factors that motivate older adults to seek mental health services, one of the respondents stated,

> Illustrative Quote *"When I was working at Raiply company as a plumber, there was one meeting we had where we were taught about mental illness. This was the first educative session I had about mental health. I learnt about a few common mental illnesses and how they appear. We were also told where to get help for ourselves or a friend who is suffering. This made me feel wiser. I hope this kind of education can be given to many more people. When I was laid off from Raiply and felt very confused I went to a counsellor for help. I was able to get help on my own" (KR, 60 years).*

On the role the community outreach and education play in encouraging older adults to seek mental health services, a respondent said that,

> Illustrative Quote *"I can remember a time when our company organized a seminar about mental health. We were taught how to take care of our mental health especially us who were going on retirement. I wrote a lot of notes and we were even given brochures of where to get help" (WJ, 63 years).*

There was further probe on how do workplace-based mental health awareness initiative impact older adults' decision to seek help. A participant stated that,

> Illustrative Quote "*Sometimes our bosses took time to speak about mental health and I found it very helpful because a lot of awareness was created and put across, this was very useful because I experienced significant growth as a person on how to handle my emotions. If other elderly people are taught, they will experience significant growth as well" (KP, 58years).*

4.4.2 Social support

For further explanations they were asked how support from partners, family, and friends affect the likelihood of seeking mental health services. A respondent indicated that,

> Illustrative Quote: *"I regret not ever being married or having children. Now I live alone and have very few friends. Most of the people I connect with are at the workplace. But once I retire, I wonder who will be in my social circle. Family is very important" (WJ, 63 years).*
>
> Illustrative Quote: *"When my husband died, I had good support from my family and church community. I felt I was not alone. My children were my pillar" (MT, 64 years).*
>
> Illustrative Quote: *"When I was diagnosed with Diabetes I felt as if my world changed drastically. I changed my eating habits, I was taking medicine every day, I felt weak and eventually diagnosed depression. My husband really supported me a lot. I thank God for him every day". (NJ,69 years).*

There was a number of respondents who agreed that treatment include support from religious groups. The church's function in assisting those with mental health issues, praising it as a remarkable support system. One said that,

> Illustrative Quote: *"So, the only people I cried to were the women in my women's guild group at PCEA church. The older women gave me advice that I applied and it decreased my stress levels". (AC, 70 years).*

4.4.3 Quality of provider - patient relationship

The researcher probed further to determine if the quality of the counselor-patient relationship influenced the decision to seek and continue mental health services. One respondent stated that,

Illustrative Quote *"You are like my daughter and you seem very knowledgeable like another lady who was invited in our church to give a talk about stress. It was very helpful especially for me because I was caring for my mother who had cancer. I was very stressed that time. But the way that lady talked I felt lighter because I knew that what I was experiencing was not new and permanent, it could be treated if I would only seek treatment" (MI, 73 years).*

The respondents were asked what makes it easier for individuals living with mental illness to seek mental health services where one stated:

Illustrative Quote *"My counsellor is one of the best. Whenever I have a problem, I call her we make an appointment. If she is not available, we talk on the phone and namaliza shida niliokua nayo. (She helped me sought out the issue I had). (MI, 73 years).*

Further question was asked on the availability and relationship with mental health providers where the respondents were asked whether personal relationships and the support of healthcare providers influence older adults' mental health. One respondent stated that,

Illustrative Quote *"My dear, are you married? Because before you get married choose carefully. For me I am old and cannot change my husband. He is jogoo wa mtaa (cockerel of the village). He sleeps around with girls in the estate and even beyond. He started it when he was working at the university here in town. When I found out I was very disappointed and experienced hate and hurt. I talked to one of the lady doctors at district hospital. She encouraged me by sharing her story as well. We were like two co wives gossiping about our husbands (laughing). But I was helped. She changed how*

I saw things and decided to concentrate on myself and my children. And that is what I have done since" (NA, 54 years).

The understanding and non-judgmental attitude of healthcare providers have facilitated the willingness of older adults to seek mental health service. The question asked was, how past positive experiences with mental health services influence the decision to seek help. This is explained by an older adult of 54 years,

Illustrative Quote *"My father was being treated with a condition I heard for the first time called dementia. He used to forget things and wonder in the village alone without any specific place he was going. At first, I thought that he had been bewitched. We tried taking him to church for prayers but nothing worked. My sister who is a teacher told us to now seek medical attention. We started with the health center. We had so many referrals until we arrived at MTRH. That is where we got help. The doctor we met was very understanding he did not judge us because we had really sought a lot of advice from various people including herbal medicine before going to the hospital. He treated my father and explained to use for almost one hour the care we should give him. It was my first time to meet a psychiatrist but I cannot regret" (AO, 54 years).*

4.4.4 Privacy and Confidentiality

It was important to know how institutional factors, such as concerns about confidentiality and trust in service providers, impact the decision to seek help thus making it easy to solve their mental issues. This is explained by one participant,

Illustrative Quote *"In the month of January when I went for my normal checkup with my doctor, he noted that I may have been having a psychological problem that required attention. Since he had been treating me for long, I trusted him. He referred me to a counselor who noted that I was very anxious.*

The counselor was welcoming and we built a good relationship. She taught me a few things that can help with reducing my anxiety. One of them was breathing in and out. And not the normal way, it is different. I have been practicing the breathing and it has worked well for me She told me that everything we talked would remain private" (CT, 67 years).

4.5 Barriers to seeking mental health services

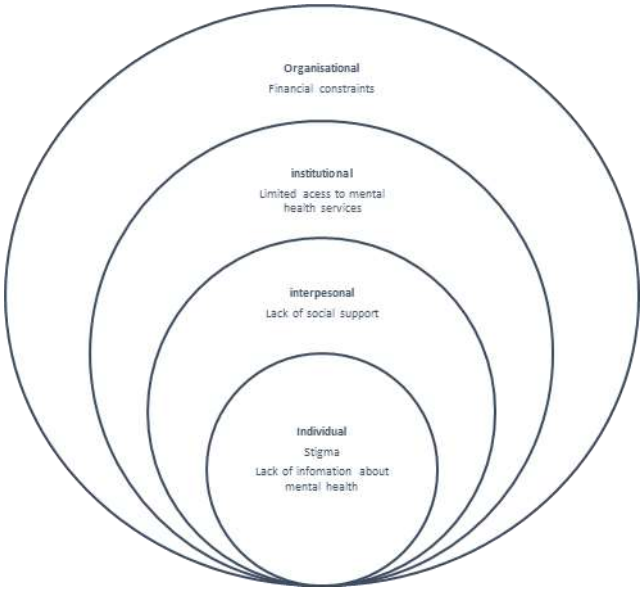

Figure 4.3 A Socio-Ecological Model of the barriers to seeking mental health services among older adults. Source: Author

Barriers to seeking mental health services among older adults are a significant public health concern, often rooted in complex social, cultural, and economic factors. Despite the growing awareness of mental health issues, many older individuals still face challenges that prevent them from accessing the care they need. These barriers can include stigma and cultural norms that discourage open discussions about mental health, a lack of information and understanding about mental health issues, misconceptions about mental illness, limited access to mental health services, financial constraints, and inadequate social support. Addressing these barriers is

crucial to ensuring that older adults receive the mental health care they deserve, allowing them to maintain a higher quality of life and overall well-being.

4.5.1 Stigma

Some of the respondent's narrate that the older people may resist seeking aid due to gender stereotypes, social stigma, and prejudice, reflecting the complex social landscape for the elderly.

The respondents were asked how does the fear of losing social or leadership positions, such as in church or community roles, influence the decision of older adults to conceal their mental health issues. One respondent stated that:

> Illustrative Quote *"I am afraid of telling people that I am being treated for a mood issue. I am women's leader in church. If I disclose that I have a mental illness they will remove me from my leadership position and even start gossiping about me. As long as I am okay to continue with my daily activities, nobody needs to know. Only my husband knows" (AK, 56 years).*

There was further probe on how the experience of sigma persist even after recovery of mental illness in older adults. To qualify the stigma issue, another participant responded thus,

> Illustrative Quote *"Imagine Kuna siku moja dada yangu alikuwa amerukwa na akili, lakini vile alipona akarudi nyumbani, watu hawakuamini kwamba amepona, saa zingine lazima uende nayeye kwa duka ndio auziwe chochote, kwa sababu wanadhani bado ni mwendazimu, imekuwa ngumu kwake na pia kwetu kama familia yake. Lakini utafanya nini?" (One day, my sister had a mental breakdown, but once she recovered and came back home, people didn't think she was cured. Occasionally, you have to go to the store with her, so that they'll sell her anything, because they still believe she's crazy. She has been*

struggling with it and so have we as her family. However, how can you cope with it?) (NL, 69 years).

Traditional ideas and traditions have a lot of weight in these societies. This is illustrated by AO, 61 years who when asked on how do traditional ideas and beliefs in their community influence the perception and acknowledgment of mental illness as a medical problem stated that:

Illustrative Quote *"People refuse to acknowledge mental illness as a medical problem despite scientific explanations of its nature because they believe it has immoral or even supernatural origins" (AO,61 years).*

The promotion of mental health acceptance in such a cultural context is obstructed, and stigmatization is intensified. On how cultural beliefs and practices in their community contribute to the stigma and misunderstanding of mental illness. This was stated:

Illustrative Quote *"I personally have never had a mental illness. But in our family, my nephew went mad a few years ago. He was caught stealing maize from the neighbors shamba. Then the next day he became mad. I think that woman 'alimuharibu'. 'Alimwendea kwa mganga'. (He went to a witch doctor). He now goes around beating people on the road" (WY, 57 years).*

4.5.2 Lack of information about mental health

On lack of information about mental health there were several questions asked to identify whether lack of information is a barrier to seeking mental health services. The first question was how does the lack of awareness about where to seek mental health services impact the decision of older adults to pursue treatment. One respondent stated:

Illustrative Quote *"I have ever heard about mental illness 'yaani ugonjwa wa akili' (mental illness) But I do not know where a person goes for help. Or even whether there is a cure for it" (MA, 64 years).*

Probing further the researcher asked how the tendency to normalize or minimize mental health symptoms affect the decision to seek mental health care among older adults. During the interview with a participant, she stated:

Illustrative Quote *"Sasa mimi unaona kama niko mgonjwa? Haha, mimi siko mgonjwa, hii ni hali ya maisha tu. Lakini ata kama saa zingine nasombwa na Mawazo aki sitaki ata kukumbuka yale ni nayo yapitia. Lakini haya yatapita sihitaji Kwenda hospitali" ("So, now, do you think I'm sick? She laughs, I am not sick, this is just life. Nevertheless, at times I am so overwhelmed by the thoughts I have not even want to remember the experiences I have been through. However, these things will be over, I don't need to go to the hospital.") (CB, 59 years).*

4.5.3 Lack of Social Support

The respondents were asked, how personal losses and the absence of support from friends and family exacerbate mental health challenges in older adults. One participant described how his sadness stemmed from lack of support;

Illustrative Quote *"After the period of COVID I tried opening up a second shop in Maili nne for my wife to run but it did not work. The day I put in stock for the shop thieves broke in and stole everything. It was very hard for me because I had taken a loan to open that shop and now, I had nothing. I was left with paying for a loan with no shop. I fell into depression and even my wife did not support me. My family members told me I was pretending to be sick." (MU, 62 years).*

This was also aligned with religious leaders and the community where they were asked how religious leaders and community figures provided alternative forms of support for older adults facing mental health challenges. One stated that,

> Illustrative Quote *"My wife committed suicide. It was a very difficult time for me. As a father I had to be strong for my children. I did not know how to grieve. The church never came to visit or console me because they felt it was my fault my wife killed herself. My family members did not support even financially during the burial." (KP, 58 years).*

4.5.4 Limited Access to mental health services

Limited access to mental health services has been seen to be a barrier to majority of the old adults. One respondent explained that,

> Illustrative Quote *"Services of mental health are mostly available in town I have not heard anyone offering counseling services apart from VCT. Even at district hospital where I regularly get treated, I have never seen a counsellor. A friend of mine had to go all the way to town and walking to referral is a journey. Ukipanda boda pesa inaongezeka"(When you use a motorbike additional money is required)" (WT, 52 years).*

Also, on the same limited access the researcher probed further and asked how the lack of trained counselors in local hospitals affects older adults' access to mental health care. One stated,

> Illustrative Quote *"I already told you that I experienced depression after my divorce. It was a difficult challenge to obtain a counselor from the district hospital. My brother had to look for a counselor from MTRH on my behalf. And even then, that counsellor was not able to understand me well due to my*

old age. I felt he was a bit harsh because of the way he was talking to me" (MR, 50 years).

4.5.4 Financial Constraints

Financial constraint is one of the major reasons as to why majority are not able to access or afford mental health services. This was identified after the respondents were asked how the costs associated with mental health medication and treatment affected the ability of older adults to manage their mental health conditions. One stated that,

> Illustrative Quote *"Let me tell you the cost of medication is a lot. I buy medicine for diabetes and it is expensive. Then when I was experiencing depression, they gave me more medicine. I could not afford it. I just had to take care of diabetes and I prayed in church for depression to go away" (MT, 64 years).*

Further the use of financial resources was identified such as transport cost and consultation cost where they were asked how do transportation costs and logistical challenges affect the ability of older adults to access mental health services. One responded that,

> Illustrative Quote *"Listen to me (*with an angry voice*) in this current economy of bottom up and taxes everywhere I cannot afford to pay for mental services. I work to feed my family and ensure my last-born finishes university. Ninafanya kazi ya vibarua. (I am a casual laborer) I will go to hospital when I am about to die. Until then zingine tunavumilia kimwanaume (We are resilient like men)" (OT, 60 years).*

Another stated,

> Illustrative Quote *"I have a sister who went mad a few years ago. She lives in Turbo with my mum. The first time she got mad I took a loan from my chama*

to bring her to Eldoret for treatment. It was very expensive. I paid for a taxi from Turbo to Eldoret that charged Ksh. 3500. We had to go to MTRH because here at the district hospital they did not have the services. They wanted to admit her but I did not have enough money for that. My sister was just given medicine and then I stayed with her to monitor how she is doing. That was an extra mouth to feed. I am employed at a wholesale shop. My salary is not enough for both of us" (WJ, 63 years).

4.7 Summary

This summary provides a comprehensive overview of the key findings from the analysis, highlighting the demographic context, perceptions, facilitators, barriers, and recommendations related to mental health service delivery among older adults in Huruma Estate, Eldoret. The study examined older adults in Huruma Estate, Eldoret, focusing on various demographic factors. The population consisted of a mix of genders, age groups, educational levels, and marital statuses, providing a diverse representation of the community. Most participants were above 50 Years, reflecting the aging population in this region. This demographic spread offered a comprehensive overview of the community, which is essential in understanding the broader context of their mental health perceptions and behaviors.

The perception of mental health among older adults in Huruma Estate was generally shaped by cultural and societal influences. Many participants demonstrated an awareness of mental health issues, acknowledging their existence and impact. However, there was a notable stigma associated with mental health conditions, where some individuals viewed these issues as a personal failing rather than a medical condition. This stigma often discouraged open discussions about mental health and created barriers to seeking help. Despite this, a portion of the population recognized

the importance of mental health care and expressed a willingness to seek services if necessary. The mixed perceptions highlight the need for education and awareness campaigns to normalize mental health discussions and reduce stigma in the community.

Several factors facilitated the willingness of older adults to seek mental health services. Key facilitators included the availability of supportive family networks, the presence of accessible healthcare facilities, and the influence of community leaders who advocated for mental health care. Additionally, participants noted that experiencing severe symptoms that disrupted daily life often prompted them to seek help. The recognition of mental health as an integral part of overall well-being also played a crucial role in encouraging individuals to access services.

The study identified several barriers that hindered older adults from seeking mental health services. A significant barrier was the stigma associated with mental illness, which led to fear of judgment from others. Economic challenges also played a role, as the cost of services was prohibitive for many individuals. Limited awareness and understanding of available mental health services further compounded the issue, with some participants unaware of where or how to access help. Additionally, cultural beliefs and mistrust in the medical system were cited as reasons for avoiding formal mental health care.

CHAPTER FIVE

5.0 DISCUSSION

5.1 Introduction

This chapter discusses the implications of the findings presented in the previous chapter, interpreting them within the context of the existing literature and theoretical framework. It critically examines how the results align with or diverge from prior studies, offering explanations for observed patterns and trends. The discussion also considers the practical implications of the findings, particularly in relation to the research objectives. By integrating the data analysis with broader academic discourse, this chapter aims to provide a deeper understanding of the study's significance and potential impact.

5.2 Demographic characteristics of respondents

The age distribution reveals that the majority of respondents were in the 50-59 age group (n=15) followed by those aged 60-69 years (n=12) and a small portion aged 70-80 years (n=3. This distribution indicates that the study predominantly targeted early adults, many whom may still be active or transitioning into retirement. The relatively low number of participants in the 70-80 age bracket may suggest reduced accessibility to participants among the oldest cohort.

The sample consisted of an equal number of male and female participants ensuring a balanced representation of an equitable analysis of perspectives across sexes minimizing gender bias in the study outcomes.

A significant majority of the respondents were married (n=19) while others identified as divorced or separated (n=6), single (n=3) and widowed (n=2). The dominance of married individuals suggest that most participants may have spousal support such as social well being and increased income sources.

The level of education varied among participants. Notably 9 respondents had no formal education, another 9 had completed primary education while 6 each had secondary and tertiary education. The variation reflects a diverse educational background likely shaped by generational access to education. The relatively high number of individuals without formal education may have implications for literacy level and access to information potentially influencing mental health outcomes.

Participants reported various sources of income. Business (n=11) was the most common source, followed by pension(n=7), support from family (n=3) and a small number relying on other sources (n=1). The data suggests that majority of the respondents are still economically active, particularly through informal or entrepreneurial means. This trend reflects the resilience and adaptability of older adults in sustaining livelihoods post-retirement.

In terms of employment status 12 respondents identified as unemployed 11, as self employed and 7 as employed. The high number of self-employed individuals point to the prominence of informal sector engagement among older adults. Meanwhile the unemployment rate (n=12) highlights the vulnerability faced by some participants in securing consistent income sources.

The religious affiliation of the respondents was predominantly Christian (n=27) with a minority identify as atheist(n=3). This overwhelming majority of Christian respondents reflects the broad religious landscape in many parts of Kenya and provides a cultural context for understanding values, behaviors and coping mechanisms among the participants. Religion can play a significant role in influencing social support systems, emotional well being and health seeking behavior.

Most respondents reported living with family members (n=22) while a smaller group (n=8) indicated they live alone. Living arrangements are a critical component of the social wellbeing especially for older adults. Those living with family likely benefit form increased social interaction, emotional support and assistance in daily needs. Conversely individuals living alone may face greater risks of social isolation, loneliness and reduced support. This demographic insight can be vital in analyzing the interplay between living arrangements and outcomes such as mental health.

The demographic profile indicates a relatively active older adult population with diverse education and income generating activities. The data also reveals a population rooted in religious tradition and family-oriented living. The high prevalence of cohabitation suggests a strong social and cultural framework that may influence participants resilience and well-being.

5.3 Perceptions about Mental Health among Older Adults

The findings from the thematic analysis substantially reflected findings in the literature about older adults' perceptions of mental health. The findings reveal a complex interplay of cultural, social, and individual factors shaping their perceptions of mental health. A significant portion of participants perceive mental health issues as a normal part of aging, which contributes to the reluctance to seek professional help.

Cultural beliefs discourage older adults from seeking mental health services with some participants attributing mental illness to supernatural causes such as witchcraft or not appeasing the ancestors. A person's ancestors are the first and most direct line to the spirit world and have an impact on the their life trajectory (Kpanake, 2018). Among the Kabye people of Togo, there is a common ritual called Kamtou. It involves a witch taking a person's Kalizo and hiding it somewhere it cannot be

reached. From that point on, the victim of Kamtou will go ill and eventually die unless they seek the advice of a traditional healer, who will be able to identify the root of the sickness and execute the necessary rituals to free the bound Kalizo (Mullet et al., 2016). This finding is further substantiated by a research done in Nigeria, there are individuals who think that mental illness might be caused by a curse, an evil spirit, or witchcraft (Chikomo, 2011).

Fear was another perception recognized at the individual level in this study. Majority of the respondents in the study shared that they were afraid of having a mental health diagnosis. These findings are similar those reported by Hispanic mental health providers who perceived that their beneficiaries were particularly worried about the possibility of a mental health diagnosis being included in their medical records or resulting in unintended consequences (Colligan et al., 2020). According to another study older persons feared that someone would find out if they sought professional care for a mental problem (Sorkin et al., 2016). In order to encourage older persons to seek help, it is good to promote peer-led support programs which have been found to be successful (Conner et al., 2016).

A number of older adults who took part in the study stressed the importance of being responsible for their own mental and emotional health. Some of the respondents shared that it was a personal obligation. These findings are supported by a study that found that dealing with depression was something each person needed to do on their own. Respondents shared that the best way of combating depression was to remain actively engaged (Colligan et al., 2020). Furthermore, Keeping physically well and socially active helped people self-manage their mental health symptoms, according to another study (Polacsek et al., 2020).

The last perspective is unwillingness to communicate about mental health. Many of the older persons in the current study were very uncomfortable sharing information about mental health or even admitting that they were being treated from a mental health issue. A study done among Southeast Asians corroborated this finding that some older adults felt uneasy talking about depression with their healthcare providers. Other participants shared that they would have difficulty sharing their feelings because these talks were a taboo (Colligan et al., 2020).

5.4 Facilitators to seeking mental health services

In order to put the identified facilitators into perspective, this study used the social ecological model (SEM). Each of the five levels of the SEM contributes to the whole. At the individual level, we find things like knowledge, attitudes, behaviours, awareness, and skills; at the interpersonal level, we have social support from people like family and friends as well as healthcare providers; at the institutional level, we have rules and regulations from healthcare providers as well as general attitudes towards research; at the community level, we have things like ease of intervention and acceptance within a defined area, as well as relationships between local organizations, charities, and information groups; and at the public policy level, we have laws and policies. At the individual level a facilitator identified is awareness about mental health and mental health services. Some participants in this study reported that their likelihood of using mental health interventions was higher when they had prior knowledge of these services, indicating that raising awareness of their existence and advantages is a key facilitator. Educational seminars and community initiatives are powerful tools for this course because they provide accurate information while dispelling the beliefs and preconceptions that fuel stigma (Mann et al., 2017). By providing spaces where people feel safe asking questions and sharing their

experiences, fosters community conversation and access that increases people's understanding of mental health.

At the interpersonal level participants identified social support as a critical factor in seeking mental health services. Informal support, in which partners and spouses, family members, and close friends have a role in helping one seek help by offering moral support, encouragement, and access to resources (Lyberg et al., 2013). A shorter duration of depression, greater recovery, more treatment concordance, and more formal help-seeking are all linked to higher levels of informal support (Esponda et al., 2020). Thus, those with robust informal networks are more inclined to seek out and make use of formal networks, as well as to exercise greater discretion when choosing a course of therapy.

Chaplains and religious leaders were identified by many respondents as crucial figures who can provide alternative sources of assistance. Religion plays a protective role, offering individuals not only spiritual guidance but also practical support, much like the traditional community-based support systems that older adults were accustomed to in their earlier years. This religious involvement is seen as a vital facilitator in the mental health journey of many older adults in the community.

At the institutional level vast majority of the respondents agreed that having a good relationship with their therapist was important. The current study found that participants' capacity to understand mental illness diagnosis and negotiate the most acceptable and successful treatment strategy was affected by the quality of their relationship with mental health professional. In order for people to feel comfortable discussing and making decisions about the pros, cons, and risks of each treatment option, a therapeutic alliance must be established between participants and their chosen health professional. This alliance is a strong predictor of good health outcomes

through effective help-seeking and treatment engagement (Polacsek et al., 2019). This is supported by another study where having an established relationship with the mental health practitioner facilitated depression screening (Colligan et al., 2020). Mental health practitioners should learn to create trust by using modest wording modifications and customized approaches to delicate subjects, which their clients may find more tolerable.

At the organisational level privacy and confidentiality was considered a facilitator by the older adults. Respodents felt confident that their information would be kept private and their identity would be kept anonymous. This is consistent with findings that older adults consider their mental health information as very sensitive and should not be shared with just anyone (Pywell et al., 2020).

5.5 Barriers to seeking mental health services

At the individual level majority of respondents reported issues of stigma as a primary obstacle. Many older adults find it difficult to discuss their mental health openly due to fears of being judged, discriminated against, or socially isolated. Mental health stigma perpetuates self-perceptions of incompetence or timidity, which in turn allow individuals to internalize feelings of depression and tragedy, worsening their mental health disorders (Schmitt et al., 2014). Furthermore, the cycle of pain is sustained by this complacency of acceptance. Labels such as "madness" or "a weak person" exacerbate the stigma associated with mental health issues (Link & Phelan, 2014). These stigmas discourage patients from seeking help when they need it, which delays diagnosis and treatment and adds unnecessary pain and suffering to their lives. A significant barrier that might cause people with mental health issues to hide their symptoms or, worse, to refuse to seek care is the harsh reality of being stigmatized or judged by society for their mental illness.

People with mental health concerns are contributing to the cycle of stigma and secrecy by not wanting to talk about it or get care, which in turn makes their condition worse for everyone involved (Harper et al., 2021). Social bonds and societal attitudes play a significant role in determining whether people will accept assistance and actually use support services, indicating that socializing significantly impacts people's perspectives on mental health. Some of the elderly participants in a US study expressed reluctance to have a depression diagnosis recorded in their medical records due to the potential negative outcomes of such a move. Some others said they felt "embarrassed" when they brought up their depression with their doctors (Colligan et al., 2020). Consistent with these other studies, the present study found that most participants are quite reluctant to tell those closest to them that they have a mental health diagnosis. This study's results also corroborate those of a previous research that looked at the effects of internalized and externalized stigma on a group of older individuals suffering from depression (Conner et al., 2016).

The variables linked to mental health help-seeking were examined in a study with a national sample of Canadians. The results showed that while public stigma did not significantly affect help-seeking behaviour, self-stigma had a strong negative influence. This suggests that people's internalized stigma was a major factor in their decision to seek help for mental health issues (Mackenzie & Pankratz, 2022).

In addition to stigma, the lack of information about mental health concerns at the community level and the absence of accessible resources further complicates the situation. Many residents were unaware of the symptoms of mental illness or the importance of seeking professional help. This gap in knowledge is compounded by a community-wide tendency to minimize or misunderstand mental health issues, often

associating them with substance abuse. Such misconceptions not only prevent individuals from recognizing their need for help but also contribute to the negative perceptions surrounding mental health care.

Limited access to mental health services is another major barrier in the institutional level. Majority of the older adults in the current study shared lack personal transportation to where mental health services are, or lack of mental health services in the nearest health facilities. The limited availability of nearby mental health facilities means that many individuals with mental health disorders are confined to their homes, unable to seek the help they need. The lack of access to appropriate mental health care services, including medication and therapy has also been reported by Colligan et al. (2020) as an obstacle that older persons face in overcoming mental health. Among Hispanic elders there was a decline in the utilization of mental health services due to a shortage of trained mental health practitioners as well as services that are age and culturally appropriate (Guzman et al., 2015).

Financial constraints further exacerbate this issue. The high cost of psychiatric medication, especially when required long-term, poses a significant challenge for these individuals, making it difficult for them to maintain the treatment necessary for managing their mental health conditions. This finding is supported by a study in Rwanda where due to a lack of resources, patients were not taken back to the health facility for the necessary follow-ups, which made the treatment follow-up seem less successful. There were other instances when patients were prescribed expensive medications that were not affordable and where they failed to attend their scheduled follow-up appointments (Rugema et al., 2015).

Moreover, the rising cost of living and other urban areas places additional strain on already limited financial resources. Older adults are often forced to prioritize basic necessities like housing, food, and utilities over mental health care, leading to delays or complete neglect of treatment. The cost of transportation to mental health facilities, whether for personal vehicles or public transit, also presents a financial burden that can discourage individuals from seeking the care they need.

Lack of social support was reflected at the interpersonal level. Unfortunately, not all older adults was able to rely on their families for support. When one is older, a parent, and dealing with mental illness, family interactions can be complicated and challenging (Lyberg et al., 2013). The results showed that loved ones may not fully grasp the complexities of dealing with a long-term mental illness, or they might just be too preoccupied with their own lives, as mentioned by a number of participants. When it comes to elderly people who are depressed, not having relatives to lean on can be just as difficult as dealing with the mental illness itself, which is a direct result of not having intimate, easily accessible relationships with other people (Lyberg et al., 2013). As reflected in literature evidence indicates that lower perceived social support is associated with increased symptom severity, diminished recovery or remission, and poorer functional outcomes at follow-up in older individuals with depression (Wang et al., 2018).

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATION

6.1 Introduction

The final chapter synthesizes the key findings and discussions from the previous chapters, offering a comprehensive conclusion to the research. It summarizes the main contributions of the study, reflecting on how the research objectives were met. The chapter also addresses the limitations encountered during the study and proposes recommendations for future research or practical applications. The aim is to provide a coherent closing argument that encapsulates the study's overall contribution to the field and suggests pathways for further exploration.

6.2 Conclusion

The findings reveal that older adults often perceive mental health through a lens influenced by stigma, cultural beliefs, and personal experiences, which either impede or encourage their willingness to seek help. The study aimed to explore the perceptions that the elderly have towards mental health. These perceptions include cultural beliefs about mental health, taking personal responsibility of mental wellness, fear of being viewed differently while suffering from a mental disorder and unwillingness to talk about mental health related topics.

The study also provided an insight into the factors that encourage the elderly to seek mental health services. The findings highlight the crucial role of social support systems, including family, friends, and religious leaders, in motivating older adults to seek help. The availability and preparedness of healthcare professionals also emerged as a significant facilitator, with respondents expressing confidence in the expertise and accessibility of mental health providers. Furthermore, community-based initiatives, such as educational workshops and support groups organized by religious

institutions, play a vital role in creating awareness about mental health and fostering a supportive environment where older adults feel comfortable discussing and addressing mental health issues. In conclusion, the study reveals that a combination of strong social support, accessible and competent healthcare services, and community engagement are key facilitators in promoting mental health care among older adults.

The barriers revealed by the respondents included stigma surrounding mental health issues, a lack of information and education about mental health, limited access to services, lack of social support and financial constraints. The stigma, often rooted in cultural and psychological factors, creates an environment of fear and shame that discourages open discussion and professional help-seeking. This stigma, combined with limited understanding and awareness of mental health, exacerbates the reluctance to seek treatment and can lead to the neglect of mental health needs. Financial barriers also play a critical role, as many older adults face difficulties affording mental health services, including consultation fees, medication costs, transportation expenses and follow up sessions. The high cost of care and medication, coupled with the rising cost of living, further strains the financial resources of older adults, making it challenging for them to prioritize and access mental health services. Additionally, the lack of accessible mental health resources and supportive social networks further compounds these challenges. Inadequate access to local mental health facilities and the absence of supportive family or community systems leaves many older adults without the necessary support to navigate the mental health care system effectively.

Seeking assistance is not always an easy task. A facilitator can assist someone deal with a diagnosis, whereas a barrier can prevent them from getting treatment or cause them to delay seeking it. In addition, facilitators encourage patients to take an active

role in therapy and decision-making. It is critical to better understand the factors that help and hinder older persons with depression when trying to seek care in order to improve access, diagnosis, and treatment. The signs of mental disorders in older persons can be difficult to spot, and getting them the help they need can be even more challenging. Help-seeking obstacles and facilitators can be effectively addressed by general and mental health practitioners. While doing so, they should work to dispel common misconceptions regarding the relationship between age and mental illness in order to encourage this group to seek treatment.

6.3 Recommendations

Psychologists and other mental health professionals can do their part to make services more culturally appropriate by continuing their education throughout their careers and by actively seeking out new ways to learn about the unique requirements of the aging population. Tailoring interventions to local cultural contexts will foster a more supportive environment for older adults to seek the care they need.

Furthermore, it is evident that, from the viewpoints of both users and professionals, education is necessary about the privacy and secrecy of information. It is important to examine how older persons may access and understand this information when crafting clearer policies about data protection. These policies should be simply understood by therapists and users alike.

To combat stigma and shift the perception of mental health issues among older adults, the existing community-based education programs be maintained and further strengthened particularly in underserved areas to ensure wider access for older adults.

Collaborating with religious leaders is also essential, as religious institutions hold significant influence in the lives of many older adults. By working with churches, mosques, and other community leaders, mental health education can be integrated into religious activities, making older adults feel more comfortable discussing and seeking care for their mental health concerns. Additionally, incorporating testimonials and peer education can further reduce stigma. Sharing stories from community members who have successfully managed mental health issues can help normalize mental health care and encourage others to seek help when needed.

There should be a focus on expanding access to affordable care. This can be achieved by introducing mobile health clinics, telehealth services, and subsidized mental health care programs to reach older adults in remote or underserved areas, ensuring that services are accessible to those with limited mobility or financial resources. Integrating mental health into primary care is also crucial; healthcare providers should be trained to recognize and address mental health issues during routine checkups, enabling early identification and intervention.

Additionally, training institutions should offer training programs to religious and community leaders, such as chaplains, to provide basic mental health support and encourage individuals to seek formal services when needed. This approach strengthens the network of support around older adults, making it easier for them to access mental health care.

Policy makers should focus on reducing financial barriers by providing government subsidies, expanding insurance coverage for mental health services, and introducing financial assistance programs specifically for older adults. These measures will help

alleviate the financial burden that often prevents individuals from seeking mental health care.

In summary, stigma, ignorance, and lack of accessibility are some of the major obstacles that older persons have when trying to get mental health services. Help seeking can be facilitated by culturally sensitive outreach, strong social support, and trust in mental health experts. Enhancing mental health outcomes in aging populations can be achieved by addressing these barriers through focused education, increased service accessibility, and relationship building in healthcare.

6.4 Future research

Given the findings of this study, future research should focus on conducting studies with older adults from diverse ethnic, cultural and social economic backgrounds. Current literature may underrepresent minority and rural populations whose experience with mental health services may differ due to cultural stigma, language barriers or access issues. Additionally, research should look at the effectiveness of mental health literacy interventions aimed at decreasing stigma among older adults. Poor mental health literacy is a known barrier and understanding how to improve knowledge can inform target outreach strategies. Future studies should explore the role of telehealth and digital mental health tools in improving access to services. Technology can reduce transportation and mobility barriers especially for those in remote or undeserved areas. Finally, longitudinal research can be conducted to understand how attitudes, barriers and services use change as individuals age. Mental health need and perceptions can evolve and cross-sectional studies may miss these dynamic shifts.

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APPENDICES

APPENDIX 1: INFORMED CONSENT FORM

MOI TEACHING & REFERRAL HOSPITAL / MOI UNIVERSITY

COLLEGE OF HEALTH SCIENCES -INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE (MTRH/MU-IREC)

INFORMED CONSENT FORM

Study Title: Facilitators and barriers to seeking mental health services among older adults in Huruma estate, Eldoret

Name of Principal Investigator(s): Winnie Watiri Mwangi

Co-investigator(s):

Name of Organization: Moi University

Address: **Telephone Number:** 0721800889

Name of Sponsor/Funding Agency:

Informed Consent Form for: Elderly person

This Informed Consent Form has two parts:

- Part I: Information Sheet [to share information about the study with you]
- Part II: Certificate of Consent [for signatures if you choose to participate]

PART I: INFORMATION SHEET

Introduction:

You are being asked to take part in a study. This information will tell you about the study. Take your time reading this form. You will have a chance to ask questions.

You do not have to take part in this research study and will still be able to get health care and other benefits even if you say no. Not taking part will not change how you are treated or paid for, or if you can join any health plans or get benefits. In this study you can quit whenever you want. If after data is collected you decide to quit, you can ask that the information you gave be destroyed while you watch. This is before the information is

combined and no longer linked to specific people. If new information comes out about the risks or benefits of this study, you will be told. After this form is signed, you will get a copy of it.

Purpose of the study:

In this study, the researchers want to find out what older people think about mental health and what helps and hurts them when they try to get mental health services. The main question that will be looked into is how much older people know about mental health programs. The goal of this study is to find out what makes it easier or harder for older people to get help for their mental health issues.

Study site: Huruma Estate, Eldoret

Study population:

You have been asked to participate in this study because you are a senior citizen and fit into the category of participants required for this study that is older persons.

Study procedures:

As a participant in the study, I hope to be able to talk to you privately about the subject and have a pleasant conversation. The interview will last between 30 minutes to one hour, and it can happen on any day that works for you. Due to the fact that I cannot type as quickly as you talk, I will record the interviews. I am also going to write some notes in my note book. Not to worry, all the information will be kept confidential.

If you agree you will do the following:

The first thing you will have to do is sign a written permission form to show that you agree to take part in the study. Second, you are going to be in the interview. We want to hear how everyone answers the questions; there are no right or wrong replies. We value your contribution to the conversation.

Benefits:

It is possible that I will not be able to give you direct benefits for your help with the study project. However, the information we gather will help us improve the mental health services we offer to older people in the community.

Risks/Discomforts:

I have no plans to hurt you. There are not going to be any invasive techniques or treatments. You might feel a little awkward, though, when you talk about personal and professional problems. In this case, we will connect you with a therapist who will help you with your mental health for free.

Payments and Reimbursements:

There will be no payment or reimbursements to be offered.

Confidentiality:

We will do everything we can to keep your protected information private. National privacy rules will be followed when this information is used or shared. When you sign the consent form for this study, you are giving your permission that your study information can be used and shared. Your private data might need to be shared with the community advisory group, MTRH/MU-IREC, NACOSTI, or the healthcare team. After the study is over, we will keep your research information for at least six years. The study data is then thrown away. If you change your mind about letting your personal information be used, you should write to the investigator and let them know. Right after that, we will stop getting any more information about you. But the health information that was gathered before this withdrawal can still be used to improve research and reporting.

Compensation for injury:

In the event of an injury resulting from participating in this study, medical expenses will be covered for treatment of that injury by Moi University.

PART II: CONSENT OF PATICIPANT:

I have read or have had someone read to me the description of the research study. The researcher or someone representing them has told me about the study and answered all of my questions. I have been told about the study's possible risks, how it might make me feel, and any benefits that might come from it. I am willing to take part in this study.

_____	_____	_____
Name of Participant	Signature of participant/Thumbprint	Date & Time
_____	_____	_____
Name of Witness [Optional]	Signature of Witness	Date & Time
_____	_____	_____
Name of the person obtaining consent	Signature of person obtaining consent	Date & Time
_____	_____	_____
Printed name of the investigator	Signature of Investigator	Date

A NOTE ON STUDIES USING VERBAL CONSENT/ASSENT:

Verbal consent/assent means that the person obtaining consent or assent verbally explains the study using a study information sheet, and that consenting individuals give their verbal consent/assent in place of written consent to participate. They should be given the opportunity to ask questions and invited to keep a copy of the study information sheet. The PI should submit a copy of the study information sheet showing this consent script and how the research team will document in their research files when the consent discussion took place, who did it, and if there were any emergent issues.

Contacts for questions about the study

Questions about the study: You may contact

Winnie Watiri Mwangi

P.O. Box 3045-10100

Nyeri

Tel: +254 721 800 889

Email: winniewatiri@gmail.com

Questions about your rights as a participant: You may contact the Institutional Ethics and Research Committee (MTRH//MU-IREC) 0787723677 or email irec@mtrh.go.ke or irecoffice@gmail.com. The MTRH//MU-IREC is a group of people that review studies for safety and to protect the rights of participants.

Thank you.

I appreciate you for taking the time to read this information sheet and for considering being a participant in this research project. I am extremely grateful.

APPENDIX II: INTERVIEW GUIDE

Cover Sheet

Facilitators and barriers to seeking mental health services among older persons in Huruma estate, Eldoret

Study Instrument: Interview Guide

Interviwer: _____

Date: ____/____/2023

Region: _____

Start Time: _____

End Time: _____

Interview:

- **Inform the participants about the study guided by the study information sheet.**
- **Provide participants with an opportunity to ask questions.**
- **Obtain written consent from each participant privately. (2 copies per participants)**
- **Provide each participant with a copy of their signed informed consent form.**
- **Complete the demographic survey for each participant privately.**

DEMOGRAPHIC CHARACTERISTICS

	Question	**Options**	**Tick where true**
1.	What is your age Group	50-59 years	
		60-69 years	
		70-80 years	
2.	What is your Gender	Male	
		Female	
3.	What is your Marital Status	Single	
		Married	
		Divorced/Separated	
		Widowed	
4.	What is your highest level of education	No formal Education	
		Primary Education	
		Secondary Education	
		Tertiary/University Education	
5.	What is your Primary Source of Income	Pension	
		Employment	
		Business	
		Support from Family	
		Other	
6.	What is your Employment Status	Employed	
		Self Employed	
		Unemployed	
7.	What is your religion	Christian	
		Atheist	
8.	What is your Living Status	Alone	
		With family Members	

Now let us start our discussion with talking about how older adults perceive individuals living with mental disorders.

A. *Perceptions about Mental Health*

1. How do older adults perceive individuals living with mental disorders?
   Probe:

   - What do you understand by the term mental health?
   - What do older adults think about the seriousness of mental disorders?
   - What kinds of treatment do older adults seek for mental disorders?
   - Who among your social circle may discourage the use of mental health services?

2. What are some of the consequences a person with mental disorder experiences?

   Probe:

   - In what ways are older adults treated differently when diagnosed with mental illness?
   - How does being diagnosed with a mental illness affect an older adults' life?

3. What are some of the types of support that individuals living with mental illness receive?
   Probe:

   - Interpersonal support (spouses, family members, peers/friends)
   - Health facility support (clinician, CHW)
   - Institutional support

4. What are some of the challenges individuals living with mental illness experience?
   Probe:

   - Interpersonal challenges (partner, family members, peers/friends)
   - Health facility challenges (clinician, CHW)
   - Institutional challenges

Let us now talk about seeking mental health services.

B. *Mental health care*

1. Which is the most common place that older adults seek mental health care and why?
   - Medical doctors
   - Chaplains
   - Mental health clinics
2. What makes it easy for individuals living with mental illness to seek for mental health services?

   Probe:

   - Intrapersonal factors (age, gender, perception of about treatment, perception about disease)
   - Interpersonal factors (partner support, family support, friends/peer support, superior support)
   - Community factors (culture, availability of services, dissemination of information about mental health)
   - Institutional factors (confidentiality concerns, credibility of service providers, time off to attend appointments, availability of transportation, policies)

3. What are some of the challenges that older adults experience when seeking mental health services?
   Probe:

   - Intrapersonal factors (age, gender, perception of about treatment, perception about disease)
   - Interpersonal factors (partner support, family support, friends/peer support)
   - Community factors (culture, availability of services, dissemination of information about mental health)
   - Institutional factors (confidentiality concerns, credibility of service providers, time off to attend appointments, provider patient relaitonship)
4. If you were to think of a program that would assist older adults living with mental illness to easily seek professional services, what would it include?
   Probe:

   - Details of the proposed program
   - Why the proposed program would be successful
   - How would this program compliment the mental health clinics?

We are about to end our discussion today. But before we end, we would like to hear about some of your recommendations for improving delivery of mental health services to older adults.

C. Recommendation for improving mental health service delivery

1. What would you recommend the society can introduce to support older adults living with mental illness and why?
2. What would be your recommendation for improving available mental health services?

   Probe:

   - Parts of the mental health services that could be improved. How?
3. What would make these recommendations sustainable?

D. Closing

We have now come to the end of our discussions today. Thank you for your time and participation. We very much appreciate your comments, discussion, and input. We plan to take into account everything that was said today as we continue to improve the services offered to older adults.

- Do you have any questions related to our discussion today?

NB: Before ending

- **Remind participants about the confidentiality of the interview.**
- **Ask if there is anything that was not raised that should have been that is important to know in understanding mental health care of older adults.**
- **Thank participants once again for their time.**

APPENDIX III: INTERVIEW GUIDE KISWAHILI VERSION

Mwongozo wa mahojiano

Karatasi ya Jalada

Wawezeshaji na vizuizi vya kutafuta huduma za afya ya akili miongoni mwa wazee katika mtaa wa Huruma, Eldoret

Ala ya Kujifunza: Mwongozo wa Mahojiano

Mhojaji: _____

Tarehe: ____/____/2023

Mkoa: _____

Wakati wa kuanza: _____

Wakati wa kumaliza: _____

Mahojiano:

- Wajulishe washiriki kuhusu utafiti unaoongozwa na karatasi ya taarifa ya utafiti
- Wape washiriki nafasi ya kuuliza maswali.
- Pata idhini iliyoandikwa kutoka kwa kila mshiriki faraghani
- Mpe kila mshiriki nakala ya fomu yake ya kibali iliyotiwa saini.
- Kamilisha uchunguzi wa idadi ya watu kwa kila mshiriki kwa faragha.

ABIA ZA KIDEMOGRAFI

	Swali	**Chaguo**	**Weka alama kwenye ukweli**
9.	Una umri gani?	Miaka 50-59	
		Miaka 60-69	
		Miaka 70-80	
10	Jinsia yako	Kiume	
		Kike	
11	Je, hali yako ya ndoa ni ipi?	Sijaolewa/ Sijaoa	
		Ndoa	
		Kutengana	
		Mjane	
12	Je, ni kiwango gani cha juu cha elimu yako?	Hakuna elimu rasmi	
		Elimu ya msingi	
		Elimu ya sekondari	
		Elimu ya chuo kikuu	
13	Nini Chanzo Chako Cha Msingi cha Mapato?	Pensheni	
		Ajira	
		Biashara	
		Msaada kutoka kwa familia	
		Nyingine	
14	Je, hali yako ya Ajira ni ipi?	Kuajiriwa	
		Kujiajiri	
		Wasio na kazi	
15	Dini yak oni ipi?	Mkristo	
		Asiyeamini Mungu	
16	Hali yako ya kuishi	Pekee yako	
		Pamoja na wanafamilia	

Sasa hebu tuanze mjadala wetu kwa kuzungumza juu ya jinsi watu wazima wanavyowachukulia watu wanaoishi na matatizo ya akili.

A. Maoni kuhusu Afya ya Akili

1. Je! Wazee huwaonaje watu wanaoishi na matatizo ya akili?

Uchunguzi:

- Unaelewa nini kwa neno afya ya akili?
- Wazee wanafikiria nini juu ya uzito wa shida ya akili?

- Ni aina gani za matibabu ambazo watu wazima hutafuta kwa shida ya akili?
- Ni nani kati ya mduara wako wa kijamii anayeweza kukatisha tamaa matumizi ya huduma za afya ya akili?

1. Je, ni baadhi ya matokeo gani mtu mwenye matatizo ya akili hupitia?

Uchunguzi:

- Ni kwa njia gani watu wazima wanatibiwa kwa njia tofauti wanapogunduliwa na ugonjwa wa akili?
- Je, kugunduliwa kuwa na ugonjwa wa akili kunaathiri vipi maisha ya watu wazima?

2. Ni aina gani za usaidizi ambao watu wanaoishi na ugonjwa wa akili hupokea?

Uchunguzi:

- Usaidizi wa kibinafsi (wanandoa, wanafamilia, wenzao / marafiki)
- Msaada wa kituo cha afya (daktari, Mhudumu wa Afya ya Jamii)
- Msaada wa taasisi

3. Ni changamoto zipi ambazo watu wanaoishi na ugonjwa wa akili hupitia?

Uchunguzi:

- Changamoto baina ya watu
- Changamoto za vituo vya afya
- Changamoto za taasisi

A. Hebu sasa tuzungumze kuhusu kutafuta huduma za afya ya akili.

Huduma ya afya ya akili

2. Ni sehemu gani ya kawaida ambapo watu wazima hutafuta huduma ya afya ya akili na kwa nini?

- Madaktari wa matibabu

- Makasisi
- Kliniki za afya ya akili

3. Ni nini huwarahisishia watu wanaoishi na ugonjwa wa akili kutafuta huduma za afya ya akili?

Uchunguzi:

- Sababu za kibinafsi (umri, jinsia, mtazamo wa matibabu, mtazamo juu ya ugonjwa)
- Mambo baina ya watu (msaada wa washirika, usaidizi wa familia, usaidizi wa marafiki/rika)
- Mambo ya jamii (utamaduni, upatikanaji wa huduma, usambazaji wa habari kuhusu afya ya akili)
- Mambo ya kitaasisi (maswala ya usiri, uaminifu wa watoa huduma, muda wa kupumzika ili kuhudhuria miadi, uhusiano wa mtoa huduma wa mgonjwa)

E. Je! ni baadhi ya changamoto ambazo watu wazima hupata wanapotafuta huduma za afya ya akili?

Uchunguzi:

- Sababu za kibinafsi (umri, jinsia, mtazamo wa matibabu, mtazamo juu ya ugonjwa)
- Mambo baina ya watu (msaada wa washirika, usaidizi wa familia, usaidizi wa marafiki/rika)
- Mambo ya jamii (utamaduni, upatikanaji wa huduma, usambazaji wa habari kuhusu afya ya akili)
- Mambo ya kitaasisi (maswala ya usiri, uaminifu wa watoa huduma, muda wa kupumzika ili kuhudhuria miadi, uhusiano wa mtoa huduma wa mgonjwa)

F. Ikiwa ungefikiria mpango ambao ungewasaidia wazee wanaoishi na ugonjwa wa akili kutafuta huduma za kitaalamu kwa urahisi, utajumuisha nini?

Uchunguzi:

- Maelezo ya mpango uliopendekezwa
- Kwa nini programu iliyopendekezwa ingefanikiwa
- Mpango huu ungepongeza vipi kliniki za afya ya akili?

Tunakaribia kumaliza mjadala wetu leo. Lakini kabla hatujamaliza, tungependa kusikia kuhusu baadhi ya mapendekezo yako ya kuboresha utoaji wa huduma za afya ya akili kwa watu wazima.

C.Mapendekezo ya kuboresha utoaji wa huduma za afya ya akili

1. Ungependekeza nini ambacho jamii inaweza kuanzisha ili kusaidia watu wazima wanaoishi na ugonjwa wa akili na kwa nini?
2. Je, unaweza kupendekeza nini kuboresha huduma za afya ya akili zinazopatikana?
3. Uchunguzi:

.Sehemu za huduma za afya ya akili ambazo zinaweza kuboreshwa. Vipi?

3. Ni nini kingefanya mapendekezo haya kuwa endelevu?

D.Kufunga

Sasa tumefika mwisho wa mjadala wetu leo. Asante kwa muda wako na ushiriki. Tunathamini sana maoni yako. Tunapanga kuzingatia yote yaliyosemwa leo tunapoendelea kuboresha huduma zinazotolewa kwa wazee.

Je, una maswali yoyote kuhusiana na mjadala wetu leo?

NB: Kabla ya kumalizika

• Wakumbushe washiriki kuhusu usiri wa mahojiano.

• Uliza kama kuna kitu chochote ambacho hakikutolewa ambacho kilipaswa kuwa ambacho ni muhimu kujua katika kuelewa huduma ya afya ya akili ya watu wazima wazee.

• Washukuru washiriki kwa mara nyingine tena kwa muda wao.

APPENDIX IV: IREC APPROVAL

MTRH/MU-INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE (IREC)

MOI TEACHING AND REFERRAL HOSPITAL
P.O. BOX 3
ELDORET
Tel: 33471//2/3

MOI UNIVERSITY
COLLEGE OF HEALTH SCIENCES
P.O. BOX 4606
ELDORET
Tel: 33471/2/3

Reference: IREC/672/2023
Approval Number: 0004634

11th January, 2023

Winnie Watiri Mwangi,
Moi University,
School of Medicine,
P.O. Box 4606-30100,
ELDORET-KENYA.

Dear Ms. Mwangi,

FACILITATORS AND BARRIERS TO SEEKING MENTAL HEALTH SERVICES AMONG OLDER ADULTS IN HURUMA ESTATE, ELDORET

This is to inform you that ***MTRH/MU-IREC*** has reviewed and approved the above referenced research proposal. Your application approval number is ***FAN: 0004634.*** The approval period is **11th January, 2024- 10th January, 2025.** This approval is subject to compliance with the following requirements;

i. Only approved documents including (informed consents, study instruments, Material Transfer Agreements (MTA) will be used.
ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by ***MTRH/MU-IREC***.
iii. Death and life threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to ***MTRH/MU-IREC*** within 72 hours of notification.
iv. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to ***MTRH/MU-IREC*** within 72 hours.
v. Clearance for export of biological specimens must be obtained from ***MOH at the recommendation of NACOSTI*** for each batch of shipment.
vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.
vii. Submission of an executive summary report within 90 days upon completion of the study to ***MTRH/ MU-IREC.***

Prior to commencing your study; you will be required to obtain a research license from the National Commission for Science, Technology and Innovation (NACOSTI) https://oris.nacosti.go.ke and other relevant clearances from study sites including a written approval from the CEO-MTRH which is mandatory for studies to be undertaken within the jurisdiction of Moi Teaching & Referral Hospital (MTRH) and its satellites sites.

INSTITUTIONAL RESEARCH & ETHICS COMMITTEE
11 JAN 2024
APPROVED
P.O. BOX 3 ELDORET

Sincerely,

PROF. E. WERE
CHAIRMAN
INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE

cc CEO - MTRH Dean - SOP Dean - SOM
Principal - CHS Dean - SON Dean - SOD

APPENDIX V: NACOSTI LICENSE

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **760263**

Date of Issue: **07/February/2024**

RESEARCH LICENSE

This is to Certify that Miss.. Winnie Mwangi Watiri of Moi University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Uasin-Gishu on the topic: FACILITATORS AND BARRIERS TO SEEKING MENTAL HEALTH SERVICES AMONG OLDER ADULTS IN HURUMA ESTATE, ELDORET for the period ending : 07/February/2025.

License No: **NACOSTI/P/24/32722**

760263

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

See overleaf for conditions