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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

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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