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Book of Abstracts

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An Assessment of Training Gaps, Barriers, and Facilitators in Managing Postpartum Depression Among Healthcare Workers and Policymakers in Nairobi, Kenya, and Zomba, Malawi

Author: Shillah Mwavua[1]

Co-authors: Anja Huizink [1]; Genesis Sungani [2]; Manasi Kumar [3]; Michael Udedi [4]

[1] *Vrije University Amsterdam*

[2] *Kamuzu University of Health Sciences*

[3] *NewYork University*

[4] *Ministry of health Malawi*

Corresponding Authors: m.kumar@ucl.ac.uk, mphatsoudedi@yahoo.co.uk, smwaniga@yahoo.com

Background
Despite the high prevalence of postnatal depression (PND), many healthcare workers in primary health facilities, do not have sufficient training to recognize and manage this condition effectively. The detection rate for mental disorders among clinicians is critically low, with figures standing at just 4.1% in Kenya and 0% in Malawi. Both countries recognize the urgent need to invest in training for both specialist and non-specialist healthcare providers, through task shifting and sharing. This study explores healthcare workers' knowledge, attitudes, and current practices in screening and management of postnatal depression. It focuses on identifying the training gaps related to mental health training healthcare workers face, specifically pertaining to their ability to recognize and provide treatment for PND in two primary healthcare facilities in Nairobi, Kenya, and two facilities in Zomba, Malawi.
Methods
A mixed-methods approach, consisting of online baseline survey with 4 FGDs and 6 in-depth interviews with experts in maternal mental health.

Results
Fifty-eight respondents participated in the online survey. e majority of respondents were female, with an average age of 39.1 years and 11.3 years of healthcare experience. While 63.8% recognized the term "postpartum depression" only 41.4% had formal training on the topic, and 81.0% had not received post-service training. Despite 62.1% feeling confident in providing mental health care, only 19.0% regularly interacted with PND patients. Common management strategies included counseling (86.2%) and specialist referrals (79.3%). Key barriers to effective PND management were inadequate training (85.5%), limited resources (55.2%), and mental health stigma (48.3%). The qualitative findings regarding healthcare workers' awareness of postpartum depression symptoms found, participants noted specific maternal behaviors that could indicate a need for screening. a health care worker said "We have seen someone denying their child or refusing to breastfeed; that's when we recognize this may be depression."Another said "a mother just carrying a crying baby, instead of breastfeeding him or her or soothing, she will not be bothered and her mind is not even there at the moment."
Regarding training, participants from both countries said mental health training they received was insufficient. "It was just a course on how to manage mental health issues; I cannot say it was adequate. We only learned the basics."Echoing this sentiment, another added, "Okay, what we learned in (medical school) was not adequate."The findings also identified several barriers to managing PND as lack of maternal mental health guidelines, limited funding for mental health programs, and the stigma surrounding mental health issues within both the community and healthcare systems.
Conclusion
There is a pressing need to address stigma and systemic issues surrounding maternal mental health in order to provide better support for women after childbirth. Raising awareness, educating the community, and creating open conversations on PND while ensuring support and resources are easily accessible is critical. Additionally, invest in training specialist and non-specialist healthcare providers, promote task shifting and sharing, coupled with establishing routine screening for PND, and provide low cost psychosocial and psychological therapies for women who struggle to find proper care is paramount.

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The Hidden Struggles among students: Mental Wellness in Kenyan Educational Institutions

Author: Francisca Mbutitia[1]

Co-author: Carolyne Chakua [1]

[1] *Moi University*

Corresponding Author: fngithil@mu.ac.ke

In the heart of Kenya's dynamic educational landscape lies an often-overlooked struggle—mental wellness among students. Behind the pursuit of academic excellence and career aspirations, many learners face silent battles with anxiety, depression, and stress, exacerbated by societal stigma and limited support systems. These hidden struggles by students within educational institutions not only affect their lives but also hinder the growth of a resilient and healthy workforce for the nation. This study aims to uncover the mental health challenges that Kenyan students endure, explore their causes, and highlight their impact on academic, personal and social growth. The study will also examine current coping mechanisms adopted by students, the interventions and propose actionable solutions.The Mixed methods approach will be used where both quantitative and qualitative methods will be triangulated to ensure the findings will cross-validate for a more robust and credible findings. The quantitative data will be collected using online Surveys specifically the Survey Monkey for students, teachers, and parents. To collect qualitative data an Interview guide and Focus Group Discussion (FGD's) will be used as well as Voice Recorders for capturing audio during interviews and focus group discussions. The quantitative data will be analysed using descriptive statistics and regression, while the qualitative data will be analysed using Nvivo Software. The preliminary results based on interactions with students and teachers reveal that common mental health challenges are: chronic stress, anxiety depression, Post Traumatic (PTSD) Stress Disorder (PTSD),Suicidal ideations and intent, substance misuse just to mention but a few which are exacerbated by bullying, unhealthy competition, high-stakes examination pressure, corporal punishment, family instability, relationships and inadequate recreational activities. Understanding students' coping mechanisms, the interventions in place, and the roles of different stakeholders could shed light on hidden struggles and lead to more effective mental health support. This study is significant in shedding light on the often-overlooked mental health struggles faced by students in Kenyan schools and also proposes early intervention strategies which are crucial to support students' well-being and academic success. The study wishes to help in normalising conversations around mental wellness and encourage open dialogue, paving the way for cultural shifts and attitudes. The conversations and dialogue around mental health seeks to inspire meaningful change in addressing mental wellness within Kenyan educational institutions and influence policies and priorities nationally.
Key words: Hidden struggles, students, mental wellness, educational institutions

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PREVALENCE, DRIVERS, AND COPING STRATEGIES FOR MENTAL HEALTH CHALLENGES AMONG COMMUNITY HEALTH PROMOTERS IN KENYA: FINDINGS FROM A MIXED METHODS STUDY

Author: Sabina Adhiambo Odero[1]

Co-authors: Constance Shumba [2]; Eunice Ndirangu-Mugo [3]; Anja C. Huizink [4]; Amina Abubakar [3]

[1] *Aga Khan University; Vrije Universiteit Amsterdam*

[2] *Aga Khan University; Medical College of Wisconsin*

[3] *Aga Khan University*

[4] *Vrije Universiteit Amsterdam*

Corresponding Author: sabina.odero@aku.edu

Background: Community Health Promoters (CHPs) in Kenya continually face challenging situations ranging from health system shortfalls to exposure to traumatic experiences in the community. This places them at risk of experiencing mental health problems. However, there is a dearth of literature exploring the mental well-being of CHPs. This study aimed to explore the mental health problems CHPs face, their drivers and the coping strategies the CHPs have adopted.
Methods: This was a mixed methods study conducted among 2027 CHPs in Kenya. The interviews were conducted between June and November 2021. Frequencies and percentages were used to summarize categorical data and mean (standard deviation) for continuous variables. Qualitative data was organized using NVivo and thematic approach used for data analysis.
Results: The average mean age (SD) of the participants was 43.91 (11.05) years, with most of the participants being female (52.8%). Most of the participants (61.3%) had secondary education as their highest educational attainment and had work experience of less than 10years (68.5%). The prevalence of depression, anxiety and posttraumatic stress disorder was 24.5%, 15.0%, and 38.2% respectively. These mental health problems are driven by psychological, work-related or family factors. Psychological stressors included: burnout, stress, and stigma. Work related factors included heavy workload, inadequate expertise, insufficient equipment supply, community hostility, volunteerism and competing demands. Family factors included lack of family support, financial constraints, and lack of stable source of income. Mental distress symptoms included self-isolation, irritability, lateness, speech patterns, and underperformance. CHPs identified coping mechanisms at individual, community, and health system levels. Individual mechanisms included understanding their role and the desire for a healthy community. Community support was crucial for CHPs to continue volunteering. Existing coping mechanisms at health system level included adequate resource supply, training opportunities, supportive supervision, peer support, and time off for those in distress. Key recommendations included establishing psychosocial support structures, reverting CHW roles to salaried roles, and capacity building on mental health.
Conclusion: CHPs face mental health problems due to health system, psychological, and socioeconomic factors. Addressing the risk factors and investing in sustainable psychosocial support programs for them is crucial for improving their well-being and managing attrition. This will ensure continuity of quality health care services provision and the achievement of universal health coverage.

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"What are the mothers saying?"Insights from the Maternal Mental Wellbeing Project in Rural South Africa

Authors: Alex Plowright[1]; Julia Greenland[2]; Sibusiso Tenza[1]; Stacey Ann Pillay[2]; Thulani Greyville[3]; Valentina Trivella[4]

[1] *Anglo American*

[2] *The Healthy Brains Global Initiative*

[3] *Matchboxology*

[4] *Right to Care*

Corresponding Author: julia.greenland@hbgi.org

Introduction

In South Africa, it is estimated the 1 in 3 women experience a common mental health disorder in the perinatal period . Despite supportive national policy to integrate mental health into maternal care pathways, the wellbeing of mothers is often overlooked, particularly in rural mining communities where mothers face a confluence of socio-economic hardships, cultural pressures, and inadequate support systems.

Through a strategic partnership between The Healthy Brains Global Initiative, Right to Care, and Anglo American we have started to transform this environment to one where mothers and their babies can thrive. Our Mma wa Nnete (Real mothers) programme leverages outcome-based contracting

and performance management to improve the mental wellbeing of mothers driven by the needs and outcomes that they have identified as most meaningful to them.

Methodology

We started our pilot with a discovery phase into the mental wellbeing needs of mothers and the ecosystem around them. The insights were gathered using a human-centered design approach through immersion interviews and focus groups with 54 mothers, healthcare workers, and community leaders.

Results

The main influencers on maternal mental wellbeing in these communities was found to be:
1. People: A mother's wellbeing is heavily influenced by their immediate social environment. Dysfunctional family dynamics and problematic partner relationships emerged as significant stressors, contributing to feelings of rejection, abandonment, and neglect.
2. Preparedness: Many mothers felt unprepared for the emotional, financial, and practical challenges of motherhood. This heightened their vulnerability to stress and anxiety.
3. Loss: Mothers frequently reported experiencing a loss of identity, freedom, and connection to their former selves. The loss of educational and career opportunities deepened their sense of despair.
4. Isolation: Isolation was both a symptom and a cause of distress. This isolation frequently escalated into loneliness, despair, and even suicidal thoughts. Limited isolation was sometimes used as a healthy coping mechanism.
5. Emotional Awareness: Mothers struggled to articulate their emotions, often defaulting to English terms instead of their mother tongue. A sense of vulnerability and mistrust in discussing dark emotions was pervasive, partly due to fear of gossip or judgment.
6. Lack of Emotional Inquiry: A significant finding was the lack of emotional inquiry by healthcare providers, with full focus being on the baby. This lack of curiosity and individualized care contributed to feelings of being misunderstood and unsupported.

Conclusion

In these communities in Limpopo, a mother's wellbeing is predominantly influenced by family dynamics, partner relationships, and social circumstances. Most mothers felt stressed and helpless around the time of childbirth. A programme to support the mental wellbeing needs of mothers in these communities would need to cover the key aspects of; 1) better connected relationships –with family, partners, and healthcare providers. 2) Supporting the mother to feel prepared –financially, emotionally, and with health knowledge and 3) helping mothers retain and regain their freedom, dreams and sense of self.

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UNMASKING THE SILENT PANDEMIC: NAVIGATING THE MENTAL HEALTH DYNAMICS AMONG HEALTHCARE WORKERS (HCWS) IN KENYA

Author: Lordlaro Lidoros[1]

Co-authors: Fanuel Khainga [2]; Owino Samuel [3]

[1] *Health Rights Advocacy Forum*

[2] *MOH*

[3] *Maseno University*

Corresponding Author: lidoros@heraf.or.ke

Background
HCWs form the backbone of our health systems yet they face insidious unprecedented mental health challenges. In 2023, the Kenya Medical Association highlighted that responses from a SADPERSONS test for suicide assessment, administered in a random Continuous Medical Education forum

in Kisumu, Kenya, revealed that 4 of the attending 52 HCWs reported experiencing suicidal thoughts. The risk further increases among health professionals working in close proximity to mental health patients as well as those working in emergency and casualty departments due to traumatic encounters. This study aimed at exploring the mental health challenges faced by HCWs and identifying strategies that would enhance mental resilience and reduce psychological distress among HCWs.
Methods
A facility-based cross-sectional survey was conducted in Kisumu, Nairobi, Kakamega and Nakuru Counties in Kenya from January to May 2024. Purposive sampling was employed to recruit 120 HCWs from each of the 4 counties totaling to 480 participants. 32 interviews and 24 FGDs were conducted to collect qualitative data which was analyzed thematically. Structured surveys with mental assessment tools (PHQ-9 for depression, GAD-7 for anxiety, SADPERSONS scale for suicide risk and PCL-5 for PTSD were also used to collect quantitative data which was analyzed thematically. Informed consent was sought before commencement of the study, while confidentiality was observed throughout the study.
Results
Qualitative analysis: Predisposing factors to the psychological distress were patient outcomes such us death or worsening of patient health status; countertransference triggered by patients'experiences and workload burnout due to job dissatisfaction, emotional exhaustion, detachment from work, high job demands and turnover intentions. Inadequate self-care practices among HCWs and systemic challenges including lack of debriefing and supervision for HCWs after handling extreme traumatic encounters or even after their shifts.
Quantitative analysis: A detailed analysis of the PHQ-9 for depression showed; depression was widespread at 67.9% (326) both moderate and moderately severe with 2.3% (11) of them presenting severe depression. GAD-7 for anxiety showed 52.1% (250) were manifested with anxiety both moderate and severe. The SADPERSONS scale for suicide showed low risk at 10% (48), medium risk was at 1.3% (6) and 0.4% (2) for high risk of committing suicide. PCL-5 analysis showed manifestation of PTSD symptoms 13.1% (63). Other prevalent disorders included; substance use disorders, adjustment disorders at 24.8 % (119), sleeping disorders 67.9% (326) and obsessive- compulsive disorders (OCD) at 2.5% (12).
Conclusion
Findings from the study underscore the pressing need for resonate interventions to address the burgeoning mental health conditions in Kenya prioritizing healthcare workers. Advocacy and policy reforms, in the healthcare sector should shift the focus on prevention strategies that seek to implement structured mental health support systems, promote resilience training, strengthen workplace policies that foster a positive culture which enhances self-care among healthcare workers.

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WORKPLACE MENTAL WELL-BEING AS A PATHWAY TO RESPECTFUL MATERNITY CARE: STUDY PROTOCOL FOR THE CPIPE INTERVENTION

Author: Linnet Ongeri[1]

Co-authors: Beryl Ogolla ; Joyceline Kinyua [1]; Maureen Oluoch [2]; Monica Getahun [3]; Patience Afulani [3]

[1] *Kenya Medical Research Institute*

[2] *global programs*

[3] *UCSF*

Corresponding Authors: linongeri@gmail.com, jk@kemri.go.ke

Introduction:
Disrespect and abuse in maternity care settings are widespread and often normalized, fueled by systemic inequities, entrenched gender norms, and the chronic stress experienced by frontline healthcare providers. High workloads, limited institutional support, and emotionally demanding work environments contribute to provider burnout and bias, which in turn compromise the quality of person-centered maternal care (PCMC). Although global attention on respectful maternity care is increasing, there remains a critical gap in interventions that simultaneously address provider mental well-being and PCMC, particularly in low- and middle-income countries (LMICs). To address this, we developed the Caring for Providers to Improve Patient Experience (CPIPE) intervention—an integrated, multi-component strategy aimed at improving both workplace mental health and maternal

care experiences.
Methods:
This is a cluster randomized controlled trial targeting up to 40 high-volume delivery facilities in Kenya and Ghana. The intervention has five components: provider training (using simulation-based emergency obstetric and neonatal care drills with integrated content on PCMC, stress, burnout, and bias), peer support, mentorship, embedded champions, and leadership engagement. We will enroll up to 400 maternal healthcare providers and three cross-sectional cohorts of 2,000 women each at baseline, midline, and endline. Study aims include: assessing the effect of CPIPE on PCMC (particularly for low-SES women), identifying mechanisms of impact through changes in provider well-being, and evaluating distal outcomes such as maternal health-seeking behavior and neonatal outcomes.
Results:
This study is ongoing. Pilot testing has demonstrated high feasibility, acceptability, and promising preliminary results across components of the intervention.
Conclusions:
CPIPE is a novel, scalable intervention that addresses both provider well-being and maternal care quality. If effective, it will offer a replicable model for improving respectful, equitable maternity care while promoting mental well-being among frontline health workers in LMIC settings

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Impacts of Societal Disruptions on Mental Health and Quality of Life of Health Workers: Qualitative Findings from the REACH Study (REsilience Amid Challenges in Healthcare)

Authors: Abigail Hatcher[1]; Eshika Kudaravalli[2]; Evelyne Owengah[3]; Janet Turan[2]; Kevin Owuor[2]; Lynnae Darbes[4]; Moses Okombo[3]; Zachary Kwena[3]; Zuha Fatima[2]

[1] *University of North Carolina at Chapel Hill*

[2] *University of Alabama at Birmingham*

[3] *Kenya Medical Research Institute*

[4] *University of Michigan*

Corresponding Author: ahelova@uab.edu

Introduction and Aim
Health system disruptions such as the COVID-19 pandemic, health workers'strikes, political unrest, floods, disruptions in funding, and limited resources may significantly impact the mental health of health workers (HWs). In these situations, HWs may experience uncertainty regarding their roles and the safety of their work environments. The stigma surrounding mental health issues may also be a barrier to seeking support. Understanding these challenges is critical for developing effective support programs and building HW resilience. This study explores the impact of societal disruptions on the mental health, personal life, relationships, and work-life balance of HWs who provide HIV and MCH services in Kenya, as well as their preferences regarding future interventions.
Methods and Materials
We conducted four focus group discussions [FGDs; two with clinical HW and two with lay HW (LHW), n=29] at two public clinics and 10 key informant interviews (KII) with a purposively selected sample of stakeholders in Kisumu County, Kenya, in OctoberNovember 2023. The eligibility criteria for FGDs were: ≥18 years, employed as a HW at an HIV/antenatal clinic, and ≥3 years of experience. KIIs included stakeholders and policymakers in the health/governance sectors in Kisumu County. FGDs and Klls were conducted in English, transcribed verbatim, and four trained study staff conducted rapid analysis, using a thematic approach and Dedoose software.
Results
Participants described significant mental health challenges faced by HWs during societal disruptions, including difficulty concentrating, restlessness, and feelings of inadequacy and self-doubt. These were described as disrupting their mental health and affecting the quality of care they provide. Societal disruptions also strained personal relationships for HW, adversely impacting couple dynamics and family interactions, often exacerbated by financial stress and difficulties accessing basic needs. Participants expressed a pressing need for programs to support the mental health and resilience of HWs, and envisioned a program with emphasis on coping mechanisms, time-stress management,

work-life balance, and emergency preparedness. Suggested techniques included training in mindfulness, cognitive restructuring, and relaxation; talk therapy and positive thinking to enhance emotional resilience, and teaching protocols for handling emergency situations, as well as mental illness stigma-reduction strategies. The preferred delivery mode was one-on-one sessions delivered via in-person sessions or video calls, due to potential stigma and privacy concerns. Participants preferred that sessions be conducted at their workplace due to financial and time constraints.
Discussion
Societal disruptions were described as having profound impact on HWs' mental health that ultimately affected their both work and their quality of life. Our results indicate that programs focusing on building resilience among HWs could have a positive effect in the event of future societal crises, as well as in the context of everyday professional burnout or stress. Such programs are potentially feasible and acceptable in this setting and aligned with Kenyan and global health priorities.
Conclusions
Health programs should prioritize accessible mental health interventions to enhance the well-being of health workers to build resilience for navigating ongoing challenges in their roles and support their ability to thrive and provide quality care.

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Working with Mentor Mothers to Deliver Problem Management Plus Intervention for Perinatal Women Living with HIV and Common Mental Health Disorders in Kenya

Authors: Abigail Hatcher[1]; Anna Helova[2]; Emma Ouma[3]; Janet Turan[2]; Jeff Szychowski[4]; Joyce Imafidon[2]; Karen Hampanda[5]; Linnet Ongeri[6]; Lisa Abuogi[5]; Manasi Kumar[7]; Maricianah Onono[3]; Mercelline Ogolla-Onyando[3]; Vincent Salano[3]

[1] *University of North Carolina at Chapel Hill*

[2] *University of Alabama at Birmingham*

[3] *Centre for Microbiology Research, Kenya Medical Research Institute, Nairobi, Kenya*

[4] *School of Public Health, The University of Alabama at Birmingham, Birmingham, Alabama, USA*

[5] *School of Medicine, University of Colorado Denver, Aurora, Colorado, USA*

[6] *Kenya Medical Research Institute*

[7] *NewYork University*

Corresponding Author: monyando@kargeno-hub.org

Background: In Kenya, mentor mothers (MMs) are lay health workers with lived experience who provide psychosocial peer support to women newly diagnosed with HIV and may have the potential to be key contributors to the mental health workforce. Prior studies have documented the successful delivery of psychosocial interventions by lay health workers, including the World Health Organization endorsed Problem Management Plus (PM+) - a problem-solving intervention that integrates behavioral strategies to reduce concerns and emotional problems. MMs' trusted relationships with HIV-positive peers and contextual understanding of mental health needs and HIV-related stigma uniquely position them to support perinatal women with HIV (PWWH), who face elevated risk for common mental disorders (CMDs). However, concerns remain regarding MMs' limited formal training and capacity to deliver structured mental health interventions. To address these gaps, we developed Tunawiri, a Collaborative Care Model that integrates mental health services into routine antenatal and HIV care at health facilities in Kenya, including delivery of PM+ sessions by mentor mothers. Prior to implementation, the current study examined the feasibility, acceptability, and capacity building needs of MMs to take on this role.
Methods: We conducted multi method data collection with stakeholders in the Kisumu County health system between January-September 2024. Focus group discussions (n=48) were conducted with PWWH with probable CMDs (2 groups), peer mentor mothers (2 groups), and clinical staff and managers (2 groups). A total of 20 in-depth interviews done with key informants, including representatives from the County and National Ministry of Health. Audio recordings were transcribed using Otter, then coded and analyzed using Dedoose, utilizing thematic analysis. Findings from the qualitative and organizational readiness research were presented to the study's external advisory board, which helped refine and finalize implementation strategies focused on building the capacity

of mentor mothers to support PWWH.
Results: Participants identified structural barriers, including low mental health awareness, inconsistent screening, weak referral systems, and a shortage of mental health clinicians, MMs were recommended as an integral partner in supporting the mental health and wellbeing of PWWH. Participants noted their potential to play a multifaceted role in supporting the Collaborative Care Model; acting as educators, messengers, counselors, and advocates for mental health promotion. Potential barriers to working with MMs in this role included lack of formal training and expertise, inability to handle difficult cases and literacy. Proper supervision by clinical staff (nurses) who provide technical support and capacity building through intensive structured training (basic counseling skills, PM+ intervention, case management scenarios) and guidelines (role and duty expectations of MMs) were emphasized as steps to implement the Collaborative Care Model to ensure the successful delivery of the PM+ component by MMs.
Conclusion: MMs appear to be an acceptable and feasible cadre of workers to collaborate with other health workers in integrating mental health services into ANC/HIV clinics in Kenya. Capacity building of this cadre to deliver mental health interventions can help to promote the mental and physical health of PWWH and their families.

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Improving Mental Health Literacy on Self-Esteem Among Adolescents Through Experiential Learning: Insights from the Holiday Escapade Program in Nairobi, Kenya

Author: Grace Mutuku[1]

[1] *DIP-CO organization*

Corresponding Author: graciemutuku0@gmail.com

Background
Adolescence (ages 10–19), as defined by the World Health Organization (WHO), is a critical developmental stage marked by identity formation, heightened emotional sensitivity, and increased vulnerability to mental health conditions. Globally, mental health disorders contribute to 16% of the burden of disease among adolescents, with depression ranked as the fourth leading cause of illness and suicide as the third leading cause of death among those aged 15–19 (World Health Organization, 2021). In Kenya, adolescent mental health challenges are increasingly prevalent but remain under-addressed due to stigma, low awareness, and limited access to mental health services. A 2020 report by Kenya's Ministry of Health indicates that nearly one in four adolescents experience significant symptoms of depression, anxiety, or psychological distress.
Low self-esteem, characterized by negative self-perception, feelings of inadequacy, and poor self-worth is a major risk factor that contributes to these challenges, often affecting academic performance, interpersonal relationships, and emotional resilience. Mental health literacy, defined as the knowledge and beliefs that enable recognition, management, or prevention of mental health disorders (Jorm, 2012), is critical for early intervention and adolescent well-being.
Objective
To evaluate the effectiveness of an experiential learning intervention in improving adolescents' knowledge and understanding of self-esteem as a key component of mental health literacy.
Methods
This study was conducted through DIP-CO, a purpose-driven social enterprise that equips children (3–12), teens (13–19), and young adults (20–24) with the emotional intelligence, life skills, and leadership capacity needed to thrive in a complex world. DIP-CO implements a dual-impact approach: youth-focused programs cultivate self-awareness and values-based decision-making, while parallel sessions support mindful parenting.
DIP-CO designed and implemented the Holiday Escapade program, a three-day experiential learning intervention delivered in churches and schools across Nairobi, Kenya. The program enrolled 87 adolescents aged 13–19. Activities included interactive workshops, storytelling,

small-group reflections, and guided self-awareness exercises facilitated by trained DIP-CO mentors. A pre-intervention assessment consisting of four structured questions was used to establish baseline understanding of self-esteem, emotional regulation, and self-worth. On Day 3, post-intervention data were gathered using attendance records and participant feedback questionnaires that captured shifts in knowledge, engagement levels, and reflections.
Results
Of the 87 adolescents enrolled, 71 attended Day 1, 77 attended Day 2, and all 87 completed Day 3. Pre-assessment data were collected from 71 participants, while all 87 completed post-assessments. Results indicated significant improvements in participants'understanding of self-esteem and its connection to emotional well-being. Feedback revealed recurring concerns around sexuality, adolescent pregnancy, parent-child relationships, emotional development, and romantic relationships. Many participants reported increased interest in personal growth, emotional intelligence, and improved communication. Key takeaways included the importance of self-worth, healthy friendships, and making value-based decisions.
Conclusion
Experiential learning programs like DIP-CO's Holiday Escapades present a promising, community-based model for enhancing mental health literacy among adolescents in urban African settings. By fostering early self-awareness and emotional resilience, such interventions can play a pivotal role in supporting adolescent mental health, particularly in environments with limited access to formal mental health education and care services.

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AFFILIATE STIGMA EXPERIENCES AMONG CAREGIVERS OF CHILDREN WITH NEURODEVELOPMENTAL DISORDERS IN RURAL KILIFI AND NAIROBI'S INFORMAL SETTLEMENTS. A PHENOMENOLOGICAL QUALITATIVE STUDY

Authors: AMINA ABUBAKAR[1]; CHARLES NEWTON[2]; EVA MWANGOME[2]; JOY YVONNE YAA[2]; VERONIKA ACHOKI[2]; VIBIAN ANGWENYI[1]

[1] *AGA KHAN INSTITUTE FOR HUMAN DEVELOPMENT*

[2] *KEMRI-WELLCOME TRUST*

Corresponding Author: evambuche@gmail.com

ABSTRACT
Background Caregivers of children with neurodevelopmental disorders (NDDs) face multifaceted challenges, among which stigma —particularly affiliate stigma—is a major concern. Affiliate stigma occurs when caregivers internalize negative societal attitudes directed towards them due to their association with their children with developmental challenges. This internalized stigma may impact on the caregiver and child's mental health, overall wellbeing, and functioning. There is limited evidence on the lived experiences of affected caregivers, particularly in the African context. Exploring these experiences is critical in tailoring contextually appropriate support resources, which remain scarce in such settings.
Objective: To explore affiliate stigma experiences, coping mechanisms, and interventional needs for caregivers of children with NDDs in rural Kilifi and Nairobi's informal settlements.
Methods:
A phenomenological qualitative study involving in-depth interviews with 35 caregivers purposively selected to represent: urban and rural settings; children of diverse age, gender, and NDD diagnosis including autism spectrum disorder, global developmental delays and intellectual disability, attention deficit/hyperactivity disorder, and epilepsy. A semi-structured interview guide was used to contextualize and explore affiliate stigma experiences. Interviews were audio-recorded, transcribed verbatim, and analyzed using a thematic approach and managed using NVivo software.
Results:
Findings revealed that caregivers experienced widespread stigma from multiple sources including family members, neighbors, community, healthcare providers, and learning
institutions. Stigma manifested as social rejection, judgement and discrimination, which led caregivers to internalize these negative experiences. The internalization of stigma resulted in feelings of shame, sadness, guilt and hopelessness. Social isolation and emotional burden were commonly reported, often resulting in diminished self-worth and a sense of being stuck in a life trajectory they

lacked control for. This further led to avoidance in public settings, people, and social events due to feelings of embarrassment, discomfort with public scrutiny, or the challenges of managing their child's behavior. Sometimes, caregivers resort to concealing their child's condition through masking or by physically hiding their child. Compounding these experiences were systemic issues such as inadequate support services, lack of trained professionals, and absence of childcare support. These factors increased the caregiving burden and limited caregivers'participation in economic and community life, leading to perceived losses in status, identity, and future potential.
Conclusion:
This study highlights the profound psychological and social impact of affiliate stigma experienced by caregivers of children with NDDs in rural and urban Kenya. There is urgent need for stigma-reduction interventions, greater community education and advocacy, development of inclusive, culturally appropriate support systems, whilst recognizing the value of validating caregivers lived experiences. Addressing affiliate stigma is critical to improving the mental health outcomes for both caregivers and children with NDDs.
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: Best practice in assessing, diagnosing and successful management of mental health challenges that culminated from temporary funding freeze for USAID among PMTCT clients at maternal child health clinic (MCH) in Mutuini Hospital (MH) from February 2025 to May 2025.

Author: Linda Ouma[1]

[1] *Mutuini hospital*

Corresponding Author: lynnphebe@gmail.com

Introduction: WHO recommends person-centered and human rights-based approaches in mental health in the community, whereby action steps are presented for developing community mental health services that respect human rights and focus on recovery. It further promotes integration of mental health services for people living with HIV in order to maintain their wellbeing and improve their quality of life at all service delivery points. In MH MCH, mental health services are offered by a team of Community health volunteers (CHVs), nurses, adherence counsellor, mental health technician (MHT) and mentor mother. The news on USAID fund freeze in January 2025 caused pmtct clients to panic. Upon their assessments using PHQ-9 and GAD-7, all of them had some anxiety. This abstract elucidates best practices used to quickly manage diagnosed clients and the role of CHVs in the management.
OBJECTIVE: To showcase the role of CHVs in the interventions that were put in place to manage anxiety among PMTCT mothers secondary to the news on cessation of USAID funding at the MH MCH between February 2025 and May 2025
Methods: Data on mental health screening was pulled from keEMR, mental health unit register, CHVs register, mentor mother's call log, and adherence counsellor's register for four months of study between February 2025 and May 2025. Cross sectional data analysis was done based on the mental health services offered to pmtct clients. All pmtct clients who came to the clinic were assessed using GAD-7 and PHQ-9. Linkage was done by nurses to the adherence counselor for clients who lost motivation to adhere to treatment. For clients who could not cope due to stress, they were linked to MHT, support group was scheduled and CHVs gave mentor mother contacts of client for wellness calls. CHVs helped in reaching clients within their areas of operation who could not be reached by phone to inform them of the support group meeting. All rumors were clarified in support group meeting on 20th Feb 2025 and anxiety was well allayed.
Results: 186 clients got screened. 150(80%) got categorized under mild anxiety, while 36(19%) had moderate anxiety 50(27%) presented with inability to cope and were linked to the mental health nurse, 74(40%) had fear of unknown which was allayed by the MCH nurses. 62(33%) clients reported lack of motivation to adhere to treatment and were linked to the adherence counselor. 120(64%) Clients met in support group on February 20th 2025 in which their questions were answered and fears allayed. Wellness calls were made to all calls thereafter and continuous reassurance was given.

By March 2025, clients only9(4%) presented with mild anxiety. CHVs have since encouraged community members with stress issues to seek medical advise.
Conclusion: Involving CHVs in clients follow ups and awareness creation may strengthen facility/community linkage and primary healthcare. The USAID fund squabbles might have affected mental health status of both its employees and clients alike hence debriefing for both is highly recommended.

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Evaluating the Clinical and socioeconomic impact of a long-acting antipsychotic injectable on schizophrenia patients - retrospective andprospective Case study within a patient access program at Mathari NationalTeaching and Referral Hospital

Author: Victoria Wamukhoma[1]

[1] *MNTRH*

Corresponding Author: wamuvicy@gmail.com

INTRODUCTION
Mathari National Teaching and Referral Hospital, in collaboration with AMREF, proposed to start a program to provide a long-acting injectable (LAI) antipsychotic known as Paliperidone palmitate to 50 patients with schizophrenia over a period of 18 months, as a response to the huge gap in management of patients suffering from Schizophrenia. This initiative aims to evaluate the socio-economic performance of the patients before and after participating in the program, with the ultimate goal of generating comprehensive cost-benefit analysis data that will inform national policy on investment in LAI medications and their potential return on investment for National development. This program aims to highlight how a LAI affects various aspects of patients' lives, clinical outcomes, healthcare costs, productivity, and quality of life.

PURPOSE: to generate comprehensive clinical and socioeconomic data to inform national policy on Mental Health Investment.

BACKGROUND
Schizophrenia is one of the most common of the severe mental disorders and is one of the top 25 leading causes of disability worldwide. It is characterized by cognitive, behavioral, perceptual, and emotional dysfunction. The disorder usually begins before the age of 25 years, persists throughout life and affects persons of all socioeconomic classes. This disorder affects not only individuals but also families, caregivers, and societies. Both the patients and their families often suffer from inadequate care, stigma, and financial strain due to the impact of the disorder. Because Schizophrenia usually begins early in life, it causes significant long-lasting impairments, requires ongoing clinical care, rehabilitation, and support services. As a result, the financial cost of the illness is heavy. Indirect costs are also enormous and often underestimated. These include a lack of patient autonomy, caregiver emotional and psychological burden, missing out on employment opportunities for both the patient and the caregiver, reduced productivity of the patient and the caregiver, and overall reduced quality of life of the patient and caregivers.
A LAI antipsychotic is a drug designed to be administered via intramuscular injection at regular intervals, typically every 2 to 12 weeks. It slowly releases the active drug into the bloodstream over an extended period, allowing for consistent therapeutic levels and reducing the need for daily dosing.
METHODOLOGY
To carry out this study, the hospital set up a specialized schizophrenia clinic and medication was provided through collaboration with AMREF. Through this 18-month patient access program, a prospective cohort (n=50) of adults with schizophrenia was selected based on the inclusion criteria. Patients with subclinical outcomes had their regimen reassessed and the LAI administered. Various variables were then measured, including clinical symptom reduction, personal and social performance, direct medical expenditures, patient autonomy and caregiver-burden scales, employment status and workdays, and standardized quality-of-life indices.
The tools used to measure the above variables include Positive and Negative Syndrome Scale (PANSS), Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), Medication Adherence Report Scale (MARS), World Health Organization Quality of Life (WHO QOL) tool, Personal and Social

Performance Scale, and a custom-designed Economic Tool 1 and 2.
FINDINGS
(Please find the attachment.)

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Improving the Mental Health Literacy of Young People in Resource-limited Settings: A Systematic Review

Author: Regeru Regeru[1]

[1] *Johnson & Johnson - Global Health Equity*

Corresponding Author: rregeru@its.jnj.com

Background: Young people aged 15–29 experience a substantial mental health burden, with 23.7–25.6% of years lived with disability in this age group attributable to mental disorders. In Kenya, mental disorders are a leading cause of disability in young people, accounting for 182,039 disability-adjusted life years in those aged 15–24 years in 2019. ~37% of this burden was due to major depressive disorder (MDD) and schizophrenia, identified by the WHO as priority conditions to address.
Young people with mental disorders living in low- or middle-income countries (LMICs) face challenges to improving their mental health. A substantial mental health gap exists, driven by resource constraints and shortages in the workforce available to address mental health concerns. Addressing mental health and mental health literacy through public health interventions has the potential to reduce the burden of mental disorders in young people. Understanding how best to design mental health literacy interventions is key to effectively using resources and maximising benefits.

Objectives: To identify characteristics of successful mental health literacy interventions for young people with severe mental health disorders in resource-limited settings.

Methods: The systematic literature review (SLR) protocol was prospectively registered on PROSPERO (CRD42024579598). Electronic database searches (MEDLINE, Embase, Cochrane Central Register of Controlled Trials [CENTRAL], PsycINFO, Global Index Medicus, African Journals Online) were supplemented with searches of conference proceedings, bibliographies of relevant SLRs and websites of NGOs. Eligible interventional or observational studies were conducted in resource-limited settings, reported characteristics of public health interventions targeting mental health literacy and ≥80% of the study population was required to be aged 15–29 years, with MDD and/or schizophrenia.

Results: 30 studies (26 on MDD and 4 on schizophrenia) were included. Most studies (25 of 30) presented a behaviour therapy intervention, usually based on an existing framework (e.g. CBT, behaviour activation). For MDD, behaviour therapies were often delivered by trained lay facilitators, students or graduates and supervised by qualified mental health practitioners.
10 studies used digital health in their programme design, including electronic/computerised versions of behaviour therapy interventions (8 studies) and use of messaging services or phones to allow participants to contact facilitators (therapists or trained laypersons) for support, guidance or skills training (4 studies).
Intervention outcomes were assessed using pre-existing validated tools such as Beck Depression Inventory-II (BDI-II), often adapted to the local context. 26 studies reported statistically significant improvements in mental health outcomes following intervention compared to baseline and/or usual care. 13 studies discussed intervention replicability or scalability. Training lay facilitators was noted as a low-cost approach to scaling an intervention. When replicating programmes across settings, adaptation to the local context was considered key for ensuring acceptability. Online programmes and digital health allowed more participants to be reached with the same resource use (human and financial) as usual care.

Conclusions: These findings demonstrate the potential for public health interventions, enabled by digital health, to improve mental health literacy and outcomes in LMICs. Other key considerations for programme design included adaptation of pre-existing intervention frameworks and use of validated tools to evaluate outcomes.

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THE ASSOCIATION BETWEEN PERCEIVED MALADAPTIVE PARENTAL BEHAVIOR AND CONDUCT DISORDER SYMPTOMS AMONG ADOLESCENTS ATTENDING THE YOUTH CLINIC AT KENYATTA NATIONAL HOSPITAL

Author: Praxides Pessah[None]

Co-authors: Anne Mbwayo [1]; Anne Obondo [1]

[1] *University of Nairobi*

Corresponding Author: ppessah@gmail.com

ABSTRACT
INTRODUCTION: Youth with a diagnosis of Conduct disorder present the highest level of impairment and distress in all the living domains when compared with youths with other mental issues. Studies in Kenya have shown a high prevalence rate of Conduct disorder among juvenile delinquents and among adolescents. However, such prevalence has not been comprehensively examined when linked to maladaptive parental behavior.
METHODS: The study applied a quantitative method and a cross-sectional study design. Adolescents attending the youth center at KNH were the target population; from which 324 adolescents between the ages of 14-17 were sampled using the stratified random sampling technique. The Standard Conduct Disorder Scale (CDS) was used to measure conduct disorder, a researcher designed socio-demographic questionnaire was used to measure socio demographic factors and the Simplified Egna Minnen Betr¨affende Uppfostran (S-EMBU) tool was used to measure maladaptive parental behavior.
RESULTS: A total of 324 adolescents participated in the study. The study finds that the prevalence of conduct disorder among adolescents attending the KNH youth centre at 37.6%. The respondents were mostly male (N=184, 56.8%) than female (N=140, 43.2%). Most respondents were between the ages of 16-17 (N-164, 50.6%) while those aged between 14 and 15 (N=160, 49.4%). Majority of the respondents had both parents (N=212, 65.4%) compared to those from single parent home (N=112, 34.6%). Majority of the respondents went to boarding school (N=226, 69.8%) than those in day schools (N=98, 30.2%). Further, only sex and age had a significant statistical difference with conduct disorder (Sex: P-value=.000; <0.05; Age: P-value=.004; <0.05). There was no statistical difference between family type and school type (family type: P-value=.202; >0.05; School type: P-value=.785; >0.05). The prevalence of perceived maladaptive parental behavior among adolescents at KNH youth centre was at 43.8%. There was a statistically significant effect of Perceived Maladaptive parental behavior on conduct disorder (p-value=<0.01).
CONCLUSION: There is high prevalence of both Conduct and perceived maladaptive parental behavior among adolescents attending the KNH Youth centre. Sex and age has an impact on Conduct disorder symptoms. Perceived maladaptive parental behavior is associated with conduct disorder symptoms. There is need for psychological interventions to help curb conduct disorder and maladaptive parental behavior to help adolescent grow mentally healthy.
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Promoting Workplace Mental Well-being; Creating Safe and Supportive Environments Across All Sectors

Author: Anne Wanjiru[None]

Corresponding Author: wanjiruann753@gmail.com

Introduction:
Workplace mental well-being is increasingly recognized as a critical factor in overall employee productivity and satisfaction. However despite the growing awareness, there are some organizations

that still lack comprehensive policies and support systems that foster mental health. As an organization, we aim to assess the current state of workplace mental well-being across different sectors both formal and informal highlighting the barriers employees face in seeking mental health support.

Objectives:

The objectives of our assessment include:

- To assess the level of employee motivation in various workplace settings.
- To evaluate the extent to which employees experience a healthy work-life balance.
- To determine employees'knowledge and awareness of workplace mental health support systems, programs, or policies.

Methods:

A cross-sectional survey was conducted to assess mental health and well-being across diverse workplace settings, including the corporate, healthcare, education, and retail sectors. A structured mental health assessment tool was developed and utilized to measure critical indicators such as the level of motivation among workers, the quality of work-life balance, the existence of mental health policies, availability and accessibility of support systems, and employees'openness to seeking help. Data were collected through anonymous, self-administered questionnaires to ensure confidentiality and promote honest participation. Quantitative data analysis was conducted, with results summarized using proportions and percentages to illustrate the distribution of responses across the various indicators. This approach enabled the identification of trends and variations in workplace mental health outcomes and support structures across
different sectors.

Findings

The assessment revealed several critical findings:

- 49.26% of the employees in the workforce indicated to be well motivated and actively engaged in their work, likely experiencing alignment with their roles, supportive work environments or meaningful work whereas 50.74% of the employees reported moderate motivation in their work with 22.06%registering very low motivation thus indicating experience of burnout,lack of recognition,unclear expectations or even misalignment between personal values and organizational mission.
- 50% of the employees reported to adequately manage both work and personal responsibilities indicating that these employees likely benefit from flexible schedules, reasonable workloads or supportive supervisors whereas 50% of the employees reportedneutral perception about their work life balance with 27.94% reporting negative perception and likely being at risk of burnout,chronic stress and diminished job satisfaction.
- 45.6% of the employees consistently recognize the availability of mental health resources making them well-informed about these programs which is a positive indicator of organizational communication and outreach efforts whereas 54.5%of employees reported moderate awareness with 38.3% reporting low to no awareness of the resources thus unlikely to access or benefit from programs designed to support their mental health, indicating a potential gap in the internal communication strategy.

These findings collectively point to the urgent need for organizations to create supportive, flexible, and psychologically safe workplaces to enhance employee motivation, work-life balance, and mental health outcomes.

Conclusion:

Continuation is in the attached file.

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ACCEPTABILITY, FEASIBILITY AND FIDELITY OF PROBLEM MANAGEMENT PLUS (PM+) FOR PREGNANT AND POSTPARTUM WOMEN LIVING WITH HIV IN A RESOURCE-LIMITED SETTING

Author: Mercelline Ogolla-Onyando[1]

Co-authors: Anna Helova [2]; Janet Turan [2]; Karen Hampanda [3]; Kevin Owuor [2]; Laura Beres [4]; Linet Ongeri [1]; Lisa Abuogi [3]; Maricianah Onono [1]; Rabbia Imran [3]

[1] *Kenya Medical Research Institute*

[2] *University of Alabama*

[3] *University of Colorado, Denver*

[4] *Johns Hopkins Bloomberg School of Public Health*

Corresponding Authors: linongeri@gmail.com, maricianah@gmail.com, monyando@kargeno-hub.org

Introduction: Pregnant and Postpartum Women living with HIV (PPWH) face elevated risks of mental health challenges, which can impede engagement in HIV care. This study assessed the acceptability, feasibility and fidelity of the WHO's Problem Management Plus (PM+) intervention adapted for PPWH, delivered in-person and via mobile phone, in a resource-limited setting.
Methods: This cross-sectional study analyzed baseline data from 120 participants in the TATUA pilot study in Kisumu, Kenya, enrolled in March -August 2024. TATUA aims to evaluate the impact of PM+ to prevent care disengagement and viral failure among PPW. PM+ is an evidence-based psychosocial intervention delivered by trained lay health workers in weekly sessions. Participants at risk for care disengagement and viral failure based on a risk calculator developed in this study were enrolled and randomized 1:1:1 to the standard of care (N=40), 5 session in-person PM+ (N=40) and 10 session mobile PM+ (N=40) arms. Acceptability was assessed through structured surveys administered at three and six months postpartum, feasibility was evaluated based on recruitment and retention rates; and fidelity was measured by intervention coverage and session completion timelines.
Results: Among the 80 participants randomized to a PM+ arm (mean age 30, Standard Deviation =7), most were married (78%), 48% had attained secondary level education, and 5% were formally employed. Acceptability was high in both in-person and mobile delivery arms, with >95% coverage and >98% reporting positive experiences at both 3 and 6 months. Feasibility was demonstrated by a 94% enrolment rate of those eligible and 95% PM+ session completion. While fidelity was high in both arms, timely completion of all sessions was more common in the in-person arm (42.1%) than mobile (13.2%). Most participants reported improved mental health (100% at 3 and 6 months) and HIV care engagement (97% at 3 months and 100% at 6 months) with minimal disruption to daily responsibilities.
Conclusion: These findings highlight the adaptability of PM+ intervention, while pointing out the importance of addressing real-world implementation considerations in future scale-up efforts. PM+ demonstrates strong feasibility and acceptability in supporting mental health and HIV care engagement among PPWH. While the potential for scalability through mobile delivery offers a promising avenue for broader implementation and increased reach in diverse settings, there is need for greater flexibility for timely completion of the sessions.

Key words: Problem management plus, acceptability, fidelity, feasibility
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Towards Formulation of Workplace Policy on Perinatal Loss in Kenya

Author: Stephen Asatsa[1]

Co-author: Nimo Jamal Sharif [1]

[1] *United States International University*

Corresponding Authors: jamaalnimca@gmail.com, steveasatsa@gmail.com

This study investigates the existing of workplace policies addressing perinatal loss in Kenya, focusing on the psychological and emotional impacts experienced by women following miscarriage, stillbirth, or neonatal death. Utilizing a descriptive survey design, the research engaged 80 participants from various corporate institutions in Nairobi, including human resource managers and women who have experienced perinatal loss. Findings reveal that many organizations lack formal policies recognizing perinatal loss, resulting in inadequate support for affected employees. Participants reported profound grief symptoms, including depression and social isolation, exacerbated by a lack of acknowledgment from employers and peers. Recommendations for policy formulation include extending maternity leave to those experiencing perinatal loss, ensuring access to benevolent benefits, and providing dedicated counseling services. Additionally, the study emphasizes the need for separate hospital wards for bereaved mothers and the implementation of compassionate leave. A significant barrier identified was the lack of awareness surrounding perinatal loss among both employees and employers, highlighting the necessity for educational initiatives within workplaces. The results underscore the urgent need for comprehensive policies that address the unique challenges of perinatal loss, fostering a supportive environment that promotes emotional recovery and well-being for grieving employees. This research contributes to the growing discourse on maternal health and workplace rights, advocating for a shift in organizational cultures to better support employees facing such profound losses.

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LEVERAGING COMMUNITY-BASED INTERVENTIONS TO IMPROVE TEENAGE GIRLS' MENTAL AND REPRODUCTIVE HEALTH OUTCOMES IN KIBERA SLUMS

Author: Ezekiel Kimondiu[1]

[1] *Kenya Malaria Youth Corps*

Corresponding Author: kimondiuezekiel20@gmail.com

Introduction
Teenage girls in Kibera Slums face several challenges that threaten both their reproductive and mental health. Poverty, gender inequality, and a lack of youth-friendly sexual and reproductive health (SRH) services contribute to high rates of teenage pregnancy and HIV infection. These adversities are compounded by mental health stressors such as stigma, trauma, anxiety, and depression, often triggered by sexual exploitation, early pregnancy, or lack of support systems. In response, CBOs, NGOs, and government agencies have implemented interventions such as peer education, economic empowerment, and club formation to address both SRH and mental health outcomes. This research aimed to evaluate effective community-based interventions for improving the SRH outcomes of adolescent girls in Kibera Slums that may be implemented in a resource-constrained context.

Objectives;
1. To assess the effectiveness of peer education initiatives on teenage girls'knowledge, attitudes, and mental well-being regarding SRH.
2. To investigate how economic empowerment initiatives improve the SRH and mental health of teenage girls in Kibera Slums.
3. To evaluate the effectiveness of newly established clubs in increasing awareness, changing behavioral beliefs related to contraceptive use, and providing mental health support among teenage girls in Kibera Slums.

Methodology
The study targeted adolescent girls aged 15-24 from five Kibera villages (Gatwekera, Soweto East, Laini Saba, Kisumu Ndogo, and Lindi) who had participated in community-based SRH and mental health initiatives. Using simple random sampling, 500 teenagers were surveyed through structured questionnaires and one-on-one interviews. Data were analyzed using descriptive statistics and presented in tables and charts.

Results

The adolescents were aged 15-24 years, with 39% aged 24, 30% between 21-23, 18% between 18-20, and 13% between 15-17. Regarding peer education programs, 33% found them very effective and 31% effective in improving attitudes and understanding of SRH and mental health by creating safe spaces to discuss stigma and emotional challenges; 25% found them less effective, and 11% ineffective. Economic empowerment initiatives positively impacted 32% of respondents who felt more empowered to express their reproductive rights and manage mental health stressors, 25% who felt less likely to be sexually exploited, 27% who made better healthcare decisions including seeking mental health care, and 17% who extended their schooling and gained improved access to sexual education, which contributed to better mental well-being. Newly formed clubs were rated extremely effective by 16% and effective by 26% in raising contraceptive knowledge and supporting mental health awareness, but 40% found them less effective and 18% ineffective, often due to limited resources and inconsistent engagement.

Conclusions
The study demonstrated how different community-based interventions are in terms of their ability to improve the mental and SRH outcomes of girls of adolescent age living in the Kibera Slums. Even while initiatives for economic empowerment and peer education have encouraging outcomes, more work is required to improve the efficacy of newly founded clubs and other interventions.

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THE FUTURE IS HERE: SUPPORTING GEN Z MENTAL WELL-BEING THROUGH SCIENTIFIC AND INCLUSIVE WORKPLACE DESIGN

Author: Faith Gichanga[None]

Corresponding Author: fgichanga@gmail.com

Introduction:
This presentation aims to examine the mental health and integration challenges facing Generation Z (born 1997–2012) in the workplace, and to offer practical, science-informed solutions for creating supportive environments that promote wellbeing and productivity across sectors. It explores how organizations can proactively adapt to the expectations, vulnerabilities, and strengths of Gen Z employees to foster sustainable engagement and mental health.

Methods:
The paper combines current research from global and regional sources on Gen Z workplace experiences and mental health. It is complemented by practice-based evidence from the presenter's work with Kenyan early-career Psychology professionals through mentorship, as well as experience in corporate wellness programs. Data points from Kenyan sources are integrated to ground recommendations in the local context.

Results:
Globally, Gen Z reports the highest levels of workplace-related mental health stress. A 2022 McKinsey Health Institute study found that over 60% of Gen Z workers globally reported symptoms of anxiety or depression, compared to 41% of Millennials.

In Kenya, the Federation of Kenya Employers reports that over 68% of employers have observed difficulty integrating Gen Z workers, with common concerns including emotional fragility, difficulty receiving feedback, and disengagement. However, Gen Z workers also bring strong digital skills, a passion for purpose, and a desire for psychological safety—qualities that, when supported, can fuel innovation.

Practice-based interventions such as peer coaching, structured mental health onboarding, and training managers in generational intelligence have shown promise in improving retention, team cohesion, and mental wellness. One local mentorship program for early-career psychologists recorded

significant improvements in confidence, communication, and job readiness after adopting a strengths-based coaching approach.

Conclusion:
To build truly supportive work environments, Kenyan organizations must shift from reactive to proactive mental health strategies that consider generational differences. Integrating neuroscience, emotional intelligence, and youth development science into workplace culture is not just good for Gen Z—it future-proofs the entire workforce. This presentation proposes a practical model rooted in inclusive leadership, mentorship, and adaptive workplace policies that equip all sectors to welcome Gen Z in ways that protect their mental health and unlock their full potential.

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Keywords:
Gen Z, workplace mental health, future of work, employee wellbeing, psychological safety, youth employment, inclusive workplaces, generational intelligence

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EARLY CHILDHOOD TRAUMA AND ITS LONG-TERM MENTAL HEALTH EFFECT IN KANGEMA CONSTITUENCY, MURANG'A COUNTY

Author: Susan Wambui[1]

[1] *N/A*

Corresponding Author: mnjeri0220@gmail.com

EARLY CHILDHOOD TRAUMA AND ITS LONG-TERM MENTAL HEALTH EFFECT IN KANGEMA CONSTITUENCY, MURANG'A COUNTY
Presenter: Susan Wambui Mukuna
Co-author(s): N/A
Presentation Type: Poster Presentation
Introduction
Long-term mental health problems are often caused by early childhood trauma with emotional, physical, sexual, and domestic violence. Such cases in Kangema Constituency of Murang'a County are often accepted as natural, kept hidden, or misunderstood since many people find mental health issues to be taboo. The purpose of this study is to find out how early childhood trauma can continue to harm mental health in Kangema, and why it is important for early interventions to come from the community itself.
Objective
Early Childhood Trauma and its Long-Term Mental Health Effect in Kangema Constituency, Murang'a County
Methods
This study was done using a descriptive research approach. A total of 160 volunteers between the ages of 18 and 35 were picked evenly from different wards in the Kangema Constituency using stratified random sampling to ensure men and women were all included. Information was gathered by using surveys that combined the ACE list with a mental health self-assessment test. The questionnaire tested how much trauma people had experienced, what mental health symptoms they had, and how supported they felt by the community. The research used SPSS for the analysis of data. Based on Cronbach Alpha and the Kaiser-Meyer-Olkin measure (KMO = 0.784), the tool proves to be reliable and there are no problems regarding sample size.
Results
It was found that 69% of participants reported having at least one type of ACE, whereas 42% had experienced three or more. A high ACE score was closely connected with depression, anxiety, using substances, and suicidal thoughts at a statistically significant level ($p < 0.05$). Having family help,

starting early interventions at school, or counseling in church reduced the mental health issues the participants faced. Barriers to care were mainly caused by cultural stigma, little awareness, and problems in referring patients.
Conclusion
It is confirmed through the study that early childhood trauma causes lasting problems for mental health within Kangema Constituency. Therefore, the use of trauma-informed practices should be adopted in regular health centers and neighborhood settings. Members of schools, churches, and families should learn how to spot signs of trauma and send them to a place where they can get help. Rural areas should be given priority in supporting mental health policies that work on childhood trauma prevention and encouraging resilience.
Keywords:
Childhood Trauma, Mental Health, Aces, Rural Kenya, Kangema, Prevention
References
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Community-Level Suicide Surveillance in Kenya: Descriptive Insight from the mDharura Application in Nakuru County (2020-2025).

Author: LYDIA NYAGA[1]

Co-authors: Ann Wanjru Kamau [1]; Elizabeth Kiptoo [1]; Joy Mugambi [1]; Moses Obiero Onyango [1]

[1] *DEPARTMENT OF HEALTH NAKURU*

Corresponding Authors: kamauann506@gmail.com, lydianyaga2015@gmail.com

ABSTRACT
Community-Level Suicide Surveillance in Kenya: Descriptive Insight from the mDharura Application in Nakuru County (2020-2025).
Authors: Lydia Nyaga1, Joy K. Mugambi1, Ann Njeri1, Elizabeth Kiptoo1, Moses Obiero1
1Department of Health, Nakuru County
Background: Suicide is a rising public health concern in Kenya, especially among adolescents and young adults. In 2021, over 700,000 suicide deaths were recorded globally, with 79% occurring in low- and middle-income countries. In Kenya, suicide rate was at 6.1 per 100,000 in 2021. However, community-level data on suicide and attempted suicide in Kenya remains limited, undermining the development of effective interventions. To address this gap, Nakuru adopted m-Dharura application in 2020 into its County Event-Based Surveillance (CEBS) system. The platform empowers community health promoters to report and escalate public health events including suicide cases, in real-time. This study analyzes suicide-related signals reported from January 2020 to April 2025 to reveal trends, demographic patterns, and response systems gaps.
Methods: A retrospective descriptive study was conducted utilizing data from the CEBS system obtained via the m-Dharura application. The Nakuru County line list was downloaded and subjected to data cleaning to exclude incomplete, unverified, and misclassified records. The analysis focused on variables such as gender, suicide method, sub-county distribution, and response type recorded. This process resulted in a final dataset of 400 verified suicide related signals. Descriptive statistics were generated using Microsoft Excel to inform policy and guide intervention strategies.
Results: Of the 400 suicide-related signals, 337 (84.25%) were complete suicides, 63 (15.75%) were attempted suicides. Men accounted for 53% of the suicide deaths, while women represented 46% of attempted suicides. Gilgil Sub-county reported the highest suicide signals, accounting for 18.5% of all cases. Most of the cases had unknown methods of suicide (74.5% for suicides and 51% of attempted suicides). Among cases with known methods, self-poisoning and hanging were most frequent at 49% and 6.8% respectively. Notably, 76.25% of suicide cases did not receive documented follow-up or response from sub county disease surveillance officers, highlighting serious gaps in emergency mental health care linkage and crisis response.
Conclusion and Recommendations: The findings highlight the value of CEBS and digital tools like the mDharura App in detecting suicide cases and supporting mental health surveillance at the community level. However, gaps in follow-up and data quality remain. Strengthening Community Health Promoters'capacity and timely reporting is key. County-level data review and quick mental health

team responses are effective low-cost steps. Nationally, adding suicide reporting to DHIS2 would improve visibility, accountability, and resource allocation, enhancing suicide prevention and mental health reforms in Kenya.

Key words: Cases, Community surveillance, Suicide.

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DEEPLY DEPRESSED OR REASONABLY DISTRESSED? A QUALITATIVE STUDY OF WOMEN'S AND HEALTH CARE WORKERS' PERSPECTIVES ON MATERNAL MENTAL HEALTH IN KAJIADO COUNTY, KENYA.

Authors: Caren Kamau[1]; Francis Makhoka[2]; Jane Karimi[3]; Kristian Ekman[4]; Louise Ohlund[5]; Lydia Munteiyan[6]; Sebastian Gabrielsson[7]; Timothy Ntinina[6]; Ursula Werneke[5]

[1] *Kajiado County department of Health & Mt. Kenya University*

[2] *Directorate of Research and Innovation, Mount Kenya Univetsity*

[3] *Department of Psychology, Mount Kenya University, Kenya*

[4] *Region Norrbotten, Lulea, Sweden*

[5] *Department of Clinical Science, Division of Psychiatry, Umea University, Sunderby Research unit, Lulea, Sweden*

[6] *Kajiado County Department of Health, Kenya*

[7] *Department of Health, Education and Technology, Lulea University of Technology, Lulea, Sweden*

Corresponding Authors: kamaucaren@gmail.com, ursula.werneke@umu.se

Introduction

For Kenya, prevalence estimates for pre- or postnatal depression range from 9 to 35%, with a wide spectrum of associated risk factors, spanning from unmet basic survival needs to social vulnerabilities. In the last three years, several cases of infanticide have received national attention. Whilst lack of material resources and social support may have contributed to each case, these factors alone may not fully explain the outcomes. To date, no study has examined maternal mental health in Kajiado County.

Aim

To explore mental health problems, social needs, and associated risk factors in women pre- and postnatally in Kajiado County in Kenya from the perspectives of women and health care workers (HCW).

Method

We conducted focus group-based interviews with pre- and postnatal mothers and HCW in Kajiado County. To ensure variation of experiences, five demographically and geographically diverse health care facilities were selected. Data was analysed using qualitative content analysis. The study followed the Standards for Reporting Qualitative Research (SRQR) checklist.

Results

Of all individuals approached, 49 (71.0%) women and 39 (61.9%) HCW agreed to participate and completed the interviews. The qualitative analysis identified three main themes: Autonomy and self-determination; Responsive maternal and mental health care; Community knowledge and acceptance of mental health problems. Women's autonomy and self-determination were constrained by restricted reproductive choice, early and forced marriage, lack of control of material resources, social isolation, and gender-based violence. Maternal and mental health care were hampered by access barriers, fear of traumatic birth for women, and resource constraints, and emotional distress among HCWs. Community knowledge and acceptance of mental health problems were limited by stigma, spiritual beliefs, and misconceptions.

Conclusions

Our findings suggest that maternal mental health is closely intertwined with gender norms and prevailing perceptions of mental health problems. While expanding mental health services is necessary,

it is unlikely to be sufficient on its own. Sustainable change will require promoting women's rights, enhancing mental health literacy at the community level, and actively involving men. Besides, fear of traumatic birth must be addressed not only at individual but also at community level to break the cycle between uninformed maternal decision making and poor birth outcomes. In a next step, we will conduct a quantitative survey informed by these findings, with the results used to formulate and test a pragmatic intervention.

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Evaluating the Impact of the mhGAP-IG Child and Adolescent Mental and Behavioural Disorders Module in Kenya: Training Outcomes on Knowledge, Attitudes, and Practices

Author: Beatrice Mkubwa[1]

Co-authors: Amina Abubakar [2]; CHARLES NEWTON [3]; Judy Gichuki [4]; Laura Pacione [5]; Marit Sijbrandij [6]; Nuru Kibirige [7]; Rachel Odhiambo [8]; VIBIAN ANGWENYI [9]

[1] *Institute for Human Development, Aga Khan University*

[2] *Aga Khan University*

[3] *KEMRI-WELLCOME TRUST*

[4] *Directorate of Health, Wellness, and Nutrition, Nairobi County Government*

[5] *Division of Child and Youth Mental Health, Department of Psychiatry, University of Toronto and Department of Mental Health and Substance Use, World Health Organization, Geneva, Switzerland*

[6] *Department of Clinical, Neuro- and Developmental Psychology, WHO Collaborating Center for Research and Dissemination of Psychological Interventions, Amsterdam Public Health Research Institute, Vrije Universiteit Amsterdam, The Netherlands*

[7] *Department of Health and Sanitation Services*

[8] *Aga Khan University, Institute for Human Development, Kenya*

[9] *AGA KHAN INSTITUTE FOR HUMAN DEVELOPMENT*

Corresponding Author: beatrice.mkubwa@aku.edu

Up to 20% of children and adolescents globally experience mental health disorders, yet in Kenya, over 75% lack access to care. Primary healthcare workers (HCWs) are key to bridging this gap, but limited training and resources hinder effective service delivery. The WHO's Mental Health Gap Action Programme Intervention Guide (mhGAP-IG) includes a Child and Adolescent Mental and Behavioural Disorders (CMH) module, but its implementation and evaluation in Kenya remain unexplored. This study aimed to implement and assess the impact of the mhGAP-IG CMH module on knowledge, attitude and practices in primary healthcare settings.

A mixed-methods study was conducted in Nairobi and Kilifi counties, Kenya, to assess the impact of training primary healthcare workers (HCWs) using a contextualized and adapted mhGAP-IG CMH module. A total of 93 HCWs participated in a structured training program on child and adolescent mental health, delivered by mental health experts. Knowledge and attitudes were assessed at three time points: baseline (pre-training), immediately post-training, and three months post-training. Knowledge was measured using a structured assessment, while attitudes were evaluated using the

Mental Illness: Clinicians' Attitudes Scale (MICA-4). Three months post-training, focus group discussions (FGDs) were conducted with trained HCWs to explore changes in mental health practices, barriers to implementation, and experiences with integrating CAMH into routine care. Quantitative data were analyzed using R software. A Friedman test assessed changes in knowledge over time, while the Wilcoxon Signed-Rank Test examined attitude changes. Qualitative data from FGDs were thematically analyzed using NVivo to identify emerging patterns related to training impact and implementation challenges.

Knowledge scores significantly improved immediately post-training ($p = 1.5e-08$) and sustained three months later ($p = 9.8e-08$), with no significant decline over time ($p = 1$), indicating strong knowledge retention. The Friedman test confirmed a significant overall effect of training on knowledge ($\chi^2(2) = 40.121$, $p = 1.94e-09$). Attitudes toward mental health also improved post-training ($p < 0.001$), with a 15.74% reduction in stigma-related scores. These improvements were maintained after three months ($p < 0.001$), despite a slight but non-significant increase (8.72%, $p = 0.93$) in attitude-related scores. Three months post-training, HCWs revealed improvements in mental health practices, including increased confidence in identifying and managing child and adolescent mental health conditions, and enhanced integration of mental health care into routine clinical services.

The findings suggest that training effectively enhances knowledge, attitudes, and practices toward mental health, with sustained benefits over time. However, barriers such as high caseloads, stigma, and weak referral networks persisted, highlighting the need for continued supervision and policy support. Sustainable implementation requires policy integration, resource allocation, and structured supervision. These findings contribute to global efforts to scale up CAMH services in LMICs through implementation of contextualized and adapted international mental health guidelines.

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Comparing Mini-IPT and Full IPT for Postpartum Depression in Kenyan Adolescent Mothers: A Feasibility Study

Author: Angela Langat[1]

Co-authors: Albert Tele [2]; Manasi Kumar [3]; Vincent Nyongesa [4]

[1] *Dr Kumar's Lab - NYU School of Medicine*

[2] *Vrije Universiteit Amsterdam (VU Amsterdam)*

[3] *NewYork University*

[4] *University of Nairobi*

Corresponding Author: angela.langat@yahoo.com

Background: Postpartum depression affects approximately 30% of mothers in urban informal settlements in Nairobi, Kenya, with adolescent mothers facing particularly high risks alongside compromised family functioning. Current evidence-based treatments like Interpersonal Therapy (IPT) have demonstrated effectiveness for postpartum depression in low- and middle-income countries and adolescent populations, but these interventions are primarily tested in Global North contexts and may be resource-intensive with standard 8-session protocols potentially leading to higher dropout rates.

Objective: This feasibility study examined whether a shortened Mini-IPT intervention (4 sessions) delivered by non-specialist healthcare workers could effectively reduce depression and improve family functioning among adolescent mothers in Kenya. We hypothesized that both Mini-IPT and Full IPT would reduce depression scores and improve family functioning compared to treatment as usual, with Mini-IPT potentially offering advantages in resource utilization and retention through an integrated systems approach.

Methods: A three-arm longitudinal feasibility study was conducted with 122 pregnant adolescent girls (ages 13-18) from Kariobangi and Kangemi informal settlements who scored ≥10 on the Edinburgh Postnatal Depression Scale. Participants were randomized to treatment as usual (TAU; n=44),

Mini-IPT with 4 sessions (n=38), or Full IPT with 8 sessions (n=40). Primary outcomes included depression symptoms measured by the Patient Health Questionnaire-9 (PHQ-9) and family functioning assessed by the Family Functioning Composite (FFC) scores. Assessments were conducted at baseline, immediately post-intervention, and at follow-up.

Results: The final sample included 101 participants post-intervention and 91 at follow-up. Both Full IPT and Mini-IPT groups showed significant reductions in depression compared to TAU immediately post-intervention; however, improvements in the Mini-IPT group were not sustained at follow-up. No significant changes in family functioning were observed across any groups. Mini-IPT demonstrated the lowest attrition rates both post-intervention and at follow-up, though differences were not statistically significant. The study was underpowered to detect smaller effect sizes.

Conclusions: Full IPT demonstrated sustained reduction in depression symptoms among adolescent mothers, while Mini-IPT showed initial promise but lacked durability. The absence of family functioning improvements suggests need for targeted family-focused interventions. Despite lower attrition rates for Mini-IPT, further research with adequate statistical power is required to establish its effectiveness. Future studies should consider implementing well-powered designs and exploring effectiveness in diverse settings, including rural populations, to inform scalable mental health interventions for vulnerable adolescent mothers.

Keywords: postpartum depression; adolescent mothers; interpersonal therapy; family functioning; Kenya; feasibility study

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Pregnancy to Parenthood: A Community-Based Task-Shifting Approach to Address Perinatal Mental Health in Nairobi's Informal Settlements

Authors: Benson Simba[None]; Hawa Mohamed[1]

Co-authors: Nawaraj Upadhaya [2]; Silas Chebon [3]

[1] *Regional Programs Manager*

[2] *Director, Peter C. Alderman Programs for Global Mental Health*

[3] *Project Manager*

Corresponding Author: hawa.abdillahi@healthright.org

Background and Objectives:

Despite a higher burden of mental health problems, especially depression and anxiety among perinatal mothers in Kenya, access to care remains fragmented and insufficient due to inadequate funding, lack of trained mental health workers at the primary health care level, and community-level stigma. To address this urgent gap, HealthRight Kenya implemented a community-based task-shifting approach to improve mental health outcomes for perinatal mothers in Nairobi's informal settlements. The primary objectives were to: 1) improve individual and community knowledge, attitudes, and practices regarding mental health and Gender-Based Violence (GBV); 2) strengthen the integration of quality mental health services, including screening and Interpersonal Group Therapy (IPT-G), into the primary level of care; 3) build the capacity of Community Health Promoters (CHPs) and Healthcare Workers (HCWs) to deliver mental health services through a task-shifting model; and 4) enhance facility-level mental health information systems for better data management and decision-making.
Study Design and Methodology:
A pre-post cross-sectional study design was utilized to evaluate the intervention's impact across three informal settlements: Mathare North, Mukuru Kwa Reuben, and Mukuru Kwa Njenga. The project, which ran from 2020 to 2023, employed a multi-faceted approach grounded in community engagement and health system strengthening. Key interventions included training 137 CHPs and 53 HCWs on the WHO mhGAP toolkit and intervention guides, facilitating mental health screenings using tools like the PHQ-2 and PHQ-9, conducting community dialogue days, and rolling out facility-based IPT-G sessions for perinatal women. Data was collected through baseline, midterm,

and endline surveys, complemented by routine monitoring data.
Results:
The project demonstrated significant positive outcomes. Awareness of mental disorders among beneficiaries increased from 31% at baseline to 94% at endline. Health-seeking behavior surged, with 82% seeking services at endline compared to 3% at baseline. A total of 37,044 community members were reached through health talks, and 943 participated in community dialogue days. Over 2,500 women were screened for mental health conditions; 281 enrolled in IPT-G sessions and 197 completed the program. Diagnoses of mental health conditions among women dropped from 70% to 50%. Satisfaction with services was high, with 99% of beneficiaries expressing satisfaction at endline.
Conclusion and Recommendations:
This project confirms that a community-based, task-shifting approach is effective in improving perinatal mental health awareness, access, and outcomes in resource-limited urban settings. Integrating evidence-based interventions like IPT-G with existing primary care and community structures, led by trained CHPs, is a scalable model. Key learnings emphasize the importance of multi-sectoral collaboration, capacity building, and adaptive program design. Future recommendations include scaling the model with a livelihoods component, integrating mental health indicators into DHIS2, digitizing screening and referral tools, and developing national guidelines for community-based mental health interventions.

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Cultivating Resilience: SWISS's Community-Led CARE Model for Mental Health Justice Among Widows

Author: Zilpher Renalda Audo[1]

[1] *smart widows support system (swiss cbo)*

Corresponding Author: swisscbo@gmail.com

Background
In Embakasi West's informal settlements, baseline screening of 150 widows revealed 78% with moderate-to-severe depression (PHQ-9 ≥10; scale range 0–27) and 65% reporting high social isolation (UCLA Loneliness Scale ≥45). Cultural violence—property seizure and forced "widow cleansing"—combined with economic exclusion, intensifies post-traumatic stress disorder (PTSD) and suicidal ideation (SWISS Strategic Plan, p.10). SWISS's CARE model—Community Advocacy, Resilience, Empowerment—was designed to reduce depression and isolation by 50% and double counselling uptake over a six-month follow-up period.

Methods
From January to March 2025, four multidisciplinary teams (8 Community Health Promoters, 15 trained paralegals, TB/HIV champions, and CHMT liaisons) implemented:

Advocacy (WORD): Five community justice hubs resolving property and GBV cases

Psychoeducation (WHIP): Grief and SRHR workshops co-designed with AMREF

Economic Action (WISEEP): Table banking circles tracked via KoboToolbox

Assessments at baseline and six months used PHQ-9, GAD-7, UCLA Loneliness Scale, WHO-5 Well-Being Index, and NVivo-coded qualitative data.

Results

Depression prevalence dropped from 78% to 42% (ΔPHQ-9 = –7 points; $p<0.001$)

Isolation scores decreased by 65% (UCLA)

38% of participants improved from "low"to "moderate"well-being (WHO-5)

Counselling uptake increased from 22% to 85%

92% of WISEEP participants earned ≥KSh 5,000/month

Over 120 property restitution cases were resolved

92% of participants rejected "widow cleansing"practices

ROI: Clinical costs averted / program cost = 3.1×

Conclusions & Next Steps
SWISS CARE demonstrates that training widows as paralegals and peer educators reduces depression, dismantles cultural stigma, and strengthens economic resilience. Embedded in CHMT systems and formalized through the Embakasi West Widow Protection Guidelines (2025), the model is scaling via a real-time digital M&E dashboard.

Next steps include expansion to two additional Nairobi wards and alignment with Kenya's County Mental Health Strategy.

Keywords

widow mental health ·cultural trauma ·community paralegals ·savings groups ·Nairobi

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ENHANCED MENTAL HEALTH DATA REPORTING: THE DEVELOPMENT OF THE MENTAL HEALTH INDICATORS AND THE MENTAL HEALTH MORBIDITY SUMMARY TOOL.

Author: Peris Wambui Mwangi[1]

Co-authors: Mercy Karanja [2]; Nicholas Kimuyu [2]; Simon Njuguna [1]

[1] *Mathari National Teaching and Referral Hospital*

[2] *Division of Mental Health-MOH*

Corresponding Author: pwambui.pw@gmail.com

Introduction
In Kenya, mental illness affects about 25% of outpatients and 40% of inpatients, with psychosis impacting 1% of the general population. Despite policy provisions, current health information systems lack adequate tracking of mental health conditions and interventions. The Mental Health Taskforce recommended creating a dedicated mental health data system and conducting regular surveys. In response, the Division of Mental Health initiated efforts to bridge this critical data gap. The goal was to strengthen mental health data reporting in Kenya by assessing existing indicators and tools, documenting the development of standardized mental health reporting mechanisms, and evaluating their integration into the national health information system.
Method
A multi-stakeholder, phased approach was used to improve mental health data reporting in Kenya. A situational analysis guided the co-development of standardized indicators and a morbidity summary tool for integration into KHIS. This informed the co-development of mental health indicators and a standardized morbidity summary tool for integration into the Kenya Health Information System (KHIS), capturing key data such as age, sex, visit type, and facility details. The tool was piloted in 16 facilities across 14 counties, followed by training, weekly reporting, and an evaluation workshop. Based on feedback, the tool was refined and validated for national scale-up.
Findings.
A situational analysis revealed that mental health data is currently captured in the Kenya Health Information System (KHIS) through various existing tools. These include the general outpatient morbidity registers for under-5s (MoH 705A) and over-5s (MoH 705B), which record the number of patients with mental health disorders seen at outpatient clinics. The Service Workload Report (MoH 717) captures psychiatry clinic attendance, while the Integrated Summary Report (MoH 711) covers a broad range of mental health services such as psycho-social counselling, alcohol and drug abuse, adolescent mental health issues, assessments, social investigations, rehabilitation, outreach services, health talks, and mental health referrals. At the community level, the Community Health Reporting Tool (MoH 515) tracks the number of individuals with mental illness referred by Community Health Volunteers (CHVs), although this data remains within the community health system rather than

being reflected at the facility level. Additional tools include the AWP Monthly Service Delivery Report, which records new outpatient cases with mental health conditions, and hospital administrative statistics that document inpatient numbers in psychiatric wards. The NCD Facility Commodity Data Report (MoH 647B), piloted in three counties, monitors the availability of selected mental health and neurological medications such as Haloperidol, Amitriptyline, and Carbamazepine.
Conclusion & recommendations
The development and piloting of the Mental Health Morbidity Summary Tool have addressed key gaps in Kenya's mental health data reporting by introducing standardized indicators into the Kenya Health Information System (KHIS). The tool proved feasible, user-friendly, and capable of generating comprehensive data to support planning and resource allocation. To sustain these gains, national rollout is recommended, alongside continuous training of health workers, stronger integration of community and facility data, routine use of mental health data for decision-making, and periodic review of indicators to adapt to emerging needs.

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Promoting service engagement for families of children with developmental disabilities in Nairobi and Kilifi: Lessons from SPARK's Implementation

Author: Vibian Angwenyi[1]

Co-authors: Eva Mwangome [2]; Beatrice Mkubwa [1]; Carophine Nasambu [2]; Brenda Nzioka [1]; Nancy Githinji [2]; Kevin Sidika [1]; Ann Muisyo [1]; Damaris Nguyo [1]; Patrick Idd [2]; Charo Nguku [2]; Walter Kisangi [1]; Eddie Chengo [3]; SPARK Consortium [4]; Charlotte Hanlon [5]; Rosa Hoekstra [6]; Charles Newton [2]; Amina Abubakar [1]

[1] *Institute for Human Development, Aga Khan University Nairobi, Kenya*

[2] *Neurosciences Department, KEMRI/Wellcome Trust Research Programme, Kilifi, Kenya*

[3] *Foundation of People with Epilepsy Neurology Centre*

[4] *SupPorting African Communities to Increase the Resilience and Mental Health of Kids with Developmental Disorders and their Caregivers in Kenya and Ethiopia*

[5] *Department of Psychiatry, School of Medicine, and Centre for Innovative Drug Development and Therapeutic Trials for Africa, College of Health Sciences, Addis Ababa University, Addis Ababa, Ethiopia*

[6] *Department of Psychology, Institute of Psychology, Psychiatry and Neuroscience, King's College London, London, UK*

Corresponding Author: vibian.angwenyi@aku.edu

Background
In Africa, families of children with developmental disorders/disabilities (DDs) including autism experience multiple barriers to accessing appropriate care and services. These include lack of awareness, stigma and exclusion, high cost of care, and long travel to access services. Primary healthcare (PHC) facilities lack available services and health personnel have limited capacity to diagnose and manage DDs. We describe SPARK's innovations and approaches to enhance community and frontline health professionals capacity for early identification and referral, diagnostic assessments, and linking families of children with DDs and their caregivers for mental health and other relevant services.

Methods
SPARK (SupPorting African communities to increase the Resilience and mental health of Kids with developmental disorders and their caregivers in Kenya and Ethiopia) is an international research collaboration funded by the NIHR-UK (NIHR200842). In Kenya, the study was implemented in rural Kilifi and informal settlements in Nairobi (Ruaraka and Dagoretti sub-counties) and implemented in catchment areas of 25 public health facilities.

This paper describes results from a multi-phased mixed-methods study, which included: i) conducting workshops with community representatives and professionals to identify needs, map service points, and develop site-specific resource-kits; ii) training of community support workers to identify and refer children at risk of delayed development using a novel detection tool; iii) training of health professionals on the principles of the WHO mental health Gap Programme (mhGAP) and

increase their capacity to conduct formal assessment in primary care settings; iv) referral and linkage to health, education, and other services by trained PHC providers and study clinicians using resource-kits/information guides; and, v) evaluation of service engagement using quantitative and qualitative approaches.

Results/lessons
Stakeholder workshops highlighted most caregivers were unaware of services available in their locality. Stakeholders recommended the importance of providing comprehensive information about these services in resource-kits/guides e.g. location, costs, operational hours, contacts, and educational messages. Caregivers reported learning and visiting places listed in these resource-kits for instance, caregivers'mental health support, medical assessments, and therapy services. Challenges included the need to increase awareness about processes involved in educational assessment and school placement for learners with special needs. Access to specialist care e.g. occupational and speech therapy, comprehensive care for children with intellectual disabilities and autism remain a challenge.

Conclusion
Improving information access and proactively identifying mechanisms to link families to relevant services is one step to enhancing the care seeking journey, particularly for families receiving first-time diagnosis. Concerted efforts from state and non-state agencies are necessary to improve the state of services, while ensuring these are accessible, affordable, and constantly available.

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RISE & REST: A SCHOOL-BASED SOUND THERAPY ROUTINE TO PROMOTE ADOLESCENT MENTAL WELLNESS AND NEURO-INCLUSION IN KENYA

Author: David Okello[1]

Co-authors: Antony Okungu [1]; Ciiro Gitonga [1]; Simon Kipkenei [2]

[1] *HEMAFRIC*

[2] *Kibabii University*

Corresponding Author: david@healthyminds.africa

Introduction:
Adolescents in Kenya face an escalating mental health crisis, with up to 40% experiencing psychological distress. In rural and boarding school settings, access to mental health support remains limited due to stigma, low availability of trained personnel, and a lack of culturally relevant interventions. Neurodivergent students are particularly marginalized within mainstream education systems. This study presents Rise & Rest, a school-based sound therapy routine designed to enhance emotional regulation, learning readiness, and neuro-inclusion using low-cost, non-stigmatizing, and scalable tools.
Methods:
The Rise & Rest program integrates brainwave entrainment through isochronic beats into structured routines built on the "R.I.S.E."model: Reset the Mind, Inner Awareness, Stress Literacy, and Evening Wind-down. Learners participate in daily and weekly activities involving breathwork, journaling, music therapy, and peer-led psychosocial support. The program was piloted in public and special boarding schools across Kenya with over 25,000 adolescents. Implementation utilized trained school health workers, student mental health ambassadors, and AI-assisted delivery tools. Data was collected using standardized surveys, focus group discussions, and in-depth interviews. A mixed-methods approach enabled measurement of both quantitative outcomes and qualitative insights. A randomized controlled trial is planned to validate long-term efficacy.
Results:
Preliminary evaluation of the pilot phase indicated:
70% of participants reported improved emotional wellbeing

65% showed enhanced classroom focus

54% experienced improved sleep quality

81% expressed increased trust in trained non-teacher facilitators

Qualitative data emphasized the accessibility and acceptability of sound therapy across diverse student populations. Implementation challenges included device availability in remote settings and facilitator retention, which are being addressed through partnerships and training manuals.
Conclusions:
Rise & Rest offers a culturally grounded, cost-effective, and inclusive model for adolescent mental health promotion in resource-constrained school settings. Its alignment with Kenya's School Health Policy and the 2023 Persons with Disabilities Act positions it for integration into national education and health frameworks. The program also presents opportunities for mental health financing innovation by demonstrating how preventive, school-based care can reduce high-cost psychiatric claims. With its strong evidence base and scalability, Rise & Rest contributes to a holistic approach to youth mental health, empowering adolescents with proactive emotional regulation tools while building inclusive school environments.
Keywords: adolescent mental health, neuro-inclusion, sound therapy, isochronic beats, brainwave entrainment, school-based intervention, Kenya, inclusive education
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Integrating Mental Health Screening and Services into HIV Management to Improve Health Outcomes for Persons Living with HIV (PLHIV) in 10 MiCARE-Supported Counties: A Case Study of USAID Stawisha Pwani (USP)

Author: Gaitho. M Mwangi[1]

Co-authors: Nancy Kerubo [1]; Jane Thiomi ; Stella Gitia ; Philip Masaulo ; Patrick Oyaro

[1] *USAID Stawisha Pwani (LVCT Health)*

Corresponding Author: michael.gaitho@lvcthealth.org

Background: Mental health is a critical yet frequently neglected aspect of HIV care, particularly in resource-constrained settings. Persons living with HIV (PLHIV) experience higher levels of exposure and vulnerability to mental health disorders such as depression, anxiety, and trauma, which negatively impact treatment adherence, retention in care, and viral suppression (WHO, 2022). Limited integration of mental health services in 10 USAID-supported counties, including those under the MiCARE project, prompted the initiation of an integrated mental health and HIV care model to improve health outcomes among PLHIV.
Description: The initiative adopted an adaptive implementation design to enhance scalability, ownership, and alignment with national priorities. Mental health screening and services were integrated into HIV service delivery points through co-creation sessions with the Ministry of Health (MOH) and key stakeholders. Training-of-trainers (TOT) sessions were conducted for healthcare workers (HCWs) and peer educators, supported by the development of customized mental health tools, registers, and indicators. Interventions included use of WHO's mhGAP, Psychological First Aid (PFA) and structured referral pathways.
Lessons Learned: Before the intervention, there were undefined pathways for mental health care post screening. In 10 months, 141 HCWs and 103 peer educators were trained as TOTs, cascading to 312 facility-based HCWs. Screening and MH service yields from EMR data (Oct 2024–May 2025) from USP counties (Kwale, Kilifi, Mombasa, and Taita Taveta) revealed a low recorded prevalence of moderate-to-severe depression (0.24%) and anxiety (0.15%), suggesting possible underreporting or

provider hesitancy in diagnosis. Notably, 100% of identified cases received PFA. Gaps emerged in screening coverage among high-risk groups: only 40% (PHQ-9) and 4% (GAD-7) of newly initiated ART clients were screened, and screening rates declined among patients with high viral loads (PHQ-9: 68%, GAD-7: 55%)—highlighting missed opportunities for targeted mental health interventions in populations with poor treatment outcomes. Compared to the pre-MiCARE period, uptake of mental health screening and services in HIV management significantly improved, with the integration now routine in high-volume facilities and included in data review processes and clinical mentorship.
Conclusion and Next Steps: Adoption of mental health tools by MOH was pivotal to national alignment and long-term sustainability. Embedding tools within MOH systems has fostered ownership and scalability. The integration of mental health screening, psychosocial support, and referral systems into HIV care is proving instrumental in improving outcomes for PLHIV. Moving forward, efforts will focus on strengthening provider confidence in diagnosis, expanding screening to underserved populations (e.g., newly initiated clients and viraemic patients), and reinforcing data use for decision-making at all levels.

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DIGITAL INNOVATION IN MENTAL HEALTH: A MOBILE APPLICATION FRAMEWORK FOR COMMUNITY-BASED MENTAL HEALTH SUPPORT IN KIAMBU COUNTY

Author: SAMUEL NJUGUNA[1]

Co-author: Luciah mugo [2]

[1] *Geospatial developer*

[2] *Computer Scientist*

Corresponding Author: njugunamaina28@gmail.com

INTRODUCTION
Mental health challenges among Kenyan youth have reached critical levels, with Kiambu County experiencing a notable rise in depression, anxiety, and suicide ideation. Persistent barriers such as limited access to care, stigma, low mental health literacy, and social isolation continue to hinder effective intervention. This study introduces a digital health solution aimed at bridging these systemic gaps through a community-based mobile application. The intervention aligns with the conference theme of securing the future through holistic approaches to mental health across generations.
METHOD
The Kiambu Mental Health App was developed using a multidisciplinary approach combining software engineering with public health and psychological principles. Built using JavaScript, Node.js, and React Native, the app integrates five core functionalities: (1) an AI-powered chatbot that offers immediate, interactive mental health support; (2) digital self-assessment tools grounded in evidence-based screening frameworks; (3) a searchable directory of mental health professionals with geolocation support; (4) a knowledge-sharing platform to improve mental health literacy; and (5) a peer support group feature for community interaction. The app's design was shaped using human-centered design methodologies and included feedback from psychologists, community leaders, and youth representatives. Though backend development is ongoing, data privacy remains a core design principle to ensure user confidentiality and system integrity.
RESULTS & CONCLUSION
The app is currently in early-stage pilot testing with at least 50 participants across Kiambu County. Preliminary feedback has been encouraging. Approximately 85% of users reported that the app would likely improve their understanding of mental health issues, while 72% believed it would facilitate access to professional support. Around 68% valued the community peer support feature, and 91% found the AI-powered chatbot helpful and responsive. These features collectively aim to reduce initial barriers to care by shortening the time between symptom recognition and access to mental health services. Here is Android (.apk) link: https://expo.dev/accounts/mainah/projects/KIAMBU_MENTAL_HEALTH_APP/builds/4c
51d5-4498-afff-4f1d635d3603
This innovation underscores the capacity of mobile technology to transform mental health service delivery in resource-limited settings. The integration of AI support, professional linkage, and community engagement forms a holistic ecosystem that addresses diverse determinants of mental wellness. Notable challenges include ensuring clinical oversight of digital tools, protecting user data, and designing for expansion beyond county borders. Nevertheless, early results indicate the app reduces

stigma, normalizes digital help-seeking, and improves referral processes. Planned enhancements include a crisis hotline, motivational content, patient journaling for recovery tracking, telemedicine integration, and predictive analytics for early intervention. These improvements aim to strengthen the app's impact, positioning it as a scalable, tech-enabled model for mental health support in Kenya and potentially beyond.

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Tracking and Evaluating Health Indicators Reporting on Mental Health and Disabilities in Nairobi and Kilifi Counties: A Mixed-Methods Study

Author: SAMLEE NYAMBU[1]

Co-authors: Vibian Angwenyi [1]; Beatrice Mkubwa [1]; Rachel Odhiambo [1]; Carophine Nasambu [2]; Eva Mwangome [2]; SPARK Consortium [3]; Charles Newton [2]; Amina Abubakar [1]

[1] *Institute for Human Development, Aga Khan University Nairobi, Kenya*

[2] *Neurosciences Department, KEMRI/Wellcome Trust Research Programme, Kilifi, Kenya*

[3] *SupPorting African Communities to Increase the Resilience and Mental Health of Kids with Developmental Disorders and their Caregivers in Kenya and Ethiopia*

Corresponding Author: samlee.nyambu@aku.edu

Background
Millions of children with developmental disorders/disabilities (DDs) live in low- and middle-income countries such as Kenya. Primary healthcare (PHC) facilities often lack adequate services and trained healthcare workers (HCW) to diagnose and manage DDs. Through SPARK (SupPorting African communities to increase the Resilience and mental health of Kids with developmental disorders and their caregivers in Kenya and Ethiopia) research, community and primary HCWs received training to support early identification, referral, and assessment of children suspected to have DDs. HCWs in Nairobi and Kilifi Counties were trained using the principles of the WHO's mental health gap action programme (mhGAP), to enhance their skills in assessing children at risk of developmental delays. This study evaluated trends in health services indicators reported in the Kenya Health Information System (KHIS) by public PHC facilities in Nairobi and Kilifi Counties, where the SPARK research was implemented. It identifies existing gaps and potential areas for strengthening health information systems, with a focus on mental health and childhood disabilities.

Methods
A mixed-methods study was conducted in public PHC facilities participating in the SPARK research. Quantitative data on health indicators capturing developmental disorders/disabilities from 25 public PHC facilities were targeted for data extraction from the KHIS during, six months before and six months after the SPARK research implementation. Descriptive statistics were used to assess indicator trends, and the analysis was performed in R software. Focus group discussions with healthcare workers (n=5, 48 participants) explored barriers and enablers influencing documentation and reporting of mental health and disability-related indicators in routine facility registers and the KHIS. Qualitative data were analysed using a thematic approach in NVivo-Lumivero© software.

Results
Extractable data were only available in five (20%) health facilities, and the missing data were mostly from lower-level facilities (dispensaries and health centres), and the community reporting form. HCWs interviewed reported that they observed more referrals and assessments of suspected DD cases during SPARK research implementation. Although there was a specific study tool to record DD cases, health professionals reported that the MoH reporting tools lacked key mental health and disability-related indicators. In addition, HCWs interviewed shared that some data captured in the facility-based registers were not posted to the KHIS, potentially due to challenges of existing reporting forms. High workload was reported as a challenge to documentation and reporting practices.

Conclusion
Sustained progress requires integrating DD indicators into various facility-based forms to facilitate reporting to KHIS. Investment in HCW training and health information systems, especially at the primary healthcare level, is critical to supporting data-driven decision-making.

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Voices from the Frontline: Mental Health Realities of CHWs in Kenya's Evolving Health System- Findings from a Qualitative Study

Author: Patricia Okoth[1]

[1] *LVCT Health*

Corresponding Author: patricia.vivian25@gmail.com

Background:
Community Health Workers (CHWs) are vital in bridging informal and formal health systems, enhancing access to underserved populations. Despite their essential roles, they often contend with heavy workloads, limited structured support, and inconsistent compensation. While existing research has focused on their responsibilities, few studies have examined their lived experiences, particularly on their mental well-being (MWB). This multinational collaborative study seeks to explore CHWs' personal and work experiences and how these influence their mental well-being in urban and rural settings. The findings will support the co-design of context-specific interventions and inform policy recommendations.

Methods:
In Kenya, the study engaged 27 CHWs (16 F, 11 M) from two contrasting settings: informal settlements in Nairobi County and rural communities in Kiambu County. Individual and work experiences were explored using Life History Interviews to explore their current motivations, stressors, and coping behaviours, and how these influenced their MWB. Participants also created life history maps to visually represent their lived experiences. All interviews were conducted in local languages, audio-recorded, translated, and transcribed verbatim. Data were analysed using the Framework Approach with the aid of NVivo 12 software. The life history maps were examined through content analysis to identify common themes.
All participants provided written informed consent. Ethical approval for this study was granted by AMREF Ethics and Scientific Review Committee (Protocol number: ESRC P1472/2023).

Results:
CHWs identified several motivators that contributed to their engagement, including the recent introduction of stipends, provision of branded attire and kits, and increased community recognition. However, participants also reported a range of stressors affecting their mental well-being. These included compassion fatigue stemming from repeated exposure to familiar trauma, such as grief, gender-based violence, and child abuse. CHW also experienced intrahousehold challenges such as intimate partner violence and family conflicts resulting from financial difficulties. Notably, CHWs highlighted the absence of formal debriefing mechanisms or mental health support within the health system. In response, many relied on informal support systems, including peers, family members, and friends, to cope with overwhelming situations.

Conclusion:
The mental well-being of Community Health Workers is shaped by both their professional responsibilities and repeated exposure to personal and community-level trauma. Although recent reforms such as the provision of stipends and formal recognition of CHWs mark important progress in Kenya's health system, these alone are insufficient. There is an urgent need for the Ministry of Health and county governments to integrate mental health support into community health programming. This includes mental health literacy, ensuring access to supportive supervision through regular debriefing, counselling on trauma and self-awareness, and field-based check-ins, as well as building CHWs' capacity in income-generating activities. Additionally, creating safe and structured forums

for CHWs to reflect on and address work-related stressors will be critical to strengthening their resilience and improving the quality and sustainability of service delivery.

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Contextualization and Adaptation of the Child and Adolescent Mental and Behavioural Disorders Module of the mhGAP-IG in Kilifi and Nairobi Counties in Kenya

Author: Beatrice Mkubwa[1]

Co-authors: Amina Abubakar [2]; Brenda Nzioka [3]; CHARLES NEWTON [4]; Judy Gichuki [5]; Laura Pacione [6]; Maina John [1]; Marit Sijbrandij [7]; Nuru Kibirige [8]; Vibian Angwenyi [3]

[1] *Institute for Human Development, Aga Khan University*

[2] *Aga Khan University*

[3] *Institute for Human Development, Aga Khan University Nairobi, Kenya*

[4] *KEMRI-WELLCOME TRUST*

[5] *Directorate of Health, Wellness, and Nutrition, Nairobi County Government*

[6] *Division of Child and Youth Mental Health, Department of Psychiatry, University of Toronto and Department of Mental Health and Substance Use, World Health Organization, Geneva, Switzerland*

[7] *Department of Clinical, Neuro- and Developmental Psychology, WHO Collaborating Center for Research and Dissemination of Psychological Interventions, Amsterdam Public Health Research Institute, Vrije Universiteit Amsterdam, The Netherlands*

[8] *Department of Health and Sanitation Services*

Corresponding Author: beatrice.mkubwa@aku.edu

The Mental Health Gap Action Programme Intervention Guide (mhGAP-IG) was developed by the World Health Organization as a key technical tool for delivering evidence-based mental healthcare in non-specialized settings around the world. It requires contextualization and adaptation for local relevance, considering healthcare and resource contexts. However, evidence on adapting the child and adolescent mental disorders module of the mhGAP-IG is limited.

This study contextualized and adapted the Child and Adolescent Mental Disorders Module of the 2016 mhGAP-IG through two workshops with local mental health experts and stakeholders. Prior to the workshops, six in-depth interviews were conducted with mental health stakeholders to explore the child and adolescent mental health system contexts in Nairobi and Kilifi. Data were analysed using thematic analysis in NVivo-Lumivero© software.

Interviews with mental health stakeholders revealed significant challenges in both counties, including a shortage of mental health specialists, frequent medication stockouts, stigma, and inadequate resources. Key adaptations to the module included using locally acceptable terms such as changing 'failure to thrive'to 'sub-optimal growth'; expanding the training to five days; inclusion of the mhGAP-IG Essential Care and Practice module to address culturally sensitive communication in care provision; streamlining referral pathways; and incorporating aspects of self-harm, suicide, and substance use linked to the child and adolescent mental and behavioural disorders module.

Contextualizing the child and adolescent mental disorders module is crucial for effective implementation. However, sustaining its impact will require addressing systemic barriers beyond the capacity-building efforts.

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DIGITAL DEVICE ACCESS, USE PATTERNS, PREFERENCES AND ACCEPTABILITY FOR DELIVERY OF MENTAL HEALTH INTERVENTIONS: INSIGHTS FROM YOUNG PEOPLE IN A RURAL KENYAN COMMUNITY SETTING

Author: Moses Kachama Nyongesa[1]

Co-authors: Edna Bosire [1]; Jasmit Shah [1]; Zul Merali [1]

[1] *Aga Khan University*

Corresponding Author: kachama.moses@gmail.com

Background: In sub-Saharan Africa, a considerable proportion of young people experience an array of mental disorders but few seek facility-based care [1,2]. Innovative approaches for increasing youth access to mental health support are needed to improve their mental well being. We collected formative data from Kenyan youth in a rural community setting to inform future design of a digital mental health intervention.

Methods: This was a mixed-design study that received ethical clearance from the Institutional Scientific and Ethics Review Committee (ISERC) of the Aga Khan University, Ref: 2024/ISERC-159. A cross-sectional survey was conducted among 200 randomly selected young people 16-24 years in rural Kilifi, Kenya, to understand their digital device access, usage patterns, and preferences via self-reporting on an Android tablet. Acceptability of using digital platforms for delivery of mental health interventions was assessed quantitatively, in the survey, and qualitatively, through three focus group discussions (FGDs) with a convinience sub-sample of surveyed youth, n=21.

Results: The mean (SD) age of the study participants was 19.98 (2.47) years; 55% males and only 3.5% with no formal education. Overall, 82.5% of the youth accessed a digital device. Over half (59.5%) owned a digital device, mostly smartphones (n=98/119), while an additional 23% had access to a shared or borrowed digital device, largely smartphones (n=33/46). More than two-thirds (n=112/165; 68%) of the youth with digital device access used these devices daily and over four-fifths (83.6%) used the internet; 40.6% using it to search for mental health information. The digitally exposed young people mostly prefer brief phone calls, an App and audio/video media for receiving mental health interventions. Quantitatively, 94% of the young people considered it acceptable to use digital technologies for delivery of mental health interventions, a finding that was corroborated in the qualitative FGDs with the young people: "For me, it is acceptable because many young people currently have access to smartphones, so it is easier for them to get online. Even if s/he goes to school, after school s/he can get online and receive mental health education"(FGD 1 participant, 17-year-old Female). High cost of devices and the internet, electricity problems and instances of poor connectivity were among the elicited barriers for youth access and use of digital technologies.

Conclusions: There is wide access and use of digital technologies like smartphones and the internet among young people in rural Kilifi, despite some existing barriers. Digital platforms could be leveraged for delivery of evidence-based mental health interventions to Kenyan youth in addition to or as an alternative complementary approach to facility-based mental healthcare as this is highly acceptable among the youth.

Keywords: Digital Device Access, Digital Mental Health, Acceptability, Young People, Kenya

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The Acceptability, Feasibility, and Adaptation of the World Health Organization Caregiver Skills Training for Children with Developmental Disabilities in Kenyan settings

Author: Vibian Angwenyi[1]

Co-authors: Eva Mwangome [2]; Eunice Ombech [1]; Victoria Lewa [2]; Beatrice Mkubwa [1]; Brenda Nzioka [1]; Constance Thoya [2]; JoY Yvonne Yaa [2]; Veronica Achoki [1]; Ann Mumira [1]; Eunice Wandei [1]; SPARK Consortium [3]; Rosa Hoekstra [4]; Charles Newton [2]; Amina Abubakar [1]

[1] *Institute for Human Development, Aga Khan University Nairobi, Kenya*

[2] *Neurosciences Department, KEMRI/Wellcome Trust Research Programme, Kilifi, Kenya*

[3] *SupPorting African Communities to Increase the Resilience and Mental Health of Kids with Developmental Disorders and their Caregivers in Kenya and Ethiopia*

[4] *Department of Psychology, Institute of Psychology, Psychiatry and Neuroscience, King's College London, London, UK*

Corresponding Author: vibian.angwenyi@aku.edu

Background
Millions of children in Africa have developmental disorders/disabilities (DDs), with the majority presenting with behaviour and communication problems. Available interventions are predominantly from high-income settings, resource-intensive, and mostly delivered by specialists posing challenges for cross-cultural adaptation. The WHO Caregiver Skills Training (CST) pilot in Kenya delivered by trained non-specialists demonstrated CST was acceptable and feasible to implement. CST's preliminary evaluation suggested improvements in child and caregiver outcomes in rural and urban Kenya. However, existing evidence on the use of non-specialist facilitators (NSFs) to deliver CST in diverse contexts is limited. Furthermore, evidence is needed on how country teams have adapted the CST materials and other contextual considerations specific to low-resource settings.

Setting and methods
SPARK (SupPorting African communities to increase the Resilience and mental health of Kids with developmental disorders and their caregivers in Kenya and Ethiopia) is an international research collaboration funded by the NIHR-UK (NIHR200842). In Kenya, the research was implemented in rural Kilifi and informal settlements in Nairobi (Ruaraka and Dagoretti sub-counties). This paper draws on a multi-phased mixed-methods study and the findings focus on: i) describing the adaptation process of the WHO CST materials for the Kenyan context; ii) sharing lessons from the training model for non-specialist facilitators and supervisors to deliver CST in diverse contexts; and, iii) a qualitative evaluation of caregivers'experiences receiving the CST intervention.

Results/lessons
The Kenyan CST team was involved in harmonising the Swahili version of the earlier CST pilot materials to align with the WHO CST updated guidelines released in 2022. Thereafter, a hybrid training delivered by a WHO CST international trainer followed. Trained NSFs undertook a series of live practice sessions with caregivers and their children to improve competency in delivering the manualised CST. The CST intervention consists of nine group sessions and three home visits delivered in community or health facility settings. Caregivers participating in the CST reported improved knowledge, a better understanding of their child's condition and ability to learn, gaining confidence applying the acquired skills. They also reported better coping with mental health stressors and stigma.

Conclusion
There is great value to using non-specialists/ paraprofessionals in delivering CST in contexts with limited specialists and overstretched health workforce. Mechanisms to embed the CST intervention within health, education, and community-based structures require further exploration.

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The Silent Crisis: Mental Health Impacts of Funding Cuts and Service Disruptions Among Key Populations and PLHIV in Kenya

Authors: Jackson Kamau[1]; KENNEDY MWANGI[1]

[1] *HOYMAS/ KP CONSORTIUM*

Corresponding Author: jacksonmuhia254@gmail.com

Strengthening Mental Health Systems / Community Approaches

Background:
Community-led health clinics have played a critical role in providing stigma-free, holistic care to key populations (KPs) and people living with HIV (PLHIV) across Kenya. However, recent reductions in donor funding have led to the closure of multiple KP-friendly facilities. This shift has not only disrupted essential HIV services but also triggered widespread mental health challenges among affected populations and service providers.

To examine the mental health impacts of service disruption, job losses, and increased stigma on KPs and PLHIV following clinic closures due to funding cuts.

Methods:
A qualitative rapid needs assessment was conducted in Nairobi and Kisumu involving focus group discussions and key informant interviews with former clinic staff, peer educators, PLHIV clients, and community advocates. The study explored emerging mental health concerns, access barriers, and perceptions of public healthcare spaces post-closure.

Results:
The assessment enrolled 389 respondents, 272 (70%) of former KP clinic workers reported moderate to severe anxiety and depressive symptoms due to abrupt job loss and identity crisis from disrupted community support roles. While 62(16%) had suicidal ideations.
Out of 389, 100 PLHIV patients feared to be outed due to stigma that is voiced by the host community.
PLHIV clients expressed fear of being outed or stigmatized when accessing medication in general public facilities, leading to treatment interruptions.
Many participants reported increased feelings of hopelessness, social isolation, and insecurity.
Peer-led mental health support systems weakened significantly, leaving communities more vulnerable to poor coping mechanisms including substance use and suicidal thoughts.
Conclusion:
The defunding of KP programs has created a mental health emergency layered on top of the HIV epidemic. The disruption of care, coupled with stigma in mainstream healthcare, leaves many KPs and PLHIV at serious psychological risk.

Recommendations:

Integrate mental health services into HIV programs and train providers on non-discriminatory care.
Support transition programs for laid-off KP workers to maintain community trust.
Advocate for domestic financing to ensure continuity of care without overreliance on external donors.
Establish safe, inclusive spaces for mental health support across all counties.

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Strengthening Mental Health Systems: The Critical Role of Psychologists in a Multidisciplinary Psychiatry Clinic

Authors: Diana Mboti Walegwa[1]; Ivy Jepkemoi[1]; Julius Ogato[None]; PERIS WAMBUI[2]; Victoria Wamukhoma[3]

[1] *Mathari National Teaching & Referral Hospital*

[2] *MATHARI NATIONAL TEACHING AND REFERRAL HOSPITAL*

[3] *MNTRH*

Corresponding Author: jmemoi10@gmail.com

Strengthening Mental Health Systems: The Critical Role of Psychologists in a Multidisciplinary Psychiatry Clinic

Ms Ivy Jepkemoi[1], Ms Diana Walegwa[1], Dr Peris Wambui[1], Dr Victoria Wamukhoma[1], & Dr Julius Ogato[1]
[1]Mathari National Teaching and Referral Hospital, Nairobi, Kenya
Corresponding author: Ivy Jepkemoi, Mathari National Teaching and Referral Hospital, Nairobi, Kenya
Email: jmemoi10@gmail.com

Schizophrenia is a chronic mental disorder characterised by both positive and negative symptoms. Historically, its management has focused on pharmacological interventions, primarily through antipsychotic medications aimed at reducing acute psychotic episodes and preventing relapse. Long-acting injectable antipsychotics (LAIs) have emerged as a valuable tool, particularly for individuals with adherence challenges, demonstrating efficacy in reducing relapse and hospitalisation rates (Correll et al., 2021; Kane et al., 2022).
However, schizophrenia is not solely a neurochemical disorder; it affects cognition, emotional regulation, interpersonal relationships, and overall functioning. Despite the clinical benefits of LAIs, many patients continue to experience poor functional outcomes, suggesting that medication alone may be insufficient. Recent literature supports a biopsychosocial approach that integrates psychological interventions such as cognitive behavioural Therapy (CBT), motivational interviewing (MI), and psychoeducation to improve insight, treatment adherence, and functioning (Mueser & McGurk, 2013; Pilling et al., 2002).
This study aimed to examine the role of psychologists in supporting patients on LAIs within a public multidisciplinary mental health setting. Conducted at Mathari National Teaching and Referral Hospital in an LAI treatment clinic, the process-based study involved data collection through direct observation, semi-structured interviews, and validated psychological assessments with patients and family members. Interventions included individual and group therapy, psychoeducation, and relapse prevention strategies. Patients were followed over a six-month period to assess treatment adherence, relapse rates, insight, and perceived quality of life.
Findings indicated that patients who received psychological support alongside LAIs demonstrated improved adherence, greater illness insight, and fewer relapses. Psychological interventions also helped address trauma histories, interpersonal difficulties, and low self-efficacy. Although the study was limited by a small sample size and short follow-up period, the results support existing evidence on the importance of combining pharmacological and psychosocial interventions (Chien et al., 2022).
These findings highlight the essential role of psychologists in delivering holistic, recovery-oriented care and underscore the importance of strengthening mental health systems through integrated, multidisciplinary approaches in public healthcare.
Keywords: schizophrenia, long-acting injectables, psychological interventions, multidisciplinary care, treatment adherence, public mental health

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POLITICAL UNREST AND ITS IMPACT ON THE MENTAL HEALTH OF THE YOUTH (A CASE STUDY IN KENYA)

Author: Everlyne Okado[None]

Co-authors: James Odongo ; Simon Owuor

Corresponding Author: okadoevelyne@gmail.com

Background
The Kenya Finance Bill of 2024 led to country-wide protests and socio-political unrest that was characterized by police excesses, enforced disappearances, loss of life, looting of businesses, and damage to property. The protests, which started in Nairobi, quickly escalated to other parts of the country after the parliament's finance committee remained adamant on passing the controversial bill that sought to increase the price of basic commodities like bread and sanitary towels. Even after the climactic protests, political tension remains, with police excesses being at the centre of concerns, victims calling for justice, and an overload of information. We aimed to assess how the political unrest in the country has affected the mental health of the youth in Kenya, and how the youth feel they can be better supported.

Method
We conducted a cross-sectional study with 67 participants responding using a widely distributed Google form. The questionnaire was based on demographics, traumatic experiences, media exposure, coping measures, and depression and anxiety levels were measured with PHQ-9 and GAD-7 scales (with a score of more than 4 indicating depression or anxiety symptoms). A penalized logistic regression model was used to assess the relationship between mental health status and predictors, including age, gender, marital status, traumatic experiences, and information overload.

Results
Out of the 67 respondents, 85.1% (n = 57) showed the symptoms of depression and /or anxiety (PHQ-9 or GAD-7 > 4). The model indicated that there is no statistically significant correlation between mental health and age, gender, employment, income, education, trauma, and news overload. Although females had increased chances of reporting symptoms (OR = 2.46), the outcome was not significant (p = 0.220). The likelihood ratio test found the multivariable model not to be significantly better than a null model (p = 0.85) while the Wald's test found some parameters may contribute significantly to the model (p=0.0013).
When asked how mental health support could be enhanced, participants reported several key areas, including affordable counselling services (n = 20) and access to finances or employment (n = 16), desire to have a confidant (n = 8) and to have access to recreational facilities and activities (n = 8).

Limitations
Our study is limited by the small sample size (n= 67), which reduces the statistical power of our model to evaluate associations between the variables. Additionally, our cross-sectional study design may restrict causal interpretation.

Conclusion
The high prevalence of mental health problems in our sample suggests a higher burden in the general population. Although the sample size limited the predictive model, and no variable was significantly associated with the participants' mental status, the model suggests these factors may play an important role. Our findings also suggest that mental health outcomes may not be determined by a single factor but rather by numerous factors that may overlap. More research with a larger sample size needs to be conducted to clarify these relationships.

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Financing Mental Health Integration in Kenya's Primary Healthcare: Progress, Challenges, and Pathways to Sustainability under the New Health Acts

Authors: Angela Onyango[1]; Jackson Kamau[1]

Co-authors: John Mathenge [1]; Kennedy Mwangi [1]

[1] *HOYMAS Kenya*

Corresponding Authors: onyangoangela7@gmail.com, muhiajackson16@gmail.com

Introduction
Kenya has undertaken major reforms to strengthen mental health services through integration into the primary healthcare (PHC) system. This transformation is supported by the Kenya Mental Health Policy 2015 to 2030 and a new financing architecture that includes the Social Health Authority (SHA), Social Health Insurance Fund (SHIF), Primary Health Care Fund (PHCF), and the Facility Improvement Financing (FIF) Act. These structures aim to expand access and promote equity, but mental health financing remains a significant bottleneck. To support the growing mental health burden, adequate and sustainable financing mechanisms are essential, especially at the PHC level where early intervention, prevention, and community support are most effective.

Methods
A qualitative desk review was conducted to analyze national health financing frameworks, policy

documents, and relevant grey literature published between 2019 and 2024. In-depth interviews with key informants including mental health practitioners and PHC facility managers in Nairobi, Nyeri and Kajiado counties provided grounded perspectives. Thematic analysis identified barriers and opportunities related to financing, service delivery, and workforce capacity under the new health acts.

Results
Five major challenges were identified. First, there are operationalization gaps in how mental health funds flow from SHIF and PHCF to PHC facilities. Disbursement channels are often unclear and delayed, limiting timely implementation. Second, allocations to PHC are insufficient to cover the full spectrum of mental health services including personnel, medications, psychosocial interventions, and supervision. Third, the mental health services included in the SHIF benefit package lack specificity, which creates confusion at the provider level and restricts service coverage. Fourth, concerns were raised about long term sustainability, especially for marginalized populations in remote or resource poor settings where services may remain out of reach. Fifth, although the FIF Act intends to give PHC facilities financial autonomy, most facilities are still unable to make independent budgetary decisions that reflect their mental health service needs.

Conclusions
While Kenya has made commendable progress in integrating mental health into PHC and establishing UHC-aligned financing structures, the system still faces significant gaps. Strengthening mental health financing must go hand in hand with enhancing PHC capacity, especially in the context of workforce development. Recommended strategies include defining mental health services more clearly within the SHIF package, increasing targeted allocations through PHCF, improving fund disbursement mechanisms, and ensuring PHC facilities have adequate autonomy and skills to manage mental health budgets. These changes are essential to build a resilient, equitable, and community-responsive mental health system capable of delivering care across the lifespan and across all regions.

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Mental Health Realities among Youth in Nairobi County: A Research Abstract

Author: Duncan Ochieng[None]

Corresponding Author: ogiraduncan@gmail.com

Background
Mental health disorders among adolescents and youth in Kenya are a growing public health concern, often overlooked in mainstream health programming. Despite the increasing visibility of depression, anxiety, and trauma-related conditions, young people—especially those in urban informal settlements—face persistent barriers to accessing mental health care. These include stigma, sociocultural myths, inadequate service availability, and high costs of care. Rise and Thrive Youth Initiative conducted this research to assess the mental health landscape for youth in Nairobi County, identify key challenges, and inform evidence-based programming and advocacy.

Methods
This study employed a mixed-methods approach combining quantitative and qualitative data collection. A structured questionnaire was administered to 500 youth respondents aged 15–30 years across five sub-counties in Nairobi, selected through purposive and random sampling.
Additionally, 20 Focus Group Discussions (FGDs) and 10 Key Informant Interviews (KIIs) with mental health professionals, peer educators, community leaders, and affected youth were conducted. Data analysis included descriptive statistics for quantitative data and thematic content analysis for qualitative insights.

Results
The study found that 68% of respondents had experienced symptoms of depression or anxiety in the past year, yet only 12% had accessed any form of professional help. 84% of participants cited stigma and fear of judgment as major barriers to seeking support. 61% indicated they were unaware of

available mental health services in their area. Financial limitations, cultural beliefs, and poor confidentiality in public health settings were also highlighted. Respondents strongly supported youth-led peer counseling, school-based interventions, and digital mental health platforms as potential solutions.

Conclusion
The research underscores a significant mental health service gap for young people in Nairobi County. It highlights the urgent need for community-driven, youth-friendly, and affordable mental health interventions. The findings advocate for strengthened mental health education, integration of services into primary healthcare, and policy reforms to support youth mental wellness. Stakeholders, including NACADA, can use this evidence to prioritize mental health in national youth development agendas and invest in innovative, inclusive care models.

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To evaluate the effectiveness of an experiential learning intervention in improving adolescents'knowledge and understanding of self-esteem as a key component of mental health literacy

Author: Grace Mutuku[None]

Corresponding Author: graciemutuku0@gmail.com

Background
Adolescence (ages 10–19), as defined by the World Health Organization (WHO), is a critical developmental stage marked by identity formation, heightened emotional sensitivity, and increased vulnerability to mental health conditions. Globally, mental health disorders contribute to 16% of the burden of disease among adolescents, with depression ranked as the fourth leading cause of illness and suicide as the third leading cause of death among those aged 15–19 (World Health Organization, 2021). In Kenya, adolescent mental health challenges are increasingly prevalent but remain underaddressed due to stigma, low awareness, and limited access to mental health services. A 2020 report by Kenya's Ministry of Health indicates that nearly one in four adolescents experience significant symptoms of depression, anxiety, or psychological distress.
Low self-esteem, characterized by negative self-perception, feelings of inadequacy, and poor self-worth is a major risk factor that contributes to these challenges, often affecting academic performance, interpersonal relationships, and emotional resilience. Mental health literacy, defined as the knowledge and beliefs that enable recognition, management, or prevention of mental health disorders (Jorm, 2012), is critical for early intervention and adolescent well-being.

Objective
To evaluate the effectiveness of an experiential learning intervention in improving adolescents' knowledge and understanding of self-esteem as a key component of mental health literacy.

Methods
This study was conducted through DIP-CO, a purpose-driven social enterprise that equips children (3–12), teens (13–19), and young adults (20–24) with the emotional intelligence, life skills, and leadership capacity needed to thrive in a complex world. DIP-CO implements a dual-impact approach: youth-focused programs cultivate self-awareness and values-based decision-making, while parallel sessions support mindful parenting.
DIP-CO designed and implemented the Holiday Escapade program, a three-day experiential learning intervention delivered in churches and schools across Nairobi, Kenya. The program enrolled 87 adolescents aged 13–19. Activities included interactive workshops, storytelling, small-group reflections, and guided self-awareness exercises facilitated by trained DIP-CO mentors. A pre-intervention assessment consisting of four structured questions was used to establish baseline understanding of self-esteem, emotional regulation, and self-worth. On Day 3, post intervention data were gathered using attendance records and participant feedback questionnaires that captured shifts in knowledge, engagement levels, and reflections.

Results
Of the 87 adolescents enrolled, 71 attended Day 1, 77 attended Day 2, and all 87 completed Day 3.

Pre-assessment data were collected from 71 participants, while all 87 completed post-assessments. Results indicated significant improvements in participants'understanding of self-esteem and its connection to emotional well-being. Feedback revealed recurring concerns around sexuality, adolescent pregnancy, parent-child relationships, emotional development, and romantic relationships. Many participants reported increased interest in personal growth, emotional intelligence, and improved communication. Key takeaways included the importance of self-worth, healthy friendships, and making value-based decisions.

Conclusion
Experiential learning programs like DIP-CO's Holiday Escapades present a promising, community-based model for enhancing mental health literacy among adolescents in urban African settings. By fostering early self-awareness and emotional resilience, such interventions can play a pivotal role in supporting adolescent mental health, particularly in environments with limited access to formal mental health education and care services.

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The Impact of Youth First on Teachers: Enhancing Teacher Mental Wellbeing through School-Based Mental Health Programming

Author: Kate Leventhal[1]

[1] *WorldBeing India Foundation*

Corresponding Author: katel@worldbeing.org

Background:
Mental disorders are the world's leading cause of youth disability and early death. Kenya's youth are no exception: a recent Kenyan government task force called mental health a "ticking time bomb,"yet found no widely-available mental health prevention and promotion services in Kenya. Youth First provides a solution as one of the first mental health prevention and promotion programs ready for scale in Kenya.

Youth First is a teacher-facilitated, school-based program that builds adolescents'social and emotional assets while improving their overall mental health. Youth First has been implemented in Kenya since 2018 and has reached more than 180,000 students and over 4,000 teachers. Multiple evaluations, including RCTs, have shown the impact of Youth First on student well-being, including on mental and physical health and education.

Youth First may also have a significant impact on teacher mental health and well-being, but fewer studies have focused on this possibility. Supporting teacher mental health and well-being is crucial in Kenya, where teacher burnout has become a significant concern. This presentation highlights recent research suggesting significant mental health and professional benefits for teachers who are trained to participate
as facilitators in the Youth First program.

Method and Results:
This presentation reviews results of three studies about Youth First's impact on teachers conducted over the past six years:
1. A 2023 RCT, which revealed that teachers who received Youth First training and facilitated the program showed notable improvements in their growth mindset and internal locus of control, suggesting greater confidence in their abilities to influence student outcomes.
2. A 2022 pre-post teacher survey, which demonstrated significant gains in emotional resilience among teachers, with qualitative interviews revealing enhanced patience, listening skills, and an increased ability to address students'challenges.
3. A 2019 pre-post study, which showed significant improvements for teachers in burnout, mental health, emotional resilience, and classroom discipline.

Discussion and Conclusion:
These findings suggest that Youth First not only supports students'mental health and well-being but also enhances the mental health and professional growth of teachers. The results underscore the potential of school-based mental health programs to support teacher development, offering valuable insights for interventions aimed at promoting both student and teacher well-being.

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COMMUNITY-LED MENTAL HEALTH ADVOCACY IN INFORMAL SETTLEMENTS: BREAKING CULTURAL BARRIERS TO ACCESS AND AWARENESS

Author: Robina Namono Ogero[None]

Corresponding Author: namsrobina@gmail.com

Mental health remains a neglected priority in many low-income communities, where cultural stigma, misinformation, and lack of access to care hinder help-seeking behavior. In Mathare, one of Kenya' s largest informal settlements, individuals struggling with depression, anxiety, and trauma often remain untreated due to deeply rooted beliefs that mental illness is a spiritual or moral failure rather than a medical condition. Despite growing global mental health awareness, community-driven solutions tailored to informal settlements remain underexplored.

This study examines the impact of grassroots mental health advocacy initiatives in breaking stigma and improving mental health literacy in marginalized communities. The research is based on community-led interventions, including peer support networks, culturally adapted psychoeducation programs, and the integration of mental health awareness into youth mentorship and vocational training initiatives. Using a qualitative research approach, data was collected through semi-structured interviews, focus group discussions, and case studies involving youth, caregivers, and local leaders engaged in mental health advocacy.

Key Findings and Implications
Preliminary findings indicate that peer-led discussions and culturally sensitive storytelling are effective in shifting perceptions and increasing help-seeking behavior. Moreover, empowering trusted community figures such as religious leaders, teachers, and youth mentors as mental health ambassadors significantly enhances acceptance of mental health education and reduces stigma.

This study provides practical recommendations for policymakers, NGOs, and mental health professionals on scaling community-based mental health interventions to improve mental health accessibility in underserved populations. By integrating mental health literacy into community structures, we can bridge the gap between awareness and action, fostering long-term mental resilience for future generations.

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Building Resilience at the Margins: Psychosocial Needs and Family-Centered Mental Health Support for Youth Living with Sickle Cell Disease in Kenya

Author: Yvonne Ochieng[None]

Corresponding Author: yvonne.ochieng@duke.edu

Keywords: Sickle Cell Disease, youth mental health, resilience, psychosocial support, family-centered care

Authors: Ochieng A. Yvonne, MPS, Patel Sonali, Nazareth Ashita Pharm D, Njoki Mwangi, Rono Wilter, Liz Owino, Saina C. Daisy Mmed, Bonner J. Melanie Ph.D. Njuguna Festus Ph.D., & Puffer S.

Eve Ph.D.
Contact information: yvonne.ochieng@duke.edu

Background: Adolescents and young adults living with sickle cell disease (SCD) in Kenya experience layered psychosocial challenges that extend beyond the clinical symptoms of the illness. Their mental health is shaped by interactions across individual, interpersonal, and
structural levels. This study explored these multi-level experiences to inform the design of culturally grounded, family-centered mental health interventions.

Methods: Guided by the socio-ecological model and community-based participatory research (CBPR) principles, we conducted 15 focus group discussions with adolescents (ages 10–25), caregivers, and healthcare providers at three public hospitals in urban, rural, and semi-urban Kenya. Thematic analysis was used to identify needs and resilience strategies across ecological levels.

Results: At the individual level, adolescents reported emotional distress related to chronic pain, fear of early death, academic disruption, and challenges in identifying and communicating emotional needs. At the interpersonal level, participants highlighted strained family communication, caregiver emotional exhaustion, and peer isolation due to stigma. At the structural level, barriers included a lack of mental health training for healthcare providers, fragmented referral systems, and geographic inaccessibility of psychosocial services.
Despite these challenges, resilience emerged through adaptive family routines, religious faith, peer solidarity, and goal setting. Caregivers and providers emphasized the importance of safe spaces for emotional expression, tools for disclosure and self-advocacy, and more integrated mental health care within chronic disease services.

Conclusion: Findings underscore the urgent need for multi-level, culturally sensitive psychosocial interventions for youth with chronic illness. Addressing adolescent mental health in the context of SCD requires coordinated efforts that strengthen individual coping, family support systems, and healthcare infrastructure.

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Bridging the Gap: Leveraging Integrated Digital Platforms to Enhance Mental Health Service Delivery in Kenya

Author: Duncan Muhilikha[1]

[1] *Tymira Health*

Corresponding Author: duncan@tymirahealth.com

Introduction.
Mental health is a critical national priority in Kenya, yet significant barriers persist. According to national data, 75% of individuals with mental health conditions do not receive treatment, largely due to stigma, lack of awareness, and insufficient resources. This treatment gap is exacerbated by a severe shortage of professionals, with a psychiatrist-to-population ratio of approximately 1:500,000—far below WHO recommendations. Addressing these challenges requires innovative, scalable solutions that empower the existing workforce and expand patient access to care, directly aligning with the goals of the Kenya Mental Health Policy 2015-2030.

This presentation will.
1. Demonstrate the impact of an integrated digital practice management system on the operational efficiency and capacity of mental health providers in Kenya.
2. Evaluate the role of integrated telehealth in increasing patient access to mental healthcare services, thereby helping to close the treatment gap.
3. Propose a scalable, technology-driven model to support the conference's objective of strengthening collaborative action between healthcare providers, technology partners, and patients.

Methodology.
Tymira Health has developed Tymira360, an all-in-one, cloud-based practice management platform,

as a direct response to these challenges. Our approach involves providing mental health professionals (therapists, counselors, psychiatrists) with a single, intuitive toolkit that combines.
● A secure, unified Electronic Health Record (EHR) system for seamless continuity of care, which includes customizable clinical templates and encrypted, secure session notes to meet professional documentation standards.
● Automated administrative workflows, including smart scheduling and billing, to reduce the significant administrative burden on providers.
● A secure, integrated telehealth module for confidential virtual consultations.
● A powerful reporting module that generates detailed analytics and reports on clinical outcomes and practice performance, enabling data-driven decision-making.
● A patient portal to empower individuals with access to their health information and improve engagement.

Results & Impact.
Our model demonstrates that by equipping providers with this integrated technology, we can achieve significant and measurable outcomes that directly address Kenya's mental health challenges:
1. Increased Provider Capacity & Efficiency. By automating time-consuming administrative tasks like scheduling and billing, our model projects a 50% increase in operational efficiency across facilities. This directly translates into more time for clinical care, allowing each provider to increase their patient capacity and help to mitigate the challenges posed by having fewer than 500 mental health professionals in the country.
2. Expanded Access to Care. The integrated telehealth feature removes geographical barriers, allowing a therapist in Nairobi to serve a patient in a remote or underserved area. This innovation is critical for tackling the severe 1:500,000 psychiatrist-to-population ratio by making the expertise of existing specialists more accessible to a wider population, regardless of location.

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Conceptualization of Mental Wellbeing in the context of Community Health Workers within two rural and urban informal settlements in Kenya

Author: Benjamin Mutuku[1]

[1] *LVCT*

Corresponding Author: benjamin.mutuku@lvcthealth.org

Authors: *Ochwal, Victoria Akoth, Clement Otendo, Benjamin Mutuku, Stella Gitia, Stephen Mulupi*

Despite the general consensus about the importance of Community Health Workers (CHWs) among the global health community, mental health policy interventions to recognize and support optimal delivery of community health services by CHWs are inadequate, especially in Lower- and Middle-Income Countries (LMICs). Consequently, impact of stressors is particularly heightened in resource constrained settings among CHWs contributing to Mental Wellbeing challenges. This study explores conceptualizations of Mental wellbeing and implication on CHWs mental wellbeing in two rural and urban informal settings.

This study was conducted in sites within rural Kiambu (2) and urban informal settlements of Nairobi City (2) Counties. Key Informant Interviews (KIIs) (19 F, 15M), 16 Focus Group Discussions (FGDs) (62F, 63M) and in-depth Interviews (IDIs) (49 F, 43M) were conducted. Data triangulation was within body mapping workshops among CHW co-researchers (n=40). Thematic analysis of verbatim transcribed narrations was conducted to identify themes.

Mental wellbeing (MWB) perceptions among majority of the stakeholders were reportedly influenced by the environment, gender, language, age and literacy levels. MWB was mainly described among informants in positive terms and characterized within five themes of positive thinking and

understanding of oneself, the absence of illness, ability to cope and make important decisions, economic stability and positive social relationships. Conversely, majority of community members explicated MWB in negative terms characterized by mental deficiency, comparison to severe illness, abnormality and unsoundness of mind. Among the CHWs, stigma categorized as internalized, public and institutionalized was fueled by limited knowledge and awareness on Mental Health and wellbeing and social cultural experiences which reportedly limited their MWB help seeking. While positive feelings were triggered by the perceived benefit of CHWs by community members and the recent landscape shift by the provision of remuneration and digitalization of the Community Health Service, negative feelings were fueled by limited prioritization for CHWs'Mental Health and wellbeing.

Developing optimal CHWs'mental wellbeing interventions should consider co-creation and targeted efforts to increase mental wellbeing awareness thereby reducing MWB help seeking disparities fueled by current MWB conceptualizations.

Key words: Mental Wellbeing, Community Health Workers, Coping, Co-production

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Prevalence of Depression and Anxiety and Their Drivers Among Sexual and Gender Minority Youth in Nairobi City County, Kenya

Author: STACY NJANI[1]

Co-authors: Frederick Wekesah [2]; Muthoni Mathai [1]; Pius Kigamwa [1]

[1] *University of Nairobi*

[2] *APHRC*

Corresponding Author: dr.stacey.njani@gmail.com

Background
Depression is a leading mental health concern globally, particularly among disproportionately affected marginalized groups. Sexual and gender minority (SGM) youth experience elevated rates of mental health challenges, including anxiety disorders and post-traumatic stress disorders, compared to their heterosexual peers due to factors such as discrimination, stigma, and minority stress. Studies in the global north reveal high levels of depression among SGM youth, compounded by experiences of bullying, lack of social support, and internalized stigma. In Kenya, there is increasing openness toward sexual and gender minorities, however, SGM youth continue to face significant hostility. There remains a critical data gap as influences of common mental health challenges among SGM youth in low- and middle-income countries (LMICs) remain underexplored. This study addresses this by exploring common mental disorders and associated factors among SGM youth in Nairobi, where cultural, legal, and social environments differ significantly from high-income countries.

Objective
To determine the prevalence of common mental health conditions and the risk and protective factors in SGM youth in Nairobi City County, Kenya.

Methods
The study was a cross-sectional, questionnaire-based study, conducted in Nairobi County including adults aged 18 years and older residing in Nairobi. Participants were required to be fluent in English and identify as members of the LGBTQIA+ community. Snowball sampling was used to select participants from organizations working with SGM individuals. Data collection involved the use of standardized online survey questionnaires to capture demographic variables and sexual and gender identity information. The Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-7 (GAD-7), and Primary Care Post-Traumatic Stress Disorder (PC-PTSD) tools were used to assess depression, anxiety, and PTSD, respectively.
SPSS version 29.0 was used for data analysis. Descriptive statistics such as frequencies and means were calculated. To examine associations between the three mental health outcomes, chi-square tests

and logistic regression analyses were performed. Ethical clearance was obtained from the KNH-UON Ethics Committee and NACOSTI.

Results
A total of 172 sexual and gender minority (SGM) youth residing in Nairobi participated in the study. The prevalence of clinically significant symptoms was 52.9% for anxiety, 45.9% for depression, and 35.5% for PTSD. Emotional support emerged as a strong protective factor; participants who lacked consistent support had significantly higher odds of reporting anxiety (OR = 8.2) and depression (OR = 6.1). Bisexual individuals were more likely to experience both depression and anxiety compared to their gay, lesbian, or pansexual peers. Additionally, individuals with a college-level education had six times higher odds of reporting anxiety compared to those with postgraduate education. Alcohol and drug use were reported by 38.4% and 39% of participants, respectively. Systemic barriers were also evident with 48.3% expressed discomfort discussing mental health with healthcare providers.

Conclusion
The findings reveal a substantial mental health burden among SGM youth in Nairobi, driven by social, psychological, and systemic risk factors. Therefore, there is an urgent need for inclusive, affirming mental health interventions and services tailored to the unique needs of this population.

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Evaluating Rehabilitation Outcomes and Service Gaps at Ihururu Treatment and Rehabilitation Hospital: A Case Study from Nyeri County, Kenya”

Author: StellaMaris Wambui[1]

[1] *Amref Health Africa*

Corresponding Author: mastellabui@gmail.com

Background:
Ihururu Treatment and Rehabilitation Hospital is a 90-bed Level 4B specialised facility for male clients, established in August 2023 by the county government of Nyeri in response to rising cases of drug and substance abuse and limited access to affordable rehabilitation services. Located 9 kilometres from Nyeri Town, the hospital provides both chemical and non-chemical rehabilitation services. Since its inception, up to June 2025, the facility has admitted 391 clients from diverse professional backgrounds. Despite growing demand and clients' aftercare follow-ups through phone calls and the existence of an Alumni wall for continued encouragement and sharing of insights, the facility faces significant challenges in maintaining long-term recovery, with relapse rates remaining high and many clients presenting with suicidal thoughts, threats, and attempts.

Methods:
A retrospective descriptive study was conducted using patients' records from August 2023 –June 2025, analysed using Excel. Data on patient demographics, treatment outcomes (sobriety, lapse, and relapse), and identified barriers to recovery were examined. Qualitative interviews with service providers and a sample of discharged clients further explored systemic and psychosocial challenges hindering effective rehabilitation.

Results:
Of the 391 clients admitted, 52% maintained sobriety, 40% relapsed, and 8% lapsed. The majority of admissions comprised individuals aged 22-35 years, accounting for 76% of the client population within this age group. A significant proportion were identified as university dropouts. Employment status distribution was as follows: Unemployed 130(33. 2%), university students 102(26.1%), police personnel 12(3.1%), medical professionals 10(2.6%), educators 15(3.8%), and other professionals 122(31.2%). Qualitative data indicated contributing factors to relapse included weak post-discharge support, poor reintegration mechanisms, unmet socio-economic needs, and lack of life skills programmes. The facility also faces challenges such as staffing shortages, with the client-to-counsellor

ratio exceeding the recommended 1:10, being approximately 1:17, limited funding, and minimal community engagement.

Conclusions and Recommendations:
The findings highlight an urgent need for strategic interventions to improve long-term recovery outcomes and mitigate suicide risk at Ihururu Treatment and Rehabilitation Hospital. Recommended actions include integrating psychosocial support, economic empowerment programmes, and structured mental health care into rehabilitation. Strengthening community involvement, aftercare follow-up, and reintegration support mechanisms is critical. Further research is recommended to develop a comprehensive, multisectoral model tailored to the unique social and economic conditions of Nyeri County.

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Exploring the effectiveness of community-driven strategies in promoting mental well-being in Othaya, Nyeri South Sub-County in Nyeri County.

Author: Priscilla Nyaga[1]

[1] *Amref Health Africa*

Corresponding Author: priscillanyaga86@gmail.com

Background
In 2024, the Amref Health Africa THRIVE project, in collaboration with the Nyeri County Department of Medical Services and Public Health, began implementing the Othaya Primary Care Network (PCN) with a strong focus on community engagement. Through dialogues, household visits, and outreach programs, communities voiced a clear need for accessible mental health services and stronger linkages to health facilities.

Methodology
In response, mental health clinics were launched in four wards in October 2024 with support from the Sub-County Health Management Team. Previously, data from local facilities showed high patient default rates, frequent relapses, and suicides. Since the clinics'introduction, more patients have sought care, indicating a growing trust in the services.
However, the clinics face serious challenges—chiefly the irregular supply of psychotropic medication. These gaps have led to relapses, suicidal ideations, and preventable deaths. Addressing supply chain issues is critical for sustaining the positive impact of mental health services.

Result
A retrospective study (October 2024–June 2025) reviewed clinic records, patient demographics, and outcomes. Qualitative interviews with caregivers highlighted barriers, particularly medication shortages and limited knowledge among caregivers and providers. Of 120 patients, 76.6% attended follow-ups regularly, 15% relapsed, 4.1% died by suicide, and 14.1% were lost to follow-up. Most patients were female, aged 11–60, with diagnoses including schizophrenia, bipolar disorder, epilepsy, anxiety, depression, and substance use disorders.

Conclusion
The findings underscore the need for consistent medication supply, integration of mental health into primary care, stigma reduction, and the development of peer support networks. Further research is essential to guide evidence-based policies, optimize resource use, and expand community-based mental health models that promote lasting recovery and well-being.