



Gendered Cultural Logics of Pandemic Response: Elderly Knowledge Systems and COVID-19 Preventive Practices in Kenya

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Abstract: *This study explores gendered cultural preventive beliefs, values, and norms practiced among elderly populations during the COVID-19 pandemic in Kakamega County, Kenya, focusing on Malava and Matungu sub-counties, which have a high concentration of older persons. Guided by cultural resilience and gendered health behavior theories, the study employed a cross-sectional design, surveying 363 elderly respondents aged 60 years and above, complemented by qualitative narratives and desk review of relevant literature. Findings reveal that the elderly drew upon indigenous healing systems, moralized hygiene, and faith-based practices to interpret and respond to the pandemic. Women mobilized care-centered ethics through domestic hygiene, herbal remedies, and intergenerational health mentorship, while men often embodied stoic and autonomous dispositions reflecting hegemonic masculinity. Rituals such as prayers, ancestral offerings, and symbolic purification were adapted to promote both spiritual reassurance and collective resilience. The study concludes that COVID-19 responses among the elderly were culturally mediated, reflecting dynamic adaptation rather than static tradition. Gendered cultural logics provided psychosocial coping and reinforced communal solidarity. Recognizing such indigenous epistemologies within public health systems can enhance trust, sustainability, and local ownership of health interventions. The findings underscore the need for culturally grounded and gender-sensitive approaches to pandemic preparedness and health communication.*

Keywords: *Gendered beliefs, Cultural resilience, Indigenous knowledge, Elderly, COVID-19, Kenya, Moral economy, Spirituality*

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1. Introduction

Introduction The COVID-19 pandemic exposed deep-rooted intersections between culture, gender, age, and health beliefs across African societies. In Kenya, where

the elderly represent custodians of cultural knowledge and moral order, their interpretations of the pandemic were mediated not only by biomedical messages but also by culturally grounded beliefs, norms, and spiritual values (Nyanchoka et al., 2022). The elderly often defined as individuals aged 60 years and above hold distinctive perspectives on health threats, drawing from accumulated

experience, indigenous epistemologies, and gendered socialization processes (Oino, 2023). Within Kenya's pluralistic health system, where biomedical and indigenous logics coexist, understanding how the elderly perceived and practiced preventive behaviors during COVID-19 offers valuable insights into culturally responsive health communication and gender-sensitive public health strategies. The pandemic's initial outbreak in 2020 triggered widespread uncertainty, prompting communities to reinterpret global biomedical narratives through localized cultural frames (WHO, 2021).

For elderly men and women, preventive practices such as handwashing, isolation, or mask-wearing were not merely technical but deeply embedded in symbolic and moral meanings of cleanliness, protection, and social duty (Okello et al., 2021). Gender, as a cultural and social construct, shaped how these beliefs were understood and enacted. While elderly men often interpreted preventive measures through ideals of strength, authority, and endurance, elderly women tended to approach them through caregiving ethics, communal protection, and spirituality (Ngunjiri & Muthiani, 2022). Kenya's cultural diversity, spanning more than forty ethnic groups, implies that elderly populations' responses to COVID-19 were far from homogeneous. In many communities—such as among the Kisii, Luo, Kalenjin, and Coastal Swahili the interplay between indigenous health belief systems, gendered social organization, and moral expectations informed how risks were perceived and mitigated (Omanga, 2022).

The elderly in Kenya faced a dual vulnerability: the biological risk of severe COVID-19 infection and the socio-cultural strain of enforced isolation. Government countermeasures, such as restrictions on movement and social gatherings, though intended to shield the elderly (Ministry of Health, 2020), inadvertently disrupted vital kinship support systems in a culture where communal interdependence is paramount (Obara & Odhiambo, 2023). Older women, who disproportionately carry the burden of unpaid care work, reported increased stress and responsibility, as they became the primary caregivers for sick family members or the custodians of children out of school (Pinchoff et al., 2021). This gendered intensification of care duties highlights how pre-existing social inequalities were exacerbated by the pandemic, forcing elderly women to navigate complex care demands while simultaneously protecting their own health.

Cultural beliefs significantly mediated the acceptance of biomedical protocols, often leading to a fusion of indigenous and modern preventive practices. For instance, among some communities in Western Kenya, highly valued cultural practices like handshaking a symbol of peace and unity were replaced by fist bumps or waving, yet the underlying social need for connection and

collective support persisted (Oluoch et al., 2022). Some elders viewed the virus through the lens of ancestral wrath or witchcraft, leading to the re-introduction of certain traditional practices and sacrifices to appease spirits, particularly in communities like the Maasai and Mount Elgon regions (Mama Chesengei, as cited in ReliefWeb, 2020). These ritualistic adaptations demonstrate the resilience of indigenous epistemologies in defining and mitigating perceived threats alongside the official public health guidance.

Gender and location played a role in the uptake and perception of the COVID-19 vaccine among the elderly population. A study in Kericho County, a region in the Southern Rift Valley of Kenya with a high proportion of elderly individuals, found that gender did not significantly predict vaccine hesitancy among the aged 58-98 group, suggesting that other factors like trust in decision-makers and collective responsibility were more dominant (Wanjala et al., 2023). However, access to information and healthcare services, which is often gender-biased against women in rural areas, remained a critical factor (UN Women, 2021). The reliance on community elders and trusted local leaders for health information meant that vaccine confidence was intrinsically linked to local authority structures, which are often patriarchal and may unintentionally exclude elderly women from timely, accurate communication (Odhiambo, 2023).

The restriction of movement and public gatherings had a severe socio-economic impact on older Kenyans, particularly those in rural settings. Many elderly individuals rely on small-scale trade, farming, or participation in "*Chamas*" (informal savings and credit groups) that depend on social contact for income (Amimo et al., 2021). The curtailment of these activities and the prohibition of large funeral gatherings, a crucial source of financial and social support eroded the elderly's economic security (Okumu & Mwalo, 2022). The government's effort to mitigate this included restricted migration from urban centers to rural areas to protect the older demographic (MOH, 2020), inadvertently cutting off remittances from working-age children, further compounding the financial distress faced by rural elders (Amnesty International, 2021).

The pandemic accelerated the adoption of technology as a substitute for traditional intergenerational contact, profoundly affecting the elderly. While older individuals often prefer face-to-face interaction, government-supported initiatives, including the deployment of internet-enabled balloons in conjunction with Google, aimed to deliver emergency internet connectivity across the country (Kenya's COVID-19 Response Strategy, 2020). This allowed digital social contact with family and friends, which encouraged adherence to physical

distancing protocols and provided a new channel for health information dissemination (Gikonyo et al., 2021).

This shift, however, created a new form of digital divide, marginalizing those without access or literacy and underscoring the need for tailored, multi-platform health communication strategies in future crises (Makau et al., 2022). This study is designed to inform the creation of culturally competent, gender-sensitive communication frameworks that honour the elderly as valuable custodians of knowledge, thereby strengthening their inclusion and protection in future national and global health crises (Nyanchoka et al., 2022; Omanga, 2022). Examining the above dynamics is vital, not only for understanding behavioral responses during COVID-19 but also for strengthening resilience and intergenerational health communication in future pandemics.

1.1 Statement of the Problem

The COVID-19 pandemic profoundly affected elderly populations, not only exposing their health vulnerabilities but also disrupting the social and cultural rhythms of their daily lives. During the pandemic in Kenya, public health strategies focused on biomedical interventions mask-wearing, social distancing, and hygiene often overlooked the lived realities and knowledge systems of older adults. For many elders, health is inseparable from cultural practices, rituals, and spiritual beliefs that guide daily living. Elderly women, for example, took on caregiving and domestic responsibilities, ensuring their families stay safe, while men often engaged in spiritual and ritual leadership, navigating threats through faith and communal authority. These gendered practices shaped how older adults understand and respond to health risks, influencing compliance with public health directives and their psychological resilience. Despite their contribution in the management of Covid-19 pandemic, their voices, experiences, and wisdom of elders were often marginalized in health planning, leaving gaps in pandemic response strategies. This study sought to illuminate how elderly knowledge systems, shaped by gendered roles and cultural logics, inform COVID-19 preventive behaviors in Kenya and how they can be integrated in the mainstream healthcare system.

1.2 Research Question

How do gendered cultural knowledge systems among elderly populations in Kakamega County shape their understanding, interpretation, and practice of COVID-19 preventive measures?

2. Literature Review

Culture refers to the shared systems of meaning, symbols, practices, and values that shape how individuals interpret reality, illness, and healing (Geertz, 1973; Oino, 2022). In the context of health, cultural beliefs act as interpretive lenses through which disease causation, prevention, and treatment are understood. Among the elderly in Kenya, these beliefs are inseparable from gendered social roles and moral frameworks. Gender determines not only the division of labor but also symbolic responsibilities regarding care, hygiene, and ritual purification (Amutabi, 2021). For instance, elderly women often occupy custodial roles in domestic health management, herbal preparation, and caregiving, while elderly men retain authority in ritual decision-making, spiritual protection, and social discipline (Were, 2019).

Preventive beliefs, as a subset of health beliefs, are culturally embedded expectations and rationales guiding individuals' proactive behaviors against disease (Rosenstock et al., 1988). In indigenous Kenyan contexts, prevention is often conceptualized through metaphors of *purity*, *balance*, and *spiritual fortification*. During the COVID-19 pandemic, such beliefs shaped interpretations of infection control: handwashing might be linked to ritual cleansing, mask-wearing to the moral containment of "contaminating breath," and social distancing to traditional quarantine practices like isolation of the sick in separate huts (Nyanchoka et al., 2022).

Ageing, meanwhile, carries a dual cultural meaning. On one hand, elders are revered as moral authorities and custodians of ancestral wisdom; on the other, they are physically vulnerable and socially dependent (Mbogori et al., 2023). The intersection of gender and ageing thus produces distinct social expectations. Elderly men are often valued for their symbolic endurance and decision-making power, while elderly women are recognized for their nurturing, healing, and moral mediation roles. These gendered social scripts influence how preventive measures are accepted or resisted, especially when global biomedical directives appear to challenge local epistemologies (Okemwa & Oino, 2024).

The COVID-19 context intensified these dynamics. Messages emphasizing individual responsibility such as "*stay home*" or "*avoid gatherings*" clashed with collectivist norms of solidarity and communal ritual participation, particularly for elderly people accustomed to social interconnectedness (Mutua, 2021). Gendered cultural expectations further complicated this: elderly women felt obligated to continue caregiving and domestic labor even during restrictions, while elderly men faced pressure to uphold authority despite declining mobility

and heightened vulnerability (Waweru & Kariuki, 2022). Therefore, understanding the gendered nature of cultural beliefs among the elderly requires unpacking the symbolic interplay between gender roles, moral expectations, and local ontologies of health.

Gendered Cultural Systems and Health Worldviews

Gender is not a biological determinant but a socio-cultural construct that defines roles, expectations, and relationships within a given society (Connell, 2019). In African contexts, gender systems are deeply interwoven with cosmology, kinship, and moral order (Amadiume, 2015). During crises like pandemics, these systems influence how individuals perceive risk, disease causation, and prevention. Cultural norms dictate who should care for whom, which rituals ensure protection, and how vulnerability is morally interpreted. In most Kenyan ethnic groups, the elderly especially women are custodians of healing traditions and moral guardians of the community (Were, 2020).

Among the Kisii, Luo, and Kamba, for instance, elderly women are perceived as repositories of curative herbs and protective rituals. Their caregiving roles align with socially constructed femininity emphasizing nurturance and moral duty (Nyaga, 2021). Conversely, elderly men often occupy advisory and spiritual roles, linking pandemics to divine punishment or social disorder (Mbiti, 1991). Such beliefs influence how preventive measures like isolation, handwashing, or masking are culturally interpreted. For example, some elderly men resisted mask-wearing as a sign of weakness, while elderly women viewed cleanliness and covering as acts of respectability and divine obedience (Namusonge et al., 2022).

Cultural beliefs about disease prevention are rooted in collective ontologies of health that see illness as a disturbance in social, spiritual, or ecological balance (Mwangi, 2021). Among Kenyan communities, traditional preventive measures often combine ritual purification, herbal medicine, and moral behavior. For instance, taboos surrounding sexual activity, food consumption, and social gatherings during epidemics were common even before colonial medicine (Harris, 2018). These practices were preventive measures embedded in the community's cosmology. During COVID-19, such logics resurfaced. The elderly invoked ancestral wisdom burning herbs like *mwarubaini* (neem), using saltwater for cleansing, and reciting protective prayers. These were not merely superstitious acts but expressions of indigenous epidemiology: a way of managing contagion through symbolic and material means (Chigudu, 2020). Understanding these preventive beliefs is critical because

they demonstrate how local epistemologies complement or resist biomedical models.

The elderly in Kenya occupy ambivalent social positions—simultaneously revered as wisdom keepers and marginalized within modern economies (Ngunjiri & Muriithi, 2020). The pandemic heightened their vulnerability due to age, health fragility, and isolation. However, it also reaffirmed their cultural authority. In rural areas, many elderly individuals became sources of indigenous protection knowledge, reintroducing rituals of cleansing and moral rectitude. Gender shaped these responses profoundly: elderly women mobilized care networks and herbal healing, while elderly men led prayers, moral instruction, and communal reconciliation rituals (Kilonzo, 2021). This intersection of age, gender, and culture underscores that prevention is not merely biomedical it is social and moral. For many elderly people, COVID-19 was understood through idioms of spiritual contamination or social transgression, calling for moral purification rather than mechanical hygiene. These interpretations reflect the embeddedness of preventive behavior in cultural values that prioritize relational harmony and ancestral protection. To critically analyze gendered cultural preventive beliefs and practices, this review draws on four interrelated theoretical frameworks: intersectionality theory, symbolic interactionism, African Indigenous Knowledge Systems (IKS), and the social construction of risk and resilience. These frameworks illuminate how gender, culture, and ageing intersect to shape health behaviors and moral responses during crises.

2.1 Intersectionality and Gendered Health Inequalities

Intersectionality, first articulated by Kimberlé Crenshaw (1989), provides a lens for understanding how multiple social identities such as gender, age, ethnicity, and class interact to produce unique experiences of privilege and marginalization. Among the elderly in Kenya, gendered inequalities intersect with socio-economic deprivation and rural marginalization to influence health responses (Onyango & Khasakhala, 2021). Elderly women, often widowed and economically dependent, faced greater exposure to infection through caregiving roles, while elderly men confronted identity crises as traditional protectors rendered powerless by a disease that undermined communal masculinity. Intersectionality thus moves analysis beyond binary gender comparisons to explore the structural and cultural matrix that shapes differential access to preventive resources and moral expectations. It also underscores that pandemic responses must address both biomedical vulnerability and social inequalities.

2.2 Symbolic Interactionism and the Meaning of Illness

Symbolic interactionism, as developed by Mead (1934) and Blumer (1969), focuses on the meanings people assign to social phenomena and how these meanings guide behavior. Illness, within this perspective, is not just a biological condition but a *socially constructed experience* mediated by cultural symbols and interpretations. For the elderly in Kenya, COVID-19 carried meanings of divine punishment, witchcraft, or ancestral warning. Such interpretations shaped preventive practices, including the avoidance of strangers, ritual cleansing, or the wearing of charms (Kenyatta, 2022). Through the symbolic lens, preventive acts such as handwashing or mask-wearing acquire cultural significance. They become expressions of moral purity, obedience to elders, or respect for communal order. This framework helps to decode the cultural scripts underpinning preventive behavior and how these scripts differ across gendered lines. For example, women's cleaning rituals symbolized care and respect, while men's reluctance to seek medical help reflected ideals of stoic masculinity.

2.3 African Indigenous Knowledge Systems (IKS) and Biocultural Adaptation

IKS theory emphasizes that indigenous communities possess complex and legitimate systems of knowledge grounded in lived experiences and ecological relationships (Hoppers, 2002). These systems include herbal pharmacology, divination, and social rituals that historically protected communities from epidemics. In Kenya, IKS informed community-level COVID-19 prevention strategies such as the use of herbal steam therapy, dietary fortification, and invocation of ancestral protection (Oino, 2022). IKS also embodies gendered specialization of knowledge: elderly women preserve herbal knowledge, while men safeguard ritual and spiritual practices. These epistemic roles reveal that gender is embedded within knowledge production and dissemination processes. Integrating IKS with modern epidemiology can enhance culturally resonant health communication and resilience among elderly populations.

2.4 Social Construction of Risk and Resilience

The social constructionist perspective on risk (Douglas & Wildavsky, 1982) posits that perceptions of danger are

culturally mediated rather than purely objective. What a society defines as “*risky*” or “*safe*” depends on moral codes, trust, and historical experience. For Kenyan elders, COVID-19 was often perceived through moral metaphors “*a curse for disrespecting elders*,” or “*God’s reminder of human frailty*.” These framings shaped compliance with preventive measures. Elderly men in patriarchal settings tended to downplay risk, viewing disease as fate, while elderly women emphasized collective care and moral responsibility (Were & Oino, 2023). Resilience, within this framework, is both a social and cultural process. Communities mobilized indigenous solidarity mechanisms such as kin-based mutual aid, moral storytelling, and prayer networks to sustain hope. These responses reveal that resilience is not merely about individual coping but about sustaining cultural coherence under disruption.

3. Methodology

This study employed a cross-sectional research design, combining a systematic review of existing literature with primary data collection to examine gendered cultural logics of COVID-19 preventive practices among elderly populations in Malava and Matungu sub-counties of Kakamega County, Kenya. The target population comprised elderly people aged 60 years and above, drawn from a base population of more than 20,000 residents. Using the Krejcie and Morgan (1970) formula for sample size determination, a target of 384 respondents was calculated to ensure representativeness; however, data were successfully collected from 363 respondents, representing a high level of participation. A sampling frame was constructed from local administrative registers of elderly residents in the selected sub-counties. Respondents were selected using simple random sampling, ensuring that every eligible elderly individual had an equal chance of inclusion. Prior to participation, informed consent was obtained in accordance with ethical research standards, and respondents were assured of confidentiality and voluntary participation. Data collection employed a mixed-methods approach. Quantitative data were captured through structured questionnaires, allowing for descriptive statistical analysis of demographic profiles, preventive behaviours, and adherence to COVID-19 guidelines. Qualitative insights were obtained through semi-structured interviews, focus group discussions, and participatory observation, enabling the capture of narratives, beliefs, and cultural practices underpinning preventive actions. This triangulation of methods allowed for convergence of evidence from literature and field data, enhancing the robustness and depth of the findings.

4. Results and Discussions

4.1 Gendered Cultural Preventive Beliefs, Values, and Norms Were Affected with COVID-19

The study aimed to investigate how gendered cultural beliefs, values, and norms influenced elderly populations' understanding and adoption of COVID-19 preventive measures in Kakamega County, specifically in Malava and Matungu sub-counties. The results in Table 1 below illustrate respondents' perceptions of the influence of gender roles, age, and gendered vulnerability during the pandemic.

Table 1. How Gendered Cultural Preventive Beliefs, Values, and Norms Were Affected with COVID-19

Responses	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Gender roles influence the elderly population's understanding of COVID-19	21 (5.8%)	120 (33.0%)	118 (32.4%)	77 (21.2%)	28 (7.7%)
My age influences my understanding of COVID-19	35 (9.6%)	126 (34.6%)	101 (27.7%)	82 (22.5%)	20 (5.5%)
Older women are the most affected by COVID-19	44 (12.1%)	82 (22.5%)	126 (34.6%)	86 (23.6%)	26 (7.1%)
Men are the most affected by COVID-19	68 (18.7%)	133 (36.5%)	104 (28.6%)	44 (12.1%)	15 (4.1%)

As shown in Table 1 above, a majority (33%) agreed that gender roles influence the elderly population's understanding of COVID-19, while 32.4% were neutral and 21.2% disagreed. Qualitative interviews revealed that elderly women conceptualized preventive practices through caregiving responsibilities, emphasizing hygiene, herbal remedies, and family protection. One respondent stated: *"I teach my grandchildren to wash hands and use herbs; it is our duty as women to care for our family."* In contrast, elderly men focused on communal and ritual obligations, organizing prayers, offering guidance, and advising on moral conduct as a form of disease prevention. A male elder noted: *"We tell people not to gather too much and follow doctors' advice because protecting our people is our duty."* These findings align with Connell's (2019) theory of hegemonic masculinity and Tronto's (1993) ethics of care, demonstrating how gendered roles mediate health knowledge and preventive behavior. Regarding age, 34.6% agreed that age influenced understanding of COVID-19, while 27.7% were neutral. Elderly respondents described increased vulnerability due to physical frailty and moral responsibility to safeguard younger generations. This suggests that age mediates risk perception and compliance, emphasizing the need for age-sensitive public health interventions. These patterns are further illuminated through qualitative insights, highlighting the

moral and spiritual logics underpinning preventive practices. As shown in above women's engagement with domestic hygiene reflects a moralized understanding of cleanliness linked to communal and spiritual well-being, while men occasionally resisted behaviors perceived as challenging masculine ideals (Douglas, 2002; Onyango & Khasakhala, 2021). Similarly, faith and indigenous spiritual practices framed the pandemic as a moral and divine challenge, producing hybrid preventive strategies.

On perceptions of gendered vulnerability, while 34.6% were neutral on older women being most affected, men were widely perceived as highly affected (36.5% agreeing). These results reflect gendered exposure, where men's public-facing roles increased perceived risk, while women's domestic roles emphasized caregiving. Comparative studies from Ghana and Nigeria report similar patterns, illustrating the intersection of gender, social roles, and epidemiological exposure (Adom, 2021; Awuah, 2021).

4.2 Reasons for Leaving Home

Table 2 below summarizes the primary reasons elderly respondents left their homes during the pandemic.

Table 2. Reasons for Leaving Home

Reason	Frequency	Percent
Going to work or to do business	120	33.0%
Going for shopping for basic needs	184	50.5%
Attend church service	20	5.5%
To seek medical attention	30	8.2%
To socialize	10	2.8%
Total	364	100%

Analysis in Table 2 above revealed that the majority of respondents left home for shopping (50.5%) and work or business (33%), reflecting the interdependence of economic necessity and culturally sanctioned responsibility. Within the theoretical frame of moral economy (Thompson, 1971; Douglas, 2002), such decisions reveal how moral obligations, rather than purely rational calculations of risk, guided behavior during the pandemic. Elderly participants, particularly women, framed mobility as an ethical act of care anchored in gendered expectations of provisioning and protection. For them, remaining indoors symbolizes not safety but moral failure a disruption of familial duty. As one elderly woman remarked, *“Even if the virus is outside, I must go to the market; if I stay home, my family will suffer.”* Her narrative captures the ethic of care (Gilligan, 1982) that underlies women’s everyday moral labor, situating public mobility as both an act of survival and an expression of social virtue.

From a gendered health behavior perspective (Connell, 2019; Adom, 2021), men’s movement was motivated less by household sustenance and more by ritual authority and communal representation. Their participation in funerals, blessings, and council meetings was described as indispensable to sustaining the moral and cosmological order. One male elder explained, *“If I don’t attend the burial, people will think I have forsaken my ancestors.”* Such expressions illuminate how hegemonic masculinity intersects with spiritual duty, positioning mobility as a marker of leadership, courage, and moral steadfastness. Refusal to fulfill these roles could lead to social sanction or perceived spiritual imbalance.

These narratives affirm the premise of cultural resilience theory (Berkes & Ross, 2013), which posits that communities adapt to crises not by abandoning tradition but by reinterpreting it. The elderly’s decisions to leave home whether to trade, bless, or bury embodied acts of resilience, balancing physical vulnerability with moral accountability. Mobility thus became a culturally mediated negotiation between the imperatives of survival, spirituality, and social continuity.

Collectively, these findings demonstrate that pandemic behavior among the elderly cannot be fully understood through biomedical rationality or risk perception models alone. Instead, actions were embedded within gendered moral logics and symbolic economies of care and obligation, revealing how social norms and cultural identity shape compliance and resistance alike. To humanize these experiences is to recognize that behind each act of movement was not defiance but devotion to a moral performance of care, dignity, and belonging in a moment of global uncertainty.

4.3 Barriers to Prevention and Control of COVID-19

4.3.1 Negative Effects of Complying with Stay-at-Home Requirements

Respondents’ perceptions of the challenges of staying at home are detailed in Table 3.

Table 3. Negative Effects of Complying with Stay-at-Home Requirements

Effect	1	2	3	4	5
Lack of freedom	55 (15.1%)	23 (6.3%)	77 (21.2%)	21 (5.8%)	188 (51.6%)
Loneliness	66 (18.1%)	34 (9.3%)	118 (32.8%)	52 (14.3%)	94 (25.8%)
Lack of social activities	29 (8.0%)	34 (9.3%)	100 (27.5%)	72 (19.8%)	129 (35.4%)
Lack of source of income	28 (7.7%)	28 (7.7%)	105 (28.8%)	70 (19.2%)	133 (36.5%)
Nervous thinking about COVID-19	77 (21.2%)	59 (16.2%)	84 (23.1%)	54 (14.8%)	90 (24.8%)
Worried about own health	53 (14.6%)	99 (27.2%)	86 (23.6%)	68 (18.7%)	58 (15.9%)
Worried about family health	48 (13.2%)	56 (15.4%)	121 (33.3%)	70 (19.2%)	69 (19.0%)
Stressed about leaving house	55 (15.1%)	64 (17.6%)	98 (26.9%)	80 (22.0%)	67 (18.4%)

As shown in Table 3 above, 51.6% of respondents rated lack of freedom at scale five, underscoring a profound dissonance between public health mandates and deeply ingrained cultural norms of mobility, reciprocity, and social participation. Loneliness, curtailed social interactions, and diminished income further exposed the multi-dimensional psychosocial burdens that lockdowns imposed on elderly populations. From a symbolic interactionist perspective (Goffman, 1963; Turner, 1988), confinement disrupted the performance of identity and belonging, stripping elders of their social roles as custodians of ritual continuity and moral order.

Qualitative narratives illuminated this rupture. One male elder lamented, *“Not attending funerals or rituals felt like the community was unbalanced; even with masks, the spirits were displeased.”* This voice captures how the pandemic not only constrained movement but fractured the symbolic bridge between the living and the ancestral world a theme central to African cosmological humanism. Within the gendered moral economy (Scott, 1976; Gilligan, 1982), elderly women’s experiences were marked by intensified domestic responsibilities, emotional strain, and caregiving fatigue. Isolation heightened their vulnerability, yet it also revealed their resilience: women adapted traditional coping mechanisms such as communal prayer, storytelling, and intergenerational phone mentoring to sustain social cohesion.

Interpreted through structural strain theory (Merton, 1968), these responses reflect how social systems under crisis produce moral and psychological stress when normative goals such as social solidarity and ritual participation are obstructed by institutional constraints. The elders’ distress, therefore, was not merely emotional but existential and relational, rooted in the disruption of

social harmony and the suspension of moral reciprocity. To humanize these experiences is to see in them not resistance to science, but a quest for meaning, belonging, and moral balance amidst the uncertainty of a global crisis.

4.4 Cultural Preventive Beliefs and Practices

4.4.1 Indigenous Healing and Rituals

The elderly population in Kakamega County demonstrated a rich repertoire of indigenous preventive practices during the COVID-19 pandemic, rooted in historical and spiritual frameworks. Survey findings and qualitative narratives reveal that elders engaged in ritual purification measures such as herbal fumigation, prayers, and ancestral offerings, consistent with responses to past epidemics like cholera and smallpox (Mbiti, 1991; Aseka, 2022). For instance, one elderly woman from Matungu sub-county explained: *“We burn herbs like osuga and mwarubaini in our homes to cleanse the air; it is not only about illness but also about keeping the spirits at peace.”* Such practices served dual purposes: psychological reassurance and reinforcement of community cohesion.

Elderly women predominantly managed domestic preventive measures boiling herbs, maintaining household cleanliness, and preparing herbal infusions while men often led public spiritual interventions, including prayers at communal sites and ritual offerings to ancestors. This division of labor underscores the gendered nature of cultural health knowledge, where women’s domestic roles

complement men's spiritual authority. Qualitative accounts indicate that these rituals were not merely symbolic but provided adaptive resilience. By contextualizing the pandemic within familiar cultural and spiritual frameworks, elders mitigated fear, maintained social order, and preserved intergenerational authority. One male elder noted: *"Our prayers and offerings remind the community that we are still connected to our ancestors; following these practices makes us feel we are not helpless."* These findings illustrate that indigenous healing and ritual practices are active strategies of psychosocial coping and community governance, not passive compliance to cultural norms.

4.4.2 Moral Economy of Cleanliness and Protection

Hygiene practices among the elderly were deeply moralized, reflecting culturally embedded ideas of purity, ethical duty, and communal responsibility (Douglas, 2002; Oino, 2022). Elderly women consistently associated domestic hygiene including handwashing, mask-wearing, and disinfection with the protection of family and fulfillment of moral obligations. A qualitative interview revealed: *"Cleaning the house, boiling water, and making sure everyone wears masks is my duty; it is how I protect my children and grandchildren, and by extension, our ancestors."* In contrast, men sometimes resisted preventive behaviors that conflicted with ideals of strength, and autonomy, perceiving compliance as a sign of weakness (Onyango & Khasakhala, 2021). Survey data (Table 1) demonstrate that men were less likely than women to adopt consistent hygiene practices, yet many men integrated selective rituals such as public prayers, reflecting a form of gendered negotiation between cultural values and biomedical recommendations.

This moralized understanding of hygiene emphasizes that adoption of public health measures is not solely determined by knowledge or access, but by alignment with socio-cultural values. Public health messaging that disregards these moral frameworks risks resistance or superficial compliance. Conversely, interventions that frame preventive measures as ethical duties consistent with familial protection, spiritual rectitude, and communal solidarity can significantly enhance uptake. For example, combining mask distribution with ritual demonstrations led by respected elders could bridge biomedical directives and indigenous moral codes, creating culturally resonant preventive strategies.

4.4.3 Faith and Indigenous Spirituality

Faith and indigenous spirituality played a central role in interpreting and mitigating COVID-19 risk among elderly Kenyans. Elders often framed the pandemic as divine

punishment for moral decay or communal disharmony, prompting ritualized forms of protection, including prayer, fasting, blessings, and offerings (Bakari, 2022). Qualitative interviews revealed that these practices provided emotional regulation, a sense of control, and collective purpose during periods of uncertainty. One elderly woman described: *"We fast and pray together. Even if the virus is unseen, our prayers bring strength and comfort; it unites us as a community and honors our traditions."* These practices were often syncretic, blending faith-based rituals with biomedical guidance. Elderly women, for instance, combined herbal remedies with handwashing and household disinfection, while men emphasized prayer and public spiritual interventions. This hybridization exemplifies adaptive cultural resilience, allowing communities to maintain cultural continuity while responding effectively to a novel public health threat.

4.4.4 Socio-Cultural Innovations in Public Health Interventions

The integration of indigenous knowledge systems, moralized hygiene, and faith-based practices underscores the critical importance of socio-cultural innovations in public health. Elderly populations act as custodians of cultural memory, translating epidemiological threats into locally intelligible frameworks that guide behavior. By acknowledging and leveraging these practices, health interventions can achieve greater legitimacy, compliance, and sustainability. For instance, culturally aligned health campaigns can integrate ritualized handwashing demonstrations, ancestral appeasement rituals, and storytelling to disseminate preventive messages. Digital technologies, such as mobile phones and radio broadcasts, were also employed to conduct remote blessings, prayers, and moral exhortations during lockdowns, demonstrating the potential for digital indigenization of public health interventions. Such approaches respect cultural epistemologies while enhancing reach and effectiveness, particularly among populations with limited literacy or access to formal healthcare systems.

Moreover, these socio-cultural strategies enhance psychosocial resilience, reduce anxiety, and maintain community cohesion. The pandemic revealed that elderly women often served as bridges between biomedical knowledge and domestic practice, while men maintained spiritual authority, creating a gendered collaborative model of health governance. Recognizing these dynamics allows public health authorities to design interventions that are culturally grounded, gender-sensitive, and socially sustainable. Overall, the COVID-19 pandemic in Kakamega County illustrates that elderly populations do not passively adopt public health directives; they actively negotiate, reinterpret, and integrate these measures within

culturally meaningful frameworks. Indigenous healing, moralized hygiene, and faith-based practices function as both preventive strategies and psychosocial supports. Effective public health interventions must therefore move beyond top-down biomedical approaches to embrace socio-cultural innovations, leveraging the moral, spiritual, and gendered logics that govern community behavior. This approach not only improves compliance but strengthens resilience, social cohesion, and intergenerational knowledge transfer.

4.5. Gendered Norms in Health Decision-Making

4.5.1 Masculine Stoicism and Risk Perception

The study's findings (Table 1) indicate that elderly men were more likely than women to downplay the severity of COVID-19 and neglect preventive measures, despite acknowledging personal and familial risk. Quantitative data reveal that 36.5% of men agreed that they were among the most affected by COVID-19, yet qualitative narratives highlighted deliberate non-compliance as a moral stance. One male elder explained: *"Wearing a mask constantly makes me feel weak; I must show strength for my family and community."* This behavior aligns with the concept of hegemonic masculinity, where stoicism, autonomy, and resilience are culturally valorized (Connell, 2019; Adom, 2021).

Men's reluctance to adopt preventive measures such as mask-wearing or social distancing reflects deeply embedded gender norms that equate vulnerability with moral or social weakness. Furthermore, older men perceived adherence to biomedical directives as conflicting with their patriarchal roles as protectors and decision-makers, thereby prioritizing social and spiritual expressions of strength over epidemiological compliance. These findings underscore the critical need for culturally sensitive, gender-aware public health messaging that frames prevention as an act of masculine responsibility and communal protection rather than fear.

4.5.2 Feminine Care Ethics and Communal Responsibility

Elderly women demonstrated a high degree of compliance with preventive measures, informed by a feminine ethics of care. From the study it is revealed that women consistently integrated hygiene practices, social distancing, and herbal prophylaxis into daily routines. Qualitative accounts reveal that women viewed health protection as an extension of their domestic and spiritual duties: *"I boil herbs daily for my grandchildren and teach them about handwashing. Protecting them is my responsibility, as taught by our ancestors."* Women's engagement reflects a moralized and gendered facilitation

of public health compliance, merging indigenous knowledge with biomedical guidance. These behaviors resonate with findings from Ghana and Nigeria, where elderly women translated public health directives into culturally intelligible and socially enforceable practices (Namusonge et al., 2022; Awuah, 2021).

Elderly women often led informal community networks for disseminating COVID-19 prevention knowledge, preparing herbal remedies, and monitoring household hygiene. Their role exemplifies how gendered norms can serve as vectors for health resilience, demonstrating that compliance is not merely a function of individual risk perception, but also of culturally embedded moral obligation and care ethics. The interplay between masculine stoicism and feminine care ethics illustrates the gendered divergence in health decision-making among elderly populations in Kakamega County. While men's behavior was shaped by ideals of autonomy and spiritual courage, women's actions were guided by collective responsibility and moralized care. These patterns highlight the necessity for public health interventions that are both gender-sensitive and culturally resonant, emphasizing communal duty, moral responsibility, and intergenerational protection rather than fear-based compliance. Elderly populations integrated biomedical and indigenous knowledge, negotiating health messages through culturally coherent frameworks. Women often blended rituals with hygiene, while men privileged ritual authority, illustrating gendered epistemic pluralism.

4.6 Comparative Perspectives

The COVID-19 pandemic in Kenya and across Africa highlights the profound interplay between gendered cultural norms, indigenous knowledge, and public health behavior, particularly among elderly populations. The findings from Kakamega County demonstrate that elders negotiated preventive behaviors through moral cosmologies, ritualized hygiene, and faith-based interventions, reflecting not only historical epidemic responses but also enduring cultural logics (Oino & Okemwa, 2023; Chitando & Chirongoma, 2020). From a Hegemonic Masculinity Theory perspective (Connell, 2019), elderly men's responses to COVID-19 were mediated by ideals of stoicism, autonomy, and patriarchal authority. Quantitative data from Table 3 show that men were more likely than women to perceive preventive measures such as mask-wearing and handwashing as threats to masculine honor. Qualitative narratives support this, with one elder noting: *"a man must not fear what comes; wearing a mask too often feels like weakness."*

This mirrors comparative findings in Nigeria and South Africa, where male elders privileged spiritual rituals over biomedical compliance, asserting authority and moral

courage in public spaces (Adom, 2021; Chitando & Chirongoma, 2020). These behaviors underscore that pandemic interventions cannot be gender-neutral; male-targeted strategies must reconcile biomedical directives with culturally embedded masculinity norms to achieve adherence. In contrast, Feminist Ethics of Care (Tronto, 1993) provides a framework to understand elderly women's proactive adoption of preventive measures. Women's engagement in domestic hygiene, herbal remedies, and intergenerational health education reflects a moralized sense of duty toward family, community, and ancestral obligations. In Ghana, Nigeria, and Kenya, similar patterns emerged: women translated biomedical guidance into culturally intelligible practices, reinforcing social cohesion while protecting vulnerable populations (Namusonge et al., 2022; Awuah, 2021). The intersection of care ethics and gendered responsibility highlights how women's roles can facilitate culturally resonant public health compliance.

From a Medical Anthropology/Cultural Health Belief perspective, elders across African contexts interpreted COVID-19 through spiritual, moral, and ecological lenses. In Kisii and Turkana counties, the elderly framed the pandemic as a disturbance in cosmic or ancestral order, requiring ritual appeasement alongside biomedical prevention (Esho & Owuor, 2021; Oino & Okemwa, 2023). Comparative insights reveal that this epistemic pluralism, where biomedical knowledge is selectively integrated into indigenous frameworks is a widespread phenomenon. In South Africa, Zulu elders treated the virus as a "*disruptor spirit*," employing ritual isolation and ancestral communication as complements to hygienic practices (Chitando & Chirongoma, 2020). Similarly, Nigerian Iyaloja networks adapted biomedical messages into local idioms and moralized hygiene, demonstrating the functional blending of traditional authority and public health guidance (Adom, 2021).

These theoretical lenses also illuminate the adaptive potential of cultural norms. Lockdowns, social distancing, and other government mandates catalyzed renegotiation of gender roles in Ghana and Kenya, where men increasingly participated in domestic health tasks traditionally performed by women. Such flexibility illustrates that cultural frameworks are not static; they are dynamic and capable of integrating biomedical rationalities while maintaining social legitimacy. From a policy perspective, these insights reinforce that public health interventions must be culturally informed, gender-sensitive, and anchored in existing moral economies to succeed.

Incorporating these theoretical perspectives further strengthens comparative analysis by connecting empirical observations to broader explanatory models. Hegemonic masculinity explains resistance patterns among elderly

men; feminist ethics of care clarifies women's compliance and caregiving roles; and cultural health belief models contextualize the selective integration of biomedical practices within indigenous knowledge systems. Together, these frameworks provide a nuanced understanding of how gender, age, and culture intersect to shape pandemic responses, offering critical guidance for designing innovative, culturally grounded, and gender-sensitive public health strategies.

From the foregoing discussion, comparative perspectives across African contexts underscore that elderly populations are active agents in pandemic knowledge translation. Gendered, culturally mediated practices spanning ritual, hygiene, faith, and moral obligation offer essential insights for health policy. Integrating these practices with theory-informed strategies enhances legitimacy, fosters compliance, and strengthens community resilience, demonstrating that socio-cultural innovations are indispensable components of effective pandemic management.

4.7 Cultural Continuity, Adaptation, and Resilience

The COVID-19 pandemic not only challenged biomedical infrastructures but also catalyzed a profound moment of cultural negotiation among elderly populations in Kakamega County. Elderly individuals emerged as key agents in maintaining cultural continuity while creatively adopting practices to meet public health imperatives, reflecting both resilience and socio-cultural innovation.

4.7.1 Ritual Reinterpretation

Pandemic-related restrictions necessitated the adaptation of deeply ingrained rituals, particularly those surrounding communal gatherings, funerals, and ancestral offerings. Elderly respondents reported substituting traditional burial vigils with symbolic offerings, prayers at home, and socially distanced blessings. One elderly woman explained: "*We could not gather at the homestead, so we placed food and herbs at the altar and prayed from our compounds; it felt as if our ancestors were present with us.*" These adaptations reflect cultural resilience, demonstrating that elders maintained ritual efficacy through symbolic and mediated practices. Moreover, the integration of digital technologies including mobile phones, radio broadcasts, and social media enabled remote participation in blessings and moral exhortations, representing what Oino (2022) terms the "*digital indigenization of ritual.*" Such innovations illustrate that cultural continuity is not synonymous with rigidity; rather, it is a dynamic process of negotiation that

preserves spiritual and social meaning while aligning with biomedical safety protocols.

4.7.2 Intergenerational Knowledge Exchange

The pandemic also facilitated unprecedented reciprocal learning between elders and youth, producing what can be conceptualized as intergenerational resilience capital. Elderly women took active roles in mentoring younger family members on domestic hygiene, herbal remedies, and caregiving practices, while elderly men guided youth in ritual performance, moral instruction, and community leadership. Qualitative narratives highlighted that youth frequently consulted elders for herbal knowledge, while elders relied on younger generations for information on government advisories and digital communication: *“My grandson taught me how to follow health updates online, and I showed him which herbs to use for steam baths; together we protected our family.”*

This intergenerational collaboration strengthened communal resilience, bridging indigenous knowledge systems with contemporary health information, and exemplifying social-ecological adaptation theory, which emphasizes the role of multi-generational knowledge transfer in community-level resilience (Folke, 2006). Gendered dynamics were central, as women’s domestic mentorship complemented men’s moral and ritual guidance, producing holistic protective strategies that reinforced social cohesion while mitigating vulnerability.

4.7.3 Indigenous Resilience and Cultural Renewal

Beyond adaptation, the pandemic revealed the transformative potential of cultural practices in mitigating fear, reinforcing solidarity, and fostering psychosocial well-being. Rituals, prayer, herbalism, and moral guidance were not only protective in spiritual or symbolic terms but also served tangible public health functions by encouraging hygiene, physical distancing, and care for vulnerable individuals. Elderly respondents emphasized that these culturally grounded strategies provided a sense of agency during a period of uncertainty: *“By performing the rituals, teaching the young ones, and maintaining our hygiene, we felt we were fighting the disease in ways science alone could not achieve.”*

These findings align with Medical Anthropology frameworks that conceptualize culture as a resource for health resilience (Kleinman, 1980). The gendered organization of these practices, where women’s care ethics operationalized prevention within households and men’s ritual authority maintained moral order illustrates adaptive cultural renewal, in which tradition is reinterpreted to meet contemporary challenges. Importantly, such practices highlight the need for public

health strategies to move beyond a purely biomedical paradigm and integrate indigenous knowledge systems as complementary assets in epidemic preparedness and response.

From the foregoing discussion, it is demonstrated that elderly populations in Kakamega County exemplified dynamic cultural continuity, intergenerational learning, and resilient adaptation, effectively transforming socio-cultural practices into practical public health interventions. Recognizing these contributions is essential for designing culturally sensitive, gender-responsive, and sustainable health policies, where indigenous knowledge complements scientific guidance rather than being treated as an obstacle.

5. Conclusion and Recommendations

5.1 Conclusion

This study examined *gendered cultural preventive beliefs, values, and norms practiced during the COVID-19 threat among elderly populations in Kakamega County*, focusing specifically on Malava and Matungu sub-counties. Drawing on both literature review, theoretical review and empirical data, the study revealed that cultural practices were not mere relics of tradition but dynamic, adaptive, and innovative systems of health protection and psychosocial resilience. Elderly men and women mobilized long-standing indigenous healing practices, moral codes of cleanliness, and faith-based rituals to interpret and respond to the pandemic in ways that complemented or contested biomedical guidelines. While masculine stoicism sometimes discouraged preventive behavior, feminine ethics of care promoted household-level hygiene, herbal therapy, and intergenerational mentorship. These gendered expressions of agency reveal the coexistence of resistance and adaptation in local health cultures.

Furthermore, the integration of faith, spirituality, and indigenous rituals constituted both a moral and psychological defense mechanism that maintained communal balance in the face of uncertainty. The study demonstrated how ritual reinterpretation, digital mediation of blessings, and intergenerational knowledge transfer transformed the crisis into a moment of cultural renewal. Through these processes, elders reaffirmed their social authority, preserved cultural continuity, and contributed significantly to public health resilience. The findings affirm that indigenous knowledge systems when viewed through the lenses of medical anthropology and cultural resilience theory are not in opposition to science but offer alternative epistemologies for understanding and managing health crises. Public health systems that ignore these cultural logics risk producing dissonance and

resistance, whereas those that integrate them can foster sustainable, community-owned solutions. Thus, the pandemic exposed not only biomedical vulnerabilities but also the enduring strength of cultural systems as protective infrastructures for collective survival.

5.2 Recommendations

1. **Integrate Indigenous Knowledge into Public Health Policy:** Policymakers should formally recognize and integrate indigenous preventive practices, rituals, and herbal medicine into county and national health strategies. This would ensure culturally legitimate communication and compliance during health crises.
2. **Develop Gender-Sensitive Health Interventions:** Public health messaging should account for gendered social roles and values. Campaigns targeting men should engage with ideals of protection, honor, and responsibility, while those targeting women should reinforce caregiving leadership and domestic hygiene roles without reinforcing stereotypes.
3. **Strengthen Elder-Led Health Communication Platforms:** Elders remain trusted custodians of moral and cultural authority. The government and NGOs should establish community health forums led by respected elders to bridge indigenous beliefs with biomedical advice, ensuring that information is locally grounded and socially credible.
4. **Promote Intergenerational Knowledge Exchange Programs:** Building on the resilience observed between elders and youth, education systems and local health programs should formalize intergenerational learning initiatives where traditional knowledge and modern health literacy coexist and complement one another.
5. **Encourage Socio-Cultural Innovation in Health Promotion:** Local health departments should support the development of culturally adapted digital tools, visual campaigns, and vernacular storytelling approaches that link hygiene, morality, and spirituality. Such innovations can enhance public trust and community engagement in future pandemics.
6. **Invest in Ethnographic and Participatory Health Research:** Future research should employ participatory approaches such as photovoice, ethnographic mapping, and narrative inquiry to capture lived experiences of the elderly and generate culturally relevant data for evidence-based policymaking.

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