

**Exploring the challenges of meeting child mental health needs
through community engagement in Kenya**

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Word count: 6,520

ABSTRACT

Background: Despite growing evidence on the extent of child mental health problems in low-middle-income countries, the gap between need and provision remains high. Previous research in high income countries has demonstrated that evidence-based interventions can be scaled-up through community consultation, particularly by engaging key stakeholders.

Aims: This study aimed to explore community stakeholders' views on children's mental health needs and culturally acceptable interventions in Kenya, to ascertain how to integrate global service standards with culturally-specific expectations.

Methods: Focus groups were conducted with community stakeholders (seven people 14-17 years, seven parents, nine teachers and 11 other professionals). These participants were recruited from an urban community of internally displaced and disadvantaged families in Nakuru.

Results: Results indicated that Kenya faced similar challenges in meeting mental health needs as in other countries, including economic constraints, limited knowledge, stigma and systemic issues, but that these were manifested in culturally-specific ways that were linked to societal and professional's attitudes and local context.

Conclusions: Stakeholders' views are important in informing the planning, delivery and evaluation of interventions. However, for such interventions to be sustained, a clear therapeutic framework, evidence-base and socio-cultural adaptation are likely to be important factors.

Key Practitioner Message

- Stakeholders' views are important in informing the planning, delivery and evaluation of interventions.
- Interventions and services can be scaled up through community consultation, particularly by engaging key community stakeholders.
- Evidence-based interventions should reflect the local context, maximise available resources, and be culturally acceptable.

Key words: Community programmes, Mental health, Poverty, Refugees, Third World children,

BACKGROUND

Many children in low- and middle-income countries (LMIC) grow up in poverty. They experience adverse circumstances such as drought, famine, intrastate conflict, [and/or](#) being trafficked for labour or commercial sex (Kohrt, 2013). The combination of threats can thus adversely influence their physical, social and mental health outcomes (Sawyer et al., 2008). These factors can mitigate children's quality of life, without which they will not develop skills to cope with future adverse circumstances (Jordans et al., 2009; WHO, 2012). Indeed, child mental health problems in LMIC have strong continuities with mental illness in later life, limited educational achievement, violence, poor sexual health and substance abuse (Patel et al., 2007a). [This clearly has an impact on the children who experience such adversities, and it is important that steps are taken to support their needs to facilitate recovery and promote their wellbeing. Through supporting children with mental health difficulties, we can reduce the social, emotional and economic consequences on families and society \(Atiola, 2014\) and on the children, themselves.](#)

Globally, at least 10% of children and young people suffer from mental health problems that impact on their daily functioning, but in LMIC there is a particularly large gap between needs and provision (Klasen & Crombag, 2012; Ehiemua, 2014). For example, in the sub-Saharan African region, mental health incidence is high, with primary care and sparse specialist services struggling to cope with demand (Kiima & Jenkins, 2010). This is due to a range of factors, including poor knowledge about child development and mental health problems (Juengsiragulwit, 2015), lack of advocacy (Sharan & Sagar 2007), and limited financial or professional resources (Kleintjes et al., 2010). Furthermore, there is often low capacity and motivation of health workers to provide quality mental health services alongside an unreliable networking infrastructure (Patel et al., 2007b).

To close the gap of unmet needs in LMIC, it is necessary to develop effective evidence-based interventions (EBIs) which are culturally appropriate and acceptable (Jordans et al., 2016). Problematically, interventions that do exist either lack robust evidence-base (Kohrt, 2013) or have been translated from high income countries (HIC) (Klasen & Crombag, 2013). Programmes targeting child mental health problems in LMIC should be planned in relevant and culturally appropriate ways (Jordan et al., 2016). To achieve this, it is necessary to first understand the [strengths](#), barriers and relevant cultural issues from the local community perspective (Patel et al., 2010). When community stakeholders are engaged, even in difficult circumstances, it has been demonstrated that their concepts of mental health are not that incongruent from those western countries (Ahmed & Palermo, 2010); and that they tend to seek individual, family and community supports for their children (Betancourt et al., 2013). Such consultation has been found to be feasible and to enhance the validity of interventions and research findings (Bryan & Henry, 2012; Yamey, 2012). [If both care and research are client-centred and client-driven, they are more likely to be acceptable to communities, thus resulting in evidence-based interventions in their sociocultural context that can also be sustainable.](#)

Research aims and context

[The rationale for this study was to examine such stakeholders' perspectives in a disadvantaged community in Kenya. The aims of this study were to: a\) explore community stakeholders' views on children's mental health needs and culturally acceptable interventions in Kenya, and; b\) to ascertain the most appropriate ways to integrate global service standards with a culturally-specific framework.](#)

Kenya is one of the poorest countries in the world, with widespread socioeconomic challenges, including violence, displacement, famine, unemployment and border troubles (Getanda et al., 2015). It has a population of 46.1 million (Ayuku et al., 2014), with half being children, one in ten of whom die before the age of five years (WHO, 2011). Importantly, Kenya has met few of the Millennium Development Goals targets that particularly reflect risks to children's health (World Bank, 2016). The healthcare system tries to tackle these issues through a six-level structure of volunteer community health workers, dispensaries, health centres; district general, provincial and national referral hospitals. Mental health services delivery has been given little attention, and is largely concentrated in higher level services, with limited community input. There are no comprehensive policies and legislative framework available, even though mental health is mentioned in various health policy documents (Kiima & Jenkins, 2010).

METHODS

This research utilised a qualitative thematic design to ensure that the findings were participant-led and data-driven. Consistent with this design, a social constructionist framework guided the analysis as this ensures a focus on the language used by participants, and recognises that childhood and mental health, are in themselves social constructs (O'Reilly and Lester, in press). This provided a mechanism to explore an area of mental health that has previously received limited attention; to address the question, 'what are the mental health needs of children in Kenya and the most appropriate ways to address them from the perspective of key stakeholders?

Participants

This study was conducted in Nakuru County, Kenya, which has approximately 1.7 million inhabitants from different ethnic groups (Getanda et al., 2015). The area was selected for both

service and research purposes, because of the high proportion of internally displaced population following ethnic violence, which is now exposed to extreme socioeconomic deprivation. Participants were recruited from a slum in Nakuru city. Purposive sampling was used to recruit key community stakeholders to four focus groups. These consisted of children, aged 14-17 years from a selected school, their parents, teachers, and professionals in contact with children such as probation officers, social workers, counsellors, police officers, church leaders and administrators.

The school was selected because of its population in terms of poverty and internal displacement. Participating children were selected following the first three children on the register of each year (14, 15, 16 and 17 years), while their parents and teachers were also invited to take part. Professionals operating in the same area were identified through teachers. The groups thus consisted of seven children, seven parents, nine teachers and 11 professionals or community leaders. Focus groups were conducted either in English or Swahili (the local language) by the lead author of the paper, who also provided any translation needed. Focus groups were guided by a relatively open schedule of questions that focused on the general areas of mental health need and emotional wellbeing, with some questioning regarding the useful translation of mental health interventions (strengths and challenges). All focus groups were audio-recorded, alongside taking field notes, until saturation was reached. Thus, sampling adequacy was assured, which meant that data collection continued until no new issues were discussed, as this is an appropriate quality indicator for thematic research (see O'Reilly and Parker, 2013). In accordance with guidelines for focus group research, saturation was assured both within and across the focus groups to promote transparency and trustworthiness (Hancock et al., 2016).

Research ethics approval was provided by the University of Leicester and the National Commission for Science, Technology and Innovation in Kenya. Additionally, approval was granted by the Nakuru County Ministry of Education and the School Principal. All adult participants provided informed consent, whilst participation was discussed with the young people prior to attending the group.

Data analysis

Data were analysed using a thematic framework to identify the salient issues raised by the stakeholders. Thematic analysis is a useful approach when engaging in an exploratory study and seeking to identify important areas of concern from the perspective of participants (Braun and Clarke, 2006). All English language recordings were transcribed directly, and those in Swahili were translated by the lead author. Data were coded facilitated by NVivo, and analysis involved a three-step process of: i) familiarisation with the data, i.e. transcribing and reading; ii) initial coding, i.e. the meaning of any phenomena, and; iii) searching for themes by categorisation of codes. In practice, this utilised a ‘pawing’ technique to coding, and collapsing categories into broader themes by relevance (Ryan and Bernard, 2003). This relies on a general ‘eyeballing’ technique, relying on familiarisation and repeated sorting (Bernard, 2000). Inter-coder reliability was assured through the creation of an initial coding framework in NVivo by the lead author, and a manual checking process by the other two authors in relation to the research question.

RESULTS

Thematic analysis resulted in the identification of four salient themes that demonstrated community stakeholders’ views on the challenges and potential solutions for meeting CAMH needs. These four themes were: 1) economic challenges and lack of resources; 2) limited mental

health knowledge and lack of culturally appropriate interventions; 3) stigma, and; 4) systemic issues.

Theme One: Economic challenges and lack of resources

Limited resources for addressing mental health is a global problem, even for high income countries, as mental health is often not prioritised by health services; but this is especially prominent in low-income countries (Prince et al., 2007). Participants identified that poverty in itself can derail mental health services, as well as contribute to poor mental health, due to housing conditions and lack of food. In such a way, economic challenges are multidimensional at the level of services, communities and families. For example, at the level of the family and community, participants talked about their social conditions and considered how those impacted on children's mental health. At service level, resources were unevenly distributed.

“The funds that people are contributing, is not enough to open those places.”

(Child 1)

“Child friendly initiatives are only in the urban centres.”

(Psychologist)

There was recognition amongst all groups of participants, including the children, that mental health is an area that needs to be better supported by funding and initiatives that are more widely spread. For example, participants argued that some initiatives, such as ‘child friendly initiatives’ are not available across the country, but just in some areas, such as in the ‘urban centres’. Participants reported that mental health services were insufficient in relation to the

number of children affected by emotional or behavioural difficulties, and that what was available tended to be ineffective.

“Many a times counselling is done by teachers, not professional guidance and counsellors...sometimes we are not so much well versed with it. So, there are things that we may assume, or there are things that we may do the wrong way.”

(Teacher 4)

Responsibility for children’s mental health is generally considered to be shared across agencies, and in most countries schools play an important role in identifying and supporting needs. In LMIC this is also the case, and yet because of economic circumstances it may be problematic that too much burden is placed on teachers when they ‘*may do the wrong way*’. In other words, teachers expressed concern that they were ill-equipped to manage difficulties presented within school, because of insufficient capacity and resources for ‘*professional guidance*’. Although it was recognised that there were no simple solutions to a national economic shortfall, participants did offer realistic proposals. They specifically argued that care equity was an ideological goal for their country, and that this ought to be available in strategic ways to ensure easy access, juxtaposed with the right motivation from professionals involved. *In other words, individual professionals were important in addressing mental health need as to work ‘with children’ requires a certain type of person.*

“Working with children, it requires people with passion and commitment.”

(Policeman)

“What you are going to guide the children or the community should come from the heart, so that you can be able to deliver what is right.”

(Teacher 8)

In many ways, the solutions suggested by participants for managing through economic crises mirror those for any country, as ultimately some of these the solutions lie with practitioners on the frontline. ‘*Passion*’, ‘*commitment*’ and delivering support ‘*from the heart*’ are attributes that are important when working with children; and identifying and retaining these individuals is part of a solution. Of course, additional resources remain essential, if we are to meet the global need for prevention and treatment of child mental health as “there is no health without mental health” (WHO, 2005) and it was argued that government budgets were important in meeting this.

“The governments should also set a budget specifically for...mental health.”

(Psychologist)

The issue of resources is clearly advocated by this psychologist, who also positions some responsibility with the ‘*government*’ by claiming that there should be a specific ‘*budget*’ for ‘*mental health*’. Indeed, this is an issue globally, as it is well known that even in high income countries, budgets that are specific to mental health tend to be rather low (London School of Economics and Political Science, 2012).

Theme Two: Limited mental health knowledge and lack of culturally appropriate interventions

In LMIC such as Kenya, mental health is not fully or consistently understood, and this has implications for the way children are supported. Evident from the data is that mental health

difficulties in children are only recently being recognised in Kenya, and there is still the prevailing view that many people in that society still have a limited understanding of the emotional challenges faced by children.

“Mental health is a new concept in Africa. And many people are ignorant on the issue of mental health.”

(Pastor)

“Friend of mine came and asked me what she should, what she should do if she can commit suicide. And I really, I didn’t know what to tell her!”

(Child 1)

Participants pointed out that lack of knowledge was problematic at different levels. For instance, it was noted that generally communities had poor knowledge of mental health, ‘*many people are ignorant on the issue of mental health*’, which had impact at an individual level, as consequently people did not know how to respond when faced with such issues. This is evident from the child’s report that they did not know how to support their friend *‘I didn’t know what to tell her’*.

“The root cause of some of these problems, are never handled well.”

(Teacher 7)

“We are always doing very little, and sometimes irrelevantly, and sometimes with wrong responses to the mental challenges that our youths are facing in the society.”

(Pastor)

Such ineffective practices were considered to be exacerbated by the failure of securing a longer-term approach to mental health care, as often the programmes applied were not sustained. Such a lack of knowledge was reported to be contributing to failing children in their care. For example, participants reported that children's problems were '*never handled well*', and with the '*wrong responses*'. For example, the pastor here recognised that there are '*mental health challenges*' faced by young people in Kenyan society, but that as a community '*very little*' is being done to address child mental health need. Furthermore, there was some recognition that the mental health symptoms were only part of the problem, and that the '*root cause*' was not being addressed adequately, which suggests that the complexity of the situation in Kenya needs to also be considered in any approach taken.

"If there is no proper follow-up, one may think within one, six months or one year, you have already put things right; without continuous follow-up, eventually the person will go back."

(Teacher 6)

Without continuing care, children's difficulties are likely to recur, particularly if these were insufficiently supported in the first place. Consequently, '*the person will go back*' and require further interventions in time. In other words, it was recognised that '*follow-up*' was necessary.

Arguably, part of the challenge is the nature of the interventions being applied, are often within a western framework. Much of the research conducted in addressing child mental health difficulties is conducted in Western situations and applied to children living in those countries. However, it was argued by the participants that any interventions applied to children in Kenya

need to account for the local cultural context that those children are living within, and the specific adversities faced by them.

“Africa as a continent had its own values. Those values have now been ignored completely, and now we have actually brought in western values, western concepts. Africa had its own system of regulating mental health ... that’s no longer happening.”

(Psychologist)

“We have tried many of these [western] solutions, sometimes they are still failing us.”

(Social worker 1)

It was made clear that some interventions were imposed on them to use, without cultural norms and appropriateness being considered. They argued that there was a lot of confusion on what programmes to use, particularly as many of those reflected ‘*western values, western concepts*’. As a result of not recognising that Africa ‘*has its own values*’, the solutions offered are ‘*failing us*’. Across all groups, participants suggested that immediate action was required to improve services by making them culturally acceptable and effective.

“I think we should repeat some ideas. If someone has put an idea and sees it’s not working, he may repeat again and again, so that the people may understand the idea well.”

(Child 6)

“I think we need to do a bit of benchmarking in terms of trying to understand what is happening in other places ...I feel we have to go out, source for ideas. Ideas which can really work for our situation.”

(Social worker 1)

Evidently, while learning from the mental health situation elsewhere can provide a useful comparison benchmark for knowledge in Kenya, the uniqueness of the local situation is essential in addressing mental health problems faced in that cultural context. Such interventions thus need to be delivered by professionals with appropriate skills, and should be flexible and sustainable to meet local needs.

Theme Three: Stigma of mental health

It has been argued that lack of knowledge is a key factor leading to stigmatising attitudes against mental health (Link & Cullen, 1983). Clearly there is a need to improve mental health awareness, as demonstrated by Theme Two, but also to tackle the stigma associated with it. Stigma is ubiquitous, but in Kenya particularly, mental health remains a widely misunderstood topic, especially in rural areas (Getanda et al., 2015). Consequently, this affects the way in which children with mental health difficulties were reported to be treated in Kenya, resulting in them being fearful of disclosure.

“Africa has grown up in, that is associated with the stigma of having a mentally challenged child in, in our midst.”

(Pastor)

“They don’t want, they don’t want to share, because they fear maybe what if I tell this person, and this and this, how will he think about me? May be there is, they don’t like, may be you may make fun of them.”

(Child 1)

Western research has demonstrated that stigma associated with mental distress has a negative impact on help-seeking behaviours (Schomerus & Amgermeyer, 2008). It is, therefore, perhaps unsurprising that this was mirrored in the African context. Participants reported that children with mental distress did not *'want to share'* because of *'fear'*. Children articulated that the result of mental distress was that others *'may make fun of them'*. This was further exacerbated by the potential ways in which they may be treated if identified, in terms of how African society appeared to cope.

"In traditional African society, to cope was by simply isolating a person mentally challenged.."

(Pastor)

Despite the inherent stigma associated with mental distress, participants acknowledged that it was important that communities accept this, and that the main solution is to raise awareness and encourage children and society to talk about it. In essence, therefore, a proposed solution was to start to recognise within the community that mental health difficulties are inherent within Kenya and to start a dialogue about child mental health need creates a way forward. Notably, *'simply isolating a person mentally challenged'* was deemed insufficient, and yet argued to be a traditional method for dealing with those who experienced mental distress.

"We need to appreciate the mental problem that we have in our society, and we need to begin speaking about it. That's when we get a solution to it. But the more we keep quiet, the more the society is going ill."

(Policeman)

“If they open up their mind, their hearts and, and, and talk about those problems, there, there will be help given to them.”

(Child 1)

Although the phraseology is different for these two participants, the point that the child and police officer were making was that mental and emotional health difficulties exist among the children of Kenya, and that by failing to address and acknowledge that it created problems. Notably, the child participant here recognised the value in talking ‘*about those problems*’ and framed this as the need to ‘*open their mind, their hearts*’. The police officer concurred that talking about mental health was an important part of the solution, and argued that society more generally needs to be more open as keeping quiet, makes society ‘*more ill*’. Indeed, the stigma created by a shroud of secrecy around mental health contributes to the problem encountered overall.

Theme Four: Systemic issues

The wider challenges of resources and stigmatising attitudes were also reflected at family level. For some parents, not fully attending to the child’s mental health needs was a necessity because of long working hours, whilst for others it was reported to be unawareness of the child’s needs. The family plays a central role in meeting children’s needs, and in western communities, it is usually the parents who initiate help-seeking when their child displays behaviours or emotions that are consistent with mental health need (Wolpert and Fredman, 1994).

“We are extremely busy and are preoccupied with trying to create a living. So in the process, our children, our young people are left on their own.”

(Church Elder)

“Parents have become reluctant. When she’s quiet, we really don’t care.”

(Parent 2)

“Some parents are so ignorant that they are not able to identify the stages of growth of these children.”

(Teacher 4)

Being busy or ‘*preoccupied to create a living*’ while the ‘*young people are left on their own*’ can be barriers for children to access the support they need. Thus, families felt they had to prioritise how they spend their time, and supporting the household financially was considered most important. However, it was also noted that some parents did not connect with their children at home ‘*when she’s quiet, we really don’t care*’, which for some was constructed as lacking knowledge or awareness of how to help their child ‘*some parents are so ignorant*’. Problematically, it was recognised that when children with problems were left on their own, they became frustrated, confused and made the wrong choices.

“That if they take those drugs, they are able to solve problems they perceive to be having.”

(Teacher 6)

A good example of how children may make the wrong choices when parents were not attending to their needs fully, was offered by this teacher, who argued that those children may turn to substances. It was argued by participants that it was not unusual for these children to ‘*solve problems*’ with ‘*drugs*’. The influence of parents on the child’s problems were also reported to be related to the well-established association between parental and child mental health, which

is consistent across cultures (Thabet et al., 2008). Participants acknowledged that there was an important link between the mental status of parents and that of their children, thus the need for a holistic approach.

“We the parents, we also are the victims of mental problem. So, we try to address a child who has mental problem, yet I myself I have a mental problem. So, it becomes difficult to address the issue of the child while I, myself I am a sick, I am a victim of it.”

(Policeman)

Participants argued that, to address these systemic issues, it is important that caregivers were made aware of the emotional and behavioural impact on their children, as they played a central role in prevention and treatment; as well as that children also needed to acquire knowledge. The participants acknowledged that parents play an essential role in addressing the mental health needs of their children. Indeed, they recognised that in some cases this was challenging for parents as the parents themselves may also be ‘sick’, that is a ‘victim’ of mental distress themselves. Thus, in trying ‘to address a child who has mental problems’ there is the challenge of helping the parents too. Nonetheless, the role of the parents was an essential aspect of helping the child to overcome their mental health difficulties, and participants felt that they could be educated in these matters to facilitate this.

“The parents must be sensitised through various awareness programmes, so that they can take their rightful roles on issues of mental health.”

(Psychologist)

“Train peer counsellors, the children themselves.”

(Teacher 1)

“To train and actually to employ the counsellors who will actually be facilitating, or who will be teaching the issues of the mental health care.”

(Chief 1)

Notably, the need for training was viewed as multidimensional and reaching out to a range of different stakeholders, including ‘peer counsellors’ and ‘the children themselves’, as well as ‘parents’ who should be ‘sensitised through various awareness programmes’. Similarly, it was suggested that professionals such as counsellors, should have regular training to provide sustainable quality services. The suggestion therefore is that education is a key way forward in tackling the problem of mental health.

DISCUSSION

The purpose of this study was to examine the views of community stakeholders improving awareness of and response to child mental health problems in Kenya. These reflected their experiences of challenges facing poor communities in the developing world. Consistent with the literature (e.g. Patel et al., 2007b; Kleintjes et al., 2010), the major challenges identified were: economic challenges and lack of resources; limited mental health knowledge; lack of culturally appropriate interventions; stigma against mental health; and systemic issues.

According to epidemiological research, economic challenges, especially poverty, are associated with common mental health problems by increasing a number of risk factors. Key areas of social life are thus affected, including health status, health care utilisation, distribution of income and access to education. For instance, children from disadvantaged families are up

to three times more likely to have mental health problems than their peers (Reiss, 2013). Similarly, young people who live in poverty are more likely to experience mental health problems, whilst those who already live with mental disorders are vulnerable to be trapped in poverty (Patel et al., 2007a). Studies in LMIC countries have shown that scarcity and inequities in distribution of infrastructure, funding, human and community resources, and facilities are major obstacles (Patel et al., 2007b; Jenkins et al., 2010).

Lack of mental health knowledge acts as a barrier to seeking and utilising mental health services in LMIC. When communities are poorly informed about mental health and illness, care pathways and service provision are inevitably affected (Patel et al., 2007a). Awareness is thus a pre-requisite to help-seeking (Rickwood et al., 2007). Notably, cultural beliefs and practices influence the delivery of mental health care, depending on how different cultural groups construe mental health. This in turn affects the way policies, plans, and interventions are formulated and implemented. Consequently, evidence-based treatments developed in high-income countries are only a partial solution. These can only be appropriate and effective through cultural adaptation that entails the use of knowledge and appropriate processes such as language, culture and context (Jordans et al., 2011).

Stigma and discrimination associated with mental disorders can enhance suffering and social exclusion. Stigma is more prevalent in LMIC, especially in Africa, where mental illness remains a taboo subject (Amuyunzu-Nyamongo, 2013). Families with poor mental health knowledge can either stigmatise their own children or they can be stigmatised themselves by the community (Knifton, 2012). Consequently, delayed help-seeking, for fear of social consequences such as shame can be problematic. For instance, children with mental health difficulties often suffer abuse, are excluded from education, and experience harsh physical

punishment such as physical restraint or being locked in the house (Ehiemua, 2014). However, there is also encouraging evidence that, through psychoeducational interventions, stigmatising beliefs can change (Killion & Cayetano, 2009). The contribution of these findings to the existing literature is that these views were shared by four stakeholders groups, representing both users and providers and, crucially, that these stakeholders integrated these challenges in the development of future culturally appropriate interventions.

Engaging parents was another challenge identified by interviewees, including parents themselves. The safety, stability, emotional sensitivity and well-being of parents are crucial predictors of children's mental health (Werner, 2012). Inconsistent, rejecting and harsh parenting styles have been shown to predict child mental health problems in many cultures (Sriskandarajah et al., 2015). Negative child rearing is strongly associated with both parental and child psychopathology (Vostanis et al., 2006). Similarly, parental mental disorders are associated with domestic violence, alcohol and substance abuse, family breakdown, child abuse and neglect. Thus the integration of awareness strategies that target cultural beliefs and stigma with promotion of parenting skills and parental mental health are essential components of family interventions in LIMC (Wieling et al., 2015).

It is recognised that this study has some limitations in the generalisability of the findings. The sample of stakeholders was selected from a particular ethnic, cultural and socioeconomic context. Interviewing families and community leads in rural areas may have elicited different views about the nature of mental health problems and traditional healing, which would be equally valuable in planning awareness and engagement strategies. Understanding help-seeking patterns in larger samples through quantitative methods and in relation to existing services (including traditional and provided by NGOs) and to specific child mental health

problems would provide insight to policy and service planning. The findings may have been influenced by social desirability bias, as participants may have attempted to come across as more positive about their community, and yet their honesty about some of the challenges and endemic problems were refreshing. Although questions aimed to explore solutions both in terms of strengths and challenges, there was an over-representation of challenges in the findings, i.e. potential strengths may not have been sufficiently explored. Yet many identified issues were perceived as representing both a strength and a challenge, namely families and staff groups. While generalisability may be limited, it is nonetheless an important contribution representing the voices of young Kenyan residents and key stakeholders, which has been absent in the literature. Furthermore, what is particularly noteworthy is that the exploratory findings from this study are consistent with other LMIC research (Jenkins et al., 2010; Jordans et al., 2010), and thus support their transferability.

Community engagement is a cornerstone in improving child mental health, particularly in the lack of extensive specialist resources. This is consistent with the body of literature and guidelines in high income countries (NICE, 2016), as well as increasing calls to strengthen service user involvement in LMIC (Loza & Effat, 2017). Community stakeholders' engagement enhances the ability to identify, mobilise and address mental health concerns that reflect local needs and are compatible with a given sociocultural context (Michener et al., 2008). Such input is crucial in generating evidence-based practice, and should be incorporated at all stages of service development and delivery. These findings will thus be useful for international and national policy makers, and other stakeholders planning services to help children in communities that face similar challenges.

ACKNOWLEDGEMENTS

We are grateful to the secondary school principal, teachers, professionals, and especially the families for their kind participation in this study.

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