Curriculum Vitae

Name: Ruvimbo Thuli Katerere

Contact Information: thulikaterere@gmail.com

Collegiate Institutions Attended:

2023 Doctor of Philosophy in Social Work
University of Maryland
School of Social Work
Baltimore, MD

2013 Master of Social Work
Tulane University
New Orleans, LA

2010 Bachelor of Arts
Franklin University Switzerland
Lugano, Switzerland

Professional Publications:

Cheung, C.K., Miller, K.A., Thomas, B.N., Lee, H., Goings, T.C., Brandon, R.E., **Katerere-Virima, T.,** Helbling, L.E., Simmons, C.D., Ross, V.A., Causadias, J.M., Roth, M.E., Berthaud, F.M., Jones, L.P., Betz, G.D., Carter, J., Davies, S., Gilman, M., Lewis, M.A., Lopes, G., Bridges, J.N., & Tucker-Seeley, R.D. (Under review). BIPOC experiences of (anti-)racist patient engagement in adolescent & young adult oncology research and advocacy: An e-Delphi study.

Cheung, C. K., Nishimoto, P. W., **Katerere-Virima, T**., Helbling, L. E., Thomas, B. N., & Tucker-Seeley, R. (2021). Capturing the financial hardship of cancer in military adolescent and young adult patients: A conceptual framework. *Journal of Psychosocial Oncology*, *40*(4), 473-490. https://doi.org/10.1080/07347332.2021.1937771

Cheung, C. K., Tucker-Seeley, R., Davies, S., Gilman, M., Miller, K. A., Lopes, G., Betz, G. D., **Katerere-Virima, T.,** Helbling, L. E., Thomas, B. N., & Lewis, M. A. (2021). A call to action: Antiracist patient engagement in adolescent and young adult oncology research and advocacy. *Future Oncology*, *17*(28), 3743-3756. https://doi.org/10.2217/fon-2020-1213

Bright, C. L., & **Katerere-Virima, T**. (2021). Going Beyond "the Moment" in Social Work Research. *Social Work Research*, *45*(2), 71-74.

Cheung, C. K., Acquati, C., Smith, E., **Katerere-Virima, T**., Helbling, L., & Betz, G. (2020). The impact of a cancer diagnosis on sibling relationships from childhood through young

adulthood: a systematic review. *Journal of Family Social Work*, *23*(4), 357-377. https://doi.org/10.1080/10522158.2020.1799897

Cheung, C. K., **Katerere-Virima, T.,** Helbling, L. E., Thomas, B. N., & Tucker-Seeley, R. (2021). Capturing the financial hardship of cancer in military adolescent and young adult patients: A conceptual framework.

Professional Positions Held:

Head of Operations and Human Resources
Rights Behind Bars
Washington, D.C.
As of July 2021

Research Assistant
University of Maryland, Baltimore
School of Social Work
Assistant to Dr. Christabel Cheung
Baltimore, MD
Aug 2019-July 2021

Therapist
City of Alexandria
Alexandria, VA
July 2017-June 2019

Community Advocate
Southern Poverty Law Center
Jackson, MS
May 2014-May 2016

Abstract

Title of Dissertation: Moving Beyond 'A white Man's Thing': A Case Study of Urban Kenyan Youth Mental Health

Ruvimbo Thuli Katerere, Doctor of Philosophy, 2023

Dissertation Directed by: Dr. Corey Shdaimah, Professor, School of Social Work

Background: Kenya is a lower middle-income country located in Eastern Africa with a population of over 54 million people and a median age of 20 (World Bank, 2020). Competing health emergencies, a healthcare infrastructure ill-prepared for crisis, and inconsistent framing of mental health in culturally relevant terms have all created a gap between mental health need and services in Kenya (Meyer & Ndetei, 2016). This study explores how 15–24-year-olds in Nairobi, Mombasa and Kisumu counties define their mental health and which resources and barriers impact their engagement with mental health services. This study was designed to contribute to the ongoing REACH-MH (Reaching, Engaging Adolescent and youth adults for Care Continuum in Health-Mental Health) project.

Methods: I used an inductive approach to answer two research questions: 1) How do adolescents/young people (AYP) define their mental health? and 2) How do relevant stakeholders describe resources and barriers to AYP mental health? For this case study focused on LVCT Health's One2One program, I used five sources of data: in-depth qualitative interviews with One2One hotline counsellors; One2One hotline data; youth focus group transcripts; stakeholder meeting notes; and government document review of the Mental Health Taskforce Report of 2020 and the Mental Health Amendment Act of 2022.

Findings: Five themes emerged from the data regarding the universality of "stress" as a concern for youth, the common conflation of mental health and mental illness, and recommendations for youth-friendly provision of mental healthcare. Overwhelmingly, study participants defined "mental health" in ways that captured broader social determinants of health, along with descriptions of "emotional, psychological and social wellbeing". Barriers to mental health included cost and a lack of trust in mental health professionals, while youth's capacity for coping and knowledge of the few, but existent, community services available were reported as facilitating factors.

Conclusions: Though challenges abound, also numerous are the strengths and resources possessed by Kenya's people who continue to solve problems and utilize ways old and new to strive toward a uniquely Kenyan conceptualization of mental health.

Moving Beyond ‘A white Man’s Thing’:
A Case Study of Urban Kenyan Youth Mental Health

by
Ruvimbo Thuli Katerere

Dissertation submitted to the Faculty of the Graduate School of the
University of Maryland, Baltimore in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
2023

TABLE OF CONTENTS

List of Tables

List of Figures

List of Abbreviations

AYP	adolescents and young people
GBV	gender based violence
LGBT	lesbian, gay, bisexual transgender
LGBTQI+	lesbian, gay, bisexual, transgender, queer/questioning, intersex, and other identities
LMIC	lower middle-income country
HIV/AIDS	human immunodeficiency virus/ acquired immunodeficiency syndrome
REACH/MH	Reaching, Engaging Adolescent and youth adults for Care Continuum in Health-Mental Health
NGO	non-governmental organization

Chapter 1: Introduction and Background

Study Background

Globally, mental health conditions account for almost 7.5% of the worldwide burden of disease (Hendler et al., 2016). In Africa, in the period from 2000-2015, healthy years lost to mental health and substance use-related disability increased by 52% (Sankoh et al., 2018). The most common mental health problems reported worldwide are depression and anxiety, broad categories that include varying degrees of severity and other more specific diagnoses, such as major depressive disorder, obsessive compulsive disorder, and post-traumatic stress disorder (Roberts et al., 2018). Since the 1960s, European and North American countries have focused on community-based treatment for those with mental health problems. This resulted in a phasing out of institutionalization, the practice of housing people with developmental, neurological and mental health differences in residential settings such as psychiatric asylums, separate from their families (Mundt et al., 2012). The current practice of psychiatry and psychology generally entails various treatments including talk therapy, pharmaceutical interventions, and holistic approaches such as group and individual psychosocial support provided in the community (Patel et al., 2007). Resources to this end have been grossly insufficient, with investment in the physical infrastructure, personnel, and public programs needed for a robust community-based mental health system often failing to meet demand (WHO, 2022).

This lack of prioritization for mental health service delivery resources is also a reality in Kenya (Marangu et al., 2014). In a resource-strapped economy such as Kenya's, competing health needs, a healthcare infrastructure ill-prepared for crisis, and inconsistent framing of mental health in culturally relevant terms have all created a gap between mental health needs and mental health services available (Meyer & Ndetei, 2016). This study explores the state of

Kenyan youth mental health by inquiring about how young people define their mental health and which resources and barriers impact their engagement with mental health services for the purpose of providing recommendations to improve access to and relevance of mental healthcare for this overlooked group.

Study Setting

The current study was conducted in Kenya, a lower middle-income country (LMIC) located in Eastern Africa with a population of over 54 million people (World Bank, 2022). LMIC is the World Bank's widely used designation based on a country's Gross National Income (Lencucha & Neupane, 2022). The people of Kenya are highly heterogenous and the land geographically diversity, including mountainous, seaside, and lakeside regions. Most Kenyans are Christians (85.5%) or Muslims (10.9%) of various affiliations who practice their respective faiths alongside traditional indigenous beliefs (Central Intelligence Agency, 2023). Ethnically, the population is comprised of more than 40 indigenous Kenyan tribes, and non-Kenyan residents who make up 9% of the country's population and include those of Asian and European descent (Balaton-Chrimes, 2021; Central Intelligence Agency, 2023). Though Swahili is widely spoken throughout the country and, to a much lesser degree, the government's official language of English, Kenya's many ethnic groups and regions have distinct dialects (Central Intelligence Agency, 2023). This diversity makes broadly generalizing the experience of Kenyans impossible and emphasizes the necessity of taking a highly localized approach to conducting mental health research and to the application of learned outcomes.

Three counties served as the sites for this study: Nairobi, Mombasa and Kisumu, each with a namesake city where primary data collected was conducted. Nairobi is Kenya's largest urban center and is the country's capital (Ingham et al., 2022) with a population of 4.3 million in

2019 (Statistica, 2019). Its location on the continent and well-connected railways have made it an important player in regional and continental politics; Nairobi serves as the United Nations' (UN) headquarters in Africa. Foreign nationals are a common sight and tourism is an integral part of the city's economy (Ingham et al., 2022). Inequity is rampant in this urban center, where over 16% of the city's population live below the national standard of poverty (Kenei, 2018), and Kibera, a sprawling informal settlement located in the city, has become one of the largest such communities in the world (Mukeku, 2018). Mombasa is located on Kenya's eastern coast along the Indian Ocean and is the country's second largest city. The county has a population of 1.19 (Statistica, 2019). An island, the old city's architecture is heavily influenced by Middle Eastern design and the county has the highest concentration of Muslims in the country. Tourism is also a key economic driver in this seaside community, which boasts scenic beaches (Ingham et al., 2022). Kisumu is the smallest of the three study locales and is Kenya's third largest city. Kisumu county has a population of 1.14 (Statistica, 2019). Considered "peri-urban", Kisumu was historically a fishing community along the banks of Lake Victoria (Roegner et al., 2020.) In recent years, fishing has become less environmentally and economically viable, and poverty and subsequent negative health outcomes have compounded throughout the county (Opiyo et al., 2018).

Absent among these study sites are rural communities, and it is important to note most Kenyans in fact live in rural locations (Ingham et al., 2022). The disparity between rural and urban areas in mental healthcare access is not unique to Kenya and is again important to note when situating this study within the context of Kenya as a whole (Dorsey et al., 2020). The concentration of mental health professionals and services in urban areas exacerbates inequity of service provision between these two areas, and poverty-related stress is more commonly found in

rural Kenya (D'orta et al., 2022). Dorsey and co-authors also found that though both rural and urban youth experiencing orphanhood reported threats to their mental health, their concerns differed; urban Kenyan youth reported greater exposure to traumatic events and rural youth reported greater hunger-related stress (2020).

Kenya is a former colony of Great Britain, gaining its independence in 1963 after 43 years of British rule (Karari, 2018). This period was marked by oppressive control and exploitation of Kenya's people and ample natural resources (Karari, 2018). "Remains" of imperial rule continue to be seen in modern-day Kenya in the country's approach to expanding its infrastructure, how wealth, including originally indigenous-owned land, is distributed, and which local and foreign investors benefit from the country's continued development (Kimari & Ernstson, 2020). Though the government bears much responsibility for post-independence corruption and resource mismanagement, it is also essential to state how a post-colonial Kenyan economy was, and still is, severely encumbered by these decades of colonialization. (Kimari & Ernstson, 2020). These consequences are visible from the national budget down to the individual standard of living for Kenyan people.

Global Mental Health

Global mental health is a burgeoning global health field increasingly focused on bringing a culturally relevant perspective to a sector historically guided by western ideas of pathology, diagnosis, and intervention efficacy (Tribe, 2014). Ample evidence exists that mental health conditions are prevalent beyond the Global North (broadly including North America, Europe, Australia and New Zealand) and necessitates investigation of the role that context plays in how mental health is conceptualized and defined, how mental health issues are addressed, and the infrastructure needed to support communities in their pursuit of mental wellbeing (Burgess et al.,

2020). Healthcare infrastructures differ greatly around the world, with varying professionals playing the role of primary mental health providers where psychologists, psychiatrists and other formally educated practitioners are scarce (Wainberg et al., 2017). In Kenya, the relatively young social work profession has evolved to include several universities that offer diplomas, certificates and bachelor's degrees in social work; master's and PhD level social work programs are still incredibly rare (Spitzer, 2019). The role of social workers varies widely, though group work and casework are common, along with social workers providing psychosocial and psychoeducational support in hospital and clinic settings, schools, prisons, and homes for the aging (Wairire, 2014). Those social workers dedicated to providing mental healthcare may earn diplomas or certificates in "psychiatric social work", but generally, social workers do not make up a significant proportion of Kenyan primary mental health providers (Muhingi & Machani, 2022).

There is an opportunity for mental health researchers and practitioners to engage in cross-cultural collaborations to better serve their communities' unique needs (Wasil et al., 2021). Challenges such as so-called "hard-to-reach" groups and dwindling resources for mental healthcare are not unique to the Global South (Africa, most of Asia, South America, Caribbean). In fact, factors such as increased vulnerability to environmental disasters and certain infectious diseases have forced LMICs to develop innovative service delivery solutions from which better-resourced parts of the world can learn (Wasil et al., 2021). The current medical care systems in the United States, including mental healthcare, are rife with inequity (Okonkwo et al., 2021). A focus on pathology and diagnosis replaces prevention efforts and wellness, with insurance companies exerting outsized control over people's health (Marvasti & Stafford, 2012). Vulnerable groups such as those living in extreme poverty and ethnic/racial minorities are underserved (Okonkwo et al., 2021). As LMICs such as Kenya work to develop more robust

systems of healthcare, including mental healthcare, they are uniquely poised to create a mental healthcare system that avoids these pitfalls of access and inequity.

AYP Mental Health

The mental health of adolescents and young people (AYPs) is of particular concern as populations in the Global South skew younger and understanding of the unique developmental needs of AYPs gains import. In 2019, the median age in Kenya was 20 (World Bank, 2022), with 20% of the population being between 15 and 24 years old (World Bank, 2022). Though COVID-19 did not have as deadly an impact in Kenya as it did in much of the Global North (Johns Hopkins, 2022), data are not yet available to indicate if the virus further impacted this population imbalance (Otiende et al., 2022). Any comprehensive mental healthcare strategy seeking to develop effective policies and practices must take into special account Kenya's young people.

For the purposes of this study, this group was further narrowed to an age range Siembida and colleagues (2021) describe as adolescence (15-17) and emerging adulthood (18-24). During these ten years, AYPs are developing the skills necessary for increased autonomy from their caregivers, navigating impulse control, beginning to form more serious romantic relationships, and potentially with that, child-rearing (Siembida et al., 2021).

In Kenya, 15% of girls ages 15-19 have given birth at least once (KDHS, 2022). Comparatively, in the same age group in the United States, 1.67% of girls have given birth (CDC, 2019). Due to a confluence of circumstances, 34% of Kenyan households are headed by someone the Ministry of Health categorizes as a youth, or between 18 and 34 years old (Kenya Ministry of Public Service, 2019). The day-to-day responsibilities of many Kenyan youth may include providing financially for themselves and/or siblings, raising children, and navigating

intimate partnerships much earlier than youth in other parts of the world (Waruiru, 2014). With these added responsibilities comes the potential for stress, anxiety, depression, and other mental health challenges (Robert et al., 2021). The dearth of elders in the community to offer mentorship and support likely exacerbates these stressors. These myriad of interacting factors highlights the importance of accounting for context when understanding mental health for Kenyan young people.

Study Rationale

This study was designed to contribute to the ongoing REACH-MH (Reaching, Engaging Adolescent and youth adults for Care Continuum in Health-Mental Health) project. REACH-MH grew out of the original REACH-AYA app which was developed in 2021 to identify risk and protective factors to youth health using a design thinking approach (Memiah et al., 2022a). REACH-AYA employed a methodology that was user (youth) centric, iteratively building on youth responses and actively collaborating with Kenyan community health workers, youth, providers and subject experts during app development, data collection, data analysis and deployment/implementation (Memiah et al., 2022a). These community-driven study procedures carried into REACH-MH and by extension, this nested study as well. Along with the Kenyan Ministry of Health and AMREF Health Africa, University of Maryland's Schools of Social Work and Medicine partnered with a Kenyan non-governmental organization (NGO), LVCT Health, to develop the project goals, and collect and disseminate data about youth mental health. The broader objective of the REACH-MH project was to identify mental health risk factors among AYPs via an app; engage in qualitative interviews to inform the development of AYP-appropriate interventions; and to identify barriers and facilitators of AYP mental health at the individual, family, community and structural levels. My in-country research from June to July

2022 included qualitative data collection to further the second and third objectives of REACH-MH.

LVCT Health is a not-for-profit non-governmental organization headquartered in Nairobi that operates satellites in almost half of the 47 counties in Kenya (LVCT Health, 2023a). Established in 2002, LVCT Health is funded primarily by USAID (United States Agency of International Development) and the United States Center for Disease Control and Prevention (LVCT Health, 2023a). The organization, headed by Kenyans with medical and public health expertise, began with a focus on reducing HIV transmission and has expanded its mandate to improving the overall health of Kenyans across the nation. The NGO now has the only nation-wide call center geared toward supporting youth health, One2One.

The One2One hotline is free and accessible to anyone in the country, with calls coming in from each across the country. One common concern that callers raise is mental health. One2One counsellors collect demographic information including the location, birth year and HIV status of callers. The system automatically documents the phone numbers from which calls are made. LVCT Health has a robust advertising campaign in which they announce their services on the radio, via social media and on television. The One2One call center also periodically sends text "blasts" with health-related public service announcement SMSs to numbers stored in their database from previous calls, encouraging recipients to utilize the free service if the need arises. Callers must opt-in to these autogenerated mass text messages.

The call center is operated by seven counsellors, each with a degree or certification in counselling, psychology, or a similar field, though none had a social work background. Comprehensive on-the job training is also part of the onboarding process. This group was chosen for their unique perspective into how people aged 15-24 describe their mental health concerns,

and what options exist in Kenya's mental health landscape for referral. This age range was established by the REACH-MH project before my involvement. In-depth interviews with call center counsellors added depth and triangulation to the focus group data collected from young people.

Purpose, Aims & Research Questions

This study aimed to understand the language youth use to define the subject of mental health in three Kenyan counties: Kisumu, Nairobi, and Mombasa, along with the factors that enable or inhibit youth mental health service uptake, and the current youth mental health landscape at the national and county levels. The language used to describe mental health can be stigmatizing and alienating, perpetuating negative attitudes towards people in need of mental health services (Walter, 2018). Understanding the phrases young Kenyans use and accept to describe their own mental health, and the topic more broadly, can be a valuable tool for developing accessible interventions that resonate with this group. Research aims were achieved using five sources of data: in-depth interviews with One2One call center counsellors; historic narrative data from the One2One call center, youth focus groups in each of the three counties; data from stakeholder meetings in two counties, and document review of government mental health policies. Knowing the language youth use to define mental health and how they experience barriers and facilitators to seeking services can inform culturally responsive and developmentally appropriate interventions and programs to improve the mental health of young people and adolescents in these counties.

Research Aims and Questions

There are two main aims of this research study meant to provide a multidimensional view of adolescent and young people's mental health in Kenya.

Aim 1: To explore the language used by adolescents and young people in Nairobi, Kisumu and Mombasa counties to define "mental health."

> ***Research Question 1***: How do adolescents and young people (AYP), aged 15-24, define their mental health?

Aim 2: To explore what factors contribute to the uptake of mental health services and inversely, act as barriers to service-seeking for adolescents and young people from Nairobi, Kisumu, and Mombasa counties.

> ***Research Question 2:*** How do relevant stakeholders describe resources and barriers to AYP mental health?

Relevance to Social Work

Within the field of Kenyan mental health research, there is little dedicated to understanding the developmentally specific experiences and needs of adolescents and young adults, though they are the largest proportion of the national population. This study will help to address this gap in literature. As the government and other large funding sources express the intent to prioritize the health of this age cohort, every opportunity to engage young people and highlight their contribution increases the likelihood that any proposed programs or interventions will have relevance to this targeted group.

Making mental health more accessible to people all over the world is also key to facilitating the self-determination of those who may have limited resources to work toward their own idea of wellness. Cross-cultural collaboration and learning were at the heart of this study which sought to exchange knowledge rather than impart it. Interested youth were trained in qualitative research methods and focus group facilitation. The young people participating in these trainings gained some tools to continue seeking understanding about their and their peers' mental health. On a global level, engaging with researchers and participants from the Global South as equal partners in mental health knowledge-building is one way to diminish the impact of inequity and injustice. Eurocentrism and imperialism have created a research and intervention environment that has historically forced Global North epistemologies onto the Global South, erasing the experiences of indigenous people (Shukla & Dash, 2020). This study is meant to add to social work's purpose of social justice which will hopefully increase opportunities for people everywhere to self-actualize.

Reflexivity & Positionality

My positionality inevitably impacted the research process. Analyzing this data provided me with many opportunities to be reflexive and consider my positionality, especially alongside my reflections whilst in-country. It was not my first time in a sub-Saharan African country, representing an American university and working with people with whom I did not share a first or indigenous language. I spent three months in Pretoria during my master's in social work program, creating a handbook for a support group that had long been operational but never codified. These two experiences had similar trajectories- I was welcomed warmly, but with some initial wariness that gradually faded as I and local project partners found both small and significant points of commonality. Constant in my mind was one call center counsellor's

description of me, used to allay another counsellor's anxiety about being interviewed for research by an outsider- "I told her you are 50/50 muzungu", she said. "Muzungu" translates to foreigner or white person, but I remember feeling heartened that our participants and partners recognized that some part of me was familiar. This theme− that I was like our study participants and also not− was recurring during data collection and throughout analysis.

In analyzing this data, I found myself recalling fondly the brief but memorable interactions with participants. I chuckled listening to audio playback of our interviews, and during transcription, would quickly remember each of their distinct speech patterns. I felt a responsibility to honor their trust in me, and make sure the understanding I communicated as we spoke would be relayed accurately and honestly in this format as well. When scheduling call center counsellor interviews, I heard concerns that counsellors did not want to appear unintelligent or be bombarded with unfamiliar vernacular, as English was not their native/first language. I sent the general topics I planned to discuss ahead of time to assuage some of these worries. At the beginning of the interviews, I had to reassure counsellors that I was only asking about things they already knew and regularly did. These exchanges caught me off guard initially; I had asked to speak with counsellors as experts on the call center and for their unique and valuable perspectives on youth mental health in Kenya, but I was treated as the expert. This was a poignant example of the power differentials inherent in the research process and the import of intentional, continuous exposure and undoing of these imbalanced dynamics.

Spurred by an anti-colonial lens, but also by own identity as a Black African from a formerly colonized state, it was important to me to highlight the potential and value of indigenous Kenyan culture whilst minimizing the role of continued colonizing influences. This was at times fraught, as some fond hallmarks of being "home" in my memory, including in

Zimbabwe or South Africa, include taking a mid-morning tea break, a most British pastime, and a staple of my time in Kenya as well. Some instances required I interrogate my internalized colonialist perspective, such as when inquiring about the role of the LGBTQ+ community as part of Kenyan youth mental health (Carlson, 2016). The data did not suggest this group was of great relevance to youth mental health service provision and not many respondents disclosed identifying as queer. Coming from the United States, where inclusion of people of various gender identities and sexual orientations is often integral to any social service provision, this was an adjustment for me. I had to be mindful not to project my own ideas onto the data and accept what respondents were saying about the limited scope of LGBTQ+-related issues. This was also an exercise in highlighting and "foregrounding" indigenous voices, part of what Carlson calls "relational and epistemic accountability to indigenous peoples" – one of the author's eight principles of anti-colonial research (2016, p. 7).

Researchers are increasingly rejecting the notion that objectivity is the only means to accomplish rigorous, robust scholarship, and in fact, the very possibility of achieving objectivity in any research endeavor (Rocha et al., 2016). To that end, Rocha and coauthors (2016) explore how biases can be useful and illuminating tools in the research process. They highlight four tenets of cultural intuition each author intentionally brings to their work, which are: professional experiences; both individual and collective familial and communal experiences; their experience with existing literature; and the process of interacting with study participants and analyzing data (Rocha et al., 2016). While aspects of my personal and professional experiences/identity may have helped me build rapport quickly with counsellors during interviews, as one example, I also took steps as outlined in the methods section to ensure that this bias did not unduly influence the integrity of this study.

Chapter 2: Literature Review

Kenyan Mental Health

The Kenyan government has recently committed to improving the mental health outcomes of its citizens. Through the introduction of policies and initiatives coming from the National Ministry of Health, including the Kenya Mental Health Policy and Mental Health Taskforce founded in 2020, a nation-wide needs assessment and funneling of resources has created more opportunities for mental health providers to reach Kenyans in need. This relatively recent push is in response to a longstanding challenge in Kenya, where 25% of people seeking healthcare services are found to also have a mental health condition (WHO Newsroom, 2021). Depression and stress/anxiety are commonly reported, as are substance use disorders (WHO Newsroom, 2021). Much like elsewhere in the world, the ripple effects of the COVID-19 pandemic increased demand for mental health services in Kenya (Pinchoff et al., 2021). As an LMIC, Kenya has had to employ a mixed approach to health service development that depends not only on top-down government and international investment, but also on community-based, hyperlocal solutions.

Integration with Other Healthcare

In many LMICs, including Kenya, mental health services are often integrated into the provision of other healthcare, most commonly, HIV treatment. The HIV/AIDS epidemic of the 1980s and 1990s was especially calamitous for the Global South, where infections spread unfettered by inaccessible new antiretroviral drugs. In 2001, over 66% of the world's new infections occurred in sub-Saharan Africa, and the region accounted for 77% of HIV/AIDS-related deaths (UNAIDS, 2001). As a result of this integration, nurses and "clinical officers",

(trained professionals with "mid-level" degrees or diplomas who supplement the work of doctors), are responsible for the bulk of mental healthcare provision (Marangu et al., 2021). Psychiatrists are especially scarce, but so too are psychologists and other formally educated practitioners (Marangu et al., 2021). Mental healthcare also occurs in conjunction with other primary care efforts such as chronic care for diabetes or respiratory disease, meaning most of the mental healthcare in Kenya is in fact delivered in non-specialist settings and by non-specialists (Ng'ang'a et al., 2018; Mwagomba et al., 2018).

An effort to train primary care health workers to recognize, treat and/or appropriately refer mental health cases began in earnest in 2005, as part of a collaboration between the World Health Organization (WHO), the Kenyan National Ministry of Health and the Kenyan Psychiatry Association (Jenkins et al., 2010). Key to this process was providing education about the characteristics of common mental health disorders (anxiety, depression, substance use disorders). This integration occurs at every level of the Kenyan health system, which can be described using six general levels; at the top is level six, or the national health hospital system, in the middle is level four, or the district health system, and level one is community health networks comprised of individual households (Jenkins et al., 2010).

Table 1. Levels of the Kenyan Health System*

Levels	Types of facilities	Mental health specialists available
Level 6 -macro	National Hospital	Approximately 20 psychiatrists and 100 psychiatric nurses total
Level 5- macro	Province Hospital	Approximately 1 psychiatrist and 2 psychiatric nurses per province

Table 1 (continued).

Level 4- meso	District Hospital	1 to 2 psychiatric nurses
Level 3- meso	Health Center	None
Level 2- micro	Neighborhood Dispensary	None
Level 1- micro	Community	None

**Adapted from Jenkins et al., 2010*

Integration of mental health and medical health services poses both opportunities to increase points of access for Kenyans in need of mental health support and the potential to undermine efforts to make mental healthcare its own health system priority. Mental "wellness" is a booming industry in the Global North, in which people in high-resource countries can access services through an app, have mental health appointments covered by health insurance, and products abound purported to reduce stress, etc. (Bauer et al., 2020; Nelson, 2019). Attaching essentially all mental healthcare to HIV or chronic illness care for the Global South relegates mental health to something supplemental, making it secondary, instead of highlighting its inextricability from overall health, as is often the case in high-income countries (Patel et al., 2018).

Task-Shifting

Task-shifting, also called task-sharing, is the practice of employing and training para-professionals or health workers from outside of the mental health specialty to diagnose, treat and appropriately refer those with mental health problems (Meza et al., 2020; Musyimi et al., 2017). The term refers to the shifting of tasks, such as providing brief solution-focused therapy and psychoeducation support, from highly trained mental health professionals, of whom there are so

few in LMICs such as Kenya, to less formally educated but trained members of the local community (Dorsey et al., 2019; Javadi et al., 2017). This arrangement allows for psychologists, psychiatrists, psychiatric nurses, and other professionals to focus their limited specialist resources on those cases of acute need (Shahmalak et al., 2019). Task-shifting has been found to be effective in decreasing client symptoms of depression and increasing self-reports of wellbeing in interventions in Kenya (Dorsey et al., 2020; Doukani et al., 2021). In similar studies, lay counsellors also reported experiencing positive effects after finding ways to contribute to their community's wellbeing and learning new skills (Chibanda et al., 2017; Wall et al., 2020).

Task-shifting in Kenya can include groups such as informal, or lay health workers/counsellors, traditional healers (TH) and faith healers (FH) (Musyimi et al., 2017). Lay counsellors can be nominated by community elders or leaders already aware of people who might do well with this responsibility (Chibanda et al., 2015). These members of the community who already have some level of trust with their neighbors are then trained to provide brief, solution-focused mental health support (Chibanda et al., 2015). In several African countries, traditional and faith healers are another resource frequently consulted by community members experiencing what are generally pathologized as mental health problems (Bitta et al., 2019). Bewitching, curses, and ancestral discontent may be blamed for symptoms of depression, psychosis, and/or emotional dysregulation (Bitta et al., 2019). Where a Western lens may suggest seeking treatment from a traditional or faith-based source conflicts with modern psychiatry, studies have shown that for many in the Global South, these expertise are sought in tandem (Gakuya et al., 2020). Part of assuming an anti-colonial framework is engaging with and fully incorporating the health supports that are already trusted and utilized within a community.

Challenges and Opportunities of the Task-Shifting Approach. Musyimi and co-authors (2017) found through focus groups including TH and FH that mistrust and stigma toward them arose from both their patients in the community and the formal mental health sector. Traditional and faith healers were challenged by patients about their knowledge and capacity to make appropriate referrals (Musyimi et al., 2017). One suggestion was for more intentional collaboration between mental health professionals and TH and FHs (Musyimi et al., 2017). This may lead to better understanding and appreciation of the role of indigenous expertise and how it fits within a community health system. This type of open dialogue can better prepare patients for the cooperation between the formal and informal health systems in their communities (Musyimi et al., 2017).

The difficulty of procuring psychotropic medication in LMICs, and the often-stark gap between urban and rural access to mental healthcare, mean the task-shifting approach cannot be considered a panacea (Javadi et al., 2017). Even with an effective lay counsellor network, once referral is established as the appropriate next step, there may be few options for procuring prescribed medication and accessing medication management care from trained professionals (Dorsey et al., 2019). Regular supervision from mental health professionals is also commonly cited as a challenge in studies examining mental health task-shifting in sub-Saharan Africa (Chibanda et al., 2017). Lay counselors have stated how helpful it is to meet regularly with mental health professionals to continue to develop their skills and to process difficult cases, though opportunities for such comprehensive supervision were few (Chibanda et al., 2017).

One area in which task-shifting offers an opportunity is to mitigate stigma in settings where people in need of mental health support might not be comfortable accessing services from a medical professional (Verhey et al., 2020). Mental health interventions conducted by local

people in their own cultural context and in their own language are also more likely to be relevant and impactful. Some older youth in Zimbabwe, another sub-Saharan LMIC former British colony, have expressed a preference for receiving youth-targeted healthcare from age peers, citing the social awkwardness of having to discuss potentially sensitive information with older people who are likely to have a relationship with their adult relatives (Wallen et al., 2021). Meza and co-authors (2020) found that teachers trained in trauma-informed cognitive behavioral therapy were uniquely positioned to support their students through parental loss. Youth could confide in and seek counsel from an already trusted adult (Meza et al., 2020). Teachers have a familiarity with their students' home life circumstances and what social resources are at their disposal (Meza et al., 2020). Some of the barriers cited for participation in this intervention, such as illness or unpaid school fees, are reflections of broader societal challenges to Kenyans' health outcomes.

Role of External Funders

In 2017, the Brookings Institute found that only four foreign donors accounted for 90% of Kenya's health development expenditure, most of which was focused on HIV/AIDS interventions (McDade et al., 2021). HIV/AIDS is the primary focus of international health-related funding to Kenya. The United States government is the biggest contributor to Kenya's HIV/AIDS response (McDade et al., 2021). And the government of the United Kingdom, The Global Fund to Fight AIDS, Tuberculosis and Malaria, and Gavi, a global vaccine alliance, are the other three foreign funding sources providing the most investment in Kenyan health (McDade et al., 2021).

The involvement of international funders in Kenya's health infrastructure brings with it opportunities and potential pitfalls. As a former colony of Great Britain, the effects of this

history are still reflected in the global health funding apparatus (Perkins et al., 2023). Calls to dismantle and move beyond the Global North's control over the Global South's development fuel ongoing efforts of anti and decolonialization (Power, 2009). One approach to anti-colonialism is facilitating the redistribution of wealth from former colonial powers to improve the lives of the historically colonized. In this vein, having high-resource nations invest in the health of Kenyans could be perceived as one form of justice. This arrangement, though, leaves LMICs like Kenya at the mercy of grantor guidelines and restrictions regarding utilization of the resources (Ushie et al., 2020) – the mandate for Kenyan health system development is filtered through the lens of the Global North.

The world's decisions about who receives assistance and for what objectives cannot be truly apolitical and have an outsized impact on aid-dependent nations like Kenya (Jordan et al., 2022). One such example of the limitations and complications of this funding dynamic is the Trump administration's ban on the inclusion of abortion as part of reproductive health strategies in Kenya (Ushie et al., 2020). This is also reflected in the current study; the NGO LVCT Health, which served as the leading Kenyan organizational partner in this study, was also founded to primarily provide HIV/AIDS health services before subsequently expanding to other facets of health, including mental health. Culturally responsive funding that adjusts to the needs of communities served instead of imposing externally determined priorities is key. This would allow Kenyan mental health services to expand beyond the HIV/AIDS space, a likely timely adjustment as new infections and deaths decrease and life expectancy for people living with HIV improves (UNAIDS, 2021).

Kenyan Adolescent and Young People's Mental Health

One of the goals and values of the REACH-MH project is to highlight youth perspectives when learning about Kenyan mental health. Because of its heavily youth-skewed population, Kenya must prioritize youth mental health if the country intends to improve the health of its citizens meaningfully (Memiah et al., 2022b). Issues pertinent to adolescent and young adult mental health in the Kenyan context include socioeconomic challenges to meeting basic needs, one of the highest international rates of gender-based violence, and relatively widespread pregnancy among girls. These numerous hardships create an environment in which youth are especially susceptible to poor mental health outcomes (Memiah et al., 2022b).

Socioeconomic Impacts of Youthful Population

Kenya and other LMICs with youthful populations experience certain socioeconomic effects related to this demographic imbalance. Unemployment is high in Kenya, at approximately 10%, but for working-aged people under 34, this percentage may reach as high as 80% (Nyerere, 2018). Large numbers of educated young people are faced with few formal sector employment opportunities, which are more likely to provide stable income, though even these salaries are often insufficient. This compounds worries about making ends meet, having obvious deleterious effects on mental wellness (Awiti et al., 2020). Young people have identified providing for themselves and dependent loved ones, managing the disappointment of relatives/parents, and failing to realize their own professional goals as causes of increased stress (Tamburinno et al., 2020). Jobs in the informal sector exist, such as selling goods at street stands or providing rides for a nominal fee as a “boda boda”, or motorcycle taxi. But these revenue streams are inconsistent, and the markets saturated (Awiti et al., 2020). Young people may experience feelings of hopelessness and despair when the trajectory from education to financial stability, and the productive future often associated with that, is disrupted (Tamburinno et al., 2020).

Addressing youth mental health requires addressing these broader socio-economic barriers to wellness.

The relationship between poverty and mental health can be described as reciprocal, with both social causation and effects (Kilburn et al., 2016). The experience of poverty puts one at higher risk of mental health challenges because of exposure to trauma, stress around meeting one's needs, and lack of resources for healthcare (Kilburn et al., 2016). Simultaneously, symptoms of mental ill mental health can result in poverty from social isolation, difficulty maintaining employment, and costly health expenditures (Kilburn et al., 2016). Kenyans aged 18 to 34 make up 25% of the proportion of those considered "multidimensionally poor" by the Kenyan National Bureau of Statistics (2020), a measure of those unable to attain their basic needs and rights, including housing, food, and sanitation. Children under 18, which would include adolescent15- to 17-year-olds, are the largest proportion of multidimensionally poor Kenyans at 48% (KNBS, 2020). A common refrain is that there is no health without mental health. But in a resource-limited setting like Kenya, where 53% of the total population is considered multidimensionally poor, the hierarchy of needs and prioritization of basic resources necessary for survival cannot be overlooked.

Intimate Partnership Considerations

Adolescent pregnancy, or pregnancy of girls aged 10 to 19, is an increasing health challenge in sub-Saharan Africa (Osok et al., 2018). According to the Kenyan Ministry of Health, in 2022, 16.2% of girls aged 15 to 19 were either pregnant or had already given birth to their first child (KDHS, 2022). Studies have shown that these girls are at an increased risk of mental health challenges such as depression and anxiety (Mutahi et al., 2022). Poverty and lack of access to educational opportunities exacerbate the sociocultural circumstances in which

adolescent pregnancy becomes prevalent (Kimbui et al., 2018). In their interviews with pregnant young people, Osok and coauthors (2018) found four main themes: depression and stress about their pregnancy; initial denial; lack of resources and medical care; and a paucity of opportunities post-pregnancy. In these interviews, young people describe their families' shame, concerns about being pushed out of school, and lack of support from the baby's father (Osok et al., 2018). A religiously conservative society such as Kenya results in pregnant girls feeling hopeless and isolated, afraid of judgment from health workers and other potential supports (Mutahi et al., 2022).

Another intimate relationship consideration relevant to youth is the high rate of gender-based violence in Kenya. Mathur and coauthors (2018) found that among a sample of almost 1800 15–24-year-old girls and women in Kenya, 19% reported experiencing sexual violence from an intimate partner in the last 12 months. Symptoms of anxiety and depression, especially related to concerns about STI (sexually transmitted infection) exposure, were associated with having experienced sexual violence from someone other than a partner but were also present in survivors of intimate partner violence (Mathur et al., 2018). In a society where violence against women is unfortunately so prevalent, adolescent girls and young women are especially vulnerable to experiencing this violence (Memiah et al., 2021). Within their sample of mostly 20–29-year-old women, Memiah and coauthors (2021) found that women who had married before age 18 were more likely to experience intimate partner violence. These gender disparities are being recognized and psychosocial programming with an expressed focus on the girl child is on the rise in Kenya (LVCT Health, 2023b).

Among adolescents, young people who identify (or are perceived) as sexual and/or gender minorities are also at particular risk of sexual and gender-based violence (Harper et al.,

2021). Stigma against LGBTQI+ (lesbian, gay, bisexual, transgender, queer/questioning, intersex and all other identities not captured) people is rooted in lack of acceptance for sexual and gender minorities, often stemming from conservative religious values (Harper et al., 2021). Youth who identify as LGBTQI+ experience violence from members of the community and intimate partners, with few options for recourse in a society that, still, legally discriminates against LGBTQI+ individuals (Haase et al., 2022). The stress of sexual and gender minoritized group status is compounded by sexual- and gender-based violence that exacerbates negative mental health outcomes, including depression and post-traumatic stress symptoms (Jadwin-Cakmak et al., 2022). In response to the myriad challenges sexual and gender minorities face, there are grassroots efforts to advocate for the human rights of LGBTQI+ young people, foster community, and facilitate resilience (Harper et al., 2021). These community-driven efforts can be leveraged to devise a truly inclusive youth mental health strategy in Kenya.

Orphanhood/Early Independence

With more than a third of the world's orphans found on the African continent, and approximately three million orphans and vulnerable minors in Kenya, the mental health of this substantial subset of adolescents and young people plays an integral role in understanding the Kenyan AYP mental health landscape (Puffer et al., 2012). Deaths related to HIV/AIDS are responsible for many of the bereaved children and young people in the Global South (Kilburn et al., 2016). Young people who have lost either one or both of their parents have difficulty remaining in school, achieving housing stability, and have an increased likelihood of experiencing symptoms of depression (Green et al., 2019). The link between poverty and poor mental health outcomes has also been shown to be relevant for orphans who face unique challenges in accessing resources. The loss of one or both parents, and the subsequent

uncertainty for orphans and vulnerable children (OVCs) often results in symptoms of trauma (Omari et al., 2021).

Though it is the case in most sub-Saharan African countries, Kenya included, that OVCs are often taken in and provided for by extended family members, some end up in institutional care or living unhoused (Omari et al., 2021). Health outcomes differ greatly depending on the housing circumstances of these young people, with "street children" being at much greater risk of contracting HIV and living with symptoms of serious mental illness (Atwoli et al., 2014). Premature parentification, or the taking on parental responsibilities before it is developmentally appropriate, of OVCs also puts a strain on this group's mental health (Harms et al., 2010). After the loss of a parent and/or guardian, orphans and other vulnerable children may become responsible for their own welfare, and often that of minor siblings as well (Harms et al., 2010). Without the necessary developmental maturity, these new responsibilities can be overwhelming for young people who are required to shift their priorities from doing well in school, for example, to gaining economic independence. OVCs and their unique needs are yet another important facet of Kenyan youth and adolescent mental health.

Chapter 3: Theoretical/Conceptual Framework

This study was conceptualized and conducted using an anti-colonial and social ecological framework that seeks to situate participants' experience of mental health within Kenya and more specifically, three urban Kenyan counties. Its exploratory nature allows for complex understandings of mental health to emerge from the data and is grounded in the premise that the people best positioned to describe and find solutions to their community's mental health needs are members of the community themselves.

Anti-Colonial Theory

Anti-colonial theory aims to recognize the lasting, deeply entrenched oppressive practices that permeate formally colonized communities and seeks to elevate ways of knowing and practices there were previously suppressed by dominant pedagogies (Lewis, 2012). I will often discuss anti-colonialism in tandem with decolonialization, as these efforts contribute to one another (Dei, 2012). Getachew and Mantena (2021, p. 361) state anti-colonialism aims to "reconstruct viable futures in the aftermath of European domination." Held (2023) calls the process of decolonialization an "undoing" of colonization.

Often aligned with resistance and activism, anti-colonialism was developed adjacent to anti-racism, feminism and other critical theories in the social sciences (Dei & Azgharzadeh, 2001). Anti-colonial social science research relies on the value of indigenous knowledge (Lewis, 2012) and defies the notion that Western/European intervention is required for peoples of the Global South to achieve a healthy society. As already discussed, mental health as a discipline is itself a Western creation, and thus, for this research endeavor, an anti-colonial approach was key to ensure the potential for discovering unique aspects of Kenyan mental health.

Titchkosky and Aubrecht (2009) assert that one of the largest promoters of global mental health development, the World Health Organization (WHO), operates under the assumption that LMICs are deficient in mental health knowledge, expertise, and appreciation. The authors posit that WHO's approach to mental illness as commonly shared problematically excludes critical cultural context, including colonial histories, from how people in "developing" countries experience challenges to their mental wellness (Titchkosky & Aubrecht, 2009). This is relevant in Kenya, where the Ministry of Health has long partnered with the WHO to facilitate the integration of primary health workers into mental healthcare provision (Jenkins et al., 2010). And as recently as 2021, the WHO and the United Nations Development Program hosted a multistakeholder meeting to identify mental health investment needs using Kenya as a test case (WHO, 2021). A critical approach to this universal conceptualization of something as socially and culturally constructed as mental health will ensure that Kenyan mental health solutions come from within, minimizing the influence of colonialist attitudes moving forward (Rocha et al., 2016).

Carlson (2016, pp. 6-7) suggests eight principles of anti-colonial research for non-indigenous researchers, many of which can be applied by non-native researchers engaging in international projects. They are:

> 1) Resistance to and subversion of settler colonialism: Acknowledges and resists the reality and impact of historical and contemporary settler colonialism to work towards the creation of a new society on Indigenous people's terms.
>
> 2) Relational and epistemic accountability to indigenous peoples: Standpoints, epistemes, perspectives, and experiences of Indigenous peoples are honored, foregrounded, and valued.

3) Land/place engagement and accountability: Acknowledges, respects, and engages with the protocols and natural laws of the Indigenous lands where [anti-colonial research] is conducted.

4) Egalitarian, participatory and community-based methods: Participants and community members contribute to the shaping of the research and the research design. The researcher embodies humility and does not elevate herself as the expert.

5) Reciprocity: Rather than focusing on taking for one's own advancement, anti-colonial settler researchers focus on what they can give, contribute, and collectively build.

6) Self- determination, autonomy and accountability: Those involved make choices regarding their involvement, anonymity, and participation.

7) Social location and reflexivity: Anti-colonial settler researchers explore the impact of their social location on the research and engage in critical reflexivity regarding the ways in which they enact and reproduce colonialism.

8) Wholism: Anti-colonial research is wholistic. It attends to values, emotion, history, and context.

This study was designed with these principles in mind and to bring to the fore young Kenyans' perspectives on mental health and their mental health needs. "Resistance to and subversion of setter colonialism" occurred as part of this study's interrogation of the impacts of colonialism in Kenya's attitudes towards mental health, economy, laws and policies, and gender and social norms. Both the historical context for and current implications of colonialism are taken into account. The qualitative methods used here honor Kenyan youth voices, highlighting

the diversity and value of youth perspectives to further epistemic accountability to indigenous experiences. This was also intended to inform potential mental health improvements, by Kenyans, versus highlighting Kenyan deficits in contrast to colonialist norms. While in Kenya, I adhered to the cultural workplace norms of our partners at LVCT Health, accommodating partner and participant schedules, preferences for meeting locations and participating in protocols like conforming to hierarchal processes for scheduling meetings. Methods employed as part of this study aimed to be egalitarian, participatory and community-based. The call center in-depth interview guide was developed in conjunction with Dr. Memiah, a Kenyan-born researcher with youth mental health expertise. I used member-checking with interview participants to ensure clarity of the interview guide, that I understood their responses, and to elicit their feedback about themes as they began to emerge. I actively resisted being elevated as an expert. One opportunity for reciprocity was qualitative research and focus group facilitation trainings I helped conduct as part of each county visit. This was one formal avenue through which the UMB research team contributed to our partners and participants' knowledge, but this also occurred informally when call center counsellors asked me about my own experiences providing mental health services to youth, working with incarcerated clients, etc. One-page summaries of findings, with potential next-steps per the data, will also be disseminated to study partners. Assent and consent, along with clear statements and follow-through that there would be no negative consequences for either refusal or involvement in the study allowed participants to exercise self-determination. Responses are all confidential and for focus group and call center caller participants, anonymous. Critical reflection, including the implications of my positionality on these data are described in this dissertation, and were discussed openly with study participants. Case study methodology that

considered multiple perspectives and how they interacted, and the inclusion of historical context helped further wholism.

Part of an anti-colonial approach to global mental health research is applying a constructionist perspective. This approach calls into question the objectivity of the delineation between "health" and "illness" (White, 2017). Cultural context dictates the generally accepted metrics for wellness, disease, what is within 'normal' limits or without, who is labeled with a diagnosis, by whom, etc. Therefore, understanding mental health in Kenya must take into account the cultural and social beliefs most commonly adopted by people of the locale. Carlson (2016 pp. 6-7) defines "Relational and Epistemic Accountability to Indigenous Peoples" as ensuring anti-colonial research is aligned with how Indigenous peoples define their own well-being.

White (2017) also recounts how psychiatry's historical insistence on being an objective science led to a backlash of skepticism, including accusations that the profession was being used as a tool for oppression along gender, ethnic, and socioeconomic lines. In the United States, racial/ethnic minority youth are more likely to be misdiagnosed (Liang et al., 2016) or diagnosed with psychotic and behavioral disorders than their white peers (Muroff et al., 2008). Class, or perceived socioeconomic status, can also impact whether, and with which diagnoses, young people are labeled (McLaughlin et al., 2012). Recognition and examination of the social construction of mental health can contribute to creating a more just and equitable mental healthcare system. We can better appreciate how, why, and with what impact labels such as "depression" or "schizophrenia" are used in the Kenyan context by applying a constructionist lens (Jakubec & Campbell, 2003). The American Psychological Association's Diagnostic Statistical Manual was not developed in a vacuum, and revisions such as removing

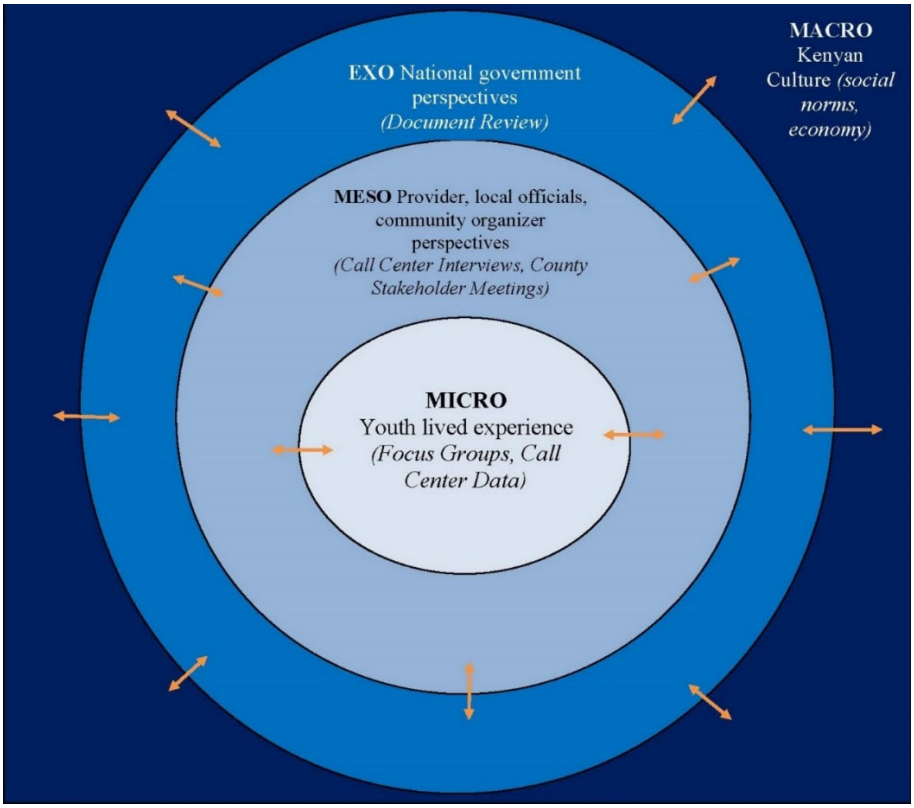
homosexuality from the list of sexual disorders serve as one example of how the Global North's understanding of "sickness" or the relationship between morality and medicine shifts with the times and in response to critical activism and scholarship (Zijlstra, 2014). Any attempt to simply translate social and cultural constructs from their place of origin in the Global North onto the ever shifting and complex societies found elsewhere in the world is a missed opportunity to discover the richness of mental health as a truly global field.

Systems Theory

The prevalence of certain mental health issues, their complex presentations, and subsequently, the approaches needed to address these challenges, can be considered using the micro, meso, exo and macro systems famously described by Bronfenbrenner's ecological systems theory (1977). Taking a macro perspective, Kenya is considered an LMIC (World Bank, 2015), which dictates its status on the global stage and position within the international development funding apparatus. On an exo level, the national government has articulated its prioritization of mental healthcare as part of a larger public healthcare strategy, launching a "Mental Health Action Plan" for the years 2021-2025 (Kenya Ministry of Health, 2021). This plan includes four key objectives: strengthening mental health governance and leadership; prioritizing promotive and preventative mental health; improving access to quality mental health services; and strengthening mental health systems and infrastructure (Mental Health Action Plan, 2021). Each of these broad objectives includes numerous specific action plans such as the establishment of independent mental health boards at the national and county levels, focusing services to prevent suicide and explore harm reduction strategies for substance use disorders, and including "comprehensive" mental health care as part of universal healthcare coverage (Mental Health Action Plan, 2021).

The three counties that serve as this study's settings have their own county-level governments, boards, community health centers, etc. that work to serve the local population's unique mental health needs at the meso level. Mental health services and resources available to individual youth vary vastly depending on household makeup, whether they are enrolled in school, their gender, and numerous other factors (Osok, 2018). Youth's self-reported, micro level experience of mental health within and across Kisumu, Nairobi and Mombasa counties create the final component of this application of the ecological systems theory. Bronfenbrenner's theory, as it has evolved, has especially highlighted the importance of understanding the intricate interactions between these various systems (Ryan, 2001). The social ecological model is itself a potentially oppressive framework; one that centers bureaucracy and formalization of a community's innate ways of functioning. This is especially true if power and influence are concentrated in the outer rings and those on a more micro level are unable to exercise agency (Adu & Oudshoorn, 2020). Its inclusion here is descriptive, as one way of depicting the Kenyan health system and of situating the five sources of data utilized. Though the social ecological model may appear to be incongruent with anti-colonial theory, the two serve different purposes in this study. My interpretation of Bronfenbrenner's model does not assume that power moves only from the external spheres inward but looks to explore ways in which influence can go outward as well. This study used multiple data sources to illuminate the concept of Kenyan mental health from the exo/macro, or national/global level to the micro level by analyzing first-hand individual accounts. As this study is part of a broader project to develop public health interventions in the three research settings, having both a systemic and individualized understanding of the issue of mental health will facilitate a more effective approach (Eriksson et al., 2018).

Figure 1. Social Ecological Model of Multi-Perspective Analysis of Kenyan Youth Mental Health



Social Work Tenets

Though I was a member of a multidisciplinary team including researchers from sociology, medicine, and public health backgrounds, at the heart of this study are several social work tenets. An inductive approach guided the qualitative methodology of this study, in which research questions, interview guide development and data collection were all to build knowledge and practice around Kenyan mental health. Striving toward social justice, as social workers are called to do, requires examination and critique of existing power structures (Khan, 2019), or what Carlson describes as resistance and subversion of settler colonialism (Carlson, 2016). One must also acknowledge the possibility that pre-colonial Kenyan society also engaged in

oppression. One way to return power to indigenous people is to value and uplift the participant perspective as expertise and to engage in person-centered research (Khan, 2019). A strengths-based perspective in describing the systemic and individual challenges of mental health in these three Kenyan counties was also purposeful in this study. Though the nation, and the counties of Kisumu, Nairobi and Mombasa, have limited resources and lack long-standing experience developing and managing an extensive mental healthcare system, people in these communities have long found ways to care for themselves and each other. Recognition of the dignity of these efforts and capitalizing on and bolstering these existing cultural strengths was the intent of this study's exploration (NASW, 2021).

Chapter 4: Methodology

This study examined how adolescents and young people in three Kenyan counties define mental health and the barriers and facilitators to their seeking mental health services. Using multiple sources of data, including data from providers who work with youth, policies and government reports that shape mental health practices at the national level, and most importantly, youth themselves, this study aimed to provide valuable insights into the landscape of Kenyan youth mental health.

I used an inductive approach to answer each research question.

Research Question 1: How do adolescents and young people (AYP) define their mental health?

Research Question 2*:* How do relevant stakeholders describe resources and barriers to AYP mental health?

The research questions were developed to explore the subject of youth mental health both nationally and in the context of Nairobi, Kisumu, and Mombasa counties respectively. As such, I analyzed multiple perspectives to learn about Kenyan mental health and within that, Kenyan youth mental health.

Case study methodology informed my approach to organizing the multiple sources of data utilized in this study. In this study, the "case" is bound by both time and place (Baxter & Jack, 2008), with LVCT Health at the center of primary data collection. All primary data was collected between June 2022 and August 2022, and Kenya generally and Kisumu, Nairobi and Mombasa counties more specifically define the limits for the locale of interest. As the question of "how" is central to this endeavor, case study methodology is an appropriate fit (Yin, 2018).

This study originally only included counsellor interviews, but upon arriving in Kenya, and hearing from counsellors, youth, and other stakeholders about the state of Kenyan youth mental health, it was clear a broader analysis would provide integral context to counsellor interview results. This resulted in what Yin describes as an embedded single-case design; the call center interviews, call center data, focus groups, and stakeholder meetings were all sources available to me through our partnership with LVCT Health (2018). In furtherance of what Njie and Asimiran (2014) call the "wholeness" of a case study, the interactions – tensions and concurrence – between what emerged from these sources were central to deriving an understanding of Kenyan youth mental health.

Study Site

This study and the broader REACH-MH project were conducted in close partnership with LVCT Health. LVCT Health operates the One2One chat and call hotline, designed to cater to all Kenyan youth, responding to topics such as sexual and reproductive health and mental health (LVCT Health, 2023b). Calls are filtered through to a single site in Nairobi where trained counsellors reply using a text/chat option or by talking on the phone with young people with health-related concerns (LVCT Health, 2023b). This study only analyzed call data and did not include texts from One2One clients. Focus groups and stakeholder meetings were coordinated by LVCT Health regional leaders with extensive community organizing, service provision and, in some cases, research experience. Their partnership was vital.

Data Sources

The following sections provide details for each of the five data sources.

Call Center Counsellor In-Depth Interviews

I conducted seven interviews with One2One hotline center counsellors, six either in person or via Zoom while I was in Kenya from June 23 to July 8, 2023, and one over Zoom after my return on July 22, 2023. Written informed consent was acquired from each participant, who were all over the age of 18. This study included every counsellor authorized to respond to calls via the hotline, all being fully trained counselors except one who was at the end of their training. Six interviewees identified as female, and one as male. Counsellors all have formal education in the mental health field, including psychology and counselling. Four of these interviews were conducted in person in a private room or office at the LVCT Health Nairobi office, lasting between 40 minutes and an hour. Three in-depth interviews occurred via Zoom both while in Kenya and after returning to the United States and were between 40 minutes and one hour long. All interviews were recorded and transcribed. The interviews were conducted in English, with participants translating in real-time any local dialects or vernacular used when I asked them to help me understand. I used an interview guide to ensure that I asked each participant about their role, what AYP callers were citing as concerns, and their perspective on facilitating and hindering factors to AYP engagement in mental health services. I took brief notes during the interviews but maintained a conversational approach that allowed for discussion of matters not explicitly asked in the interview guide, which is included as Appendix A.

Counsellors' backgrounds and education varied, with no one identifying as a social worker. Degrees in counselling and psychology were common, but some hotline counsellors also had degrees or certificates in areas like philosophy, development studies, interior design, and economics. One counsellor described the education and training of mental health professionals as still being in its nascent stages. All of the counsellors apart from the one intern had worked previously in a counselling capacity, and so training at 1190 was centered on learning hotline

logistics and operation of the systems used to log calls, keep notes, and engage on the various platforms.

Table 2. Call Center Interview Participant Characteristics

Characteristic	**Total number of participants (n= 7)**
Sex	Female 6 Male 1
Average age	30 years
County of origin	Nairobi 6 Kenyara 1
Native/first language	Swahili 3 Luhya 1 Kikuya 2 Dholuo 1
Average time at the call center	2.4 years

One2One Call Center

One2One, also called "1190" for the phone number used to access the hotline, is a website and communication platform operated as part of LVCT Health and free of cost to Kenyans. This service is "aimed at meeting young people's needs in sexual and reproductive health, HIV, gender-based violence and mental health" (LVCT Health, 2023b). Hotline counsellors described having specialty areas including gender-based violence (GBV), mental health, or menstrual health, depending on their interest and previous experience. This expertise, described by one counsellor as causes they "champion", helps inform counsellors' decisions to refer clients to one another and is a source of support when a case proves challenging.

There is a research component to LVCT Health's work, the results of which inform One2One's programmatic foci; the REACH-MH project is one such example. YACH (Youth Advisory Champions for Health) is an LCVT Health-founded program in which young people provide peer education and support in their communities in the areas of health, including sexual health, gender-based violence, and mental health (Itunga, 2020). YACH acts as an important conduit to One2One, communicating how young people are talking about their mental health needs and concerns. YACH feedback were described by one counsellor as an important consideration in how One2One articulates complex or sensitive issues related to youth mental health, reflecting One2One's prioritization of the youth voice when creating content and interventions for this age cohort. Counsellors described receiving on-the-job practice in providing tele-counselling, distinct from their experience working with clients in-person.

The hotline can be accessed via phone, WhatsApp, SMS and Facebook Messenger between 8am and 10pm, with counsellors working in three shifts. Both tele-counselling and in-person therapy are provided free of charge. Counsellors have a quota, albeit not one strictly enforced, to answer 10 calls per shift. Sessions are generally under an hour and occur according to a mutually developed treatment plan established by both the counsellor and client. Counsellors all sit in the same room, answering calls and speaking via headsets or typing their responses. Clients are directed to 1190 several ways; One2One maintains a social media presence and LCVT staff prioritize raising awareness of this resource. If searching for information about self-harm or suicide in Kenya, Google will direct you to reach out to 1190 for help.

The One2One hotline has a robust system for documenting calls they receive from across Kenya. When a call is made, the counsellor refers to the caller's self-described presenting issue to assign a "reason for calling" using the broad call center topics listed on their website. These

topics include distinct issue areas such as “interpersonal relationships” “general health inquiries”, “abuse and violence” and “mental health”. Demographic information such as age and location are also collected. The callers’ initial inquiry is noted verbatim, with counselors recording how the caller described their need in English and/or Swahili. This data set can be further narrowed to reflect calls from a limited time period or from certain locales. I filtered call center data from June 1, 2022, to August 31, 2022 to only include callers aged 15-24, whose calls were categorized as seeking “mental health” support by counsellors, resulting in 89 callers. These dates overlapped with the time during which focus group, in-depth interview, and stakeholder meeting data were collected in person, resulting in more accurate triangulation. From the call center data, I retrieved descriptive statistics about youth mental health callers, and qualitative data about how callers describe their presenting problem/need.

Focus Groups

In Kisumu, Mombasa, and Nairobi counties respectively, pairs of staff engaged in LVCT Health’s community mental health efforts conducted four to five youth focus groups in their respective locale. These focus groups occurred from late-June to late-July 2022. Focus groups included young people from each locale aged 15-17 years old and, separately, 18-24 years old and ranged in size from eight to ten. Focus group duration was approximately 90 minutes and participants were provided a Ksh1000 incentive to cover transportation costs and subsidize a meal. Small American candies were also distributed. As focus group facilitators were already engaged in community youth mental health advocacy/service provision, they utilized their networks to seek focus group participants. From there, snowball sampling was used to find more group participants, with youth asking one or two peers among their contacts if they were interested and eligible to participate in the research study (Parker et al., 2019). Youth were

recruited from communities, not from LVCT Health programs or settings, meaning though there might have been some service users among focus group participants, most were not. This was done to avoid perceived coercion and to allow for a more diverse participant pool.

These focus groups were conducted in rooms at county-level governmental health centers agreed by facilitators to be easily accessible for people in the area. These rooms were located away from regular health center activities or at a time the health center was not otherwise operational to allow for participant privacy. The focus group guide used broad prompts: 1) What is "mental health" and what is your understanding of the scope/prevalence of the issue? 2) What services or resources are available locally for young people seeking mental health support? 3) What local factors act as inhibitors or facilitators to young people accessing mental health services? And 4) Do you have any recommendations for how better to serve young people in need of mental health services? Focus group facilitators recorded these focus groups and a third-party company transcribed and translated the data.

Each facilitator had a history of peer leadership, either as a member of YACH or in their current position at LVCT Health. Before the focus groups in each respective county, facilitator pairs, along with other interested LVCT Health-affiliated youth, engaged in two days of training, conducted by Dr. Fernando Wagner, me, and another UMB student. This training included content on community-based participatory research, qualitative research methods, ethics, and provided facilitators specifically an opportunity to simulate and practice focus group data collection skills.

Though discussions in a group setting can deter participants from speaking openly, especially about a potentially sensitive subject such as mental health, focus groups were still deemed the best format in which to hear a range of mental health experiences from the specified

age cohort (Rabiee, 2004). Furthermore, focus groups can be one way to employ research design to combat stigma around discussing mental health by encouraging an appropriately supportive environment (Sagar-Ouriaghli et al., 2020).

Stakeholder Meetings

In Kisumu and Mombasa counties, I was present for stakeholder meetings that included representatives from local NGOs, county-level government workers, and practitioners working in hospitals and clinics, all focused on mental health. Youth who were either current or former YACH leaders were also well-represented in these meetings. Attendance varied between fifteen and twenty attendees. I was present at the Mombasa stakeholder meeting on June 27, 2022, and the Kisumu stakeholder meeting on July 4, 2022. Three call enter interviews occurred before these meetings, and four afterward. Focus groups were also happening concurrently. These meetings were convened to gather information for the prioritization of youth mental health and invitations were sent out to representatives from all levels of the health system using the extensive network developed by LVCT Health. The same four questions posed to focus group participants were also discussed in small groups at these stakeholder meetings and groups created brief presentations using the Google Jamboard feature to report their responses. These boards, similar in format to a PowerPoint page, depicted text responses to each of the prompts, and were compiled by a designated group note-taker to include input from all group members. The prompts were not an agenda item or provided to participants beforehand. Each group was given a pseudonym and so responses shown on Jamboards are confidential.

In each instance, my role as a researcher was announced and I explained that I would be taking notes and making observations during group discussions. My observations were partially participatory in that I would provide technical assistance with Jamboards when asked, or provide

reminders about the time remaining in the given exercise (Ciesielska et al., 2018). I did not, however, contribute to the content of discussions about Kenyan youth mental health, the research topic at hand (Ciesielska et al., 2018).

Document Review

In 2020, the newly formed Mental Health Taskforce released an over 100-page report on the country's mental health and wellbeing (Ministry of Health, 2020). Most recently, and informed by these earlier efforts, President Kenyatta signed the Mental Health Act into law in June 2022 (Healthcare Middle East and Africa, 2022). This law will likely have far-reaching impacts on the future of Kenyan mental healthcare. A close read and summation of these two documents helped to illuminate the government's position regarding the necessity of and best approach for a national mental health strategy. I chose these documents because they are the most current and comprehensive mental health artifacts produced by the national government.

Rigor

Several steps were taken to improve rigor and address bias throughout this study's development and data collection phases, and such steps continued into data analysis. There was an embedded and immersive nature to my three weeks of in-country research, which addressed the inherent bias of my being an outsider attempting to understand youth mental health in this setting (Morse, 2015). Though I often could not fully participate in or understand what was being said, I was present for three focus group discussions, observing what time people arrived, the mood, etc.

I would speak casually with young participants during breaks at stakeholder meetings. I would take this opportunity to seek clarity about comments or phrases I had heard in passing, but

we would also connect on personal commonalities such as being parents. This afforded me brief glimpses into intersectional challenges youth may face, expressed in their own voice. Even my young Uber drivers, decrying the superfluity of voting in the upcoming presidential election when nothing ever improves, or the difficulty but necessity of leaving their rural homes for Nairobi to work several odd jobs to survive, provided valuable sociocultural context in which I sought to understand the mental health of young people.

To organize this almost constant stream of data, I kept a research journal, and processed experiences in real time with members of the research team, including Drs. Memiah and Wagner from the University of Maryland, along with my Committee Chair, Dr. Shdaimah. (Probst, 2015). I used a research journal to note down ad-hoc observations and conversations I had while in Kenya that might help provide important context to the data I was collecting formally. This journal is also where I processed my reactions to my experiences for the purposes of critical reflection. Though I would describe this practice as regular, I did not journal daily. Discussing the research process with staff from LVCT Health provided key cultural context and as interviews progressed, I would seek feedback from participants about the interview guide and what I was beginning to glean from the data, also known as member checking (Birt et al., 2016). I would ask participants about my wording, if the questions were clear, ensuring my meaning was being conveyed and taking their suggestions about what terminology would aid in this clarity. Engaging in continuous reflexivity also aided in keeping my positionality in perspective throughout the research process (Mackieson et al., 2019).

By utilizing multiple data sources to answer two broad research questions, triangulation, or as described by Barbour and others (2001) as crystallization, was also integral to rigor. The experience of youth and adolescent mental health was explored from various perspectives by

talking to youth themselves in focus groups, counsellors who provide call center support to youth via interviews, community service providers at stakeholder meetings, and reading the government's public position on the subject through document analysis. This was intended to provide a comprehensive, thorough, and more well-rounded view of the state of youth and adolescent mental health in Kenya, again minimizing the influence of the researcher as instrument (Noble & Heale, 2019).

Data Analysis

There were five sources of data utilized in this study and they were analyzed in the following order: 1) One2One counsellor in-depth interviews; 2) One2One call center data; 3) Focus groups; 4) Stakeholder meetings; 5) Government document review. This order was intended to facilitate the various data contributing to understanding of the other. This order also allowed for a progression of understanding youth mental health from the individual/micro level to the macro/exo level, as well as across levels. One2One counsellor responses were triangulated with One2One caller data. One2One caller data helped provide preliminary codes or common phrases to be cognizant of when analyzing youth focus group transcripts. I sought intersections between responses from youth in focus groups and themes that emerged from stakeholder meetings. All of this data was in dialogue with the government's statements on youth mental health, assessing for patterns or discord in how the topic is described. I was also able to revisit each set of data, circling back to analyze government documents alongside counsellor responses, for example, to continue to find points at which data sets interacted, observing how data from different sources was in alignment or contradiction.

Table 3. Data Sources and Analysis

Data Source	Method of Analysis	Objective
Counsellor In-Depth Interviews **RQ 1 & 2**	Qualitative thematic analysis	Counsellors have insight into youth's mental health concerns and opportunities and challenges to mental healthcare provision on an individual and systemic level
Call Center Data **RQ 1**	Descriptive statistics (age, gender, county, employment status); qualitative content analysis	Understanding characteristics of callers; qualitative data about the specific language youth use when seeking mental health support
Focus Groups **RQ 1 & 2**	Qualitative thematic analysis	Youth, in their own voice, describing what mental health means to them as well barriers and facilitating factors to service uptake as they experience them
Stakeholder Meetings **RQ 1& 2**	Qualitative thematic analysis	Feedback from mixed groups comprised of youth, providers, and local government officials about the current state of youth mental health at the county level
Document Review **RQ 2**	Content analysis	Policies, best practice recommendations, legislation from the national government ostensibly dictating mental health provision throughout Kenya

As I used multiple sources of data, methods of analysis differed as appropriate for the type of data. I conducted qualitative thematic analyses on the in-depth counsellor interviews, focus group data and data from stakeholder meetings. Document review and One2One data did not allow for complex thematic analysis, resulting in more content analysis (Bowen, 2009). The static and fixed nature of these types of data restricted my ability to explore how context impacted the qualitative inputs, and as these data were created independent of the research

process, there was no opportunity for inquiry for clarity or exploration (Bowen, 2009). For call center data, I coded caller's responses using what I learned from call center counsellors about young people's concerns and confirmed these using what the youth themselves said in focus groups.

My position to the primary data differed relative to each source. When engaging with participants one-on-one, such as in interviews, it was easy to build rapport, my approach was casual, and discussion was semi-structured. I entertained a few tangents and used informal parlance at times, I believe, making my status as researcher a bit less prominent. At stakeholder meetings, I was introduced along with the rest of the UMB research team, highlighting my foreignness and framing my engagement with participants in a formal capacity. I was present at focus group discussion sites along with our LVCT Health partners, but as I was not in the room during discussions, I was not always introduced, making me one of several people in the background, so to speak, but not actively participating.

In-Depth Interviews

Each interview was transcribed verbatim. I read all interview transcripts in their entirety to familiarize myself with the data before beginning coding. Codes were allowed to emerge from the data, organized by the broad topics included in the interview guide (Williams & Moser, 2019). These categories can generally be described as: 1) How counsellors describe themselves, their role, their qualifications, etc. 2) Who are the AYPs who call and what are their concerns? 3)What mental health resources do AYPs have? 4) What prevents AYP's uptake of mental health services? 5) And any thoughts or observations that do not respond directly to any portion of the interview guide. After categorizing each respective transcript according to these five prompts, I conducted a subsequent round of coding to collate and analyze data for codes within each of the

five aforementioned prompts. These data were analyzed using an inductive approach in which no hypothesis was tested but instead understanding of Kenyan youth mental health was expected to emerge from the data (Williams & Moser, 2019). This process continued to reduce numerous codes down to several themes, (e.g., characteristics of callers or how counsellors described users of the hotline), until saturation was reached, and no novel data emerged.

One2One Call Center

Characteristics of One2One callers were analyzed using descriptive statistics. This helped to triangulate data from call center counsellor interviews about the demographics and concerns of the callers into the call center. After focus group data was analyzed and I learned of the extent of substance use disorders, for example, it helped to put in perspective the frequency and manner in which substance use was mentioned by One2One callers during this three-month period. The qualitative information from this database was placed in one document and coded to discover common phrases in both English and/or Swahili callers employed to describe their reason for reaching out to the call center. Swahili text responses were translated into English using a translation service.

Focus Groups

Transcripts were provided to me in English for each respective county's focus groups. This was the version I analyzed similarly to the in-depth interviews. The original audio was transcribed and translated by a third-party agency based in Kenya. Each county had at least four transcripts which underwent multiple rounds of coding with the intent for themes described by youth themselves to emerge from the data. I triangulated these results with what I heard in counsellors' interviews to derive deeper understanding of issues. One example is how

counsellors described youth participation and engagement in the therapy process, as they understand and provide it, as a challenge, citing lack of mental health literacy and knowledge of "what therapy is" as the causes. But it was illuminating to hear from some youth in focus groups that they did indeed understand what was expected of them in therapy (i.e., going to talk to a person for some time about your problems/concerns), and this arrangement was not meeting their needs. It was not consistently documented whether transcriptions were from groups of 15–17-year-olds or 18–24-year-olds, so all focus group data were grouped and analyzed by county. As young people in focus groups often interjected their contributions in the discussion, opportunities for thick, extensive quotes were limited.

Stakeholder Meetings

I analyzed notes I took while observing small group discussions and the brief presentations groups made to discover themes in response to the four broad questions posed to them. Exploring emergent themes across counties to establish where responses differed or overlapped allowed for a richer understanding of the data (Kleinheksel et al., 2020).

Document Review

The focus group and stakeholder prompts meant to reveal how mental health is defined, the factors that act as facilitators and barriers to young people receiving services, and future recommendations served as "key areas" of government documents analysis (Wach & Ward, 2013). Categorizing qualitative data according to these four broad areas helped to organize documents before I commenced more specific coding (Wach & Ward, 2013). This analysis revealed the government's public stance on the matter, and a birds-eye perspective of what resources and/or interventions are needed for Kenyan mental health. One such example was the

Mental Health Amendment Act's failure to define mental health and its prioritization of processes for maintaining facility-based care (2022). Though these documents are a polished version of the government's position, tailored for public consumption, these data enriched the highly localized data found in the focus groups and stakeholder meetings. They presented another opportunity to triangulate across data sources.

Data Management Plan

Every recording of the counsellor's in-depth interviews is password-protected on a locked device. Transcriptions and coding iterations are kept on a password-protected device. Confidentiality was paramount to participants who all worked together, especially as some discussed limitations or frustrations with their roles. Participants were given the option of an alias to protect their identities further and any identifying information mentioned during interviews was removed. For recruitment, I was introduced to all the call center counsellors whilst visiting LVCT Health's Nairobi site, where I explained my role as researcher and that I would be reaching out to counsellors to request to schedule an interview. I sent individualized emails to each counsellor informing them of my research interests, sharing a few examples of the types of questions I hoped to ask them, and stressed the voluntary nature of my request. That contents of the interview would remain confidential was also communicated several times to potential interview participants.

The call center database I had access to is entirely de-identified, the phone numbers and names of callers replaced with ID numbers. Focus group participants' identities were never known to me, and participants were allowed to provide aliases. Focus group participants signed consent forms, the dissemination and collection of which were managed by LVCT Health staff. LVCT Health partnered with an outside service to transcribe the original audio recordings, to

which I never had access. The documents reviewed as part of this study are all a matter of public record.

Plans for data collection and management were approved by the University of Maryland and by AMREF Health Africa IRBs, as both parties played a role in providing oversight and accountability for the REACH-MH project. When I joined the team, my research questions and interview documents were submitted to the IRB as part of an amendment to the original IRB submission. Interview documents included the call center counsellor in-depth interview protocol and a consent form to be reviewed with each participant, with consent being confirmed by signature. According to IRB requirements, these consent forms are kept with me or in a secured location. I reiterated during recruitment and again when reviewing consent at the time of the interviews that participation was fully voluntary and that there would be no personal or professional repercussions for opting out.

Ethical Considerations

As an outsider making inquiries, I needed to communicate clearly and directly about the research process, make myself available to answer any subsequent questions, and consider how to offer support should it be needed. As I was talking with call center counsellors about their work and not their personal health experiences, there were no instances in which I was required to offer additional support after an upsetting exchange. This was a more likely outcome in the focus groups, where youth sometimes required redirection from disclosing details about their own mental health concerns to the subject of youth mental health more broadly. At each focus group meeting, LVCT Health ensured a qualified mental health professional was present on the premises, but not in the room, to offer support to any youth who were triggered or requested mental health services for themselves. Focus group participants were encouraged to discreetly

inform facilitators after conclusion of the focus group should they require professional mental health services, and facilitators would make the appropriate introduction.

Though adolescents and young adults, for the purposes of this study, are defined as 15–24-year-olds, focus groups were composed of 15-17 year olds and then, separately, those over 18. The research team decided this was best to allow for participants of all ages to feel comfortable to speak freely, disagree, and engage as equals; something deemed less likely between a 15-and 23-year-old, for example, for cultural reasons related to respecting elders. A clause was included in focus group consent forms that stated that any LVCT Health services youth were currently receiving would be wholly unaffected by their participation, or lack thereof, in this research study.

The work culture I observed in Kenya was one in which hierarchies were strongly observed and though I am confident that all call center interview participants met with me willingly, the fact that I was sampling at counsellors' workplace has the potential to have introduced some bias. I explained to counsellors both in-person when meeting them as a group and individually when finalizing interview times that I would not report the contents of interviews, nor the very fact of their participation to their supervisor. This was one way to communicate my commitment to study participants' right to self-determine, in line with anti-colonial research ethics (Carlson, 2016). Still, I cannot guarantee they believed there would be no consequences for opting out of the study.

Chapter 5: Findings

Situating the Data

Data Collection Environment

The various types of settings in which data were collected are important to consider when engaging with this study's findings. The two stakeholder meetings I attended in Mombasa and Kisumu took place in hotel conference rooms, and though they included youth health workers, they also had an air of formality. County health officials were given deference to make opening or concluding statements, with everyone using their professional titles and operating within the allotted time.

The atmosphere was markedly different around focus groups. Though they rarely began on time, young people waited patiently to begin if focus group facilitators had not yet arrived, talking amongst themselves if they knew each other or sitting quietly. These discussions were sometimes loud, boisterous, and often punctuated with outbursts of laughter. In Mombasa, late-comers were incorporated into a group that had just begun introductions with little fuss. To ensure focus group participant privacy and confidentiality, these discussions often occurred in somewhat cramped quarters in a room with a door, with youth sitting in chairs in a tight circle.

The LVCT Health office at which I conducted call center counsellor interviews and learned about the call center more broadly was in a multi-story newly built structure along a major thoroughfare in Nairobi. There was a receptionist often at the desk downstairs who would begin the chorus of "good mornings" as I entered the building and was greeted like a colleague by LVCT staff. The REACH-MH team met in a conference room that was fully equipped with audio visual equipment to facilitate Zoom meetings with anyone not in-person. The building had

a buzz about it as everyone seemed quite busy- on their way to or from somewhere. That was, until it was time to break for tea around 10 o'clock. As guests, we were often offered generous helpings of cake or other snacks to go along with tea and coffee, and this spread would entice other LVCT Health staff to help themselves as well. This provided an opportunity to chat with LVCT staff not directly involved with REACH-MH-related activities, occasionally trying out my severely limited Swahili while enjoying local treats.

Characteristics of Youth Seeking Services

Several discernible youth demographic patterns emerged from this study. Characteristics of callers into the One2One hotline are depicted in Table 4. There was data to support potential expansion of both the definition of "youth", (considered ages 15-24 for the purposes of this study), and the age groups on which to focus mental health outreach. At the Kisumu stakeholder meeting, one YACH member stated "youth" should include children as young as ten, requiring a targeted effort to reach children even before their teens, and before some commonly used definitions of adolescence. LVCT Health defines "adolescents and young people" as those between 10 and 24 years old (LVCT, 2023b) but the One2One website does not describe a target audience and does not limit its services according to age. One call center counsellor suggested:

> I'd like to see more things implemented for people of a certain age as well- older people. Like 45,50 plus. Because it's really good to concentrate on the youth. It's really good. But yeah, who raises them? Who are their caregivers?

Callers into 1190 were overwhelmingly urban, with one call center counsellor positing a reason:

> I think they [in urban areas] know more because they have more access to let me just say "technology", in one word - like phones, you can access social media,

there's this information everywhere. But for people in rural areas, it's so difficult for them to have access.

Focus groups occurred in and around urban centers, thus, participants were unable to provide a rural perspective which is relevant in a country in which most people continue to live in rural areas.

The gender disparity observed in call center data was often overstated by counsellors, who either described male callers as "very rare" or reported that "most" of their callers were male. It is relevant to note also that in the call center's record keeping, there is no option to report one's gender outside of the female/male binary; these two are the only options. This was not mentioned as a problem by youth or counsellors, and there was no discussion of gender outside of the binary or on a spectrum by any participant in this study. Youth in focus groups noted that "mental health affects us equally" but reported differences in how the genders experience and respond to mental health challenges. "For a girl, you can reach out to your mom. But for a man, mostly, to find a man talking- it is not easy."

Socioeconomic status cannot be easily discerned from call center data as that information was not captured, though 24 of 89 callers stated their occupation as "unemployed." Among the qualitative responses stating reasons for calling 1190, "losing my job" was cited as a cause for stress. In focus groups, participants explained how both being of means and going without can cause different, but potentially equally significant, mental health problems. "I can get depression because of heart break; you can get depression because you lack food. All of them are depression." Youth considered having money as a protective factor in some ways, including the apparent ability to meet one's "basic needs of life like food, shelter and clothing", but it was not

considered a solution to all life's problems. "People are hurting outside here, in our slums and even in those posh houses; it may look a posh house but there is fire inside."

In considering "special populations", all youth, women, and members of the LGBT community were named, among others, by the government's 2020 Mental Health Taskforce Report (p. 24). Though not included in either government document that I analyzed, review of literature and data from youth themselves also highlighted the unique mental health challenges of young mothers, several of whom were represented in call center data and in focus groups. "...You expect the owner of that pregnancy to offer his assistance...but she did not get that assistance. That one is affecting many girls a lot." Despite listing members of the LGBT community as citizens in need of specialized and non-discriminatory mental healthcare, the Taskforce Report did not call for the repeal of laws that make homosexuality illegal in Kenya. In early March 2023, the Supreme Court in Kenya did rule it was unconstitutional to bar an LGBT association from forming but did not go as far as to permit same-sex unions (Muiruri, 2023). This heteronormativity (an assumption of, and bias toward, heterosexuality) was also reflected in focus groups, where there was only one instance of someone self-identifying as gay. "Because I am gay- my mother would not want me to be gay but that is how I am." Call center counsellors made few mentions of receiving calls from members of the LGBT community experiencing mental health issues, saying "very few" called, or rather, disclosed, their sexual orientation. Though the other data sources analyzed suggest this is not a significant special population in understanding youth mental health, "LGBT", "lesbians" and "gays" came up rather frequently in focus group discussions, with generally negative connotations. Across all data, the overall tone was consistent: "They are not accepted" and, "That is how Africa is."

Table 4. Characteristics of One2One Mental Health Callers June-August 2022

Characteristic	Percentage of participants (n=89)	
Sex	Female:	48%
	Male:	42%
Age range	22-25:	61%
	15-21:	39%
Home County	Nairobi:	43%
	Kiambu:	16%
	Mombasa, Machakos:	6%
	Kajiado:	5%
	Murang'a, Kisii:	3%
	Bungoma, Embu, Homa Bay, Kisumu, Meru:	2%
	Busia, Kirinyaga, Kitui, Makueni, Nakuru, Nandi,Trans Nzo:	1%
Sexual orientation	"Other"/Same sex":	7%
	"Opposite sex":	93%
Occupation	Student:	58%
	Unemployed:	27%
	Employed/Self-Employed:	15%
Relationship Status	In a relationship:	31%
	Single:	69%
Language of Request	English:	82%
	Swahili:	18%

Theme One: Definitions of Mental Health

These findings reflect variation in participant responses and how individualized and personal Kenyans' ideas for improving youth mental health can be. Analysis of all data sources revealed a diversity of responses to the question "What is mental health?" Answers ranged from the specific and clinical to broad and psychosocial. The Taskforce Report used the WHO definition:

> Mental health is a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. (2020).

The Taskforce included as part of its stated purpose, “happiness” and “mental wellbeing” as being components of mental health (2020, p. 3). To measure happiness, the Taskforce recommended more widespread participation in the World Happiness Report and use of their index. The Mental Health Amendment Act did not define mental health but does define mental illness as inclusive of anyone with “substance use disorder and suicidal ideation and behavior” (2022). Youth and other stakeholder definitions of mental health focused on being free of disease and difficult emotions, but there was no mention of “happiness.” Focus group participants offered up phrases such as, “emotional, psychological and social wellbeing”, “one’s peace of mind” and “being physically and emotionally well” when prompted to share how they understand the term “mental health.” Focus group responses also included the idea that mental health challenges are not always characterized by acute mental illness and can affect anyone.

> You do not have to be crazy- I can be sane, I am okay, but there is some common stress that is bothering me, you may ask me a question, but I just explode, you wonder why is this one exploding like that?

Callers into 1190 described their mood using words such as, “tired”, “lost”, or “struggling”, and employed much more diagnostic language including saying, “I think I am having post-natal depression” or “I am feeling anxious,” phrases they learned from what one counsellor called “Doctor Google.”

The conflation of mental health and mental illness occurred in nearly all interviews, focus groups, call center data and stakeholder meetings. One focus group participant stated, “To me, my understanding on mental health is, there is a term people use and that is depression or going crazy.” Understandably, when counsellors were asked how young people talk about or define their mental health, the terms they often cite had more to do with mental ill health, which is what

prompts calls in the first place. Young people would either use diagnostic terms such as “depressed”, “anxious” or “bipolar disorder” or describe their mood as “low”, “down”, or “tired.” “Probing” was repeatedly cited as a useful tool to get to the meaning behind some of what youth shared with call center counselors, with one providing this example:

> A client will call, and they'll be like, ‘Is this 1190?’ ‘Of course, yes, this is 1190. How may I help you?’ And then be like, ‘I'm just calling to say hi.’ And then so you ask like how old [are they], where are they calling from? What are they doing at the moment- are they in school? Then you hear them say that no, they finished college they don't have a job yet. So, what are they doing? ‘Ah - I feel so stressed I don't know what to do.’ Then you see it slowly by slowly starts coming. ‘I live with my stepdad, and he's always been very negative, you know. Nothing I do makes sense for him. And then even last week maybe I was even thinking I don't even have friends. I feel like committing suicide. I've given up.’ So, it starts way from like, not really mental health but then as you probe, you now realize, ‘Oh, this is a mental health issue.’

“Stress” was heard from all data sources as being a common, albeit all-encompassing and unspecific word to describe when one is not mentally well. Focus group participants stated, “Stress is stress", and that, “Even when you have depression it is stress. Even when you have anxiety issues, it is stress.”

Youth in focus groups also used the occasion to clarify and verify messages they had heard in their communities, “You hear things. I don’t know if they are myths or misconceptions. I have heard that maybe it is caused from being bewitched. I have heard drugs and maybe accidents.” Contributing to this idea that symptoms and signs of mental illness are a bad omen

was the belief, stated more than once in youth focus groups, that wealthy families attain their good fortune by "sacrificing" one of their family members who ends up cursed and unwell. One call center counsellor stated explicitly that One2One does not provide youth with the American Psychiatric Association definition of mental health or mental illness, for example, because they would not be appropriate for the Kenyan context. She cited cultural beliefs about the relationship between mental illness and witchcraft as a challenge in building mental health awareness.

> Especially when it comes to content development. Because you need to still accommodate the spiritual aspect of it. Because in order to reach this young person, in those spiritual spaces, we have to integrate. And understand what does it mean for them and now we meet in the middle. So sometimes it becomes very difficult to actually convey messaging around that area. And that is why we work hand in hand with the unlicensed peer educators who we refer to as the peer- the youth advisory champions for health. Because they're able to tell us on [the] ground. What does it mean- like what [are] the needs of this young person? What are the cultural beliefs in terms of where they're coming from?

Some focus group participants stated that "in the community", they hear mental health described as an "unsound mind", as they distinguished themselves from the average person in their community. The tendency for some focus group participants to be knowledgeable of mental health matters suggests sampling bias as these youth were more likely to be connected to LVCT Health and not all representative of youth in Nairobi, Kisumu and Mombasa, respectively.

There were several examples of stigmatizing or language with negative connotations used to describe someone perceived to have a mental illness. "Chizi" translating to madman, nuts, or crazy was referenced by multiple data sources, often accompanied with uncomfortable chuckles

or laughter, as participants seemed hesitant to describe its meaning. Notably, this is how Kenyans would describe others. Youth in focus groups or users of the call center did not describe themselves this way- highlighting the derogatory nature of the term. Focus group participants also used terms such as “lunatics” and “abnormal” to describe mental illness. The import of language in framing mental health and mental illness was not lost to contributors to the Mental Health Taskforce Report and Mental Health Amendment. Several references to “mental disorder” were changed to “mental illness” in the Amendment. And the Taskforce document stated “wazimu” should be removed from Kenyans’ lexicon (2020, p. 43). Translating to another way to say “crazy”, this term did not appear in any interviews, focus groups, or call center data during this study.

English was the language of official government documents but was also the more commonly used language in youth’s requests to the One2One call center. Counsellors confirmed that youth were more likely to use English to describe their mental health needs, the word “stress” always expressed in English, even within a Swahili sentence. Of 89 qualitative call center responses analyzed, only 16 required translations to English, and there was no discernable pattern in the issues callers expressed in English versus Swahili. Though it is possible this indicates some selection bias related to education and/or exposure to the English language, this might also reflect how the vocabulary for mental health matters in indigenous languages is still developing (Tele et al., 2023). Language access beyond English and Swahili was framed as a barrier to youth mental healthcare provision in one stakeholder meeting, but not cited as a problem by youth in focus groups or by hotline counsellors. Occasionally, as part of establishing ground rules in focus groups, youth would collectively decide to use only Swahili and/or a

combination of English and Swahili so as not to exclude speakers of Kenya's numerous local languages.

Theme Two: Concerns Affecting Youth Mental Health

Several factors contributing to the ill mental health of youth emerged from focus groups, call center counsellors, call center data, government documents, and stakeholder meetings, though reports of the extent of these stressors at times differed.

Described by youth and call center counsellors as "relationship issues", focus group participants spoke extensively about the "stress" of their own romantic relationships and of familial dynamics. To be expected for this developmental stage, young people were preoccupied with dealing with unreciprocated advances, boy/girlfriends cheating, leaving them, etc. One caller into One2One stated, "I feel depressed after breaking up with my boyfriend last week- what can I do?" Gender-based violence (GBV) was also a commonly cited threat to mental health. Youth in focus groups described its effects, both personally and as witnesses. "You find that parents are not having good relationships at all. This child is affected by this instability." The relationship between sexual trauma and potential mental illness was well-articulated by one focus group participant, stating:

> You will find most of those who are in our stage, like 15-19, have passed through sexual assault or maybe they are passing through this violence that they see at home. So, you see these ones can lead to trauma and they get stress, and it can lead into mental illness.

Callers into the call center also mentioned GBV or stated explicitly, "My husband beats me" when seeking services. One counsellor described the recent spate of familial and intimate partner

murders that had, for better or worse, shone a light on mental health issues in Kenya, and the inextricability of mental health and socioeconomic factors:

> It's a poverty issue. It's a mental health issue. It's very difficult to tell. Because at this point in time, people are really suffering. The economy is really bad. So it's really hard to distinguish whether this is purely mental health issue or a person who has mental health problems due to their economic state. So, you find that client, or you find an individual lost his job because of COVID and went and murdered his whole family. Now will you say it's the losing of a job or will you say he had a mental health issue? It's very difficult to pinpoint. But if you- I think if you remove the poverty aspect, then a lot of the mental health issues will be dealt with. And then, yeah. Then fix relationships and even more mental health issues will be dealt with.

The frequency with which GBV was mentioned, and the way study participants described its impact, was incongruous with the brief quarter of a page of the Mental Health Taskforce Report dedicated to the subject. In the Report, the prevalence of gender-based violence in Kenya specifically was not stated; the issue was described in broad, universal terms, with the concluding recommendation that GBV survivors receive mental health services to avoid post-traumatic stress disorder.

Study participants cited early pregnancy as a major contributor to youth ill mental health but this was not included in the Taskforce Report as a Kenyan mental health priority. Focus groups discussed how early pregnancy most impacted life outcomes for the young woman, though a male participant occasionally interjected to note that making a girlfriend pregnant is stressful for them as well.

> If a boy and girlfriend are still school-going age, they can have a relationship. When the girl gets pregnant, she won't study with focus because the pregnancy is distracting her, leading to emotional stress, forcing her to discontinue her studies.

Early marriage was cited a risk factor for mental illness by the Taskforce, and as a barrier to youth mental health in at least one Mombasa focus group. Of the YACH members in attendance at stakeholder meetings, several parents were among them, including at least two focus group moderators. Aside from the stress of finding out one is pregnant whilst still school age and living with parents and guardians, the economic challenges of providing for oneself, let alone a dependent once the child arrives, are compounded for young Kenyans.

At the heart of what caused youth's mental health to suffer was money, or more accurately, the lack of it. One call center caller stated, "I want to go back to school but we can't afford it, now it's stressful." Youth also described frustration at not being able to afford necessities such as rent, food more nutritious than "chipati" and menstruation products. The outsized influence of peers at this age contributed to participants' feeling pressure to keep up appearances. "As a youth, you want to be current; your clothes need to be smart- you don't have cash. At that point, you'll start worrying and your mental health won't be so much correct." Focus group participants identified the dearth of employment opportunities as a contributor to their economic woes. "Like now to get a job is very hard. You have all the certificates and everything but to get a job is hard. So, you find your morale goes down." From these economic difficulties, youth cited "sponsors", "sugar daddies" or "mubabas" as one way for, young women especially, to cover their expenses.

> Especially if the home is experiencing poverty, yet you witness others eating well, dressing well. This compels one to fall for a man with ready money and his promise

> of a good life, all likely leading to early pregnancy because the money offered is in exchange for sexual favors.

These relationships create a dynamic also ripe for GBV and transmission of sexually transmitted infections. These men with means are often older, resulting in a power imbalance between them and young women with far fewer resources.

Though new HIV infections have decreased significantly in Kenya and health outcomes for those with HIV/AIDS have vastly improved (UNAIDS Estimates, 2021) there were differing perspectives on how much bearing this chronic condition continues to have on youth's mental health. Youth in focus groups consistently cited HIV-related concerns, stating, "When one finds out that he is [HIV] positive, he puts in mind that he is dying. He will suffer mental health" and, "You may be on medication and people will still find out. [Your mother] sees you are the perfect child and maybe you haven't shared with her that you have the disease." Youth reported how the hardship of adhering to medication and the social stigma and shame of infection could negatively impact one's mental health. HIV/AIDS-related issues were also cited in stakeholder meetings as a relevant factor in understanding the scope of mental health challenges affecting youth. In contrast, some counsellors de-prioritized the role of HIV/AIDS when addressing youth mental health. One counsellor described current HIV courses on campuses as "redundant" because education and awareness on the issue has been in "every space" for so many years. The Taskforce Report also cited the government's national response to the HIV/AIDS crisis of the 1990's as a template for how it might respond to current mental health challenges, describing the burden of mental disorders as an "epidemic," and framing HIV/AIDS as a past priority (2020, p. 2). Another hotline counsellor stated that though there has been a widespread campaign to reduce new HIV infections, one could not assume that this knowledge was commonplace. "When it

comes to HIV and AIDS many young people of a certain age do not know. Honestly...you'd be surprised."

Substance use and abuse were often considered a high priority for youth mental health. Focus group participants mainly spoke about alcohol and "bhang", or marijuana, use. Callers into One2One mentioned "bhang" numerous times, stating they were reaching out to "quit" or "stop using", or seeking support for a loved one whose bhang use was "affecting our daily life." "Miraa" or khat, another plant native to Eastern and Southern Africa and chewed for its stimulant properties, was cited as a problem for youth. One2One counsellors reported receiving some drug-related calls, but not proportionate to the problem. One counsellor explained that these types of calls were "referred out" and that the existence of the National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA) hotline means One2One is not the first line of response to substance use disorder-related issues. The Taskforce Report describes the all too familiar occurrence of "young men loitering the streets of urban centres in states of advanced intoxication with drugs and alcohol" and how this "continue[s] to prick our collective conscience" (2020, p. 10). Marijuana use specifically was on many people's minds as one of the forerunning presidential candidates in the August 2022 election was campaigning on the promise to legalize recreational marijuana. Much like in the United States, there were differing opinions as to whether this was a reasonable response to an already-common practice or a governmental endorsement of criminality, and as heard in focus groups, a gateway to potential mental illness.

Suicide was mentioned in every focus group, was explicitly cited as the reason for several One2One callers reaching out, and was identified by the Taskforce as a major aspect of youth mental health. One call center counsellor explained, "We have had a lot of suicides of late, especially late last year and early this year. There's been suicidal cases all over news everywhere.

Young people have been killing themselves." The young ages of these children have caused alarm, serving as one impetus for, and rationale behind, the increased prioritization of mental health in Kenya. The tone with which focus group participants discussed suicide was at times almost casual, noting what a common occurrence it had become. One participant suggested it was something to even be teased about - "I had a friend who wanted to throw herself in the river- that becomes what they keep reminding them about, laughing at them that, 'You wanted to kill yourself.'" One young participant did express concern about this issue, sharing about a friend:

> I have a friend who when he is stressed or if there is something bothering him, he disappears. So, you cannot know if he has gone to commit suicide. Someone like that one, how can I help him? He will not share out when he stressed up - he will just disappear.

Complicating any attempts to respond to and treat those who have exhibited suicidal behaviors or ideation are the laws criminalizing and penalizing such behaviors. Though there are some calls to repeal to this law, people continue to be prosecuted for suicidal behaviors, a crime punishable by a fine and/or up to two years jail time (Ochieng & Kamau, 2021). The Mental Health Act of 2022 includes "a person with suicidal ideation or behavior" in its definition of "person with mental illness" but makes no other mention of suicide (p.329). The Taskforce Report cites these laws as a barrier to help-seeking, as did call center counsellors, but youth participants in this study made no mention of these statutes.

Theme Three: Challenges and Barriers to Youth Mental Health

Stakeholders, including youth service-users, cited several challenges or barriers to efficacious access to, and provision of, mental health services at the local and national levels.

Counsellors reported several challenges to providing mental health services to young callers, both practical/technical and more systemic. Prank callers, estimated between 40 and 60 percent of calls, caused great disruption to the hotline, engaging lines and prohibiting callers with legitimate concerns from getting through. More frequent at night, these prank callers were "bored", calling to tease and harass counselors with no intention of genuinely engaging in services. Internet connectivity problems and transferring the call center to a new building made providing consistent and reliable services to callers challenging. Data was lost when the One2One counsellors changed location, interrupting counselling services that had begun and making follow-ups with first time callers to initiate counselling difficult.

These technical barriers to providing reliable mental healthcare may have contributed to youth lacking trust and confidence in mental health professionals. Young people were unconvinced that counsellor communications were private, sharing rumors they heard that these calls would be "leaked." Provider stakeholders in Kisumu lamented a problematic trend in which unlicensed individuals assume the title of "counsellor", charging fees and offering services not backed by training, unregulated, and free of accountability to standards of care intended to protect clients. Describing these services as "empowerment", one focus group participant stated how these fees hurt clients, saying, "You cannot empower someone without a fee, the empowerment maybe is helping him but at the same time, you are punishing him." Youth were also wary of counsellor's commitment to confidentiality, suggesting, "I tell you my deep secret. Of course, you are also a human being, you will get another client and you will tell them my story." Potentially supporting youth's concerns is somewhat vague language dictating professionals' responsibility to confidentiality in the recently passed Mental Health Amendment Act. In this document, disclosure of "confidential information" is permitted when ordered by court, required by law, and/or to

"prevent likelihood of serious harm" (2022, p. 345). It continues that disclosure is also legally permitted when necessary for treatment, and when it "is in the best interest of the person with mental illness and it "is in the public interest" (2022, p. 345). These final two scenarios, stated so broadly, allow mental health providers much discretion in deciding what of their clients' mental health information they share.

More systemic are problems finding services to refer clients in their vicinity. Mental health services, and health services more broadly, are concentrated in more populated parts of Kenya, leaving few options for callers from rural areas and/or those in need of specialized care to get appropriate care. Though counsellors cite the One2One hotline's national reach as a facilitating factor for youth help-seeking, ensuring continuity of care and finding in-person facilities for diagnostic psychological assessments, specialist care, and other services impossible to do remotely is a barrier to best serving youth in need of mental health support. A dearth in available services is thus two-fold; there are few mental health resources available generally, but also very limited options for specialist care.

One mental health issue for which callers frequently reached out to One2One exemplified this challenge- suicidal ideation and behavior. Unlike for substance use, there is no dedicated suicide hotline, making One2One counsellors the primary resource for people seeking help for suicidal ideation. Responding to a client in crisis and at imminent risk of self-injury is exponentially more difficult to do remotely, as is assuring such clients have the appropriate follow-up appointments once out of immediate crisis. "Sometimes people just disappear, and you don't know what happened with them," one counsellor admitted. Services such as mobile crisis response units were not available, so counsellors relied on clients to put counsellors in touch with trusted people in their support system. The police, one party equipped to physically respond to an

emergency in a timely fashion, although not necessarily best suited to handle mental health crises, were also not an option. As suicide attempts are punishable by law in Kenya, understandably, counsellors were unwilling to reach out to the police in such cases.

These infrastructural challenges are echoed too in the Taskforce Report, which, along with those in "slums" and on the outskirts of urban centers, describes people living in rural areas as, "the poorest of the poor, with even lower access to social services such as education and health, including mental health – yet they are the most at risk" (2020, p. 37). A group of stakeholders in Mombasa stated that "Level 2 facilities at the grassroot cannot dispense psychiatric medicine. There are no mental health specialists such as psychiatric nurses or psychologists and counsellors." Level 2 facilities are situated in neighborhoods, making them much more convenient than the next level of facilities which would serve a significantly larger catchment area. Gaps in documentation such as electronic health records and a lack of a national network of mental health providers was included as another barrier to continuity of care.

From every data source, there was one challenge raised repeatedly: cost. One focus group participant described wanting to use counselling services at a mall but being unable to receive services after arriving because "...I did not have even a shilling." Call center counsellors heard constantly from their clients about the difficulty of paying for services, one sharing an anecdote about a prominent public figure, a radio deejay:

> For me, the other thing I think generally, when someone asks to go to see a therapist and they're going through a mental health issue, the pricing- it's too high. Like those who have jobs, middle class and upper class, they can afford it. But now we are now looking at all these other people who are not able to afford it. The poor, poor. The poor don't have jobs. So it's hard on them. They can't afford it so what's next

> for them? It's just that they'd say that we are dealing with it as well as we want to but, you know. Like a month ago, there was a deejay who actually committed suicide because he went to seek for help and he was told the price is 6,000Ksh [approximately $40.00 USD] per session. So, he's like, I have come for help from you and you tell me such an amount- how?

This did not impact counsellors' ability to provide services through One2One, which are always free of charge, but would come up when counsellors were preparing to refer clients to specialists or other in-person services. The governmental mental health programs and services that do exist are underfunded. The Mental Health Taskforce identified "underfunding of the [mental health] sector" as a reason for "poor service delivery" (2020, p. 41). And stated that "medication and psychosocial follow-up is too expensive for the majority of Kenyans who live on less than a dollar a day (KNBS, 2016)." The economic circumstances in Kenya more broadly, in which unemployment is high, and people are struggling to make ends meet, have created an environment in which prioritizing mental healthcare has been a challenge. The Taskforce admitted as such by stating Kenyan mental health has been long neglected, "as we spent most of the available energy and resources on trying to fix our economy and with equal vigor, the challenging politics of our country" (2020, p. 10). One counsellor described the impacts of this systemic dysfunction on youth mental health this way:

> And honestly, I feel like more and more young people are just becoming self-aware of the fact that there's so many things that happened to them that are not - because especially in the political and economic climate we're in right now - it's not their fault. But it does affect them. So just wanting to understand, 'Is everyone else going through the same things I am, or am I just alone in this world?', you know?

Beyond cost being prohibitive, call center counsellors stated callers would often ask, “What can you give me?” when invited to regular, in-person therapy. When asked if youth were more likely to engage in person, one counsellor stated,

> In my opinion, if you're not paying money to get the service then you don't feel obliged to actually show up because it’s a service that is offered. But then if you are actually paying for sessions and you want to come and, actually, you know - value for your money.

When asked to share their thoughts on this conundrum, the counsellor continued:

> Yeah, they don't value it because, like I don't know. It's like, honestly, I cannot even explain. It should be like you should be happy you're actually receiving the service for free. You should be showing up and getting help. But then, no, even when it’s free some people still ask for incentive. They're like, ‘Okay, so now are you going to give me something at the end of it?’ and you’re like, ‘The service is already free!’ [exasperated chuckle].

Youth from focus groups provided a different perspective on this matter, using “token” and “reimbursement” to mean incentive, explaining, “If there is a token, they will go, they do not want the free ones. Here in Koch, [Korogocho, Nairobi informal settlement] people are used to reimbursement. But now those who are suffering genuinely and need assistance are the ones who will go.”

Affecting Kenyans from all walks of life and often simply described as “culture,” negative attitudes about people with mental illness and seeking mental health services were common. This stigma was cited by call center counsellors, youth in focus groups, at stakeholder

meetings, and in government documents as a deeply entrenched barrier to more access to and utilization of mental healthcare. Stakeholders stated that "more sensitization" was needed because "literacy is lacking." One focus group participant explained, "You see, in our community (Mombasa), people don't know what mental health is, they don't even understand. So even if something happens, they won't know who to run to." Youth described "someone going to speak about themselves for two hours to get help" as a "waste." Undergirding ideas that experiencing mental illness or engaging in services for one's mental health are contrary to Kenyan culture were focus group participant's statements that "mental health issues are for the white." In the context of the focus groups, one participant described these attitudes as "a problem."

Concerns about how they would be perceived for needing mental health support echoed in every focus group discussion, with one youth saying, "Supposing I have something on my mind that is bothering me, but because of fear, I cannot disclose to my friend, saying to myself, 'What will they think about me?'" When discussing how gender factors into such considerations, participants were able to cite how boys and girls may experience stigma differently. Male participants described the importance of men appearing strong- "If you open up, you are seen as a weakling", and highlighted the man's role in society as a helper to others and "not the other way around." Girls, on the other hand, are taught that any unhappiness or dysfunction in the home is their responsibility:

> They are the ones to either build or break a marriage. There is this pressure that, if things are not working out, you are not supposed to leave that home. Maybe you are undergoing sexual and gender-based violence there but you cannot talk about it.

Young people also shared about challenges with speaking up about mental health concerns specific to their age group. In one focus group, participants expressed not feeling they would be believed if they were to speak up about being abused, for example. “A child will not speak out- not unless a teacher or parent notices the same.” Youth in focus groups did not feel encouraged to disclose mental health issues to parents or other elders in the community for fear of being told, “Why are you stressed yet you are provided for everything?” Call center counsellors also reported observing this attitude from parents especially, who may express indignation at the suggestion they are failing to take care of their children, saying, “What don’t you have in this house? You have food. People talk to you.”

Theme Four: Facilitating Factors to Youth Mental Health and Coping

Despite these numerous challenges, youth and other stakeholders were able to share several factors that facilitated youth mental health, along with ways in which youth coped with their mental health concerns.

Though few, youth-friendly centers where mental health services were also available were known to youth in some focus group discussions. “For getting counselling it is called SWOP in Landmark [corporate plaza].” Counselling services in a school setting were described positively by one focus group participant, “Many schools have this guidance and counselling offices, where if you have an issue, you can go. At school you can easily go because you know where it is.” But according to one call center counsellor:

> Even though most of the schools have counselors, most of the students fear going for the counselling sessions or whatever, to seek help, because number one, they

are known. Number two, there is no confidentiality- or they believe that there is no confidentiality.

This was especially relevant for students who sought support as members of the LGBT community who could "even be expelled" after disclosing their sexual orientation at school. Focus group participants said a positive reception, or "a facility dealing with you well", and quality- "If you tell someone that you went to a certain facility and got cured of depression, many will turn up", would motivate young people to seek services.

For many youths in focus groups and One2One counsellors, the "anonymity" provided by tele-counselling facilitated youth help-seeking and served to allay concerns around confidentiality, peer pressure and stigma. Anonymity, when used by participants in this context, meant that though counsellors may know the names, phone numbers, school, etc., of callers, they do not know them in the ways that are meaningful to young people, i.e., they do not have the ability to recognize them and do not know others in their social circles. Described colorfully by one focus group participant as a means for him to not "lower [his] gangster points", especially in close-knit communities, participants stated how important it was that clients and counsellors are not known to one another. In one focus group, youth were aware of 1190, specifically. Finding mental health support on social media was another facilitating factor youth mentioned, with platforms such as TikTok offering both welcome distractions and information. "There are so many therapists online that help people." But this was presented as a double-edged sword, with one young person stating, "Social media contributes a lot in young people going into depression."

When asked about mental health resources at their disposal, youth listed "counsellors", "mentors" and "peer mentors", though the types of support they described applied "mental

health" broadly. Focus group participants stated, "Even your mom can be your counsellor. Even your church elder" and, "Any person can be your counsellor." One focus group participant self-identified as a counsellor, saying, "Even me I am a counsellor because I am in another forum for the Red Cross. I am a facilitator, so I teach on those issues of life skills." One group in Nairobi said their understanding of "counsellor" had only to do with substance use. "Peer mentors" in Nairobi were described by focus group participants as giving advice, lending a listening ear, and suggesting short courses young people can take. Of note was the language youth used to describe the purpose of counselling, including "guidance", "advice", "solutions", and "opinions". These expectations conflicted with what call center counsellors believed their role to be. One counsellor described "contending" with clients who expect counsellors to "tell [them] what to do", while another stated, "We empower them. You just try to ask what they would want to do." Young people explained that seminars or talks labeled as "mental health" were often about abstaining from substance use, early pregnancy, GBV, etc. This reflected a theme seen throughout the study in which Kenyan mental health is mostly concerned with mitigating external stressors and threats to psychological health.

In addition to reaching out to others and more formal sources of support, youth in focus groups shared multiple ways in which they coped when experiencing stressors. Along with going to the gym and meditating to maintain mental health, youth also reported they "look for alcohol to drink and sleep" and "I will go buy piriton [an antihistamine], put on loud music then dance, I shout, I cry. When the piriton takes effect, I sleep" as a response to stress. One participant mentioned "taking a stroll." Another participant shared, "But us men we cry in the bathroom when the shower is pouring. You cry in the bathroom and tell God to make a way." Also included as a way of coping was drugs: "What youth turn to mainly is drugs. One takes these, feels high for

some time, and likely feels stress free momentarily." Getting together and laughing with friends, engaging in hobbies such as football, and playing video games were also ways in which focus group participants said they respond to mental health challenges. One participant stated they like, "Singing, dancing, anything that will make me be busy." Coping strategies were often described as ways to distract, "forget" or "keep away" from thinking about stressors.

Theme Five: Recommendations

Stakeholders, including youth themselves, had numerous recommendations to improve Kenyan youth mental health at the micro, meso and macro levels. Aside from the obvious removal of the many barriers cited by this study's participants and sources, stakeholders were able to illuminate concrete and specific changes that would positively impact Kenyan youth mental health, and the provision of care to this subset of Kenyan citizens.

Normalizing Mental Health

One starting point identified repeatedly was the need for mental health to be "normalized" and talked about in "every space." This was described as one way to address the profound impact of stigma and lack of information on the subject. One obvious setting for youth mental health-centered activities was schools, including primary schools, as one focus group participant stated, "Take these teachings to schools and help students have that knowledge because that's where the majority of youths are." Other spaces where youth may seek mental health services need to be especially welcoming for people 15-24 years old. Youth in focus groups suggested these places could be open 24-hours, have televisions or games, free Wi-Fi and be a place for community first, where young people can also, almost secondarily, receive mental health services. Once a facility becomes known primarily for mental healthcare provision, young

people may be less willing to be seen entering. One focus group participant stated these spaces should explicitly be, “not hospitals”, another saying, “Not in an open place where someone will see you go in.” Another component of a youth-friendly service or intervention according to some study participants was that youth themselves were disseminating mental health information. “Those who are offering the services should be youths since there is no way a youth can open up to an older woman.”

The media, including radio, news, billboards and television shows were also cited as avenues through which talking about mental health can be commonplace. One hotline counsellor stated that mental health needed to be “in the headlines of the newspapers.” The Mental Health Taskforce described the potential pitfalls of extensive media coverage of “bad news” such as “insecurity, ethnic clashes, homicides and suicides, among others” as they “were also reported to be stressors that lead to mental ill health” (2020, p. 38). One focus group participant captured the importance of not only talking more about mental health and mental illness but doing so mindfully and with intention. “When we do sensitization, let us not stigmatize during that moment. It depends on how you display information - it matters a lot.” Including positive depictions of mental health help-seeking in popular television shows was another suggestion in line with this participant’s point.

Role of the Family

The family unit too was included as having a role to play in increasing awareness of and supporting youth mental health. Focus group participants stated the opportunity presented to parents and guardians to be present with and affirm the experiences of the young people they are raising. “Guardians [need] to be talked to and told that sometimes they should listen to their children and society should stop that mentality of saying, ‘It’s just nothing.’” In hotline

counsellor interviews, the average modern parent was described as very busy, working from "eight to five" and before COVID, hardly home. The rise in people working from home was not described as a panacea for previous familial problems or poor communication. One young person stated, "Parent[s], take time with your child. When the child comes from school, go and sit with them." The idea that better youth mental health starts at home was echoed in counsellor interviews, with one counsellor citing "dysfunctional homes" as a reason for the recent spate of child suicides. Overwhelmed parents and guardians might not have time, meaning, "even as the child is going through these issues, they don't even realize." In response to Kenyans' feedback that "good parenting" was needed to improve youth mental health, the Taskforce recommended a government sponsored family initiative that "promote[s] all-inclusive parenting that includes mental health and wellness" (2020, p. 17). Notably, the role of families/guardians was not included amongst the recommendations provided at county stakeholder meetings, the composition of which was mostly mental health professionals, potentially most concerned with meso and exo-level improvements.

Policies and Laws

Policies and laws that reflect prioritization of mental health were identified as another way to make help-seeking for mental health challenges mainstream. The Taskforce Report calls for the repeal of the statute that criminalizes suicidal behavior, stating this would "lead to persons with depression seeking early treatment while data on suicide is also likely to be more accurately kept" (2020, p. 11). As stories of suicide garnered "much media attention", the value of accurate data becomes especially apparent. Youth in focus groups offered up anecdotes and conjecture about the rate and risk factors of suicides in Kenya, including saying that, "Most people who commit suicide are from campus and colleges"; "Men commit suicide more than

women"; and "If you check these stories of people committing suicide, mostly, they are done by the rich." In these quotes, school-related stress, beliefs about women being more willing to talk about their problems than men, and the burdens of maintaining a wealthy lifestyle were all presented as explanations for the rise of suicides in Kenya. Openness and transparency about this charged subject beginning at the highest levels of legislature would be yet another tool to combat stigma and improve mental health literacy and education at the micro level.

Tele-Health

Expanding online services was a recommendation heard from almost all data sources, with youth in focus groups stating, "When we invest more on online services, it will be easier for these adolescent and young people to open up because they are dealing with someone who is not there with them- they don't know each other." A mixed group of stakeholders recommended "digitization of mental health services" and to "increase awareness in the technology and digital platforms." Hotline counsellors listed the multiple points of access on numerous platforms on One2One besides phone calls, including SMS, a chatbot, Facebook messenger and WhatsApp, as factors that facilitate youth getting the help they need. One counsellor described One2One as a "one stop shop", especially important to this "Wi-Fi generation." The Taskforce Report described telemedicine and telepsychiatry as "modern tools" at Kenya's disposal because of the country's "high penetration of mobile telephony" and "availability of internet connectivity" 2020, p. 72). Though the Taskforce Report calls for "a new legal and regulatory framework" to respond to the growing popularity of tele-health, there is no mention of tele-health, telemedicine, or digital or virtual services in the 2022 Mental Health Amendment Act.

Prioritization of Prevention

Youth, counsellors, stakeholders and government documents included prioritizing prevention to improve Kenyan youth mental health. One counsellor shared their hope of the future of youth mental health - that "self-care" would be more commonplace and "everyone knows how to take care of themselves- when they get to that tipping point, you know?" One focus group participant shared their perspective that, "Most of these programs target to help after it has happened. I have never seen one that helps before it happens. They tell you, 'If something comes up, you inform us.'" Another young person did know of a youth center taking a more proactive approach:

> There is the part for youth center at Kasandani. You don't have to be a problem for you to attend the session. Like, you know how to cope with your emotions, you know how to cope with your stresses, your environment.

One of the Mental Health Amendment's primary purposes is to "co-ordinate the prevention of mental illness" and this charter is echoed, along with a focus on young people, in the Taskforce Report recommendations that, "Any efforts at prevention and promotion of mental disorders must start with young children" (2020, p. 10). Stakeholders suggested facilitating preventative mental healthcare through its inclusion under universal healthcare coverage or UHC. One counsellor spoke of the import of having mental health conditions covered under insurance, stating, "It's a medical condition." But when asked if UHC currently or was slated to cover mental healthcare, this counsellor replied, "No, I don't think it is. I've never heard of such a thing." Plans to roll out UHC have been delayed, and communication about services covered is apparently unclear. The Taskforce Report states mental health services are included, albeit at a prohibitive cost (2020).

Funding

Participants in this study also noted that improving Kenyan youth mental health would come at a cost. More than one hotline counsellor stated that “funding mental health” was essential. One stakeholder meeting participant asserted “direct and undivided funding for mental health services” was needed, along with a recommendation that the “government provide[s] commodities to manage mental health conditions at facilities.” The Taskforce Report accuses Kenya’s treasury of making a “negligible budgetary provision” for mental health, and states that, “The recommended budget for mental health is KES 250 per capita but Kenya is spending 15 cents” (2020, p. 2 & 79). And though prevention and community-based care are favored by youth, “Most of government expenditure in mental health goes towards facility-based services with very little going to preventive and promotive community-based services” (2020, p. 79). The Mental Health Act stipulates that “county governments shall allocate funds necessary for the provision of mental healthcare in the county budgets" but makes no mention of a national mental health budget (2022, p. 334). Relatedly, one counsellor describes the relationship between mental health and development on an exo and macro level this way:

> But then now when you look at the economic aspect, the political resources, the social resources, you cannot be- the people won't be able to tap into these resources if they're not mentally healthy. So, there's that aspect of poverty of the mind. Yeah, so I felt the need of dealing with the poverty of the mind to be able to address the human capital because I feel like once the human capital has been addressed, then it's very easy to even tap into these other external resources that come to be. And at the end of the day, we have development.

Gender Considerations

Stated in focus groups, in the Taskforce Report, and less directly by one call center counsellor, participants described what they characterized as an overcorrection in society's focus on the girl child, leading to a dearth of opportunities for boys and young men. One focus group participant lamented, "Nowadays, the boy child has been neglected a lot. You find that many projects consider the girls so much." The Taskforce made numerous recommendations to address this perceived marginalization of boys, including, "The programmes and intervention[s] that support empowering of women and girls must engage men and boys as well" (2020, p. 31). One tangible social sphere in which boys are understood to be lagging behind their female counterparts is school attendance, caused primarily, according to the Taskforce Report (2020), by poverty forcing families to send their boy children to work instead of school. One young respondent cited the value of training more men to be counsellors so they can "do counselling for their fellow man." One2One has one male counsellor on staff, and his account mirrored this recommendation, as he described having uniquely frank and open conversations with male callers, stating, "There are guys who call in and literally just cried just because they're talking to another man." Another call center counsellor shared her perspective that though GBV is rightly very frowned upon, blame for the problem and responsibility for solutions is unfairly placed solely at the feet of men.

> With GBV what I've learned, unfortunately, whether we like it or not, as much as we see the behavior, it's two-way, unfortunately. And we do not address this two-way; we address what we see. We're reacting to GBV response. Yet it's a relationship that needs to be both ways. You'll see the physical violence, but not the emotional violence from one party...we're not talking about women emotionally

abusing men. We're not talking about women verbally abusing men. That cycle- we never fully address it.

When asked if this was likely a common perspective, this counsellor stated, "No, no, no. All the families will kill me for saying what I'm saying. But I agree with you- he should not at all. But also, *she* should not."

Table 5. Summary of Findings

Themes	Codes
Definitions of mental health	"Emotional, psychological and social wellbeing" "stress" ubiquitous and unspecific Diagnostic language Stigmatizing language English vs. Swahili Conflation of "mental health" and mental ill health
Concerns of Kenyan youth	"Relationship issues" (GBV, early pregnancy, family conflict) Poverty and unemployment HIV/AIDS Substance use Suicide
Barriers to youth mental health	Lack of confidence in mental health professionals Limited referral options Cost Stigma
Facilitating factors to youth mental health	Some services available (NGOs, health centers in the community, school counsellors) Coping
Recommendations	Normalizing mental health Role of the family Policies and laws Tele-Health Prioritization of Prevention Funding Gender Considerations

Chapter 6: Discussion

Theory and Findings

Social Ecological Model

The social ecological model is an apt representation of providing medical and mental healthcare in conjunction - a multi-sectoral approach often suggested in LMIC settings (Semrau et al., 2015). The bulk of the specific plans laid out in the Mental Health Amendment Act (2022) concentrated on improving the hospital and facility-levels of mental healthcare, despite one of its stated purposes being to "adopt a holistic approach to community-based mental health services" (p. 330). Youth said they were most interested in community-based care, and what stakeholders described as "grassroots" services are the best situated to engage in preventative care as well (Thornicroft et al., 2016). One way to understand governmental priorities is in observing what resources are funded. The various levels of Kenya's health system are inter and co-dependent, so underfunding of community services results in fewer appropriate avenues for referrals and missed opportunities for building mental health literacy and resilience at the individual and familial levels (Falkov et al., 2016). There were major challenges cited at each level of the social ecological model, calling into question the efficacy of a multi systems approach (e.g., community health workers operating alongside a district clinic to improve care) to healthcare provision in a Kenyan context. One stakeholder noted the limitations of "level two" dispensaries, which are located within neighborhoods and thus most accessible to the average person, in meeting the mental health needs of Kenyans. Health centers and district facilities can be difficult for people to reach, and even there, seeing a mental health specialist is not guaranteed. The further the services, costs, including travel expenses, increase significantly.

For a comprehensive response to youth, and truly all Kenyans, mental health services need to involve, but also go beyond, integration with HIV and other chronic condition care. A health approach focused on treating disease versus promoting wellness can reinforce stigma, another barrier to youth help-seeking (Skeen et al., 2010). According to youth responses, connecting mental health services with a local clinic or health center further pathologizes mental health, discouraging some from attending. This might be counteracted by expanding "integration" to include mental health as a facet of social wellbeing and healthy development as recommended by Hetrick and coauthors (2017). The addition of social services to primary and mental health services will help ensure care is relevant for youth and may also address some of the challenges that arise when mental health and mental illness are not differentiated (Hetrick et al., 2017). Open, youth-led discussions about how to engage in healthy romantic relationships and seminars which include youth's parents about improving relationships may have greater mental health impact than direct discussions of stress or suicide, for example.

Data revealed tensions between individual definitions of mental health and the government's framing. The exo level of the mental health system did not share the micro-level's understanding of mental health; youth described survival whilst government documents made recommendations for thriving. The Mental Health Taskforce included feedback from community forums which informed the Taskforce's recommendations. Insights gained from the Taskforce purportedly instructed the legislature as they drafted the Mental Health Amendment Act. This study suggests some essential data were lost when information was translated to the highest level of stakeholders. Overwhelmingly, study participants described "mental health" as staving off stress and coping with economic hardship. It was telling that the government's Mental Health Act does not define a vision for mental health, leaving one to assume the government's

understanding of mental health is the absence of mental illness (2022). This conceptualization contradicts respondent's recommendations for the future which centered on prevention, empowerment, and opportunity.

In interrogating whether a social ecological model is even the best or the only way to facilitate administration of health in Kenya, one must consider the role of what most sources cited as the bedrock of improved mental health: families and community. It is not obvious whether and how people's capacity to take care of themselves, and therefore, offer support to their loved ones would benefit from government involvement. Finan and Yap (2021) concur that the effect of governmental policies is inconclusive when examining parental engagement in prevention programs for youth mental health. One of the Mental Health Act's commitments is for the national government to "collaborate with county governments in expanding and strengthening community and family-based care and support systems for persons with mental illness" (2022, p. 332). The Taskforce Report states that, "A key building block of our nation is the family unit" and describes plans to work with faith and civil society organizations to again "strengthen" families (2020, p. 2). Participants in this study spoke repeatedly about the government's responsibility to rectify a dysfunctional economy that results in poverty and subjects citizens to scarcity. No study data suggest that Kenyan youth, counsellors and other relevant stakeholders expect the government to address problematic inter and intrapersonal dynamics, many of which are in fact traced back to a lack of tangible resources and the ensuing stress. This potential discrepancy in understanding the role of government in achieving Kenyan wellness reflects another breakdown in communication between the levels of the Kenyan health ecosystem.

Anti Colonialism

The vestiges of colonialism can still be felt in Kenyan society and policy. One such example is the existence of anti-suicide laws in Kenya when such codes were repealed decades ago in their country of origin, the United Kingdom (Adinkrah, 2016). As independence cannot be confined to a day, and is in fact ongoing, turning a critical eye to historical statues that no longer serve Kenyans is a vital component of the anti and decolonizing processes. For years, Kenyan scholars have been calling for these laws to be struck from the penal code, calls echoed by the Taskforce, but not yet heeded by the Kenyan legislature (Kang & Sesi, 2020; Mudeyi, 2021; Ochieng & Kamau, 2021). Thought to originally act as a deterrent to suicidal and self-injurious behaviors, subsequent evidence has shown that these laws have had no such effect (Ochieng & Kamau, 2021). It is reasonable to imagine that if a person was desperate enough to decide to fatally harm themselves, their capacity to reason and consider potential negative outcomes and consequences to themselves and/or their families is impaired. Moreover, none of this study's youth participants discussed anti-suicide laws, suggesting that outside of professional circles, awareness of the law is limited. This too undermines any argument that the law's existence will influence public behavior (Adinkrah, 2016). Anti-suicide statues also perpetuate the misconception that mental illness and criminality go hand in hand, reflected even in the parallel language used to describe one who might "commit theft" or "commit rape" (Ochieng & Kamau, 2021) and the Taskforce's continued use of the phrase "commit suicide" (2020 p. 90). Ochieng and Kamau (2021) found that from 2016 to 2020, there were eight cases on record related to suicidal behavior, showing that the statute is still very much in use. Especially in programmatic settings, the possibility for criminal punitive measures looms large. This study has shown the concrete ways in which the anti-suicide law hinders mental health service provision when people

are in crisis and, more systemically, leaves the government ill-equipped to deploy data-informed solutions.

Another lasting effect of British colonial rule was its reinforcement and introduction of new justifications for patriarchy within Kenyan society (Boulanger, 2008). Participants in this study described rigid gender roles and responsibilities, which youth in focus groups cited as a source of stress under what sometimes felt like unrealistic expectations. Though "domesticity, the control of sexuality and the need to stabilize the family" developed into central tenets of womanhood during the colonial era, resistance from Kenyans and continued adherence to traditional customs complicated any attempts to make these changes sweeping (Kanogo, 2005, p. 5). The backlash described by participants in this study to what the Taskforce calls the recent "female liberation movement" exemplifies the continued impact of colonial patriarchy (2020, p. 31). The promotion of girls' education, and subsequent improvement of life outcomes, occurred because of historically low enrollment of girls in, especially, secondary school, as "home" or domestic science was considered for girls (Kinuthia, 2009). This inequity still exists today: one call center counsellor lamented the influence of male policymakers to limit access to and education about contraceptives to young people, when women are those predominately on the frontlines of providing support to young mothers shunned and left destitute. Though women have been afforded fewer economic opportunities, and thus, fewer opportunities to exercise agency over their lives before, during and after the colonial period, it took only a few years for men to label this sort of societal exclusion as untenable and demand change − a striking double standard.

The social construction of mental health was apparent in this case study as ideas of what constitutes a positive, indigenous value or practice versus something perceived as negative and foreign shaped Kenyan attitudes toward mental health broadly (Ezeugwu & Ojedokun, 2020).

Therapy was described more than once as being for white people or not African. In a globalized world, part of resisting the oppression of colonialism is Kenyans deciding for themselves what version of "mental health" would be an asset to their society – not simply wholesale rejection but the development of alternative frameworks (Dei et al., 2000). If current mental health discourse leads Kenyan youth to conclude that talking about "mental health" is antithetical to their identity, the task is discussing mental health in terms and within contexts that make its utility and value relevant to the average Kenyan (Ruiz-Casares, 2014). Youth's pushback to the "usual ways" of doing therapy, including sitting and talking for extended periods of time and utilizing their own time and resources without receiving something tangible in return are contrary to how mental healthcare has functioned in the West. These points of resistance can result in what Rivera-Segarra and co-authors call "sovereign acts" − the agency to behave beyond established norms (2022, p. 599). Such insights offer a pathway to building a Kenyan mental health infrastructure that is by and for Kenyans, and thus, more likely to offer the support that Kenyans want and need.

Kenya is still in the formative stages of developing a robust mental health infrastructure-a period marked by potential. As mental health education tracks expand, indigenous ways of knowing, a focus on uplifting indigenous voices and challenging sources of power can remain at the center (Wane, 2008). An anti-colonial approach to educating and training Kenyan mental health practitioners will ameliorate the dissonance between "foreign" ideas about what mental health is and how Kenyans experience it (Kyere & Khandare, 2020). These considerations can lead to curriculums that include Afro-centric theories developed by Black/African scholars, critical readings of texts perhaps considered foundational in the Global North, and an explicit interrogation of the role of colonialism in Kenya's society (Kyere & Khandare, 2020). This

approach would help ensure that all ways of knowing are honored – something the One2One call center appeared to do well, though from youth and other stakeholders, there were sometimes suggestions that there are "correct" understandings of mental health, and other opinions are backward and in need of correction.

Kenyans are not a monolith, made apparent during the duration of this study, as participants hailed from various linguistic and religious backgrounds. These groups held different ideas about the role of traditional healers and/or religious leaders in mental healthcare, what their religion has to say about mental illness, and whether to prioritize facility or community-based care. Just as highly nuanced and localized mental healthcare services are best practice, so should be the approach to mental health training and education. One such example, the use of teleconferencing to train local mental health workers in rural South Africa, is cited by Liu and coauthors (2016) as one creative response to the diverse demands of increasing mental health capacity in sub-Saharan Africa. The overall formalization of mental health support services should also be undertaken with caution and intention; involving institutions, be they governmental or educational, can create structures that may result in new, and perpetuate existing, systems of oppression (Voronka, 2017).

This study's findings support what was evident during my review of Kenyan mental health literature; foreign national governments and international organizations such as the Red Cross and WHO drive mental healthcare funding and thus, provision in Kenya (Mathai et al., 2019). With youth, providers, partners and other stakeholder participants in this study, these organizations were household names. This funding dynamic, where predominately foreign actors shape the mental health landscape in Kenya, would benefit from greater scrutiny, especially as more resources are directed toward the development of mental health programs and services.

Awareness of how Kenyans' mental health needs and priorities may differ from the social imperatives of the Global North is key to ending colonialist influence in the health practices of the Global South. One example of how outside imperative conflict with or fail to address prominent concerns identified in this study is in participants' questioning the necessity of programs focused on the girl child despite their proliferation, including at LVCT Health. Though the intention behind such targeted efforts often have merit, without collaborating with the community and those affected by these types of programmatic policies, goodness of fit in implementation is lost, sacrificing contextual relevance and potentially, the intervention's efficacy. An important area for future study is how current mental health funding priorities compare to participants' reports of their most pressing concerns, and shedding light on how non-profit and global funding mechanisms shape government and agency policies and programming.

Implications of Findings

Tele-Health Recommendations

Participants described various roles for the practice of tele-health. Though call center counsellors were experienced and qualified, they offered consistent feedback of the difficulties they experienced adjusting from providing counselling services in-person to working at the call center. Counsellors learned how to engage with youth via telephone and chat, and how to probe to learn what might have been more evident with the benefit of facial and nonverbal cues. One counsellor admitted that their education did not prepare them for tele-health, and that different, albeit not entirely, skills were at play. Certificates and "short courses" are common in Kenya, at times, in lieu of a multi-year degree. This higher educational infrastructure lends itself well to better preparing those already qualified as counsellors to provide services online. In tandem with

this option for post-graduates, tele-counselling can be integrated into existing counselling and psychology programs to ensure graduates' preparedness for this increasingly online world.

Clear guidelines and expectations for counsellors and clients in a tele-health environment might also help to instill confidence in and allay youth suspicion of the legitimacy of such services. Relevant during in-person services as well, but perhaps even more so remotely, is youth understanding a counsellor's relationship to confidential information, and the purpose of recording sessions. Stakeholder meeting participants noted the need for an improved network of mental health providers, for clients to know what resources exist in their area, but also for professionals to be aware of one another for purposes of referral, consultation, etc. Establishing associations for various, or perhaps for all mental health professionals, would also aid in communication about standards of practice, ethics, and consequences for violation of these rules to the public. Within these groups and/or in collaboration with the Ministry of Health, specific guidelines for providing remote mental health services, including expectations of privacy, confidentiality, and follow-up can be established.

Though the government has stated its intention to make tele-health common and widespread, plans to provide the infrastructure to facilitate this expansion are scant. Though Kenya has been touted as a well-connected LMIC with more SIM cards than residents, this wireless access is not universal and equal. One counsellor explained that some families may be forced to share a phone, as access for people of little means remains challenging. Sharing a phone with others would also affect a young person's expectation of privacy and anonymity in reaching out to 1190. The discrepancy between the volume in rural and urban callers also does not necessarily connote a difference in mental health needs but is more likely a tendency for

urban dwellers to be more aware of mental health issues and where they might find resources, i.e., a deficit in outreach.

The challenge of creating equitable mental health awareness is also compounded by issues of service access. Call center counsellors complained of electricity and network outages that disrupted their work, downing phone and chat lines for hours. This inconsistent availability erodes public trust in the service. And though 1190 operates the only suicide hotline in the country, there are no crisis response teams or mobile mental health units to buttress this service and provide direct care for those with immediate need. This gap in services dramatically limits the hotline's ability to provide and connect clients to continuous care (Perlis, 2022). This comes at obvious cost to the clients, who after hanging up with a One2One counsellor must use their own initiative to physically go to a clinic or health center. But this also took a toll on call center counsellors, who stated they may never know the ultimate outcome of a suicide call, as attempts to follow-up are not always successful. True in any setting but especially difficult in resource-limited contexts like Kenya, increased access to tele-health must come with a network of in-person providers to respond in crisis situations. Otherwise, Kenyans are left with an incomplete service unfit to respond to their full array of needs (Menon et al., 2018). The pitfalls of increasing use of tele-health without the necessary supports are especially acute in rural areas, which already experience health disparities.

Mental Health and Development

Relevant in all settings, but perhaps more so in LMICs such as Kenya, is the relationship between economic development and a population's mental health. Government priorities to address mental health varied, with the Taskforce Report including anti-poverty measures among its recommendations and the Mental Health Amendment Act making glaring omission of plans

to address poverty as a social determinant of ill mental health. This oversight was in stark contrast to what was learned during the course of this study. Though one can reasonably assume that governmental plans to address poverty exist elsewhere, inclusion of these plans, even as a reference, as part of a comprehensive mental health strategy is one way to acknowledge the inextricable link between one's ability to meet their basic needs and their mental health. Failure to acknowledge the stress caused by going without is a missed opportunity by those in positions of power to communicate to their constituents that they have truly heard and will be responsive to Kenyans' feedback. The relationship between mental health and development emerged explicitly from other study data. The Taskforce Report acknowledges inequity and lays out the cost to the nation's overall productivity and growth that the burden of diseases imposes (2020). One call center counsellor described how a well population can enable a developing nation to "tap into" the "human capital" at its disposal.

One explanation for the discrepancy between the population's understanding of the role of poverty in their mental health and the national government's framing may be that, for many, government officials are at fault for Kenya's sorry economic situation. Corruption is notoriously rampant in Kenya, with each new candidate for major office promising to stamp it out. Like so many other resource-rich nations, Kenyan citizens expressed contempt at the gulf between their standard of living and that of those in power. For youth, they reported seeing this in their failed attempts to procure employment, with nepotism so often getting in the way of their earned advancement. Pessimism about government follow-through on plans to materially support the development of Kenya's mental health landscape systemically, and for individuals, was widespread.

The question of the role of Maslow's hierarchy of needs in thinking about how to interrupt the cycle of poverty and mental ill health was a nagging concern whilst in Kenya and during data analysis. While conducting research in South Africa, Nama and Swartz (2012, p.294) wondered if, "Money spent on psychological research could better go into food or social programmes" and the ethics of studying mental health interventions when working in communities with dire need. In societies with some economic opportunity and/or social safety net to catch those unable to work, beginning with improving individual mental health is a viable and logical avenue to alleviate the impacts of poverty (Marbin et al., 2022). In many LMICs such as Kenya, this logic does not translate and addressing poverty first is an effective avenue to improved mental health (Zimmerman et al., 2021). Though there is certainly value in providing youth with resources, skills and tools that may help them improve their relationships and cope with stressful events out of their control, it is a failing for the government, the body able to impact economic circumstances in Kenya, to overlook that which was cited as a fundamental and universal cause of poor mental health. Indeed, Memiah and colleagues (2022b) posit that improving socioeconomic status can lead to better mental health outcomes for Kenyan youth, thus creating an environment in which interventions such as REACH-MH can achieve their greatest potential impact.

Diversity in Findings

What some participants described as facilitating factors were often categorized as challenges by others, reflecting the complicated nature of understanding which interventions might best improve youth mental health. There are some young people for whom seeing a counsellor in person was described as comforting and helpful in building trust. For others, the familiarity was off-putting, concerns about being recognized overrode any potential benefits, and

the burden and inconvenience of traveling to an office prohibitive. One potential solution to this challenge is offering hybrid services, as One2One does, so youth can choose between in-person and tele-health. Having providers either within walking distance or even available to travel to clients would also go a long way to lowering barriers to mental healthcare engagement. True for anyone but perhaps especially so for this age group of interest, 15–24-year-olds, investment in and commitment to participate in health services is low; fewer instances in which youth must exercise their own initiative to engage in a service increases the likelihood of engagement (Renwick, et al., 2022).

Study participants also provided different views on the utility of school counsellors as a resource for youth in need of mental health support. Some youth listed school counsellors as a helpful resource, others, including call center counsellors, described an environment in which confidentiality could not be assured, leading to severe consequences for some students. This data, albeit mixed, suggests there is an opportunity to capitalize on the presence of counsellors in schools, with some potential changes to how these programs operate, to reach more young people. One call center counsellor stated she was unsure if those working in schools were "proper" counsellors, or perhaps just teachers given the title, and thus, did not know if school counsellors were beholden to any professional standards or ethics. Clarifying the role of a "school counsellor", including requirements for qualification, and subsequently ensuring equal access to these qualified counsellors, would be a worthwhile endeavor in efforts to increase access to and literacy about mental health for youth.

The differences in how youth, counsellors and stakeholders discussed the merits of offering free or extremely low-cost services and the expectation for an incentive for utilizing services is another instance requiring a tailored response. For a person with some means, paying

a nominal or sliding scale fee may instill a sense of investment in a process and elicit feelings that what one is receiving is of value and of high quality (Rhee, 2009). For clients on the older end of the 15-24 spectrum, and who do have income, this approach could be a viable option for counsellors such as those at LVCT Health. For the majority of young people, even a small fee may be more than they can afford, and it may be important to differentiate the services of an organization like LVCT Health from those of other counselors who may charge exorbitant fees by keeping One2One totally free of cost. Though potentially surprising at first, the request of some youth for something in return after receiving a free service makes more sense when considering the often-difficult economic circumstances in which they live. Going to a counsellor or attending a talk will seem more worthwhile if there is cash or food on offer (Galárraga et al., 2020). The types of incentives youth in focus groups mentioned were hardly extravagant and included items such as juice or soda. This practice may also serve as a tool to diminish the effects of stigma, allowing youth to claim they attended a seminar or session just for the snacks. Within reason, and of course below the threshold of coercion, the inclusion of token incentives such as small food stuffs have the potential to increase engagement with mental health and other related activities amongst youth.

Opportunities for Prevention

Prevention is an important and underdeveloped component of improving the mental health of Kenyan youth. Young people in focus groups described prevention to promote mental health in terms of having services and resources available and accessible *before* one has what might become a mental health problem. According to one participant, these services were focused on teaching coping skills. The importance of building resilience was highlighted also by one call center counsellor who included knowing the value, and particular strategies for, self-

care, framing them as part of “life skills”, as one way to prevent mental health issues. The One2One website is one place youth may learn more about this, but it has only a brief page titled “Self-Care Explained”, which offers these suggestions: “Taking yourself to the movies; Reading books; Engaging in social activities you enjoy with the people you care about” (LVCT Health, 2023c). “Practicing mindfulness and meditation” is also mentioned, but with no further resources on how to do that. The other pages under the “Self-Care” tab, which is an option under “My Body” and not “Mental Health”, focus on physical steps young people can take to maintain overall wellness such as getting adequate sleep, exercising, eating healthy foods and dental hygiene (LVCT Health, 2023d). Though obviously more an expert than representative sample, hotline counsellors were able to describe the ways in which they take care of themselves when asked, though the question was often met with nervous chuckles and long pauses to think. Taking time off from work, leaning on their fellow counsellors, participating in therapy themselves, getting together with friends and having a drink, and getting involved in projects related to, but not exactly their usual call center work, were all self-care steps cited by One2One counsellors. It was unclear how often these types of strategies were discussed with One2One callers; call center counsellors are well-poised to spread awareness about self-care as a mental health strategy. A greater focus on self-care can also contribute to implementation of a broader array of health and wellness activities for youth outside of what may be stigmatizing clinical content billed as “mental health.”

Though challenges to improved provision of mental healthcare in Kenya abound, so too are inherent strengths and opportunities for people to manage within their often-difficult circumstances. Broadly speaking, the social fabric of Kenya fosters social connectedness and collectivism, and these characteristics can be leveraged to develop and provide sustainable youth

mental health interventions (Basu et al., 2022). The traditional social norms such as checking in on neighbors, leaning on relatives to help raise children, and seeking solutions for problems from community elders are useful tools to building resilient communities, but are under threat in a more isolating, urban, capitalist economy (Van Breda, 2019). Study participants described parents and guardians preoccupied with having income to meet their family's needs, often at the expense of work/life balance. And a wave of rural to urban economic migration has created a large migrant population, more likely to occupy informal settlements in which embedding into any one community and fostering strong connections would prove difficult (Winter et al., 2020). This migration pattern is especially acute in Nairobi. More conversations amongst Kenyans about what self-care and coping strategies are at their disposal and fit culturally would capitalize on people's strengths and agency to improve their mental health.

From a public health perspective, a prevention-focused approach will help to decrease the burden of mental disorders on the Kenyan population (Beksinska et al., 2021).This study has laid out the ways in which the Kenyan government is failing to provide high quality mental health treatment for most of its people; promoting mental health to prevent mental ill-health will be a better use of limited resources (Skeen et al., 2010). Coupled with greater attention paid to the existing strengths of the Kenyan people, this paradigm shift in healthcare provision policy and practice can have outsized economic and social ramifications. Though stated in both government documents I analyzed as a top priority, the government did not lay out a specific plan, nor dedicate funding to bolster the prevention apparatus, instead, stating plans to continue to funnel most mental health spending to facilities.

Though often discussed in terms of Kenyan mental health service provision (Dorsey et al., 2020) and physical health services (Task Sharing Policy Guidelines, 2017), task-shifting or

task-sharing emerged from this study as a potential tool for prevention. Young people's openness to seek counselling from non-specialist practitioners suggests they would engage with mental health programs in settings such as schools, houses of worship, and in conjunction with life skills training. As some participants also expressed a preference for peer support, training other youth to be advocates of mental health, including psychoeducation on self-care, is one way to shift the work of prevention to culturally and developmentally responsive lay persons. As young participants also described the stigma affiliated with attending a clinic or health facility, employing a task-shifting approach would further dissociate mental health from other medical services, eliminating one barrier to help-seeking. Teachers, faith leaders, parents, and community health workers are all groups well-suited to promote mental health and increase awareness of signs of mental ill health amongst Kenya's youth.

After conducting a global review of trial interventions aimed at improving adolescent mental health, Skeen and co-authors (2019, p. 6) identified seven domains common in successful programs: "interpersonal skills, emotional regulation, alcohol and drug education, mindfulness, problem solving, assertiveness training, and stress management". There are several parallels between these domains and the results of this study, as "interpersonal skills" could be called upon to help with "relationship problems" so often cited. Learning tools to manage the ubiquitous "stress" would also have obvious utility. Adapting mindfulness to ensure its relevance to Kenyan youth is another area of prevention potential, as is understanding the role of youth "assertiveness" within a culture that is very hierarchal, often along the lines of seniority and maturity (Mutua & Kiruhi, 2021). Skeen and colleagues (2019) note that one limitation of their review is the overrepresentation of high-income countries, and subsequent uncertainty about the results' generalizability to LMIC contexts. These recommended areas through which to promote

mental health and prevent mental ill-health comprise one part of the World Health Organization's Helping Adolescents Thrive (HAT) Toolkit published in 2021, which may be a useful resource for the Ministry of Health in its youth mental health program development, and organizations such as LVCT Health as they also create content and programming for youth.

Implications for Social Work

Global Social Work

Social workers are well-positioned to lead in the field of global mental health. Our profession's perspective, that every person and place have inherent strengths and positive qualities, and that helping people achieve their own goals and definition of wellness requires an approach that goes beyond pathology, appreciates that many components work together to influence life outcomes (NASW, 2021). Social work is unhindered by the rigid treatment and practice parameters of some other health and psychiatric professions as social workers can act as conduits between the various facets of health and wellness (Akesson et al., 2017). This mindset can be translated and adapted to operate within various global settings. The International Federation of Social Workers (2014) provides a global definition of social work that includes "promot[ing] social change and development, social cohesion, and the empowerment and liberation of people" by accessing, among other theories, "indigenous knowledges." The International Federation of Social Workers and the International Association of Schools of Social Work together agreed on nine principles of global social work (Sewpaul & Henrickson, 2019, pp. 3-4). These principles are:

1. Recognition of the inherent dignity of humanity
2. Promoting human rights

3. Promoting social justice and equity

4. Promoting the right to self-determination

5. Promoting the right to participation

6. Respect for confidentiality and privacy

7. Treating people as whole persons

8. Ethical use of technology and social media

9. Professional integrity

These guiding principles of global social work are not a panacea for ending imperialist practices, namely exacerbated by the long-standing reality of Global North/South inequities. Sewpaul and Henrickson (2019) state these are constantly evolving, an active process that makes it more likely such guidelines can help to achieve a healthier and more just world.

This study's findings have the potential to contribute to the field of global social work. The cultural strengths inherent in many Kenyan communities that contribute to prevention are also relevant for social workers practicing in cross-cultural settings. Openness to the possibility that these strengths may be intertwined with harm will be key. For example, we can celebrate Kenyans' resilience whilst acknowledging many are harmed by historic and current socioeconomic inequity that unjustly forces them to be resilient. We must also be willing, through global social work education and practice, to engage with the discomfort of our own role in perpetuating colonialist attitudes (Palattiyil et al., 2019). This is especially true as the field of global social work expands, and social workers are employed from the grassroots to leadership levels of governments and non-profit or non-governmental organizations operating on an

international scale (Palattiyil et al., 2019). When centered on what Olcon calls "deep listening, genuine engagement, and a commitment to learning" (2020, p.326), our training prepares social workers to navigate complicated spaces, utilizing tools like critical reflection and supervision. International social workers in Kenya and other LMICs would also benefit from applying a critical lens to the funding structure of their work, advocating and making space for those impacted by budgetary and policy decisions to not only have a seat at the table, but sit at the head.

Social Work in Kenya

The current mental health landscape in Kenya does not include a substantial role for social workers, though the opportunities for social workers to have a positive impact are numerous (Mungai et al., 2014). Cited often from every source included in this study is the dearth of mental health professionals. Training more social workers would help alleviate this pressure on practitioners in the mental health field, resulting in more options for potential consumers as well. The Taskforce and Mental Health Amendment Act's use of words like "holistic" to describe the optimal approach to improving Kenyan (youth) mental health fits well within social work's conceptualization of engaging with a person whilst considering their environment (Lombard & Wairire, 2010). As mental health services are further integrated to include responses to social determinants like poverty and violence, social work training would be an asset in identifying what social services are needed and connecting clients to resources (Lombard & Wairire, 2010). The first step in doing this is increasing the number of social work programs at institutions of higher learning and avenues to gain certificate level training in social work (Wairire, 2014).

Social workers can also help to fill the mental health research void in Kenya. This need was stated explicitly as it related to suicide data, but data informed strategies for efficacious prevention and service provision to special populations are also needed. If the government is to be successful in its goals of expanding mental health services, evaluation of programs and interventions will be necessary to ensure efficacy. Keeping the Kenyan people at the center of mental healthcare expansion plans will also require professionals who can facilitate solutions that are responsive to cultural and societal needs. The tenets of social work research, including beneficence, (social) justice and respect, would aid in Kenya's bringing forth more equitable mental healthcare policies and practices, as social workers are charged with upholding all human dignity (Anastas, 2020).

Dissemination Plans

Key to conducting non-exploitative and ethical research is ensuring knowledge production is not only linear − from participants to researcher, but that findings uncovered are communicated back to their source, ideally to inform future practice and/or research (Israel et al., 2021). One of the primary sources of data for this study is the One2One program, an affiliate of LVCT Health. Counsellors provided high-level responses on their roles broadly, but also about the practicalities of their work at the call center, not all of which were appropriate to report in this dissertation. Some of this information, including promoting counsellor self-care and discussion of self-care with clients, suggestions for call screening tools to minimize the disruption of prank callers, and some of the technological challenges cited by counsellors could be used to improve the functionality of the call center. As such, I will send a document summarizing relevant call center findings and outlining counsellor recommendations to all the

call center counsellors interviewed as part of this study, including the counsellor in charge of 1190 and Dr. Lilian Otiso, the Executive Director of LVCT Health.

Data gathered from government documents, and how they interacted with the framing of the issue of youth mental health heard from young people in focus groups, are another vital part of this study's analysis. The Ministry of Health was responsible for the Mental Health Taskforce Report, which, as it was partially based on responses from community members, mostly mirrored what was said in focus groups. But the contents of the Mental Health Act Amendment differed significantly from how stakeholders, inclusive of young people, described their mental health concerns and preferred approaches to mental healthcare provision. The Ministry of Health still operates a website for the Mental Health Taskforce on which submissions of memoranda are accepted. There is an option to attach documents through this form, and to include a brief description. Via this online submission form, I will send my findings about the Mental Health Act's shortcomings in responding to this sample's concerns about mental health literacy, service accessibility and quality (Taskforce on Mental Health Submission of Memoranda, 2023). Within this report I will also lay out potential next steps based on this study's findings, including increasing avenues through which more Kenyans can be trained and educated to provide mental healthcare, and a reallocation of resources to community-based approaches.

Strengths and Limitations

Strengths

One of the strengths of this research undertaking is the multiple perspectives included on the single subject of Kenyan, and youth, mental health. This triangulation often resulted in thick, rich findings to answer research questions that required nuanced and culturally appropriate

analysis. Tensions and discrepancies between these different stakeholders were exposed and explored to find meaning in these findings. These numerous data sources play various roles in the system of mental healthcare provision, and so analyzing how each one describes youth mental health and each party's plans to address this need helped to illuminate the points at which these sectors could be better aligned.

Though my status as an outsider, foreign to Kenya and unable to speak any of the indigenous languages, was in some ways a limitation of this study, this position was an asset at times. I was able to make observations a person with insider status might take for granted and ask questions to seek clarification when matters might have seemed obvious to a Kenyan. Coming from outside, I did not have opinions about the party in power nor was I in a position to make assumptions or stereotype about regional or tribal characteristics, for example. Not being well-versed in the socio-political fabric of everyday life in Kenya meant I could make inquiries free of some of the biases that come from knowing, and being affected by, the policies and practices that shape healthcare provision there.

The comprehensiveness of the data used for this case study also provided an advantage. I was able to speak with every 1190 counsellor giving me a full picture of that experience. From each county, I had at least four focus groups transcriptions. I was able to code these transcriptions until I reached saturation, providing a clear and consistent picture of the youth perspective in Nairobi, Kisumu and Mombasa counties. The Mental Health Taskforce Report is a comprehensive document of over 100 pages that covers almost every relevant facet of mental health raised by stakeholders. The Mental Health Act, as a piece of legislation, is the final word from Kenya's highest official body on the provision of mental healthcare across the country.

Limitations

This study was developed as part of a broader project already in progress. This dictated the scope and required that the aims of this study fit within the larger REACH-MH goals. This did not create conflict for me as my interests were in line with those of REACH-MH, but is worth noting to understand the origins and impetus of the study, and the limitations of my decision-making in some of this study's design.

As language is so integral to making meaning, it was limiting that I did not speak or understand Swahili, which was the most widely spoken language I encountered (Van Nes et al., 2010). In the somewhat formal interview setting and especially when in more casual conversations, stakeholders would have to pause when trying to make a point to translate a phrase or explain local applications of a word I knew in a different context. I was most likely to hear spontaneously from someone who was very comfortable speaking English and may have missed out on the perspectives of those more confident communicating in another language. This language barrier highlighted my status as an outsider and may have hindered my appreciation of concepts which were already complex and layered with cultural specificity (Casado et al., 2012). With the exception of the in-depth counsellor interviews, this limitation was considered and accounted for; youth focus groups and stakeholder meetings included fluent Swahili-speaking Kenyans engaging as members of the research team. This language challenge is less stark in call center data which were collected by native Kenyans but remains relevant in focus group discussions which had to be transcribed and translated by an outside party. As Van Nes and colleagues (2010) posit, even though it was translated by research team members with a shared language with participants and in real-time, all qualitative data has been translated, analyzed,

discussed and interpreted to present in English, leaving the possibility for some meaning to be lost.

Conclusions

Repeatedly, "mental health" was defined by study respondents in ways that captured broader social determinants of health, as participants were focused on interpersonal and economic factors that affected their mental health. "Mental health" was also defined as "emotional, psychological and social wellbeing" and occasionally in clinical terms to describe mental illness, such as "depressed" and "anxious", contrasting with the government's goal toward "happiness." In line with Kenya's integrative healthcare provision strategy, including mental health literacy in programs geared to improve young people's romantic relationships, family dynamics and connect young people to work opportunities is likely to have the most impact and relevance. This approach would be congruent with youth's statements about wanting freedom and autonomy over their lives, and hotline counsellors' goal to "empower" youth. An anti-colonial lens, and a focus on how various socioecological systems interact to impact Kenyan health, will aid in Kenya's stated prioritization of a more robust and responsive mental health infrastructure, while avoiding the health inequities and inefficiencies often seen in many high-income nations. The Kenyan mental health landscape, broadly and for youth specifically, is characterized by opportunity and potential. Though challenges abound, mostly material and political, also numerous are the strengths and resources possessed by Kenya's people who continue to solve problems and utilize old and new ways to strive toward a uniquely Kenyan conceptualization of mental health and wellness.

Appendices

Appendix A. In-depth Interview Guide for Counsellors

1. **Introductions**

Thank you for taking the time to talk with me about mental health issues and needs for adolescent and young adults in urban populations based on your experience as a counselor. My name is Thuli and I'm a PhD Student at University of Maryland School of Social Work. This study is a partnership between University of Maryland, LVCT Health, Kenya Ministry of Health and Amref Health Africa with a goal to: (1) identify key mental health risk factors among AYP using digital technology to solicit information; (2) conduct targeted qualitative interviews regarding the culture and complexity of AYP lives to inform the development of tailored interventions; (3) identify barriers and facilitators of mental health among AYP at the individual, family, community, structural, and health system levels. This interview is entirely voluntary and confidential. I will not be reporting back to your supervisor or anyone outside of the immediate research team what you share. You will not be penalized for refusing to participate.

In-Depth Interview Questions

Discussion begins, make sure to give the respondent time to think before answering the questions and don't move too quickly.

1. How would you describe your role? What role do you play in addressing the issue of mental health among the AYP in this organization*? (Probe re: their expertise in receiving calls and offering counselling to the mental health issues raised by AYP)*

2. Please tell me about your educational and professional training (*Probe for educational and professional/on-the-job mental health training, content, duration, etc.)*
3. How would you describe the AYPs who call? (*Probes: issues that they call about; their communities with which they identity; demographics)*
4. What are some of the mental health issues that AYPs who call face? *(Probe for mental health issues and conditions experienced by the youth in the area, magnitude of the disease)*
5. Is there anything unique or distinct about the callers who present with mental health concerns?
6. When responding to a call from an AYP, how do you differentiate between categorizing the call as "psychosocial support" from "mental health"? (*Probe for any mechanisms, standard operating procedures, and "trigger words" used in the call center to identify a mental health call- presence of/process for developing a code book- who's involved?)*
7. What are some of the challenges/gaps, if any, that you experience in supporting mental health services for AYPs? *(Probe on the gaps- Human Resources for Health, Services (Youth friendly services, quality and access of services) Infrastructure, Policies, Funding, governance and leadership, Information health systems-availability for Data for decision making)*
8. Do you feel like you are able meet the needs for AYPs? What facilitates/impedes your ability to meet the mental health needs raised by AYP?
9. In your experience, what motivates youth to take up the mental health services you offer? *(Probe for enablers and facilitators to uptake and utilization of services at on individual, family, societal, organizational and health care levels)*
10. In your experience, what prevents AYP from taking up and utilizing these services? *(Probe on barriers to uptake and utilization)*

11. Is there anything else you would like to add?

****

That concludes our interview. Thank you so much for sharing your valuable thoughts and experiences with us.

References

Adinkrah, M. (2016). Anti-suicide laws in nine African countries: Criminalization, prosecution and penalization. *African Journal of Criminology and Justice Studies, 9*(1), 279.

Adu, J., & Oudshoorn, A. (2020). The deinstitutionalization of psychiatric hospitals in Ghana: An application of Bronfenbrenner's social-ecological model. *Issues in Mental Health Nursing*, *41*(4), 306-314.

Akesson, B., Burns, V., & Hordyk, S. R. (2017). The place of place in social work: Rethinking the person-in-environment model in social work education and practice. *Journal of Social Work Education*, *53*(3), 372-383.

Anastas, J. (2020, July 30). Ethics in Research. Encyclopedia of Social Work. Retrieved 29 Nov. 2023, from https://oxfordre.com/socialwork/view/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-135.

Atwoli, L., Ayuku, D., Hogan, J., Koech, J., Vreeman, R. C., Ayaya, S., & Braitstein, P. (2014). Impact of domestic care environment on trauma and posttraumatic stress disorder among orphans in western Kenya. *PloS One*, *9*(3), e89937.

Awiti, A., Orwa, C., Mbuvi, L., & Karumba, M. (2019). *Whole Youth Development in Kenya: Survey of employers and employees in the formal and informal sectors to determine entry-level skills among youth (18-30 yrs) in employment Kenya.* East African Institute. https://ecommons.aku.edu/cgi/viewcontent.cgi?article=1028&context=eastafrica_eai

Balaton-Chrimes, S. (2021). Who are Kenya's 42 (+) tribes? The census and the political utility of magical uncertainty. *Journal of Eastern African Studies*, *15*(1), 43-62.

Barbour, R. S. (2001). Checklists for improving rigour in qualitative research: A case of the tail wagging the dog?. *British Medical Journal*, *322*(7294), 1115-1117.

Basu, D., Nagpal, S., Pillai, R. R., Mutiso, V., Ndetei, D., & Bhui, K. (2022). Building youth and family resilience for better mental health: Developing and testing a hybrid model of intervention in low-and middle-income countries. *The British Journal of Psychiatry*, *220*(1), 4-6.

Bauer, M., Glenn, T., Geddes, J., Gitlin, M., Grof, P., Kessing, L. V., ... & Whybrow, P. C. (2020). Smartphones in mental health: A critical review of background issues, current status and future concerns. *International Journal of Bipolar Disorders*, *8*(1), 1-19.

Beksinska, A., Jama, Z., Kabuti, R., Kungu, M., Babu, H., Nyariki, E., ... & Kimani, J. (2021). Prevalence and correlates of common mental health problems and recent suicidal thoughts and behaviours among female sex workers in Nairobi, Kenya. *BMC Psychiatry*, *21*(1), 1-17.

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research*, *26*(13), 1802-1811.

Bitta, M. A., Kariuki, S. M., Gona, J., Abubakar, A., & Newton, C. R. (2019). Priority mental, neurological and substance use disorders in rural Kenya: Traditional health practitioners' and primary health care workers' perspectives. *PloS One*, *14*(7), e0220034.

Boulanger, S. (2008). A puppet on a string: The manipulation and nationalization of the female body in the "Female circumcision crisis" of colonial Kenya. *Wagadu: A Journal of Transnational Women's & Gender Studies*, *6*(1), 5.

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal*, *9*(2), 27-40.

Bronfenbrenner, U. (1979). The ecology of human development. Harvard University Press.

Burgess, R. A., Jain, S., Petersen, I., & Lund, C. (2020). Social interventions: A new era for global mental health?. *The Lancet Psychiatry*, *7*(2), 118-119.

Carlson, E. (2016). Anti-colonial methodologies and practices for settler colonial studies. *Settler Colonial Studies*, *7*(4), 496-517.

Casado, B. L., Negi, N. J., & Hong, M. (2012). Culturally competent social work research: Methodological considerations for research with language minorities. *Social Work*, *57*(1), 1-10.

Center for Disease Control and Prevention. (2019, January). *Teen births.* National Center for Health Statistics. https://www.cdc.gov/nchs/fastats/teen-births.html

Chibanda, D., Bowers, T., Verhey, R., Rusakaniko, S., Abas, M., Weiss, H. A., & Araya, R. (2015). The Friendship Bench programme: A cluster randomised controlled trial of a brief psychological intervention for common mental disorders delivered by lay health workers in Zimbabwe. *International Journal of Mental Health Systems*, *9*(1), 1-7.

Chibanda, D., Cowan, F., Verhey, R., Machando, D., Abas, M., & Lund, C. (2017). Lay health workers' experience of delivering a problem solving therapy intervention for common

mental disorders among people living with HIV: A qualitative study from Zimbabwe. *Community Mental Health Journal*, *53*(2), 143-153.

Central Intelligence Agency. (2023, February). *The world factbook-Kenya*. https://www.cia.gov/the-world-factbook/countries/kenya/

Ciesielska, M., Boström, K. W., & Öhlander, M. (2018). Observation methods. *Qualitative Methodologies in Organization Studies: Volume II: Methods and Possibilities*, 33-52.

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Sage.

D'Orta, I., Eytan, A., & Saraceno, B. (2022). Improving mental health care in rural Kenya: A qualitative study conducted in two primary care facilities. *International Journal of Mental Health*, *51*(4), 470-485.

Dei, G. S. (2012). Indigenous anti-colonial knowledge as 'heritage knowledge' for promoting Black/African education in diasporic contexts. *Decolonization: Indigeneity, Education & Society*, *1*(1).

Dei, G. J., Hall, B. L., & Rosenberg, D. G. (2000). *Indigenous knowledges in global contexts: Multiple readings of our world*. University of Toronto Press.

Dei, G. J. S., & Asgharzadeh, A. (2001). The power of social theory: The anti-colonial discursive framework. *The Journal of Educational Thought (JET)/Revue De La Pensée Éducative*, 297-323.

Dorsey, S., Lucid, L., Martin, P., King, K. M., O'Donnell, K., Murray, L. K., ... & Whetten, K. (2020). Effectiveness of task-shifted trauma-focused cognitive behavioral therapy for

children who experienced parental death and posttraumatic stress in Kenya and Tanzania: A randomized clinical trial. *JAMA Psychiatry*, *77*(5), 464-473.

Dorsey, S., Meza, R. D., Martin, P., Gray, C. L., Triplett, N. S., Soi, C., ... & Whetten, K. (2019). Lay counselor perspectives of providing a child-focused mental health intervention for children: Task-shifting in the education and health sectors in Kenya. *Frontiers in Psychiatry*, *10*, 860.

Doukani, A., van Dalen, R., Valev, H., Njenga, A., Sera, F., & Chibanda, D. (2021). A community health volunteer delivered problem-solving therapy mobile application based on the Friendship Bench 'Inuka Coaching'in Kenya: A pilot cohort study. *Global Mental Health*, *8*.

Eriksson, M., Ghazinour, M., & Hammarström, A. (2018). Different uses of Bronfenbrenner's ecological theory in public mental health research: What is their value for guiding public mental health policy and practice?. *Social Theory & Health*, *16*(4), 414-433.

Ezeugwu, C. R., & Ojedokun, O. (2020). Masculine norms and mental health of African men: What can psychology do?. *Heliyon*, *6*(12).

Falkov, A., Goodyear, M., Hosman, C. M., Biebel, K., Skogøy, B. E., Kowalenko, N., ... & Re, E. (2016). A systems approach to enhance global efforts to implement family-focused mental health interventions. *Child & Youth Services*, *37*(2), 175-193.

Finan, S. J., & Yap, M. B. (2021). Engaging parents in preventive programs for adolescent mental health: A socio-ecological framework. *Journal of Family Theory & Review*, *13*(4), 515-527.

Gakuya, D. W., Okumu, M. O., Kiama, S. G., Mbaria, J. M., Gathumbi, P. K., Mathiu, P. M., & Nguta, J. M. (2020). Traditional medicine in Kenya: Past and current status, challenges, and the way forward. *Scientific African*, *8*, e00360.

Galárraga, O., Kuo, C., Mtukushe, B., Maughan-Brown, B., Harrison, A., & Hoare, J. (2020). iSAY (incentives for South African youth): Stated preferences of young people living with HIV. *Social Science & Medicine*, *265*, 113333.

Getachew, A., & Mantena, K. (2021). Anticolonialism and the decolonization of political theory. *Critical Times*, *4*(3), 359-388.

Green, E. P., Cho, H., Gallis, J., & Puffer, E. S. (2019). The impact of school support on depression among adolescent orphans: A cluster-randomized trial in Kenya. *Journal of Child Psychology and Psychiatry*, *60*(1), 54-62.

Haase, S., Zweigenthal, V., & Müller, A. (2022). Using online spaces to recruit Kenyan queer womxn and trans men in restrictive offline settings. *Archives of Public Health*, *80*(1), 1-13.

Harms, S., Jack, S., Ssebunnya, J., & Kizza, R. (2010). The orphaning experience: Descriptions from Ugandan youth who have lost parents to HIV/AIDS. *Child and Adolescent Psychiatry and Mental Health*, *4*(1), 1-10.

Harper, G. W., Lewis, K. A., Norwitz, G. A., Odhiambo, E. O., Jadwin-Cakmak, L., Okutah, F., ... & Graham, S. M. (2021). “God didn’t make a mistake in creating me”: Intrapersonal resilience processes among gay and bisexual male youth in Kenya. *Adolescents*, *1*(3), 267-282.

Health Care Middle East and Africa. (2022, July). *Kenya's landmark decision to inaugurate the Mental Health Act 2022*. https://www.healthcareafrica.info/kenyas-landmark-decision-to-inaugurate-the-mental-health-act-2022/

Held, M. (2023). Decolonizing science: Undoing the colonial and racist hegemony of western science. *Journal of Multi Disciplinary Evaluation*, *19*(44), 88-101.

Hendler, R., Kidia, K., Machando, D., Crooks, M., Mangezi, W., Abas, M., ... & Jack, H. (2016). "We are not really marketing mental health": Mental health advocacy in Zimbabwe. *PLoS One*, *11*(9), e0161860.

Hetrick, S. E., Bailey, A. P., Smith, K. E., Malla, A., Mathias, S., Singh, S. P., ... & McGorry, P. D. (2017). Integrated (one-stop shop) youth health care: Best available evidence and future directions. *Medical Journal of Australia*, *207*(S10), S5-S18.

Ingham, K., Ominde,. Simeon Hongo and Ntarangwi,. Mwenda (2022, November 1). *Kenya*. *Encyclopedia Britannica*. https://www.britannica.com/place/Kenya

International Federation of Social Workers. (2014*). Global definition of social work.* https://www.ifsw.org/what-is-social-work/global-definition-of-social-work/

Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (2001). Community-based participatory research: Policy recommendations for promoting a partnership approach in health research. *Education for Health*, *14*(2), 182-197.

Itunga, Eddy. (2020, May 11). *LVCT Health Newsletter*. LVCT Health. https://lvcthealth.org/we-have-a-lot-of-fear-young-peoples-experiences-and-challenges-during-the-coronavirus-pandemic-a-call-for-action/

Jadwin-Cakmak, L., Lauber, K., Odhiambo, E. O., Collins, B., Gumbe, E., Norwitz, G. A., ... & Harper, G. W. (2022). "When you talk it out… you will feel like the burden has somehow gone down, you will feel light": Social support received by gay, bisexual, and other men who have sex with men in Western Kenya. *International Journal of Environmental Research and Public Health*, *19*(3), 1667.

Jakubec, S. L., & Campbell, M. (2003). Mental health research and cultural dominance: The social construction of knowledge for international development. *Canadian Journal of Nursing Research Archive*, 74-89.

Javadi, D., Feldhaus, I., Mancuso, A., & Ghaffar, A. (2017). Applying systems thinking to task shifting for mental health using lay providers: a review of the evidence. *Global Mental Health*, *4*.

Jenkins, R., Kiima, D., Okonji, M., Njenga, F., Kingora, J., & Lock, S. (2010). Integration of mental health into primary care and community health working in Kenya: Context, rationale, coverage and sustainability. *Mental Health in Family Medicine*, *7*(1), 37.

Johns Hopkins University & Medicine. (n.d.). *Mortality Analysis.* Retrieved December 16, 2022, from https://coronavirus.jhu.edu/data/mortality

Jordan, L. S., Seponski, D. M., Kelley, A., & Krpo, N. (2022). The politics of humanitarian aid. *Psychotherapy & Politics International*, *20*(1 & 2).

Kand, D., & Sesi, J. K. M. (2020). Criminalization of suicide intention as a prevention measure to committing suicide: A study of its impact among Christian believers from Muslim backgrounds in Dandora, Kenya. *International Journal of Social Sciences and Management Review. 03(06).*

Kanogo, T. (2005). *African womanhood in colonial Kenya, 1900-50*. Boydell & Brewer.

Karari, P. (2018). Modus operandi of oppressing the "savages:" The Kenyan British colonial experience. *Peace and Conflict Studies*, 25(1), 2.

Kenei, Steve (2018, May 30). *The needs of Kenyans by county: Exploring the latest poverty data.* Development Initiatives. https://devinit.org/blog/the-needs-of-kenyans-by-county-exploring-the-latest-poverty-data/

Demographic and Health Surveys (2022). *Kenyan Standard Demographic and Health Survey 2022*. https://dhsprogram.com/publications/publication-PR143-Preliminary-Reports-Key-Indicators-Reports.cfm

Kenya Ministry of Health (2017). *Task sharing policy guidelines 2017–2030: Expanding access to quality health services through task sharing.* Republic of Kenya Ministry of Health. https://www.hesma.or.ke/wp-content/uploads/2017/02/Task-Sharing-Guideline-2017.pdf

Kenya National Bureau of Statistics (2020). *Comprehensive poverty report: Children, youth, women, men and the elderly.* Republic of Kenya. https://www.genderinkenya.org/wp-content/uploads/2020/08/CPR-Report-10_08_2020.pdf

Khan, M. (2019). A social work perspective on Indigenous knowledges, anticolonial thought, and contemplative pedagogy: Thoughts on decolonization and resistance. *Journal of Critical Anti-Oppressive Social Inquiry*, *2*, 8-46.

Kilburn, K., Thirumurthy, H., Halpern, C. T., Pettifor, A., & Handa, S. (2016). Effects of a large-scale unconditional cash transfer program on mental health outcomes of young people in Kenya. *Journal of Adolescent Health*, *58*(2), 223-229.

Kimari, W., & Ernstson, H. (2020). Imperial remains and imperial invitations: Centering race within the contemporary large-scale infrastructures of East Africa. *Antipode*, *52*(3), 825-846.

Kimbui, E., Kuria, M., Yator, O., & Kumar, M. (2018). A cross-sectional study of depression with comorbid substance use dependency in pregnant adolescents from an informal settlement of Nairobi: Drawing implications for treatment and prevention work. *Annals of General Psychiatry*, *17*(1), 1-15.

Kinuthia, W. (2009). Educational development in Kenya and the role of information and communication technology. *International Journal of Education and development using ICT*, *5*(2).

Kleinheksel, A. J., Rockich-Winston, N., Tawfik, H., & Wyatt, T. R. (2020). Demystifying content analysis. *American Journal of Pharmaceutical Education*, *84*(1).

Kyere, E., & Khandare, L. (2020). The role of social work education in fostering empowerment of people of African descent: The significance of the history of slavery and colonialism. In *Global social work-cutting edge issues and critical reflections*. IntechOpen.

Lencucha, R., & Neupane, S. (2022). The use, misuse and overuse of the 'low-income and middle-income countries' category. *BMJ Global Health*, *7*(6), e009067.

Lewis, A. G. (2012). Ethics, activism and the anti-colonial: Social movement research as resistance. *Social Movement Studies*, *11*(2), 227-240.

Liang, J., Matheson, B. E., & Douglas, J. M. (2016). Mental health diagnostic considerations in racial/ethnic minority youth. *Journal of Child and Family Studies*, *25*(6), 1926-1940.

Liu, G., Jack, H., Piette, A., Mangezi, W., Machando, D., Rwafa, C., ... & Abas, M. (2016). Mental health training for health workers in Africa: A systematic review. *The Lancet Psychiatry*, *3*(1), 65-76.

Lombard, A., & Wairire, G. (2010). Developmental social work in South Africa and Kenya: Some lessons for Africa.

LVCT Health. (2023a). *About Us.* Who we are - LVCT Health

LVCT Health (2023b). *One2One*. https://lvcthealth.org/adolescent-young-people-one2one/

LVCT Health (2023c). *Self-Care.*. https://one2onekenya.org/topics/self-care

LVCT Health (2023d). *Self-Care Explained.* https://one2onekenya.org/articles/self-care-explained

Mackieson, P., Shlonsky, A., & Connolly, M. (2019). Increasing rigor and reducing bias in qualitative research: A document analysis of parliamentary debates using applied thematic analysis. *Qualitative Social Work*, *18*(6), 965-980.

Marangu, E., Mansouri, F., Sands, N., Ndetei, D., Muriithi, P., Wynter, K., & Rawson, H. (2021). Assessing mental health literacy of primary health care workers in Kenya: A cross-sectional survey. *International Journal of Mental Health Systems*, *15*, 1-10.

Marangu, E., Sands, N., Rolley, J., Mansouri, F., & Ndetei, D. (2014). Mental healthcare in Kenya: Exploring optimal conditions for capacity building: opinion paper. *African Journal of Primary Health Care and Family Medicine*, *6*(1), 1-5.

Marbin, D., Gutwinski, S., Schreiter, S., & Heinz, A. (2022). Perspectives in poverty and mental health. *Frontiers in Public Health*, *10*, 975482.

Marvasti, F. F., & Stafford, R. S. (2012). From "sick care" to health care: Reengineering prevention into the US system. *The New England Journal of Medicine*, *367*(10), 889.

Mathai, M., Stoep, A. V., Kumar, M., Kuria, M., Obondo, A., Kimani, V., ... & Rao, D. (2019). Building mental health research capacity in Kenya: A South-North collaboration. *Global Social Welfare*, *6*, 177-188.

Mathur, S., Okal, J., Musheke, M., Pilgrim, N., Kishor Patel, S., Bhattacharya, R., ... & Pulerwitz, J. (2018). High rates of sexual violence by both intimate and non-intimate partners experienced by adolescent girls and young women in Kenya and Zambia: Findings around violence and other negative health outcomes. *PloS One*, *13*(9), e0203929.

McDade, K. K., Munge, K., Kokwaro, G., & Ogbuoji, O. (2021, March 2). *Reducing Kenya's health system dependence on donors.* Brookings. https://www.brookings.edu/articles/reducing-kenyas-health-system-dependence-on-donors/

McLaughlin, K. A., Costello, E. J., Leblanc, W., Sampson, N. A., & Kessler, R. C. (2012). Socioeconomic status and adolescent mental disorders. *American Journal of Public Health*, *102*(9), 1742-1750.

Memiah, P., Ah Mu, T., Prevot, K., Cook, C. K., Mwangi, M. M., Mwangi, E. W., ... & Biadgilign, S. (2021). The prevalence of intimate partner violence, associated risk factors, and other moderating effects: Findings from the Kenya National Health Demographic Survey. *Journal of Interpersonal Violence*, *36*(11-12), 5297-5317.

Memiah, P., Lathan-Dye, M., Opanga, Y., Muhula, S., Gitahi-Kamau, N., Kamau, A., & Otiso, L. (2022a). Highlighting a Digital Platform to Assess Young People Needs: Reaching and Engaging Adolescents and Young Adults for Care Continuum in Health Project (REACH). *Adolescents*, *2*(2), 150-163.

Memiah, P., Wagner, F. A., Kimathi, R., Anyango, N. I., Kiogora, S., Waruinge, S., ... & Otiso, L. (2022b). Voices from the youth in Kenya addressing mental health gaps and recommendations. *International Journal of Environmental Research and Public Health*, *19*(9), 5366.

Menon, V., Subramanian, K., Selvakumar, N., & Kattimani, S. (2018). Suicide prevention strategies: An overview of current evidence and best practice elements. *International Journal of Advanced Medical and Health Research*, *5*(2), 43-51.

Meyer, A. C., & Ndetei, D. (2016). Providing sustainable mental health care in Kenya: A demonstration project. In *Providing sustainable mental and neurological health care in Ghana and Kenya: Workshop summary*. National Academies Press (US).

Meza, R. D., Kiche, S., Soi, C., Khairuzzaman, A. N., Nales, C. J. R., Whetten, K., ... & Dorsey, S. (2020). Barriers and facilitators of child and guardian attendance in task-shifted mental health services in schools in western Kenya. *Global Mental Health*, *7*.

Ministry of Health, Kenya. (2022). *Ministry of Health Mental Health Taskforce*. https://mental.health.go.ke/

Ministry of Health, Kenya. (2023). Ministry of Health Mental Health Taskforce Submission of Memoranda. https://mental.health.go.ke/submission-of-memoranda/

Ministry of Public Service, Youth and Gender Affairs. (2019). *Kenyan Youth Development Policy 2019.* Republic of Kenya. https://www.prb.org/wp-content/uploads/2020/06/Kenya-Youth-Development-Policy-2019.pdf

Ministry of Health, Kenya. (2020). *Mental Health Taskforce Report. Mental Health and Wellbeing- Towards Happiness and National Prosperity*. Republic of Kenya. https://mental.health.go.ke/download/mental-health-and-wellbeing-towards-happiness-national-prosperity-a-report-by-the-taskforce-on-mental-health-in-kenya/

Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research*, *25*(9), 1212-1222.

Mudeyi, M. (2021). Protecting the dignity of mentally ill offenders: The Kenyan context securing the dignity of persons with mental health issues and disabilities in the criminal justice system. *SSRN*, 4142483.

Muhingi, W. N., & Machani, S. O. (2022). Medical social work in Kenya: Scope, relevance, and utility. *The International Journal of Social and Development Concerns 16*, 2.

Muiruri, P. (2023, March 3). *Kenya's LGBTQ community wins bittersweet victory in battle for rights.* The Guardian. https://www.theguardian.com/global-

development/2023/mar/03/kenyas-lgbtq-community-wins-bittersweet-victory-in-battle-for-rights

Mukeku, J. (2018). Urban slum morphology and socio-economic analogies: A case study of Kibera Slum, Nairobi, Kenya. *Urbanisation*, *3*(1), 17-32.

Mundt, A. P., Frančišković, T., Gurovich, I., Heinz, A., Ignatyev, Y., Ismayilov, F., ... & Priebe, S. (2012). Changes in the provision of institutionalized mental health care in post-communist countries. *PloS One*, *7*(6), e38490.

Muroff, J., Edelsohn, G. A., Joe, S., & Ford, B. C. (2008). The role of race in diagnostic and disposition decision making in a pediatric psychiatric emergency service. *General Hospital Psychiatry*, *30*(3), 269-276.

Musyimi, C. W., Mutiso, V. N., Ndetei, D. M., Unanue, I., Desai, D., Patel, S. G., ... & Bunders, J. (2017). Mental health treatment in Kenya: Task-sharing challenges and opportunities among informal health providers. *International Journal of Mental Health Systems*, *11*(1), 1-10.

Muroff, J., Edelsohn, G. A., Joe, S., & Ford, B. C. (2008). The role of race in diagnostic and disposition decision making in a pediatric psychiatric emergency service. *General Hospital Psychiatry*, *30*(3), 269-276.

Mutahi, J., Larsen, A., Cuijpers, P., Peterson, S. S., Unutzer, J., McKay, M., ... & Kumar, M. (2022). Mental health problems and service gaps experienced by pregnant adolescents and young women in Sub-Saharan Africa: A systematic review. *EClinical Medicine*, *44*, 101289.

Mutua, J. N., & Kiruhi, T. M. (2021). Volunteer public leaders' values-driven leadership: The case of village elders in Kenya. *Heliyon*, *7*(3).

Mwagomba, B. L. M., Ameh, S., Bongomin, P., Juma, P. A., MacKenzie, R. K., Kyobutungi, C., ... & Berman, J. (2018). Opportunities and challenges for evidence-informed HIV-noncommunicable disease integrated care policies and programs: Lessons from Malawi, South Africa, Swaziland and Kenya. *Aids*, *32*, S21-S32.

Nama, N., & Swartz, L. (2002). Ethical and social dilemmas in community-based controlled trials in situations of poverty: A view from a South African project. *Journal of Community & Applied Social Psychology*, *12*(4), 286-297.

Nelson, Scott. (2019, October 14). *Why the wellness business is booming and how to succeed in the industry.* Forbes. https://www.forbes.com/sites/forbesbusinessdevelopmentcouncil/2019/10/14/why-the-wellness-business-is-booming-and-how-to-succeed-in-the-industry/?sh=50da1c2641aa

Njie, B., & Asimiran, S. (2014). Case study as a choice in qualitative methodology. *Journal of Research & Method in Education*, *4*(3), 35-40.

Ng'ang'a, P. W., Mathai, M., Obondo, A., Mutavi, T., & Kumar, M. (2018). Undetected psychiatric morbidity among HIV/AIDS patients attending Comprehensive Care Clinic (CCC) in Nairobi Kenya: Towards an integrated mental health care. *Annals of General Psychiatry*, *17*(1), 1-7.

Noble, H., & Heale, R. (2019). Triangulation in research, with examples. *Evidence-Based Nursing*, *22*(3), 67-68.

Nyerere, J. (2018). Youth unemployment in Kenya: Incorporating entrepreneurial and transferable skills in education. *Youth Entrepreneurship and Africa's Sustainable Industrialization*, *125*.

Ochieng, O., & Kamau, L. (2021). Critical analysis of section 226 of Kenya penal code: A case for urgent reform. *International Journal of Law and Policy*, *6*(1), 28-40.

Okonkwo, N. E., Aguwa, U. T., Jang, M., Barré, I. A., Page, K. R., Sullivan, P. S., ... & Baral, S. (2021). COVID-19 and the US response: Accelerating health inequities. *BMJ Evidence-Based Medicine*, *26*(4), 176-179.

Olcon, K. (2020). Confronting whiteness: White US social work students' experiences studying abroad in West Africa. *Journal of Teaching in Social Work*, *40*(4), 318-335.

Omari, F., Chrysanthopoulou, S. A., Embleton, L. E., Atwoli, L., Ayuku, D. O., Sang, E., & Braitstein, P. (2021). The impact of care environment on the mental health of orphaned, separated and street-connected children and adolescents in western Kenya: A prospective cohort analysis. *BMJ Global Health*, *6*(3), e003644.

One2One Kenya. *Top Topics.* https://one2onekenya.org/

Opiyo, P., Obange, N., Ogindo, H., & Wagah, G. (2018). The characteristics, extent and drivers of urban food poverty in Kisumu, Kenya. Maseno University Institutional Repository.

Osok, J., Kigamwa, P., Huang, K. Y., Grote, N., & Kumar, M. (2018). Adversities and mental health needs of pregnant adolescents in Kenya: Identifying interpersonal, practical, and cultural barriers to care. *BMC Women's Health*, *18*(1), 1-18.

Otiende, M. O., Nyaguara, A., Bottomley, C., Walumbe, D., Mochamah, G., Amadi, D., ... & Scott, A. (2022). Impact of COVID-19 on mortality in coastal Kenya: A longitudinal open cohort study. *MedRxiv*, 10.

Palattiyil, G., Sidhva, D., Pawar, M., Shajahan, P., Cox, J. (I), & Anand, J. C. (2019). Reclaiming international social work in the context of the global agenda for social work and social development: Some critical reflections. *International Social Work*, *62(3)*, 1043–1054.

Parker, C., Scott, S., & Geddes, A. (2019). *Snowball sampling.* SAGE Research Methods Foundations.

Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., De Silva, M., ... & Van Ommeren, M. (2007). Treatment and prevention of mental disorders in low-income and middle-income countries. *The Lancet*, *370*(9591), 991-1005.

Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., ... & UnÜtzer, J. (2018). The Lancet commission on global mental health and sustainable development. *The Lancet*, *392*(10157), 1553-1598.

Perkins, S., Nishimura, H., Olatunde, P. F., & Kalbarczyk, A. (2023). Educational approaches to teach students to address colonialism in global health: A scoping review. *BMJ Global Health*, *8*(4), e011610.

Perlis, R. H. (2022). Mending the holes in the suicide safety net. *JAMA network open*, *5*(7), e2225794-e2225794.

Pinchoff, J., Friesen, E. L., Kangwana, B., Mbushi, F., Muluve, E., Ngo, T. D., & Austrian, K. (2021). How has COVID-19-related income loss and household stress affected adolescent mental health in Kenya?. *Journal of Adolescent Health*, *69*(5), 713-720.

Power, M. (2009). The Commonwealth, 'development' and post-colonial responsibility. *Geoforum*, *40*(1), 14-24.

Probst, B. (2015). The eye regards itself: Benefits and challenges of reflexivity in qualitative social work research. *Social Work Research*, *39*(1), 37-48.

Puffer, E. S., Drabkin, A. S., Stashko, A. L., Broverman, S. A., Ogwang-Odhiambo, R. A., & Sikkema, K. J. (2012). Orphan status, HIV risk behavior, and mental health among adolescents in rural Kenya. *Journal of Pediatric Psychology*, *37*(8), 868-878.

Rabiee, F. (2004). Focus-group interview and data analysis. *Proceedings of the Nutrition Society*, *63*(4), 655-660.

Renwick, L., Pedley, R., Johnson, I., Bell, V., Lovell, K., Bee, P., & Brooks, H. (2022). Mental health literacy in children and adolescents in low-and middle-income countries: A mixed studies systematic review and narrative synthesis. *European Child & Adolescent Psychiatry*, 1-25.

Rhee, S. K., & Rha, J. Y. (2009). Public service quality and customer satisfaction: Exploring the attributes of service quality in the public sector. *The Service Industries Journal*, *29*(11), 1491-1512.

Rivera-Segarra, E., Mascayano, F., Alnasser, L., van der Ven, E., Martínez-Alés, G., Durand-Arias, S., ... & Susser, E. (2022). Global mental health research and practice: A decolonial approach. *The Lancet Psychiatry*, *9*(7), 595-600.

Roberts, K. J., Smith, C., Cluver, L., Toska, E., & Sherr, L. (2021). Understanding mental health in the context of adolescent pregnancy and HIV in sub-saharan Africa: A systematic review identifying a critical evidence gap. *AIDS and Behavior*, *25*(7), 2094-2107.

Roberts, T., Miguel Esponda, G., Krupchanka, D., Shidhaye, R., Patel, V., & Rathod, S. (2018). Factors associated with health service utilisation for common mental disorders: A systematic review. *BMC Psychiatry*, *18*(1), 1-19.

Rocha, J., Alonso, L., Mares-Tamayo, M. J. L., & McGovern, E. R. (2016). Beyond theoretical sensitivity: The benefits of cultural intuition within qualitative research and Freirean generative themes-four unique perspectives. *The Qualitative Report*, *21*(4), 744.

Roegner, A., Sitoki, L., Weirich, C., Corman, J., Owage, D., Umami, M., ... & Miller, T. R. (2020). Harmful algal blooms threaten the health of peri-urban fisher communities: A case study in Kisumu Bay, Lake Victoria, Kenya. *Exposure and Health*, *12*(4), 835-848.

Ruiz-Casares, M. (2014). Research ethics in global mental health: Advancing culturally responsive mental health research. *Transcultural Psychiatry*, *51*(6), 790-805.

Ryan, D. P. J. (2001). *Bronfenbrenner's ecological systems theory.* National-Louis University.

Sagar-Ouriaghli, I., Brown, J. S. L., Tailor, V., & Godfrey, E. (2020). Engaging male students with mental health support: A qualitative focus group study. *BMC Public Health*, *20*(1), 1-14.

Sankoh, O., Sevalie, S., & Weston, M. (2018). Mental health in Africa. *The Lancet Global Health*, *6*(9), e954-e955.

Semrau, M., Evans-Lacko, S., Alem, A., Ayuso-Mateos, J. L., Chisholm, D., Gureje, O., ... & Thornicroft, G. (2015). Strengthening mental health systems in low-and middle-income countries: The Emerald programme. *BMC medicine*, *13*, 1-9.

Sewpaul, V., & Henrickson, M. (2019). The (r) evolution and decolonization of social work ethics: The Global Social Work Statement of Ethical Principles. *International Social Work*, *62*(6), 1469-1481.

Shahmalak, U., Blakemore, A., Waheed, M. W., & Waheed, W. (2019). The experiences of lay health workers trained in task-shifting psychological interventions: A qualitative systematic review. *International Journal of Mental Health Systems*, *13*(1), 1-15.

Shukla, S., & Dash, B. M. (2020). Colonial legacy and professional imperialism in social work: Calls for bharatiyakaran/Indianisation of social work education in India. *African Journal of Social Work*, *10*(2), 16-22.

Siembida, E. J., Reeve, B. B., Zebrack, B. J., Snyder, M. A., & Salsman, J. M. (2021). Measuring health-related quality of life in adolescent and young adult cancer survivors with the National Institutes of Health Patient-Reported Outcomes Measurement Information System®: Comparing adolescent, emerging adult, and young adult survivor perspectives. *Psycho-Oncology*, *30*(3), 303-311.

Skeen, S., Kleintjes, S., Lund, C., Petersen, I., Bhana, A., Flisher, A. J., & The Mental Health and Poverty Research Programme Consortium. (2010). 'Mental health is everybody's business': Roles for an intersectoral approach in South Africa. *International Review of Psychiatry*, *22*(6), 611-623.

Skeen, S., Laurenzi, C. A., Gordon, S. L., du Toit, S., Tomlinson, M., Dua, T., ... & Melendez-Torres, G. J. (2019). Adolescent mental health program components and behavior risk reduction: a meta-analysis. *Pediatrics*, *144*(2).

Spitzer, H. (2019). Social work in East Africa: A mzungu perspective. *International Social Work*, *62*(2), 567-580.

Statistica. (2019). *Total population in Kenya in 2019 by county.* https://www.statista.com/statistics/1227219/most-populated-counties-of-kenya/

Tamburrino, I., Getanda, E., O'Reilly, M., & Vostanis, P. (2020). "Everybody's responsibility": Conceptualization of youth mental health in Kenya. *Journal of Child Health Care*, *24*(1), 5-18.

Tele, A. K., Carvajal-Velez, L., Nyongesa, V., Ahs, J. W., Mwaniga, S., Kathono, J., ... & Kumar, M. (2023). Validation of the English and Swahili adaptation of the patient health questionnaire–9 for use among adolescents in Kenya. *Journal of Adolescent Health*, *72*(1), S61-S70.

Thornicroft, G., Deb, T., & Henderson, C. (2016). Community mental health care worldwide: Current status and further developments. *World Psychiatry*, *15*(3), 276-286.

Titchkosky, T., & Aubrecht, K. (2009). The anguish of power: Remapping mental diversity with an anticolonial compass. In *Breaching the Colonial Contract* (pp. 179-199). Springer, Dordrecht.

Tribe, R. (2014). Culture, politics and global mental health. *Disability and the Global South*, *1*(2), 251-265.

UNAIDS. (2022). *Kenya country profile.* https://www.unaids.org/en/regionscountries/countries/kenya

UNAIDS Estimates. (2021). *Prevalence of HIV total, Kenya*. https://data.worldbank.org/indicator/SH.DYN.AIDS.ZS?locations=KE

Ushie, B. A., Juma, K., Kimemia, G., Magee, M., Maistrellis, E., McGovern, T., & Casey, S. E. (2020). Foreign assistance or attack? Impact of the expanded Global Gag Rule on sexual and reproductive health and rights in Kenya. *Sexual and Reproductive Health Matters*, *28*(3), 23-38.

Van Breda, A. D. (2019). Developing the notion of Ubuntu as African theory for social work practice. *Social Work*, *55*(4), 439-450.

Van Nes, F., Abma, T., Jonsson, H., & Deeg, D. (2010). Language differences in qualitative research: is meaning lost in translation?. *European Journal of Ageing*, *7*, 313-316.

Verhey, R., Chibanda, D., Vera, A., Manda, E., Brakarsh, J., & Seedat, S. (2020). Perceptions of HIV-related trauma in people living with HIV in Zimbabwe's Friendship Bench Program: A qualitative analysis of counselors' and clients' experiences. *Transcultural Psychiatry*, *57*(1), 161-172.

Voronka, J. (2017). Turning mad knowledge into affective labor: The case of the peer support worker. *American Quarterly*, *69*(2), 333-338.

Wach, E., & Ward, R. (2013). Learning about qualitative document analysis. *IDS Practice Paper in Brief 13,* Brighton: IDS

Wainberg, M. L., Scorza, P., Shultz, J. M., Helpman, L., Mootz, J. J., Johnson, K. A., ... & Arbuckle, M. R. (2017). Challenges and opportunities in global mental health: A research-to-practice perspective. *Current Psychiatry Reports*, *19*(5), 1-10.

Wairire, G. G. (2014). The state of social work education and practice in Kenya. *Professional social work in East Africa: Towards social development, poverty reduction and gender equality* (pp. 93-107). Fountain Publishers.

Wall, J. T., Kaiser, B. N., Friis-Healy, E. A., Ayuku, D., & Puffer, E. S. (2020). What about lay counselors' experiences of task-shifting mental health interventions? Example from a family-based intervention in Kenya. *International Journal of Mental Health Systems, 14*(1), 1-14.

Wallén, A., Eberhard, S., & Landgren, K. (2021). The Experiences of counsellors offering problem-solving therapy for common mental health issues at the youth friendship bench in Zimbabwe. *Issues in Mental Health Nursing*, *42*(9), 808-817.

Walter, M. (2018). *Language effects on mental health stigma*. [Master's thesis, Washburn University].

https://wuir.washburn.edu/server/api/core/bitstreams/91ad7937-b4fe-4973-9986-c5c0e8472908/content

Wane, N. N. (2008). Mapping the field of indigenous knowledges in anti-colonial discourse: A transformative journey in education. *Race Ethnicity and Education*, *11*(2), 183-197.

Waruiru, W., Kim, A. A., Kimanga, D. O., Schwarcz, S., Kimondo, L., Umuro, M., ... & Maina, W. K. (2014). The Kenya AIDS indicator survey 2012: Rationale, methods, description

of participants, and response rates. *Journal of Acquired Immune Deficiency Syndromes (1999)*, *66*(Suppl 1), S3.

Wasil, A. R., Osborn, T. L., Venturo-Conerly, K. E., Wasanga, C., & Weisz, J. R. (2021). Conducting global mental health research: Lessons learned from Kenya. *Global Mental Health*, *8*.

White, K. (2017). The social construction of mental illness. In *Routledge international handbook of critical mental health* (pp. 24-30). Routledge.

WHO Newsroom. (2021, May 23). *Experts join forces for mental health in Kenya.* https://www.who.int/news-room/events/detail/2021/05/23/default-calendar/experts-join-forces-for-mental-health-in-kenya

Williams, M., & Moser, T. (2019). The art of coding and thematic exploration in qualitative research. *International Management Review*, *15*(1), 45-55.

Winter, S. C., Obara, L. M., & McMahon, S. (2020). Intimate partner violence: A key correlate of women's physical and mental health in informal settlements in Nairobi, Kenya. *PloS one*, *15*(4), e0230894.

National Association of Social Workers. (2021). *NASW code of ethics.* https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

World Bank. (2022). *Population ages Kenya.* United Nations Population Division. https://data.worldbank.org/indicator/SP.POP.65UP.TO.ZS?locations=KE

World Bank. (2023). *World Bank country and lending groups.* https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups

World Health Organization. (2004). *Promoting mental health: Concepts, emerging evidence, practice: Summary report*. World Health Organization. https://www.who.int/publications/i/item/9241562943

World Health Organization (2022). *World mental health report: Transforming mental health for all.* World Health Organization. https://archive.hshsl.umaryland.edu/bitstream/handle/10713/20295/WHO%20Report%202022.pdf?sequence=1&isAllowed=y

Zijlstra, I. (2014). The turbulent evolution of homosexuality: From mental illness to sexual preference. *Social Cosmos*, *5*(1), 29-35.

Zimmerman, A., Garman, E., Avendano-Pabon, M., Araya, R., Evans-Lacko, S., McDaid, D., ... & Lund, C. (2021). The impact of cash transfers on mental health in children and young people in low-income and middle-income countries: A systematic review and meta-analysis. *BMJ global health*, *6*(4), e004661.