REACH - MH

REACHING AND ENGAGING ADOLESCENTS AND YOUNG ADULTS FOR CARE CONTINUUM IN MENTAL HEALTH

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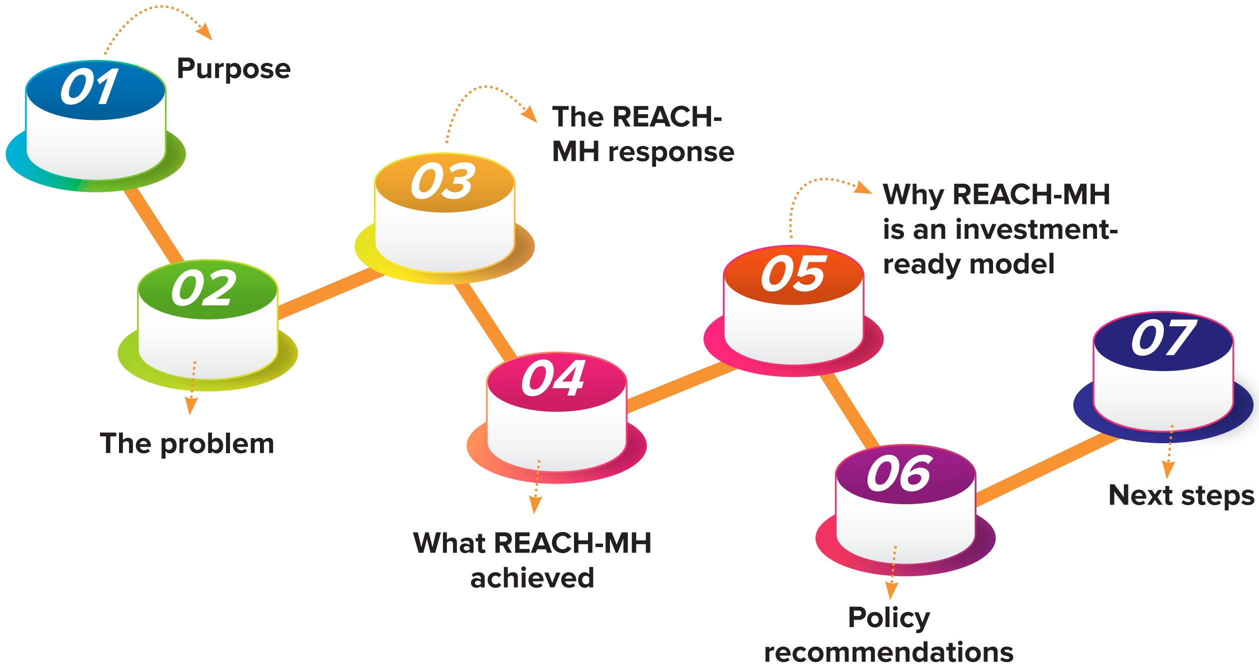
POLICY BRIEF

From Evidence to Action: Lessons from the REACH-MH; Addressing Adolescent Mental Health through Youth-Led Digital Innovation in Kenya



1 Purpose

This brief summarizes key evidence and policy implications from the REACH Mental Health (REACH-MH) initiative, a youth-led, digitally enabled platform implemented in Nairobi, Mombasa, and Kisumu counties between 2021 and 2025. It is intended to inform county and national decision-makers, development partners, and funders seeking scalable, system-embedded approaches to adolescent and youth mental health in Kenya.

2 The problem

Adolescent and young adult mental health is a critical but underprioritized public health issue. Globally, around 1 in 7 adolescents live with a mental disorder, and suicide is among the leading causes of death in young people. In Kenya, available evidence suggests that nearly 30% of adolescents and young adults report symptoms of depression or anxiety and about 10% meet criteria for a current mental disorder. An estimated four people die by suicide daily, with many of these deaths occurring among young people.

Despite this burden, adolescent mental health in Kenya suffers from fragmented, facility-based data, limited youth engagement in evidence generation, and significant gaps between policy commitments and implementation. Service capacity is constrained by workforce shortages, limited integration of mental health into primary care and community platforms, and persistent stigma, especially in urban informal settlements.

There is a pressing need for locally generated, youth-centered evidence that can guide county-level planning, resource allocation, and practical service models aligned with Kenya's devolved health system and national mental health policies.

3 The REACH-MH response

REACH-MH (Reaching and Engaging Adolescents and Young Adults for the Mental Health Care Continuum) was designed as an integrated evidence-to-implementation platform rather than a single research study. REACH-MH explicitly applied an implementation science lens, using the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework to guide how evidence was generated, interpreted, and translated into action across counties.

Core features

- **Digital mental health assessment platform:** A youth-friendly, offline-capable app with 13 modular domains covering mental health symptoms and key psychosocial, economic, relational, and structural determinants of wellbeing.
- **Youth-led evidence generation:** Youth Advisory Champions for Health (YACH) were trained as co-researchers, mobilizers, and peer facilitators, supporting ethical, trusted engagement around topics such as distress, self-harm, violence, and substance use.
- **Embedded referral pathways:** The app was integrated with LVCT Health's established hotlines and counseling services, ensuring that risk indicators triggered immediate referral and support, not just data collection.
- **System-anchored partnerships:** Implementation was led by LVCT Health in partnership with county governments, the Ministry of Health's Division of Mental Health, and the University of Maryland, Baltimore, aligning evidence generation with policy and service delivery systems.

What REACH-MH achieved

Scale and feasibility

During implementation across Nairobi, Mombasa, and Kisumu, REACH-MH demonstrated strong feasibility and acceptability among adolescents and young adults. The platform recorded over 3,000 app downloads and approximately 1,800 completed surveys uploaded to a central server. Twelve youth-led focus group discussions provided in-depth qualitative insight into lived experiences and service preferences.

Youth-reported mental health needs

Across the three counties, adolescents and young people reported widespread emotional distress:

- Around 30–40% reported frequent symptoms of stress, anxiety, or low mood.
- More than half described recurring sleep disturbance, fatigue, poor concentration, or feelings of hopelessness.
- Economic pressure, family and social expectations, relationship stress, violence and safety concerns, and uncertainty about the future were consistently identified as key drivers, with notable variation by gender, age, and county context.
- Risk behaviors and coping reflected this distress. Between 20–25% reported experiences or thoughts related to self-harm, and many described withdrawal, substance use, or risky behaviors during periods of heightened stress.
- Non-disclosure emerged as a critical signal: 20–30% of youth were unwilling or uncomfortable disclosing experiences related to violence, sexual health, or self-harm, suggesting that observed prevalence likely underestimates actual need. Youth emphasized confidentiality, trust, and accessibility, with strong demand for youth-friendly digital and hotline-based options.

Systems and capacity gains

REACH-MH delivered a set of system-relevant outcomes, including:

- County-specific mixed-methods datasets on adolescent and youth mental health, suitable for planning and policy dialogue.
- A trained cadre of Youth Advisory Champions who can support ongoing data collection, community engagement, and co-design of interventions.
- Strengthened research-to-practice linkages between digital platforms, community services, county health management teams, and national stakeholders.
- A multi-institution learning network linking LVCT Health, county governments, the Ministry of Health, and academic partners.

5 Why REACH-MH is an investment-ready model

Evidence from REACH-MH demonstrates that youth-led, digitally enabled, community-embedded approaches can generate implementation-ready mental health evidence at scale in urban Kenyan settings. The model directly addresses key challenges highlighted in recent analyses of adolescent mental health policy in Kenya, including limited data, weak youth participation, and gaps between policy and implementation. REACH-MH shows not only *what* problems exist, but also *how* to move from exploration of needs to preparation, implementation, and sustainment of youth-centered

Key comparative advantages for policy and investment include:

- **Alignment with Kenyan policy frameworks:** REACH-MH supports implementation of the Kenya Mental Health Policy (2015–2030), the Mental Health Action Plan, and adolescent health policies by generating locally owned evidence and linking youth to care.

- **Systems integration:** The platform is anchored in existing service ecosystems (LVCT Health hotlines, county health services, and national structures), reducing fragmentation and duplication.

- **Youth workforce and governance:** YACH champions embed youth voice into evidence generation and service design, directly countering the exclusion of adolescents from decision-making highlighted in recent political economy analyses.

- **De-risked scale:** The model has been tested in three diverse urban counties, creating a proven foundation for expansion to additional counties and settings.

6 Policy recommendations

For the Ministry of Health (national level)

1. **Recognize and adopt REACH-MH as a scalable model for adolescent mental health data and service linkage.**
   - Integrate REACH-MH indicators and tools into national adolescent mental health surveillance and monitoring frameworks.
2. **Formalize youth participation in adolescent mental health policy and program design.**
   - Use YACH and similar structures as formal advisory and co-design bodies at national and county levels.
3. **Invest in digital mental health infrastructure and standards.**
   - Develop national guidance on youth-friendly digital mental health tools, including data protection, referral protocols, and linkages to national hotlines.

For county governments

4. **Use REACH-MH data to inform county planning and budgeting.**
   - Incorporate REACH-MH findings into County Integrated Development Plans, Annual Workplans, and adolescent/youth health strategies, with explicit budget lines for mental health.
5. **Scale youth-led digital screening and referral in priority sub-counties.**
   - Expand REACH-MH or similar platforms in informal settlements, schools, TVET institutions, and community hubs, with clear referral pathways to county and partner services.
6. **Strengthen multisectoral collaborations.**
   - Engage education, labor, social protection, and community-based organizations to address structural drivers of distress, including unemployment, violence, and poverty.

For development partners and funders

7. **Support county and national scale-up of REACH-MH.**
   - Fund expansion to additional counties, adaptation for rural and humanitarian settings, and integration with broader youth health and social protection initiatives.
8. **Invest in youth research and implementation capacity.**
   - Provide multi-year support for YACH and similar youth leadership models as core system assets, not time-limited project roles.
9. **Back innovation within a tested platform.**
   - Use REACH-MH as a foundation for piloting enhanced content (e.g., trauma-informed modules, gender-based violence, substance use), AI-supported triage, and inclusive design for marginalized groups.

7 Next steps

With a functioning digital platform, trained youth workforce, and established partnerships across three counties, REACH-MH is ready to transition from a successful implementation initiative to a sustained national asset. Strategic investments in scale-up, systems integration, and continuous learning can help Kenya move from fragmented, under-resourced responses toward an equitable adolescent mental health system grounded in youth voice, ethical practice, and local ownership.

REPORT SUMMARY

Background and Rationale

Adolescent and young people's mental health is a growing global public health concern, with approximately 1 in 7 adolescents worldwide experiencing a mental disorder. In Kenya, the burden is substantial. Available evidence indicates that almost 30% of adolescents and young adults report symptoms of depression or anxiety, while approximately 10% meet criteria for a current mental disorder during a critical developmental period. Suicide further underscores this burden. In Kenya, an estimated four people die by suicide each day, and suicide is recognized as one of the leading causes of death among young people, reflecting a deepening and under addressed public health crisis.

Despite this burden, Kenya, like many countries, lacks harmonized, youth-centric mental health evidence that captures lived experiences, psychosocial drivers, help seeking preferences, and barriers to care in ways that directly inform county level planning and service delivery. Current evidence generation and response systems are fragmented and predominantly facility based, providing limited understanding of the lived realities of adolescents and young people aged 15–24 years, especially in urban and peri urban contexts.

To address these gaps, the REACH Mental Health project was implemented between June 2021 and December 2025 across Nairobi, Mombasa, and Kisumu counties. REACH Mental Health applied a user-centered digital health approach, grounded in community based participatory research and implementation science, to generate actionable and scale-ready evidence while strengthening youth leadership, institutional capacity, the research to practice interface, and pathways to mental health care and psychosocial support services.

30%
of adolescents and young adults report symptoms of depression or anxiety

1 in 7
adolescents worldwide experiencing a mental disorder

10%
of adolescents meet criteria for a current mental disorder during a critical developmental period.

Project Design and Implementation

REACH-MH was designed as an integrated evidence-to-implementation platform rather than a stand-alone research study. The project combined a purpose-built digital mental health assessment platform, youth-led qualitative inquiry, and integration with existing hotline and chat-based counseling services.

A core feature of the model was the engagement of Youth Advisory Champions for Health (YACH) as co-researchers, mobilizers, and ambassadors. Youth were trained in CBPR principles, research ethics, digital data collection, and peer facilitation, enabling trusted community entry and ethical engagement around sensitive topics such as emotional distress, self-harm, violence exposure, and substance use.

The REACH-MH digital application comprised 13 modular domains capturing mental health symptoms alongside key psychosocial, economic, relational, and structural determinants of wellbeing. The platform was youth-friendly, offline-capable, and intentionally designed to promote autonomy, confidentiality, and safe disclosure. Importantly, it was integrated with established counseling and hotline services, ensuring that identified risk triggered referral and support pathways rather than remaining a purely extractive data exercise..

Outputs

During pilot implementation, REACH-MH demonstrated strong feasibility and acceptability across all three counties. The platform achieved over 3,000 application downloads, with approximately 1,800 completed surveys successfully uploaded to the central server. In parallel, twelve youth led focus group discussions engaged adolescents and young people aged 15–24 years, generating rich mixed-methods insight into lived experiences, coping strategies, and service preferences.

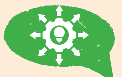
Beyond evidence generation, REACH-MH strengthened youth research capacity through structured training and mentored field implementation, produced county specific datasets to support localized interpretation, and established strong research to practice linkages connecting digital platforms, community services, youth support systems, and meaningful county and partner engagement.

Key Findings: What Kenyan Youth Reported

Across Nairobi, Mombasa, and Kisumu, adolescents and young people reported widespread emotional distress. Nearly 30–40% reported frequent symptoms of stress, anxiety, or low mood, while over half reported recurring challenges related to sleep disturbance, fatigue, poor concentration, or feelings of hopelessness. Economic pressure, family and social expectations, relationship stress, safety concerns, and uncertainty about the future were consistently identified as key drivers, with variation by age, gender, and county context.

Risk behaviors and coping responses reflected this distress. Between 20–25% of youth reported experiences related to self-harm or thoughts of self-harm, with higher levels observed in some county contexts. Qualitative findings showed that while many adolescents relied on peer or family support, a notable proportion described withdrawal, substance use, or engagement in risky behaviors during periods of heightened stress. Preferences for support consistently emphasized confidentiality, trust, and accessibility, with strong demand for youth friendly digital and hotline-based options.

Importantly, non-disclosure emerged as a major finding. Between 20–30% of respondents were unwilling or uncomfortable disclosing experiences related to violence, sexual health, or self-harm, indicating that observed prevalence likely underestimates true need. These patterns complimented by qualitative insights highlight persistent trust gaps and stigma, underscoring the need for trauma informed, youth centered approaches that prioritize safety, autonomy, and trusted pathways to care.

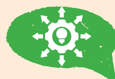


Contribution and Value

REACH-MH demonstrates that youth-led, digitally enabled, and community-embedded approaches can generate large-scale, implementation-ready mental health evidence in urban Kenyan settings. Rather than focusing on long-term clinical outcomes, the project delivered planning-grade intelligence, operational learning, and a tested engagement model capable of informing adolescent mental health programming, service design, and investment decisions at county, national, and global levels.

Interpretation of REACH-MH findings through an implementation science framework further clarified which contextual factors belong to Exploration, which assets support Preparation, how age and gender differences shape Implementation, and what conditions are needed for Sustainment of youth-centered mental health services.

Critically, REACH-MH functioned as a de-risking platform for scale. It aligned participatory evidence generation with digital infrastructure, youth workforce development, and institutional partnerships, enabling translation from data to action. The platform directly informed and seeded multiple competitive funding pathways and positioned adolescent mental health as an investment-ready domain rather than a pilot-dependent agenda.



Future Directions

The REACH-MH platform is positioned to evolve from a successful implementation initiative into a sustained system-level asset. Future pathways emphasize county-level translation and action, platform enhancement and inclusive design, and alignment with national and global policy and investment priorities. Continued investment builds on an established digital platform, a trained and deployable youth research workforce, and a multi-level learning network spanning communities, counties, academia, and national institutions.

By grounding scale in youth voice, ethical practice, and system alignment, REACH-MH offers a transferable model for strengthening adolescent mental health systems in Kenya and comparable low- and middle-income urban settings globally.

VIGNETTE 01

Voices from the Youth in Kenya: Addressing Mental Health Gaps and Recommendations

What this study did

This all-inclusive REACH-MH participatory study convened an adolescent and young people (AYP)–led national stakeholder meeting with 41 participants, including youth representatives, Ministry of Health officials, academic experts, and implementing partners, to identify mental health challenges facing AYP in Kenya and co-develop practical recommendations. The meeting objectives were to (1) map efforts supporting national and regional mental health priorities for AYP, (2) develop immediate action plans for strengthened services, (3) review and improve coordination mechanisms, and (4) use county experiences to inform national action. Stakeholders, together with Youth Advisory Champions for Health (YACH), synthesized challenges into three domains—legislative, service provider/Ministry of Health, and adolescent/individual-level factors—and generated a package of system and service recommendations, including digital and telehealth components.

Implications

The study shows that when young people are placed at the center of agenda setting, they identify a broad ecosystem of gaps—from laws and financing to provider attitudes, stigma, and lack of youth friendly spaces—that collectively drive the mental health treatment gap in Kenya. The resulting recommendations emphasize not only more services, but also more youth leadership, digital innovation, and coordinated system responses, directly echoing the design choices later operationalized in youth centered digital platforms such as REACH MH, AGILE and the One2OneAGILE ecosystem. For policymakers and partners, these findings underscore that bridging adolescent mental health gaps requires aligning legislative reform, service delivery, youth capacity building, and digital health investments under a shared, youth driven framework. Embedding digital and participatory models within this framework offers a concrete pathway to move from high level recommendations to sustained action across counties and national structures.

Recommendations

- Legislative level: Fully implement and resource the Kenya Mental Health Policy (2015–2030), ensure policies explicitly address adolescents and young people, and strengthen legal protections and insurance coverage for AYP mental health care.
- Service provider / MoH level: Establish adolescent friendly spaces and integrated mental health units in facilities, improve coordination across programs, develop comprehensive assessment tools, and build a national mental health database for AYP.
- Adolescent / individual level: Train Youth Advisory Champions and other youth leaders to provide peer based mental health literacy, advocacy, and support, using interactive and youth friendly service models.
- Digital and community approaches: Expand telehealth services, “digital villages,” and other digital health tools to reach AYP where they live, study, and socialize, ensuring these platforms are linked to real services and response teams.
- Coordination and response capacity: Mobilize a functional, multi sectoral mental health response team at national and county levels to translate youth priorities into funded plans and monitor implementation progress over time.

Source

Memiah P, Wagner FA, Kimathi R, Anyango NI, Kiogora S, Waruinge S, Kiruthi F, Mwavua S, Kithinji C, Agache JO, Mangwana W, Merci NM, Ayuma L, Muhula S, Opanga Y, Nyambura M, Ikahu A, Otiso L. Voices from the Youth in Kenya Addressing Mental Health Gaps and Recommendations. Int J Environ Res Public Health. 2022 Apr 28;19(9):5366. doi: 10.3390/ijerph19095366. PMID: 35564760; PMCID: PMC9104498.

1 BACKGROUND AND RATIONALE

1.1 Partnership Foundations for REACH-MH

The REACH Mental Health (REACH-MH) initiative was deliberately designed as a locally-anchored, globally-informed partnership to address adolescent and youth mental health needs in urban Kenya. The collaboration brings together academic leadership, community-embedded implementation expertise, and county and national health systems to generate evidence that is credible, actionable, and scalable within Kenya's devolved health system.

1.2 Partner Institutions and Their Roles

At its core, REACH-MH reflects a shared commitment to youth-centered, ethical, and implementation-ready research, with local institutions leading design, execution, and interpretation.

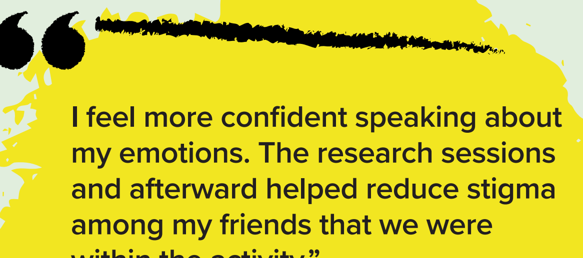
1.2.1 University of Maryland Baltimore (UMB)

UMB provided the academic and implementation science backbone for the REACH-MH initiative. Through its global health and implementation science leadership, UMB contributed methodological rigor, ethical oversight, and analytical frameworks that ensured the study met international research standards while remaining responsive to local context.

UMB's strengths in this collaboration included:

- Design of participatory research methodologies grounded in implementation science
- Integration of theory-informed frameworks to support interpretation, learning, and future scale
- Support for youth research capacity development as a long-term systems investment

Importantly, UMB's role was not to direct implementation, but to co-create knowledge with Kenyan partners, ensuring that evidence generation strengthened local systems rather than extracting data.



"The program gave us skills for life. It was not only about learning, but about healing and building resilience."

Participant, Mombasa

1.2.2. LVCT Health

LVCT Health served as the lead local implementing and coordinating partner, anchoring REACH-MH within communities and health service ecosystems across Nairobi, Mombasa, and Kisumu. With decades of experience delivering adolescent- and youth-friendly services, LVCT Health brought deep contextual knowledge, trusted community relationships, and operational credibility.

LVCT Health is one of the largest youth-serving health organizations in Kenya and hosts the largest youth-focused hotlines in East and Central Africa, providing confidential counseling, psychosocial support, and referral services to adolescents and young people. This One2One © platform strengthened REACH-MH's ethical grounding and referral pathways, particularly for youth disclosing distress, self-harm, or violence.

The organization also maintains a broad, established youth engagement infrastructure, including large-scale peer and youth networks that informed REACH-MH's model. Through Youth Advisory Champions for Health (YACH), adolescents and young people were trained and supported as co-researchers, mobilizers, and interpreters of findings, ensuring the youth voice was embedded throughout the research lifecycle rather than treated as a consultative add-on.

Key strengths of LVCT Health included:

- Established presence and trust within urban and peri-urban communities
- Proven experience implementing youth-friendly, rights-based health programs
- Capacity to recruit, train, and mentor youth as co-researchers rather than passive respondents
- Operation of a large-scale youth hotline and referral platform supporting ethical response mechanisms
- Oversight of ethical review and compliance across U.S. and Kenyan institutions
- Strong relationships with county governments and frontline service providers

LVCT Health ensured that REACH-MH was locally led, culturally responsive, and ethically grounded, translating research protocols into practice without compromising community trust.

1.2.3. County and National Government: Nairobi, Mombasa, Kisumu, and the Ministry of Health

REACH-MH was implemented in close collaboration with the county health systems of Nairobi, Mombasa, and Kisumu, reflecting Kenya's devolved governance structure for health service delivery. Counties provided stewardship and contextual leadership, ensuring that the study aligned with county mental health, adolescent health, and community health priorities.

County governments played a critical role by:

- Providing stewardship and alignment with county mental health and adolescent health priorities
- Facilitating access to communities, health facilities, and youth networks
- Supporting integration of findings into county-level planning, dialogue, and service improvement discussions

Each county brought distinct contextual strengths ranging from large, diverse urban populations to strong community and informal settlement networks allowing REACH-MH to generate comparative, multi-county evidence relevant for sub-national decision-making and national learning.

At the national level, REACH-MH aligns with Kenya's mental health policy and reform agenda under the Ministry of Health Kenya, particularly through the Division of Mental Health, which provides policy leadership, coordination, and technical guidance for mental health services nationwide. National stewardship plays a critical role in standard setting, workforce guidance, service integration, and harmonization of learning across counties. Consistent with national evidence and reform priorities, the Division of Mental Health emphasizes strengthening community-based platforms, improving coordination between policy and practice, and accelerating implementation of existing mental health strategies areas directly supported by REACH-MH's multi-county, youth-centered evidence base.

This combined county- and national-level engagement ensured that REACH-MH findings were not siloed but were positioned to inform both localized service improvement and broader system-level learning and scale.

1.3 How the Partnership Was Formed?

The REACH-MH partnership emerged from a longstanding collaborative relationship between the University of Maryland, Baltimore, and LVCT Health, built through multiple joint projects and sustained investments over time. This history of collaboration, supported by substantial multi-year funding and shared implementation experience, created a strong foundation of trust, complementary expertise, and operational alignment.

Against this backdrop, partners came together around a shared recognition that youth mental health challenges in Kenya require locally generated evidence that is both ethically produced and scalable within existing systems. Rather than importing tools or relying on externally driven models, the partnership adopted a co-development approach that integrated community-based participatory research principles, digital innovation responsive to youth realities, and youth leadership embedded throughout the research lifecycle.

This collaboration built on existing trust between LVCT Health and county governments, with the University of Maryland Baltimore contributing technical and learning expertise to strengthen study design, analysis, and global relevance.

1.4. Rationale for a Local-First Partnership Model

The REACH-MH partnership was intentionally structured to demonstrate that local organizations and county systems are not implementation bottlenecks, but engines of innovation and scale. By positioning LVCT Health and county governments as leaders and youth as co-creators, REACH-MH generated evidence that is contextually valid and ethically sound, immediately useful to county and national stakeholders, and aligned with Kenya's devolution and health systems strengthening agenda.

This foundation positions REACH-MH not as a standalone study, but as a platform for sustained learning, adaptation, and scale, grounded in local ownership and strengthened through global collaboration.

1.5 Study Aims and Intended Outputs

REACH-MH (Reaching, Engaging Adolescents and Young Adults for the Mental Health Care Continuum) was designed to generate actionable, implementation-ready evidence on adolescent and young adult mental health in urban Kenya through youth-led, digitally enabled, and ethically grounded approaches. The study responded to persistent gaps in locally generated mental health data, limited youth participation in research design, and weak translation of evidence into county and national systems.

Implemented through a collaboration between University of Maryland Baltimore, LVCT Health, county governments, and the Ministry of Health Kenya, REACH-MH aimed to strengthen both the evidence base and the capacity for sustained youth-centered mental health action.

1.6 Overall Goal

To generate youth-centered, context-relevant evidence on mental health risks, protective factors, and service access among adolescents and young adults, while building a scalable platform for ethical evidence generation, youth research leadership, and system learning.

1.7. Study Objectives

The study pursued four interlinked objectives:

- To identify and characterize mental health risk and protective factors among adolescents and young adults (ages 15–24) using digitally enabled, youth-administered assessment tools.
- To document lived experiences, contextual stressors, and coping pathways through targeted qualitative inquiry, capturing the social, cultural, and structural realities shaping youth mental health.
- To examine barriers and facilitators to mental health and service access across individual, family, community, structural, and health system levels within Kenya's devolved context.
- To build youth and institutional capacity for mental health research and implementation, embedding adolescents and young adults as co-researchers and strengthening linkages between evidence, services, and policy.

1.8 Expected Outputs and Contributions

Table 1: Expected Outputs and Contributions

Objective Area	Key Outputs	Contributions
Digital youth mental health assessment	Multi-domain, smartphone-based data capturing mental health symptoms, psychosocial risks, and protective factors	Demonstrated feasibility of ethical, youth-led digital data collection at scale
Qualitative and contextual inquiry	Youth narratives on stress, violence, substance use, schooling, family dynamics, and digital life	Informed interpretation of quantitative findings and intervention design
Multi-level barrier analysis	Evidence spanning individual, household, community, structural, and health system constraints	Supported county and national dialogue on service gaps and priorities
Youth research capacity (YACH)	Trained youth co-researchers embedded in data collection, interpretation, and community engagement	Built a transferable youth research workforce and leadership model
County-relevant evidence products	County-specific findings and cross-county comparative insights	Enabled devolution-ready learning and sub-national planning relevance
Ethical referral and response pathways	Linkages to youth-friendly services and hotline-based support mechanisms	Strengthened ethical safeguards and service integration

1.9 Geographic and Institutional Scope

REACH-MH was implemented in Nairobi, Mombasa, and Kisumu, selected to reflect geographic, cultural, and socio-economic diversity across urban Kenya. This multi-county design enabled both localized learning and cross-site comparison, strengthening the relevance of findings for county governments and national stakeholders.

The project also supported cross-campus collaboration within UMB, engaging faculty and students across health and social science disciplines. Through structured mentorship and applied research engagement, the initiative contributed to workforce development in global and adolescent mental health, reinforcing the project's dual mandate of evidence generation and bi-directional capacity strengthening.

VIGNETTE 02

Highlighting a Digital Platform to Assess Young People Needs: Reaching and Engaging Adolescents and Young Adults for Care Continuum in Health Project (REACH)

What this study did

This study described the user inclusive development and pilot testing of the REACH AYA digital survey app, a theory based platform designed to identify protective and risk behaviors among young people aged 10–24 years in Nairobi, Kenya. Using a five step design thinking process, the team co created a 98 item, skip logic enabled smartphone survey covering 10 behavioral, lifestyle, and psychosocial domains, drawing from validated instruments. An initial pilot with 33 young people assessed usability, timing, and adaptability, after which the app was disseminated via social media using respondent driven sampling, reaching 1,101 youth; approximately 80% (n ≈ 887) completed the survey. The study demonstrated the feasibility and acceptability of a user centered digital approach for engaging adolescents and young adults and collecting actionable data on their needs.

The REACH AYA experience provided a digital, engagement, and sampling foundation later expanded in REACH MH to focus more deeply on adolescent and youth mental health and service pathways within Kenyan county systems.

Implications

The study shows that a well designed mobile app, co created with young people and disseminated through their preferred digital channels, can rapidly generate high completion, multi domain data on youth needs at scale. This confirms that digital platforms can serve as powerful entry points for youth engagement and risk identification in contexts like Nairobi, where smartphone access and social media use are high. For policy and practice, REACH AYA illustrates how user centered digital tools can de risk subsequent investments in more targeted initiatives: insights on feasibility, acceptability, and recruitment directly inform the design of mental health–focused platforms such as REACH MH. Embedding these tools within county and national youth health strategies can help Kenya move toward an integrated, digital first ecosystem in which early risk screening, including for mental health, is routinely linked to responsive services and youth led follow up.

Recommendations

- Use human centered and design thinking approaches when developing digital health tools for adolescents and young adults, involving them in co design, pre testing, and iterative refinement of content and features.
- Leverage social media and peer driven recruitment (e.g., respondent driven sampling) to reach diverse and often hard to reach youth populations, especially in urban settings with high data connectivity.
- Integrate multiple behavioral and psychosocial domains into a single, brief, mobile survey to efficiently screen for a wide range of risks and protective factors relevant to youth wellbeing.
- Link digital screening platforms to real world services, such as youth friendly clinics, hotlines, and community programs, so that identified risks translate into concrete support rather than remaining as stand alone data.
- Build on early digital prototypes (such as REACH AYA) to develop more specialized, implementation oriented platforms like REACH MH that focus on specific priorities such as mental health, violence, and psychosocial distress.

Source

Memiah, P.; Lathan-Dye, M.; Opanga, Y.; Muhula, S.; Gitahi-Kamau, N.; Kamau, A.; Otiso, L. Highlighting a Digital Platform to Assess Young People Needs: Reaching and Engaging Adolescents and Young Adults for Care Continuum in Health Project (REACH). Adolescents 2022, 2, 150-163. https://doi.org/10.3390/adolescents2020014.

2

MENTAL HEALTH AMONG ADOLESCENTS AND YOUNG PEOPLE (15–24 YEARS) IN KENYA

2.1 Demographic Context of Kenyan Youth

Kenya is experiencing a pronounced youth bulge that carries profound implications for development, labor markets, and health systems. Young people aged 15–34 account for approximately 35% of the national population, underscoring the demographic centrality of youth to Kenya's present and future trajectory[1], [2]. With an estimated total population of 57–58 million in 2025–2026, more than four in five Kenyans are under the age of 35, and the national median age is approximately 20 years, placing Kenya among the youngest populations globally[3].

> Before joining the sessions in the study, I didn't know what mental health is something we can talk about openly. Now I understand my feelings better and I know where to seek support".
>
> ***Adolescent participant, Kisumu***

Within this broader youth cohort, adolescents and young people aged 15–24 years represent a particularly significant and growing segment. Population projections have consistently shown a sustained increase in the absolute number of young people, rising from approximately 9.5 million in 2015 and projected to approach 18 million by 2065, with this age group continuing to comprise roughly 17–20% of the total population across projection periods[4]. This demographic momentum means that the conditions shaping the health and wellbeing of today's adolescents and young adults will have lasting consequences for Kenya's social and economic development.

The 15–24-year age period is a critical developmental window, marked by transitions from secondary education to higher education or vocational training, entry into the labor market, identity formation, and the establishment of intimate and social relationships. In Kenya, these transitions unfold within a challenging structural environment. Youth unemployment remains persistently high, with employer-based estimates for ages 15–34 frequently exceeding 60%, while internationally modeled estimates for ages 15–24 suggest unemployment rates in the range of 11–12% figures that nonetheless mask widespread underemployment and informal work[5]. These economic pressures intersect with persistent poverty, gender inequities, and exposure to interpersonal and community violence, compounding psychosocial stress during a formative life stage. The burden of these stressors is particularly acute in urban informal settlements, where rapid urbanization has produced environments characterized by overcrowding, insecure housing, food insecurity, limited access to quality education and health services, and weak social protection mechanisms. For adolescents and young people living in these contexts, structural vulnerability is not episodic but chronic, shaping daily experiences, future aspirations, and mental health trajectories.

> I used to think stress was just something to endure. Now I know practical ways to manage anxiety and ask for help early."
>
> ***Youth Participant, Nairobi***

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1 National Council for Population and Development (NCPD). (2021). Youth Bulge in Kenya: A Blessing or a Curse. https://ncpd.go.ke/wp-content/uploads/2021/02/Brief-56-YOUTH-BULGE-IN-KENYA-A-BLEESING-OF-A-CURSE.pdf

2 Federation of Kenya Employers (FKE). (2025). Youth Employment. https://www.fke-kenya.org/policy-issues/youth-employment

3 Kenya National Bureau of Statistics (KNBS). (2025). Economic Survey 2025 & Facts and Figures 2025. https://www.knbs.or.ke/

4 United Nations, Department of Economic and Social Affairs, Population Division (2024). World Population Prospects 2024: Methodology of the United Nations population estimates and projections..

5 World Bank/ILO. (2024–2025). Unemployment, youth total (% of total labor force ages 15-24) (modeled ILO estimate) - Kenya. https://data.worldbank.org/indicator/SL.UEM.1524.ZS?locations=KE

2.2 Global Burden of Adolescent Mental Health Conditions

Globally, mental health conditions represent one of the most significant and least adequately addressed health challenges facing adolescents and young adults. Mental disorders frequently emerge during adolescence and early adulthood, and their effects often extend across the life course, shaping educational attainment, employment prospects, social participation, and long-term health[6].

Current global estimates indicate that approximately one in seven adolescents lives with a mental disorder, with mental health conditions accounting for about 15% of the total disease burden in this age group when measured in years lived with disability. Depression, anxiety, and behavioral disorders consistently rank among the leading non-fatal causes of illness and disability worldwide, underscoring the extent to which mental health challenges undermine wellbeing during this formative period of life[7].

The consequences of unmet mental health needs are stark. Suicide is now the third leading cause of death among young people aged 15–29 years globally, reflecting profound gaps in prevention, early identification, and access to effective, youth-responsive care. Together, these patterns highlight a global mental health burden that is both substantial in magnitude and persistent across contexts, one that demands targeted, age-appropriate, and scalable responses[8].

6 Memiah, P.; Wagner, F.A.; Kimathi, R.; Anyango, N.I.; Kiogora, S.; Waruinge, S.; Kiruthi, F.; Mwavua, S.; Kithinji, C.; Agache, J.O.; et al. Voices from the Youth in Kenya Addressing Mental Health Gaps and Recommendations. Int. J. Environ. Res. Public Health 2022, 19, 5366. https://doi.org/10.3390/ijerph19095366

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8 Bertuccio P, Amerio A, Grande E, La Vecchia C, Costanza A, Aguglia A, Berardelli I, Serafini G, Amore M, Pompili M, Odone A. Global trends in youth suicide from 1990 to 2020: an analysis of data from the WHO mortality database. EClinicalMedicine. 2024 Feb 29;70:102506. doi: 10.1016/j.eclinm.2024.102506. PMID: 38440131; PMCID: PMC10911948.

2.3 Mental Health Status of Adolescents and Young People in Kenya

Research from Kenya demonstrates a substantial and concerning burden of mental health symptoms among adolescents and young people across both school-based and community settings[9]. Studies among secondary school students report that nearly half exhibit clinically significant depressive symptoms, while over one-third experience anxiety, with risk shaped by gender, social support, and exposure to stressors[10,11]. These findings suggest that emotional distress among Kenyan youth is not marginal but widespread during a critical developmental period.

Community-based research further reveals that mental health challenges are particularly acute among adolescents and young adults living in urban informal settlements. Studies conducted in Nairobi's informal settlements document elevated levels of depression, anxiety, and post-traumatic stress disorder (PTSD), with adolescent girls and young women disproportionately affected due to heightened exposure to gender-based violence, economic insecurity, and unsafe living environments[12] . These patterns reflect the intersection of mental health risk with broader social and structural inequities.

> **REACH program helped me realize I am not alone. Sharing with others in the group made me feel lighter and more hopeful about my future".**
>
> ***Young woman, Kisumu***

Urban youth in informal settlements experience layered and persistent vulnerabilities, including poverty, overcrowding, community and intimate-partner violence, limited access to quality education and health services, and constrained livelihood opportunities[13]. These conditions are strongly associated with chronic emotional distress and poorer mental health outcomes. Among adolescents and young people who use alcohol or other substances, research shows particularly high levels of depression, anxiety, stress, and suicidal ideation, often occurring alongside adverse childhood experiences (ACEs) and ongoing social instability[14] .

Together, these findings underscore that mental health challenges among adolescents and young people in Kenya are deeply embedded in social context rather than isolated clinical conditions. They point to an urgent need for interventions that are not only clinically sound, but also youth-centered, trauma-informed, and responsive to the structural realities shaping young people's lives.

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12 Friedberg, R. D., et al. (2023). Mental health and gender-based violence: An exploration of depression, PTSD, and anxiety among adolescents in Kenyan informal settlements participating in an empowerment intervention. PLOS One, 18(3), e0281800.

13 Apondi, E., et al. (2025). A pilot study of alcohol and substance use, mental health symptoms, and associated factors among adolescents and youth living in informal settlements in Nairobi, Kenya. Global Mental Health

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VIGNETTE 03

A descriptive phenomenological study of school-related gender-based violence: Lived experiences of symbolic violence, harassment, and systemic complicity in a mixed secondary school in Nairobi, Kenya

What this study did

This qualitative study used a descriptive phenomenological approach to explore how adolescents experience school-related gender-based violence (SRGBV) in a mixed secondary school in Nairobi County, Kenya. Through in-depth interviews and focus group discussions with students, the study examined everyday experiences of symbolic violence, verbal and sexual harassment, intimidation, and teacher or institutional responses, focusing on how gendered power dynamics are perceived to be perpetuated and normalized. The analysis identified how students interpret interactions among peers, teachers, and parents, and how these interactions contribute to psychosocial harm, including fear, isolation, mistrust of authority, and emotional withdrawal.

By documenting how SRGBV shapes adolescents' emotional wellbeing and trust in institutions, the study provides rich contextual insight that complements implementation-focused initiatives such as AGILE and REACH-MH which seek to understand and respond to youth mental health needs across school and community settings.

Implications

The study shows that SRGBV in Kenyan schools is not limited to isolated incidents, but operates through interwoven structural and cultural mechanisms—symbolic violence, peer pressure, and custodial complicity—that students internalize over time. These dynamics undermine adolescents' sense of safety, belonging, and trust in adults, with clear implications for mental health and help seeking. For policy and practice, this underscores that effective SRGBV responses must combine structural reforms (policies, accountability, reporting systems) with cultural and psychosocial interventions that address stigma, silence, and harmful gender norms. Linking school based SRGBV work to youth centered mental health platforms can create interconnected pathways where students can disclose violence, access confidential support, and receive trauma informed care beyond the school boundary. Such integration can help counties and national actors move toward coordinated strategies that confront both violence and its mental health consequences in adolescents' daily lives.

Recommendations

- Develop and enforce clear school-level SRGBV policies that explicitly address symbolic and psychological violence—not just physical acts—and hold staff and students accountable for harassment, survivor blaming, and inaction.
- Train teachers, administrators, and non teaching staff to recognize and respond appropriately to SRGBV, including how everyday comments, "jokes," and disciplinary practices can reinforce harmful gender norms and silence survivors.
- Establish confidential, student friendly reporting and support mechanisms (e.g., trusted focal teachers, school counselors, hotlines, digital platforms) that protect learners from retaliation and provide timely psychological and practical support.
- Engage students, parents, and community leaders in dialogue and co creation of norms that challenge patriarchal attitudes, victim blaming, and peer complicity, using participatory approaches led by adolescents themselves.
- Integrate mental health and psychosocial support into SRGBV prevention and response, recognizing that exposure to symbolic and gendered violence contributes to anxiety, depression, and other forms of distress highlighted in broader youth mental health work such as REACH MH.

Source

Mokaya, A.G., Kikuvi, G., Mutai, J. et al. A descriptive phenomenological study of school-related gender-based violence: lived experiences of symbolic violence, harassment, and systemic complicity in a mixed secondary school in Nairobi, Kenya. BMC Public Health 25, 3926 (2025). https://doi.org/10.1186/s12889-025-25341-0

2.4 Service Coverage, Access Barriers, and System Gaps

Kenya faces a severe and persistent gap in mental health service capacity, driven by both workforce shortages and uneven geographic distribution. Recent estimates suggest that approximately 140–150 psychiatrists serve a population exceeding 50 million people, with the vast majority concentrated in major urban centers. Fewer than half of the country's counties employ even a single psychiatrist in the public sector, and far fewer have access to clinical psychologists or specialized mental health teams. Earlier assessments similarly documented extremely limited numbers of psychiatrists, psychologists, and mental health nurses, underscoring that this treatment gap is structural rather than temporary[15].

These workforce constraints are compounded by systemic weaknesses in service delivery. Despite national policy commitments to integrate mental health into primary health care, school health programs, and community platforms, implementation has been uneven. Mental health services remain largely facility-based, under-resourced, and insufficiently embedded in the settings where adolescents and young people most often seek care or support[16].

For adolescents and young people, access barriers extend beyond service availability. Commonly cited obstacles include low mental health literacy, stigma and discrimination, concerns about confidentiality, direct and indirect costs, distance to services, and mistrust of adult-dominated or punitive institutional environments[17]. These barriers are particularly pronounced for young people in informal settlements and other underserved contexts, where competing social and economic pressures further constrain help-seeking.

As a result, many adolescents and young adults experiencing depression, anxiety, substance-related problems, or suicidal ideation do not receive timely, appropriate, or youth-responsive care even when they come into contact with health, education, or social service systems[18]. This disconnect between need and response highlights a critical systems gap and reinforces the urgency of approaches that expand access beyond traditional service models, prioritize youth acceptability and trust, and strengthen early identification and linkage to care.

> "The program connected us to services beyond the research sessions. Knowing there is support available has made a big difference."
>
> ***Participant, Nairobi County***

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15 Ndetei, D. M., et al. (2023). Mental healthcare services in Kenyan counties: A descriptive survey of four counties in Western Kenya. BMC Health Services Research, 23, 478

16 Kenya Psychiatric Association (KPA). (2025). Kenya's mental health crisis: 150 psychiatrists for 50 million people (press statement/brief, reported in The Star). The Star, 4 September 2025.

17 Mbugua, M. N., et al. (2024). Exploring the barriers to mental health care and mitigation strategies in Kenya. International Journal of Research and Innovation in Social Science, 8(1), 2227–2247.

18 Memiah P, Wagner FA, Kimathi R, Anyango NI, Kiogora S, Waruinge S, Kiruthi F, Mwavua S, Kithinji C, Agache JO, Mangwana W, Merci NM, Ayuma L, Muhula S, Opanga Y, Nyambura M, Ikahu A, Otiso L. Voices from the Youth in Kenya Addressing Mental Health Gaps and Recommendations. Int J Environ Res Public Health. 2022 Apr 28;19(9):5366. doi: 10.3390/ijerph19095366. PMID: 35564760; PMCID: PMC9104498.

2.5 Limitations of Existing Data and Need for Youth-Centered Evidence

Routine health information systems and large household surveys in Kenya have historically captured limited and often indirect information on adolescent and young people's mental health. National data sources tend to emphasize broad or proxy indicators such as substance use, injuries, or reported suicide attempts while rarely measuring depression, anxiety, self-harm, or trauma-related symptoms using validated mental health instruments[19]. As a result, the emotional and psychosocial dimensions of adolescent and youth wellbeing remain largely invisible within routine data systems[20].

Where more detailed mental health outcomes are available, evidence is frequently drawn from narrowly defined sub-populations, including school-going adolescents, youth living in urban informal settlements, or young people who use alcohol or other substances. While these studies provide important insights, their focus limits generalizability and leaves critical gaps for out-of-school youth, unemployed young adults, and adolescents in rural or peri-urban settings, who may face equal or greater vulnerability but remain underrepresented in research and surveillance efforts.

This fragmentation of evidence constrains effective decision-making. Policymakers and program implementers lack granular, disaggregated, and youth-centered data to guide the design, targeting, and scale-up of contextually appropriate mental health promotion, prevention, and treatment interventions for adolescents and young people aged 15–24 years. Addressing this data gap is essential not only for understanding the true magnitude and distribution of mental health needs, but also for ensuring that investments respond to young people lived realities and support equitable, evidence-informed action (WHO; MoH Kenya).

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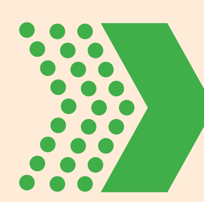
20 Mugotitsa B, Bhattacharjee T, Ochola M, Mailosi D, Amadi D, Deso P-A, Kuria J, Momanyi R, Omondi E, Kajungu D, Todd J, Kiragga A, Greenfield J. Integrating longitudinal mental health data into a staging database: Harnessing ddi-lifecycle and omop vocabularies within the inspire network datahub. Front Big Data. 2024;7:1435510. 10.3389/fdata.2024.1435510



THE REACH MENTAL HEALTH MODEL

The REACH Mental Health (REACH MH) model was designed to address persistent gaps in adolescent and young people's mental health data, access, and engagement in Kenya through a partnership-driven, youth-centered, and digitally enabled approach. The model integrates institutional collaboration, community-based participatory research, and digital mental health tools to generate actionable evidence while strengthening pathways to responsive support.

3.1 Partnership Structure

REACH MH was implemented through a multi-institutional partnership that combined academic leadership, community-based implementation expertise, and sub-national government engagement. The partnership brought together LVCT Health, University of Maryland Baltimore, and county-level stakeholders in Nairobi, Mombasa, and Kisumu. LVCT Health served as the primary implementing partner, leveraging its longstanding presence in community health programming, youth engagement, and HIV and mental health service delivery. The University of Maryland Baltimore provided scientific leadership, implementation science expertise, and oversight of study design, data systems, and analysis. County governments and local stakeholders supported contextual adaptation, community entry, and alignment with existing health and social service structures. This partnership structure was intentionally designed to balance scientific rigor, community trust, and policy relevance. Clear roles and shared accountability mechanisms enabled coordinated implementation while ensuring that evidence generated through REACH MH was grounded in local realities and positioned for uptake by county and national decision-makers.

3.2 Community-Based Participatory Research (CBPR) and Youth Leadership in Practice

Within the REACH Mental Health (REACH MH) model, Community-Based Participatory Research (CBPR) was operationalized as a youth-led, system-embedded approach, rather than a discrete research technique. The model was intentionally anchored within existing youth leadership infrastructure coordinated by LVCT Health, leveraging the organization's national Youth Advisory Champions for Health (YACH) network. This network reaches over one million adolescents and young people across Kenya through peer education, advocacy, digital engagement, and community mobilization, providing a scalable and trusted platform for youth participation in research and action.

LVCT Health's long-standing emphasis on participatory and rights-based programming particularly in HIV, sexual and reproductive health and rights (SRHR), mental health, and adolescent and young people's wellbeing created an enabling environment for meaningful youth leadership within REACH MH. The project embodied core CBPR principles by positioning young people as co-designers, implementers, and knowledge brokers, rather than passive respondents. The project benefited from embedding research activities within an already operational, socially embedded youth-led ecosystem aligned with national and county health priorities.

In practice, the REACH MH CBPR approach closely aligned with Youth Participatory Action Research (YPAR), a youth-centered adaptation of CBPR that recognizes adolescents and young adults as experts in their own lived experiences. Youth leaders from the YACH network were engaged across multiple stages of the research lifecycle, including the contextual refinement of data collection tools, community entry and mobilization, peer-led data collection via digital platforms, and interpretation of findings. This approach enhanced cultural relevance, reduced power asymmetries, and improved disclosure, particularly for sensitive domains such as emotional distress, self-harm, substance use, exposure to violence, and household adversity.

Youth leadership within REACH MH extended beyond data generation. Young people participated in hybrid knowledge-exchange models that combined in-person community engagement with digital modalities such as webinars, social media campaigns, youth-led dissemination products, and mental health dialogue forums. These platforms enabled continuous, bidirectional learning between youth, implementers, researchers, and policymakers, while allowing the project to adapt rapidly to local contexts and emerging insights.

From an implementation science perspective, embedding CBPR within a national youth network strengthened key implementation outcomes, including acceptability, feasibility, and sustainability. Youth-friendly engagement structures, peer leadership, flexible participation, and

alignment with youth development frameworks supported sustained involvement and reduced attrition. Moreover, because YACH members routinely engage with county governments, the Ministry of Health, and development partners through advocacy and policy dialogue, the model enhanced the likelihood that evidence generated through REACH MH would inform real-world decision-making and program adaptation.

By embedding CBPR within an established youth leadership system, REACH MH moved beyond consultative participation toward institutionalized youth leadership in mental health research and action. This approach ensured that findings were not only methodologically robust but also socially grounded, equity-oriented, and positioned for translation into responsive, youth-centered mental health policies and interventions.

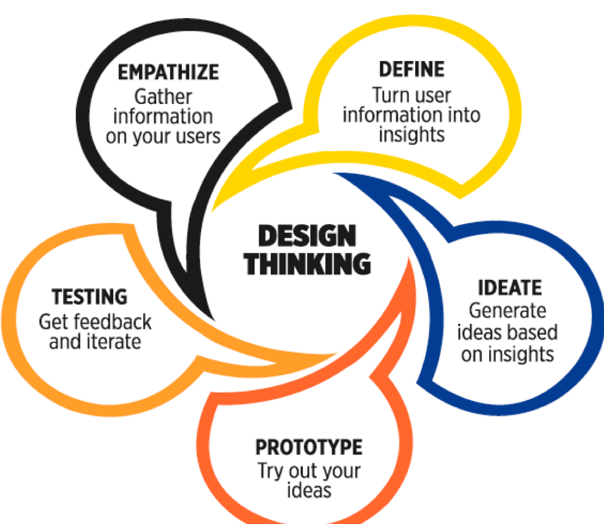
3.3 The REACH MH Digital Platform and Hotline Integration

The REACH Mental Health (REACH MH) digital platform functioned as the central operational backbone of the model, integrating data collection, self-assessment, and pathways to care within a single, youth-friendly system. While the platform was implemented and refined within the REACH MH project, its development preceded the project and was grounded in extensive formative research and human-centered design. This foundation enabled REACH MH to build on a mature, field-tested digital tool, rather than developing a platform de novo.

3.3.1. The Original REACH-AYA Digital App

The platform originated as the REACH-AYA app (Reaching and Engaging Adolescents and Young Adults for Care Continuum in Health)[21], developed in response to gaps in the literature and practice, where much of the evidence on adolescent behavior in sub-Saharan Africa has traditionally been derived from narrow demographic or health service perspectives. In contrast, the REACH-AYA app was intentionally designed using a comprehensive psychological, social, and developmental framework, capturing the multidimensional realities of adolescents and young people aged 10–24 years. The tool was conceived to support holistic self-screening and has the potential to be used by trained community health workers and other frontline providers at the community level.

Development of the REACH-AYA platform followed a design thinking approach, a human-centered, solution-oriented methodology widely applied to complex public health challenges. This iterative process encompassed five interlinked stages empathize, define, ideate, prototype, and test and prioritized user experience, contextual relevance, and adaptability. Adolescents and young people, adolescent champions, mental health specialists, clinicians, social workers, community health workers, and other service providers were engaged throughout the process to ensure that the platform reflected real-world needs, preferences, and constraints.



Design Thinking Approach – Source Memiah et al, Highlighting a Digital Platform to Assess Young People Needs: Reaching and Engaging Adolescents and Young Adults for Care Continuum in Health Project (REACH)

Through environmental scans, rapid literature reviews, focus group discussions, and expert consultations, the development team identified critical gaps in existing adolescent health screening approaches, particularly the lack of tools capable of holistically assessing mental health within broader social, familial, and structural contexts. Existing validated instruments were systematically reviewed, contextualized for Kenya and the wider sub-Saharan African setting, and integrated into a single digital architecture.

The resulting application incorporated validated screening tools, including the HEEADSSS psychosocial

21 Memiah P, Lathan-Dye M, Opanga Y, Muhula S, Gitahi-Kamau N, Kamau A, Otiso L. Highlighting a Digital Platform to Assess Young People Needs: Reaching and Engaging Adolescents and Young Adults for Care Continuum in Health Project (REACH). Adolescents. 2022; 2(2):150-163. https://doi.org/10.3390/adolescents2020014

VIGNETTE 04

Using Friendship Ties to Understand the Prevalence of, and Factors Associated With, Intimate Partner Violence Among Adolescents and Young Adults in Kenya: Cross-Sectional, Respondent-Driven Survey Study

What this study did

This cross sectional study used respondent driven sampling and a phone based REACH AYA app survey to estimate the prevalence of intimate partner violence (IPV) and identify associated risk and protective factors among 887 adolescents and young adults aged 15–24 years living in Nairobi, Kenya. The interactive digital survey captured behavioral, psychosocial, friendship network, school, and substance use variables, with particular focus on how friendship ties and peer networks relate to IPV experiences. IPV prevalence was 22.3%, and multivariable analyses showed higher odds of IPV among respondents whose friends or family used alcohol, tobacco, or marijuana, who had been bullied, suspended, or repeated a class, and who socialized predominantly with opposite sex peers. Conversely, positive peer relationships (e.g., satisfaction with social networks, low criticism, fewer conflicts) were associated with reduced IPV risk. By leveraging the REACH AYA digital platform and friendship based recruitment, this study provided critical methodological and contextual foundations for REACH MH's later focus on adolescent mental health, violence, and peer driven engagement.

Implications

The study demonstrates that friendship ties and peer environments are central to understanding which adolescents and young adults are most at risk of IPV, highlighting peer networks as both potential drivers of harm and important protective buffers. It also shows that digital, youth friendly data collection methods can successfully capture sensitive information on violence, mental health–related risk factors (e.g., bullying, school difficulties), and substance use among urban youth. For Kenya, these findings support integrated approaches in which IPV prevention efforts, school based programming, and youth mental health initiatives—such as REACH MH and the One2One/AGILE ecosystem—jointly leverage peer networks and digital platforms to identify at risk youth early and provide layered psychosocial and safety supports. Embedding such peer and digital informed strategies within county and national adolescent health plans can help shift from fragmented responses to a coordinated system that addresses violence, mental health, and social determinants together.

Recommendations

- Integrate IPV screening and brief counseling into youth friendly clinics and other touchpoints where adolescents and young adults already seek reproductive and general health services.
- Design IPV prevention interventions that explicitly address peer and friendship networks, including strategies to strengthen positive peer support and reduce maladaptive influences such as bullying and substance using peer groups.
- Use schools and digital platforms together to identify and support youth at elevated risk especially those who have been bullied, suspended, or repeated a class through targeted mentoring, counseling, and linkage to services.
- Address alcohol and drug use among adolescents and their social networks as part of IPV prevention strategies, recognizing the correlation between substance involved networks and IPV experiences.
- Build on digital tools like REACH AYA (and, subsequently, REACH MH) to routinely collect data on peer dynamics, mental health, and violence, and to connect at risk youth to confidential support (hotlines, chatbots, and community based services).

Source

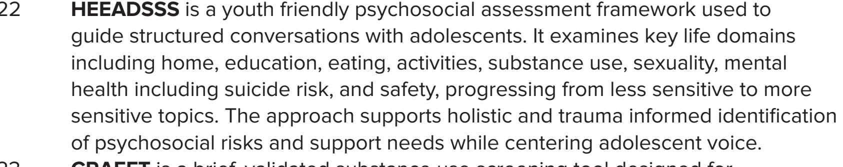
Memiah P, Kamau A, Opanga Y, Muhula S, Nyakeriga E, Humwa F, Cook C, Kingori C, Muriithi J. Using Friendship Ties to Understand the Prevalence of, and Factors Associated With, Intimate Partner Violence Among Adolescents and Young Adults in Kenya: Cross-Sectional, Respondent-Driven Survey Study. Interact J Med Res. 2020 Dec 31;9(4):e19023. doi: 10.2196/19023. PMID: 33382380; PMCID: PMC7808892.

assessment framework[22], the CRAFFT substance use screening tool[23], the Risk Assessment Screening Tool (RAST)[24] adapted by the Kenya Ministry of Health, the World Health Organization multicountry gender-based violence screening tool[25], and adolescent-adapted mental health screening instruments. These tools were embedded within a modular structure and supported by logic-based skip patterns and age-appropriate sequencing, enhancing usability while maintaining clinical and research rigor.

3.3.2 The REACH-MH App

During the REACH MH project, this REACH-AYA foundational platform was further refined, contextualized, and operationalized using the same human-centered and participatory design principles that guided its original development. Rather than treating the platform as a fixed instrument, the project intentionally applied iterative engagement processes, including stakeholder inception meetings, structured consultations with adolescents and young people, Youth Participatory Action Research (YPAR) training, and end-user piloting, to ensure contextual relevance across Nairobi, Mombasa, and Kisumu counties.

These refinement processes included hybrid national and county entry meetings, systematic review of the digital tool with youth representatives and technical experts, CBPR capacity-building for Youth Advisory Champions for Health (YACH), and a formal functionality review and pilot involving adolescents from all three regions. Feedback from these engagements informed adjustments to content clarity, module flow, logic patterns, and usability prior to full deployment. This approach ensured that the REACH MH application retained methodological rigor while remaining responsive to adolescents lived realities and evolving implementation contexts



22 **HEEADSSS** is a youth friendly psychosocial assessment framework used to guide structured conversations with adolescents. It examines key life domains including home, education, eating, activities, substance use, sexuality, mental health including suicide risk, and safety, progressing from less sensitive to more sensitive topics. The approach supports holistic and trauma informed identification of psychosocial risks and support needs while centering adolescent voice.

23 **CRAFFT** is a brief, validated substance use screening tool designed for adolescents and young people. It assesses risky alcohol and drug use through questions that explore situations such as riding in a car with an impaired driver, using substances to relax or fit in, using alone, memory loss, concerns raised by others, and trouble related to substance use. The tool is widely used in clinical and community settings to support early identification of problematic substance use and guide timely counseling, referral, or intervention in a youth friendly and nonjudgmental manner.

24 Risk Assessment Screening Tool (RAST) adapted by the Kenya Ministry of Health is a brief screening tool used to identify adolescents and young people at increased risk of HIV and related health vulnerabilities. It assesses behavioral, social, and contextual risk factors such as sexual behaviors, substance use, exposure to violence, and structural vulnerabilities to support risk stratification. The tool is used in clinical and community settings to guide targeted prevention, referral, and linkage to appropriate health and psychosocial services in line with national guidelines.

25 World Health Organization multicountry gender based violence screening tool is a standardized instrument developed by the World Health Organization to identify experiences of physical, sexual, and emotional violence, including intimate partner violence, among women and adolescents across diverse settings. It uses behaviorally specific, nonjudgmental questions to support safe and ethical disclosure. The tool is designed for use in clinical, community, and research contexts to inform referral, protection, and survivor centered care while minimizing harm and prioritizing confidentiality and safety.

The refined REACH MH application consisted of 13 distinct modules, capturing mental health and protective factors across individual, family, community, and structural domains:

The application was designed for smartphone use, allowed offline completion, and enabled participants to pause, resume, and modify responses, supporting autonomy and data quality. Data were securely synchronized with the REACH web server once connectivity was available, minimizing cost barriers and maximizing accessibility. Geographic location access was used to confirm residence within study catchment areas, ensuring contextual validity.

Critically, the REACH MH digital platform was integrated with hotline-based human support, transforming it from a screening and data-generation tool into a responsive, ethically grounded system. Adolescents and young people who screened positive for distress, reported safety concerns, or requested assistance were linked directly to trained counselors through established hotline services. This integration ensured that risk identification was paired with timely, confidential support and that research participation was directly connected to care.

From an implementation science perspective, the combined digital platform and hotline integration enhanced reach, timeliness, and scalability, while maintaining robust safeguards for confidentiality and participant safety. By building on a rigorously developed, user-centered digital foundation and refining it through REACH MH, the model demonstrated how digital innovation can be systematically adapted, implemented, and embedded within adolescent mental health systems, generating high-quality evidence while strengthening real-world pathways to support.

The REACH Mental Health (REACH-MH) project was implemented between June 2021 and December 2025 across three counties in Kenya Nairobi, Mombasa, and Kisumu selected to reflect Kenya's geographic, cultural, and socio-economic diversity. Implementation followed a phased, community-engaged approach that integrated digital innovation, youth leadership, and county-level systems strengthening to generate actionable mental health evidence among adolescents and young people (AYP) aged 15–24 years.

4

REACH- MH PROJECT IMPLEMENTATION AND REACH

4.1 REACH-MH App Data Collection Processs

Data collection for REACH-MH was conducted using the REACH-MH mobile application, a purpose-built digital tool described in detail in Section 3.3.2, which captures multidimensional mental health risks and protective factors among adolescents and young people. The application comprised 13 structured domains, with approximately 120–150 items depending on participant responses, and incorporated built-in skip logic to tailor question pathways based on age, gender, schooling status, sexual activity, and prior responses. This adaptive design minimized respondent burden while ensuring depth and relevance across psychosocial wellbeing, lived experiences, protective assets, service awareness, and help-seeking pathways.

The tool was iteratively refined through stakeholder consultations, youth feedback, and pilot testing conducted between late 2021 and early 2022, culminating in a version optimized for large-scale field deployment. Key design features included offline data capture with delayed synchronization, automated completeness checks, and secure server upload, reducing data-cost barriers and strengthening data quality in low-connectivity settings.

4.12 Ethical Review

All study procedures were conducted in accordance with the principles of the Declaration of Helsinki and adhered to internationally accepted standards for research involving human participants. Ethical review and approval were obtained prior to implementation from the Amref Health Africa Ethics and Scientific Review Committee, the University of West Florida Institutional Review Board, and the University of Maryland Institutional Review Board. Additional county-level entry processes and approvals were secured in collaboration with national and county health authorities to ensure alignment with local governance structures and safeguarding requirements for adolescent research.

4.3 Youth Training and Capacity Building: Youth Advisory Champions for Health (YACH)

Central to the REACH-MH implementation model was an intentional investment in Youth Advisory Champions for Health (YACH) as co-researchers, mobilizers, and ambassadors of the study. Between 2021 and 2023, YACH representatives were identified across Nairobi, Mombasa, and Kisumu through youth-led organizations, peer educator networks, educational institutions, and trusted community-based partners. This deliberate recruitment strategy ensured geographic diversity, local credibility, and strong peer embeddedness within participating communities.

YACH members underwent structured and progressive capacity-building grounded in Community-Based Participatory Research (CBPR) principles. Training emphasized research ethics, informed consent, qualitative and quantitative data collection methods, digital research literacy, and responsible engagement with peers and vulnerable populations. A landmark three-day hybrid CBPR training conducted in early 2022 brought together youth leaders from all three counties, combining in-person facilitation with virtual participation. The curriculum focused on epistemology, community entry, power-sharing in research, validity and reliability, and ethical responsibilities when conducting peer-led mental health research. Additional refresher and advanced training were delivered throughout the implementation period to reinforce competencies, respond to emerging field realities, and address priority areas identified by the YACH network. These sessions were intentionally adaptive and demand-driven, reflecting the evolving needs of youth researchers operating in dynamic community contexts.

Training delivery was supported by a multidisciplinary facilitation team that included project investigators, county-level technical experts, and external partners such as AMREF Health Africa, strengthening alignment with national and subnational health systems and reinforcing best practices in ethical and participatory research. Beyond technical skill development, the YACH model prioritized leadership, reflexivity, and youth ownership of evidence generation. YACH members actively contributed to tool refinement and piloting, community sensitization, peer mobilization, and real-time problem-solving during field implementation. This approach strengthened community trust, enhanced data quality, and positioned young people not merely as study respondents but as credible producers, interpreters, and translators of mental health evidence.

4.4 County-Level Implementation: Nairobi, Mombasa, and Kisumu

County-level implementation was rolled out sequentially between 2022 and 2024, following stakeholder engagement meetings, county entry approvals, and localized training of facilitators and YACH mobilizers.

In Mombasa, implementation commenced with a county stakeholders' meeting followed by focused training for data collection teams. Qualitative and quantitative activities were conducted across sub-counties including Kisauni, Nyali, Changamwe, and Mvita, engaging adolescents and young people in youth-friendly health facilities and community spaces.

In Kisumu, similar preparatory activities were conducted, with data collection concentrated in Kisumu East, Kisumu West, and Kisumu Central. The implementation explicitly explored contextual differences across age groups, schooling status, gender, and urban-rural settings, allowing for nuanced interpretation of mental health stressors and coping mechanisms.

In Nairobi, implementation combined intensive CBPR refresher training with community-based data collection in informal settlements such as Korogocho and Mukuru Kayaba. Data collection sessions emphasized safe spaces, culturally appropriate facilitation, and language accessibility, with discussions primarily conducted in Kiswahili and local dialects.

Across all counties, implementation was supported by regional coordinators who served as the link between YACH mobilizers and the LVCT Health technical team. Continuous communication channels, including WhatsApp groups and scheduled check-ins, enabled rapid troubleshooting and adaptive management throughout the data collection period.

4.5 Mobilization, Survey Administration, and Data Capture

Survey mobilization relied on a peer-to-peer recruitment model, leveraging the social networks, credibility, and digital fluency of YACHs, MindSKILLZ[26] coaches, peer educators, and youth-led community-based organizations. Mobilization activities took place across 2023–2024, combining in-person outreach, institutional engagement, and targeted digital promotion through social media platforms.

Participants downloaded the REACH-MH application directly onto their smartphones and were able to complete survey modules offline, uploading responses once connectivity was available. This design feature significantly reduced participation barriers related to data costs and connectivity constraints, particularly in informal settlements and peri-urban settings.

During active mobilization periods, progress was monitored in near real time through regional coordination calls and rapid reporting mechanisms. Follow-up reminders were sent to participants who had initiated but not completed surveys, contributing to high completion rates.

By the close of the pilot implementation phase in April 2024, the REACH-MH app had recorded 3,004 individual downloads, with 1,831 completed surveys successfully uploaded across the three counties, demonstrating both the feasibility and reach of youth-led, digitally enabled mental health research in diverse Kenyan contexts.

26 MindSKILLZ is an innovative, sport-based mental health program for adolescents aged 10–14 years in Kenya, developed by Grassroot Soccer and implemented in partnership with LVCT Health, with contextual adaptation and delivery supported by the Nairobi County Department of Health and the Mombasa County Department of Health. The program uses soccer-based metaphors, interactive games, and trained non-specialist “Coaches” to build mental health literacy, reduce stigma, strengthen resilience, and enhance coping skills related to anxiety, depression, stress, substance misuse, and mindfulness, with a strong emphasis on prevention and early support. Through youth-friendly, safe-space, and experiential learning approaches, MindSKILLZ has reached over 4,000 adolescents across Nairobi and Mombasa, contributing to efforts to bridge gaps in child and adolescent mental health care by equipping trusted community actors to support youth wellbeing. The initiative was highlighted at the Kenya Child and Adolescent Mental Health Summit for its effectiveness in engaging young people through culturally relevant, sports-based mental health programming.

4.6 Data preparation and analysis

We ensured that the report was representative of the adolescent/youth population across three cities in Kenya. Sampling weights were applied to account for the unequal distribution of respondents by city. The adjustment was important because Mombasa accounted for approximately half of the study participants, which could otherwise bias population-level estimates. Sampling weights were calculated based on the estimated adolescent population in each city. For example, Kisumu has approximately 253,000; each study participant represents 973.08 adolescents[27]. In Mombasa, with an estimated adolescent population of 240,000, each participant represents 282.02 adolescents after weighting[28]. Nairobi had the highest adolescent population of 956,844; each participant represents 1,646.90 adolescents after weighting[29]. These weights were applied during descriptive analyses using cross-tabulations.

27 Population Reference Bureau (2025). Investigating sexual and reproductive health to give Mombasa's youths a bright future. PRB. Retrieved from: https://www.prb.org/resources/investing-in-sexual-and-reproductive-health-to-give-mombasas-youth-a-bright-future/?utm_

28 Nyamai, F. N., Ndolo, U. M. & Ndwiga, S. (2025). Public Benefit Organizations' Education Interventions and Sustainable Household Poverty Reduction in Mwingi North Sub-County, Kitui County, Kenya. Journal of Research Innovation and Implications in Education, 9(3), 883 – 889 https://doi.org/10.59765/pjt539

29 County Government of Nairobi. (2023). County Integrated Development Plan for Nairobi City Coun ty 2023-207. Retrieved from, https://maarifa.cog.go.ke/sites/default/files/2024-06/NAIROBI-CITY%20CIDP%202023-2027.pdf?utm_s

VIGNETTE 05

Utilizing User Preferences to Design the AGILE Chatbot: A Youth-Centered Digital Approach to Gender-Based Violence Information and Support in Kenya

What this study did

This study used an exploratory qualitative design to inform the human-centered development of the AGILE ((Accelerating Access to Gender-Based Violence Information and Services Leveraging on Technology Enhanced) chatbot, a digital tool to accelerate access to gender-based violence (GBV) information and services among vulnerable populations in Kenya, including adolescents, young women and men, and sexual and gender minorities. We conducted focus group discussions with 150 participants (9–10 per group) to explore their prior experiences with intelligent conversational assistants, information needs, safety concerns, and preferred features of a GBV-focused chatbot. Thematic analysis, drawing on grounded theory, generated 14 salient themes spanning forms of violence, help seeking behaviors, desired content, and design and access preferences, which directly shaped the AGILE chatbot's content, tone, and functionality.

Insights from AGILE complement broader youth focused digital work such as REACH-MH by demonstrating how user preferences can be systematically translated into acceptable, context appropriate technology for sensitive issues like violence and mental health.

Implications

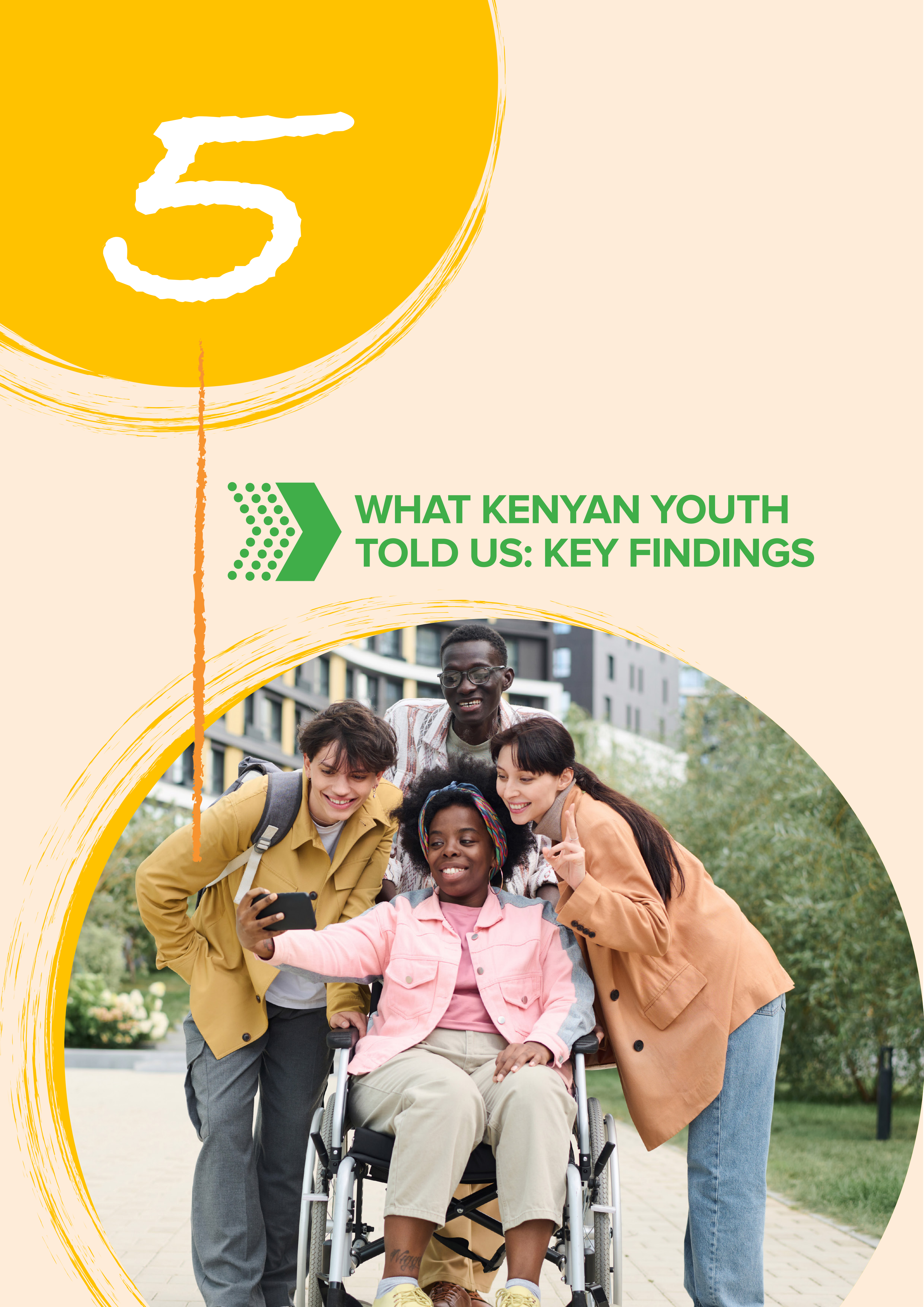
Findings show that when vulnerable youth help define content, tone, and features, chatbots can become trusted entry points for GBV information and support that are more responsive than static websites or one way campaigns. For policymakers and implementers, AGILE illustrates how user preference data can de risk digital GBV innovations by clarifying what survivors actually want and what they will use, before large scale rollout. Embedding AGILE within existing service platforms—such as hotlines and youth serving organizations mirrors the systems anchored approach used in REACH-MH, and underscores the value of linking digital tools to real world care pathways rather than creating stand alone apps. More broadly, integrating GBV-focused chatbots with youth centered mental health initiatives offers an opportunity to build coherent, digital-first support ecosystems that reflect how young people in Kenya seek help across violence, wellbeing, and psychosocial needs

Recommendations

- Adopt human-centered, user driven design as a standard for digital GBV tools, with iterative consultation of adolescents, young adults, and marginalized groups to ensure relevance, safety, and trust.
- Embed GBV chatbots like AGILE within existing service and referral ecosystems (hotlines, psychosocial support, legal and health services) so that digital disclosures reliably connect survivors to help rather than ending at information provision.
- Prioritize privacy, confidentiality, and low barrier access in chatbot design, including options for discrete interfaces, data protection, and flexible entry points (e.g., social media, SMS, web) that reflect young people's digital realities.
- Integrate GBV and mental health content, recognizing that many survivors experience co occurring emotional distress and may benefit from trauma informed self care information and linkages to mental health support platforms such as REACH aligned services.
- Support ongoing monitoring, user feedback, and co governance mechanisms so that AGILE and similar tools can adapt to emerging forms of violence (including technology facilitated abuse) and changing user needs over time.

Source

Ngũnjiri A, Memiah P, Kimathi R, Wagner FA, Ikahu A, Omanga E, Kweyu E, Ngunu C, Otiso L. Utilizing User Preferences in Designing the AGILE (Accelerating Access to Gender-Based Violence Information and Services Leveraging on Technology Enhanced) Chatbot. Int J Environ Res Public Health. 2023 Nov 3;20(21):7018. doi: 10.3390/ijerph20217018. PMID: 37947574; PMCID: PMC10647327.



5

WHAT KENYAN YOUTH TOLD US: KEY FINDINGS

5.1 Quantitative Insights from the REACH-MH App Survey

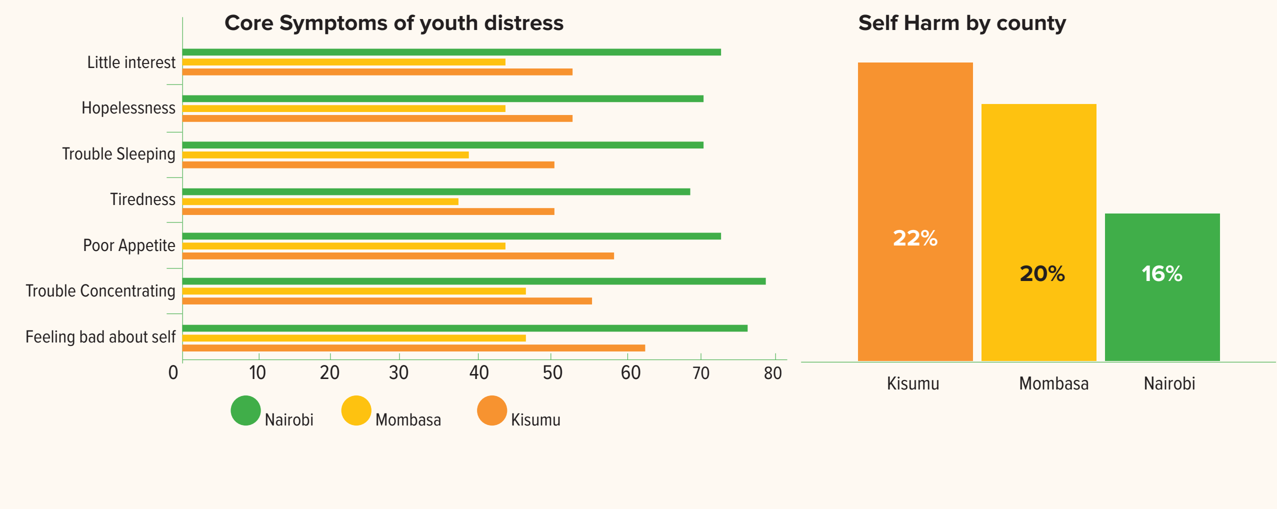
The REACH Mental Health study employed a Community-Based Participatory Research approach across Nairobi, Mombasa, and Kisumu, engaging stakeholders and training 150 youths to support smartphone-based data collection. Peer-facilitated and self-administered digital surveys captured mental health and related social and behavioral factors. Of 1,692 participants recruited, 1,199 youths aged 15–24 years were included in the final analysis. Across multiple sensitive domains, including self-harm, sexual experiences, HIV-related questions, and substance use, a substantial proportion of responses were recorded as missing or "not comfortable disclosing." These patterns are reported transparently and treated as substantive findings, reflecting issues of stigma, trust, and safety, rather than as mere data limitations.

5.1.1. Participant Characteristics and Context

Across all three cities, the sample was predominantly composed of older youth. Participants aged 20–24 years accounted for approximately 84–86% of respondents in Nairobi, Mombasa, and Kisumu, while those aged 15–19 years comprised roughly 14–16%.

Young women constituted the majority of participants in all three cities. Females accounted for 57% of respondents in Nairobi, 62% in Mombasa, and 63% in Kisumu. Economic insecurity was widespread. In Nairobi, 78% of youths reported having no income. In Mombasa and Kisumu, approximately 64% reported no income, while Kisumu had the highest proportion of youths reporting some income (26%).

Educational attainment varied by city and provides important context for interpreting the findings. In Nairobi, 27% of youths reported having a bachelor's degree or higher, compared with 19% in Kisumu and 8% in Mombasa. Mombasa had the highest proportion reporting college-level education (39%) and also the highest proportion reporting primary education as their highest level (7%). Across all three cities, approximately 28–32% reported secondary school as their highest level of education. These patterns indicate that the distress documented in this study is present among youths who are largely engaged with, or recently connected to, formal education systems.



5.1.2. Mental Health Distress and Common Stressors

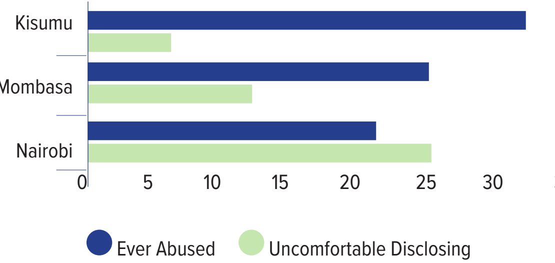
Mental health distress was widespread across Nairobi, Mombasa, and Kisumu, with particularly high concentrations in Nairobi. Nearly three-quarters of youth in Nairobi (71%) reported experiencing little interest or pleasure in doing things nearly every day, compared to 43% in Mombasa and 51% in Kisumu. Feelings of hopelessness followed a similar pattern: 69% of Nairobi youth reported feeling hopeless nearly every day, compared to 43% in Mombasa and 51% in Kisumu.

Sleep disturbance emerged as a consistent stressor. In Nairobi, 69% of youth reported trouble falling asleep nearly every day, compared to 38% in Mombasa and 49% in Kisumu. Persistent fatigue was also common, with 67% of Nairobi youth reporting feeling tired nearly every day, compared to 37% in Mombasa and 49% in Kisumu. Appetite disturbance followed the same pattern, with 71% of Nairobi youth reporting poor appetite nearly every day, compared to 42% in Mombasa and 57% in Kisumu.

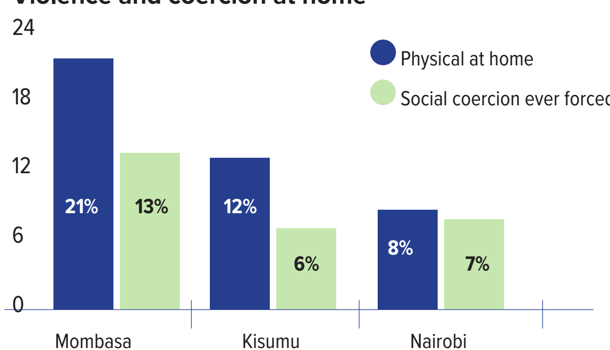
Difficulty concentrating was particularly pronounced in Nairobi, where 77% of youth reported trouble concentrating nearly every day, compared to 45% in Mombasa and 54% in Kisumu. Emotional self-perception indicators were also elevated: 75% of Nairobi youth reported feeling bad about themselves nearly every day, compared to 45% in Mombasa and 61% in Kisumu.

Indicators of suicidal ideation, while less frequently endorsed, were present across all counties. Approximately 5% of respondents reported not wanting to live nearly every day, while an additional 14% reported these thoughts on several days or more than half the days. Self-harm was reported by 22% of youth in Kisumu, 20% in Mombasa, and 15% in Nairobi, though substantial proportions of respondents either did not answer or reported discomfort disclosing, suggesting likely underestimation.

Abuse and disclosure by County



Violence and coercion at home



VIGNETTE 06

Predictors of Depression among Adolescents Joining Public Secondary Schools in Nairobi County, Kenya

What this study did

This study assessed the prevalence and predictors of depression among 539 adolescents aged 11–18 years as they joined five selected public secondary schools in Nairobi County, Kenya. Using the Patient Health Questionnaire–Adolescent (PHQ A) to measure depressive symptoms, the Suicide Behavior Questionnaire Revised to assess suicidal behavior, and the Adolescent Peer Relations Instrument to capture bullying victimization, the study estimated depression prevalence and examined associated risk factors. Generalized linear models with a log link and Poisson distribution were used to generate adjusted prevalence ratios for a common binary outcome of depression. The prevalence of depression at school entry was 14.5%, with a mean PHQ A score of 6.16, and depression was strongly associated with suicide risk and lifetime alcohol use, highlighting an important burden at the transition into secondary school.

These findings on early secondary school entrants complement broader youth-focused digital and community mental health work by underscoring the need to identify and support at-risk adolescents before and during key educational transitions.

Implications

The presence of clinically significant depressive symptoms in more than one in seven students at the start of secondary school shows that the entry transition is a critical window for identifying and supporting adolescents at risk. The strong associations between depression, suicide risk, and lifetime alcohol use point to the need for multi component approaches that combine mental health screening with prevention and early intervention for self harm and substance use. For policymakers and implementers, these findings argue for integrating adolescent mental health into school health policies and for building bridges between school based identification and community or digital support systems. Digital and youth led platforms such as REACH MH and the One2One hotline provide complementary channels for ongoing monitoring, self help information, and referral, especially for students who may be reluctant to disclose distress in school settings. Together, school entry screening and youth centered digital ecosystems can help Kenya move toward a more proactive, connected mental health response for adolescents as they navigate high stakes educational transitions.

Recommendations

- Integrate routine, brief depression screening (e.g., PHQ A) into school health and guidance services at the point of entry to secondary school, with clear pathways for follow up of students screening positive or expressing suicidal thoughts.
- Train teachers, school counselors, and school health staff to recognize depressive symptoms, suicide risk, and alcohol use in adolescents, and to provide basic psychosocial support and timely referral to mental health services.
- Address co occurring risk factors by combining mental health promotion with targeted interventions on bullying, school stress, and early substance use, including peer support and anti bullying programs tailored to the local context.
- Strengthen linkages between schools, community health services, and youth serving digital platforms so that adolescents identified at risk in school can access confidential, youth friendly support outside the classroom.
- Incorporate adolescent mental health indicators into county and national education and health information systems to monitor trends over time and evaluate the impact of school based interventions.

Source

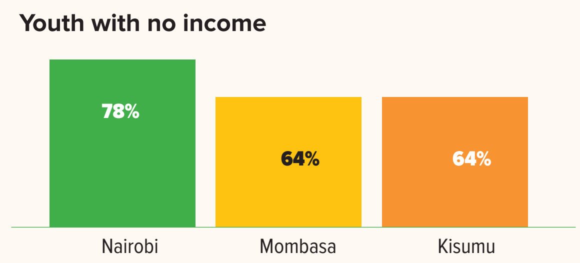
Mokaya AG, Kikuvi GM, Mutai J, Khasakhala LI, Memiah P. Predictors of depression among adolescents joining selected public secondary schools in Nairobi County, Kenya. Psychology in the Schools. 2023 Feb 7. doi:10.1002/pits.22873

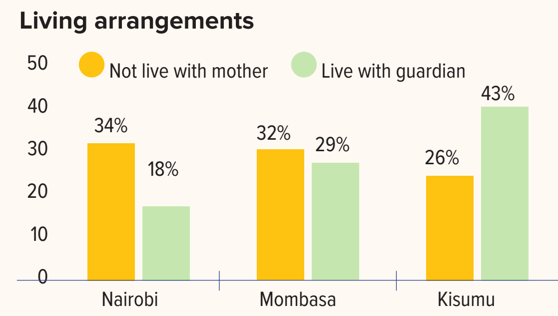
5.1.3. Violence, Safety, and Gendered Experiences

Experiences of abuse and violence varied by county. Youth reporting having ever been abused accounted for 32% in Kisumu, 25% in Mombasa, and 21% in Nairobi. Notably, 25% of Nairobi youth reported being uncomfortable disclosing abuse, compared to 12% in Mombasa and 6% in Kisumu, highlighting important differences in disclosure patterns rather than exposure alone.

Physical violence at home was reported by 21% of youth in Mombasa, compared to 12% in Kisumu and 8% in Nairobi. Experiences of sexual coercion were also reported: 13% of youth in Mombasa, 7% in Nairobi, and 6% in Kisumu indicated they had ever been forced to do something sexual. Among those reporting on first sexual experiences, 5% in Mombasa and 6% in Kisumu indicated that their first encounter was forced, though missing data exceeded 60% in Nairobi and Mombasa, limiting precision.

Online safety concerns were prominent. Feeling bullied by online activity was reported by 15% of youth in Mombasa, 14% in Kisumu, and 5% in Nairobi. Embarrassment due to online cyberbullying was reported by 20% in Mombasa, 18% in Kisumu, and 12% in Nairobi. Additionally, 25% of youth in Mombasa reported having shared pornography, compared to 22% in Nairobi and 18% in Kisumu.



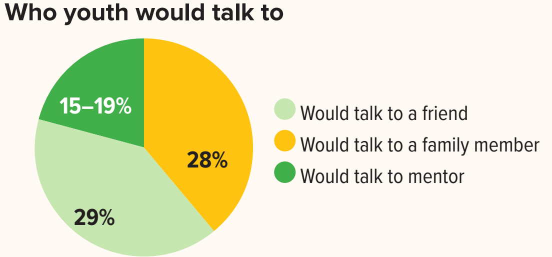


5.1.4. Economic Pressure, Relationships, and Daily Survival

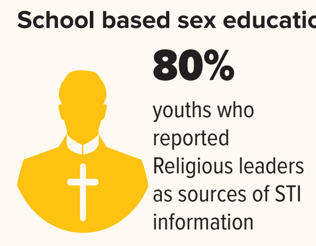
Economic vulnerability was substantial, particularly in Nairobi, where 78% of youth reported having no income, compared to 64% in Mombasa and 64% in Kisumu. Food insecurity was common across all counties. In Nairobi, 31% of youth reported sometimes missing meals, while 9% of youth in Kisumu reported often missing meals. Across the three counties, approximately 8–9% of youth reported often lacking enough food.

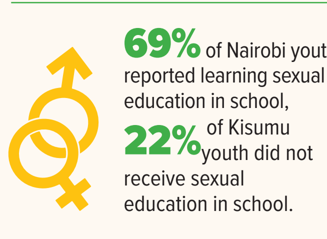
Feelings of family-related pressure were striking. 82% of youth in Nairobi reported feeling that they had let their families down nearly every day, compared to 53% in Mombasa and 72% in Kisumu. Living arrangements varied across sites: 34% of Nairobi youth did not live with their mothers, compared to 32% in Mombasa and 26% in Kisumu. In Kisumu, 43% of youth reported living with a guardian, compared to 29% in Mombasa and 18% in Nairobi.

Relationship dynamics intersected with health risk. Condom use at first sexual encounter was reported by 49% of youth in Kisumu, while 29% of youth in Mombasa reported not using a condom. Discomfort disclosing condom use was highest in Nairobi (22%). Knowledge of partners' HIV status was limited, with 36% of Nairobi youth reporting discomfort disclosing partner HIV status and 16% reporting unknown status, underscoring ongoing challenges in communication and trust within relationships.



School based sex education





5.1.5. Coping, Help-Seeking, and Service Preferences

When asked whom they could talk to in the event of sexual abuse, 29% of Nairobi youth reported a friend, 28% a family member, and 15–19% a peer educator or mentor. However, 16% of Nairobi youth, 13% in Mombasa, and 13% in Kisumu reported that they would talk to no one, indicating significant gaps in perceived safe support options.

School and community spaces played mixed roles. While 69% of Nairobi youth reported learning sexual education in school, 22% of Kisumu youth reported not receiving sexual education in school. Religious leaders were reported as sources of STI information by over 80% of youth across all counties, reaching 86% in Mombasa, suggesting broad reach but not necessarily safe spaces for disclosure of distress or abuse.

5.1.6. Digital Access, Trust, and Use of Support Platforms

Mobile phone ownership was high across counties, with 94% of Nairobi youth owning a phone, compared to 85% in Mombasa and 83% in Kisumu. Despite this access, trust in digital spaces was uneven. In Mombasa, 18% of youth and 14% in Kisumu reported regretting an online activity, compared to 5% in Nairobi.

Online embarrassment and bullying were more commonly reported in Mombasa and Kisumu than in Nairobi, suggesting that digital engagement carries different social risks across contexts. While high access supports the feasibility of digital mental health platforms, these findings underscore the importance of trust, privacy, and safeguarding in the design and implementation of digital mental health interventions.

5.2 Qualitative Methods and Findings: Youth-Led Focus Group Discussions

To complement the REACH-MH quantitative findings, Focus Group Discussions guided by a Community-Based Participatory Research approach were conducted to capture youth-led perspectives on mental health risks, coping strategies, and service pathways across Nairobi, Mombasa, and Kisumu. Across all sites, FGDs were audio-recorded with consent, transcribed, and thematically analyzed. Youth facilitators were engaged in reflective discussions to validate interpretations and ensure findings remained grounded in lived experience. The qualitative findings contextualize the high levels of distress observed in the quantitative survey, explain patterns of non-disclosure, and highlight youth-defined priorities for mental health support.

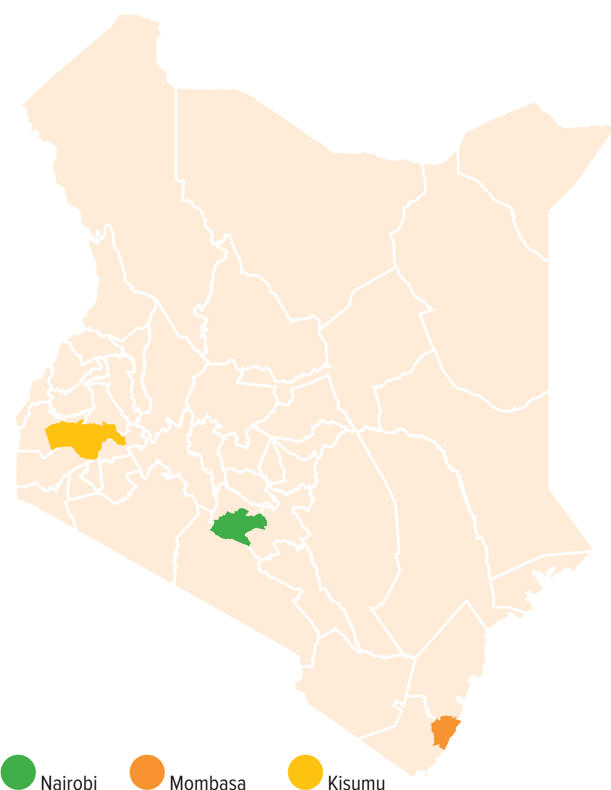
5.2.1. Preparatory Engagement and Capacity Building

The qualitative process began with in-country introductory and planning meetings by LVCT Health in Nairobi following the arrival of the University of Maryland team, comprising two UMB faculty members and two UMB students, one studying medicine and the other a PhD candidate, both conducting studies based on REACH-MH. The purpose of this engagement was to immerse the team in the local mental health ecosystem, learn directly from local experts and youth, and ground the research in Kenyan adolescent and youth realities.

These introductory meetings were conducted in person at the LVCT Health headquarters and focused on orientation to existing mental health service structures, including the national hotline system and LVCT Health's stepped care model for adolescent mental health. This was followed by advance planning for a two-and-a-half-day hybrid training designed to prepare youth facilitators for qualitative data collection.

Participants from Nairobi, Mombasa, and Kisumu attended the training, which covered ethical principles in qualitative research, informed consent procedures, facilitation techniques, management of group dynamics, confidentiality, and strategies to minimize bias during data collection. Emphasis was placed on facilitators' dual roles as peer researchers and community members, as well as the importance of reflexivity throughout the research process.

Following the training, facilitators from all three counties participated in a structured hybrid coordination meeting to review expectations, discuss anticipated challenges, and reinforce ethical and methodological standards. It was agreed that facilitators would receive ongoing mentorship during county-level implementation to support adherence to research protocols and address emerging issues in real time.



5.2.2. County-Level Data Collection and Stakeholder Engagement

Mombasa

Qualitative activities in Mombasa commenced with a stakeholder engagement meeting to introduce the study objectives, align expectations, and secure local buy-in. This was followed by a focused refresher training for the data collection team to ensure familiarity with discussion guides, consent forms, digital recording tools, and facilitation techniques.

Four FGDs were conducted with a total of 40 adolescents and young people aged 15–24 years across Kisauni (Junda Dispensary), Nyali (Bamburi Dispensary), Changamwe (Chaani Youth Friendly Centre), and Mvita (Mvita Clinic Youth Friendly Centre). Discussions explored perceived mental health challenges, availability and accessibility of services, and barriers and facilitators influencing service uptake.

Youth described overlapping stressors, including normalization of substance use, relationship challenges, insecurity, unemployment, teenage pregnancy, and limited parental guidance. Digital tools such as the 1190 hotline and One2One platform were frequently cited as referral pathways, valued for their confidentiality and youth-friendly design.

Kisumu

In Kisumu, youth facilitators received similar training prior to data collection. FGDs were conducted in Nyaweri with 40 adolescents and young adults drawn from Kisumu East, Kisumu West, and Kisumu Central sub-counties.

Discussions explored differences in mental health experiences across socioeconomic status, school attendance, gender, age group, and urban–rural context. Youth identified stress, depression, and anxiety as dominant challenges, driven by relationship pressures, family and societal expectations, financial insecurity, sexuality, and gender norms. Participants described both positive coping strategies (talking to friends, family members, religious leaders, or counselors) and negative coping strategies (substance use and risky sexual behavior).

Youth emphasized leveraging existing community structures, particularly school guidance and counseling teachers and HIV testing and adherence counselors, as trusted entry points for mental health support. Preferences for counselor gender varied, with trust and confidentiality ultimately prioritized over gender matching. Differences between younger adolescents (15–17) and older youth (18–24) were emphasized, reinforcing the need for age-responsive services. Strong linkages between online and in-person counseling were consistently highlighted.

Nairobi

In Nairobi, qualitative activities were embedded within broader adolescent- and youth-led solution-building efforts. A CBPR training was conducted in a hybrid format with participants from Nairobi, Mombasa, and Kisumu, strengthening capacity in participatory research principles and practice.

Qualitative data collection occurred in August 2022 through four FGDs involving 40 participants aged 18–24 years in Korogocho and Mukuru Kayaba. Sessions began with rapport-building activities and clear explanations of consent, confidentiality, and group norms. Discussions were conducted primarily in Kiswahili, with facilitators allowing local dialects to support nuanced expression.

These discussions focused on lived experiences of mental health distress, family and economic pressure, help-seeking behavior, and perceptions of formal and informal support systems. Exit meetings with facilitators and stakeholders were used to reflect on findings, validate emerging themes, and discuss practical implications for service delivery.

5.2.3. Qualitative Findings: Cross-Cutting Themes

Findings from FGDs across the three counties revealed consistent and context-specific themes that deepened interpretation of the quantitative results. These are summarized in Table X.

Table 2: Qualitative Findings: Cross-Cutting Themes

Thematic Domain	What Youth Reported (Cross-Cutting Themes)	Contextual Nuances by County	Implications for Programming & Services
Everyday Mental Distress	Youth consistently described stress, persistent sadness, loss of motivation, sleep disturbance, and emotional exhaustion as part of daily life rather than episodic events. Mental distress was often normalized and framed as something to be endured rather than treated.	**Nairobi:** Distress linked to economic pressure, overcrowding, and family expectations. Mombasa: Stress intertwined with insecurity, substance use, and peer influence. **Kisumu:** Emotional distress strongly linked to relationships, school transitions, and uncertainty about the future.	Mental health services must address chronic, cumulative stress rather than crisis-only models. Preventive, low-threshold, youth-friendly supports are essential.
Economic Pressure and Survival Stress	Youth described financial strain as a constant source of anxiety, including lack of income, food insecurity, and pressure to contribute to family needs despite limited opportunities.	**Nairobi:** Acute pressure to "hustle" and support families despite unemployment. Mombasa: Informal work and tourism-related instability heightened stress. Kisumu: Youth contrasted experiences of "rich vs poor," noting stigma and exclusion.	Mental health interventions should integrate economic stress screening and referrals, and avoid framing distress solely as individual pathology.
Relationships, Gender, and Emotional Burden	Romantic relationships were a major source of stress, particularly around trust, jealousy, pregnancy fears, and expectations tied to masculinity and femininity. Family expectations amplified emotional burden, especially for older youth.	**Kisumu:** Clear distinctions in stressors between ages 15–17 and 18–24. Nairobi: Strong narratives of "letting family down." Mombasa: Gendered expectations intersected with substance use and peer pressure.	Programs may assist youth and young adults reflect on changing gender roles. Counseling approaches should be age-and gender-responsive, and explicitly address relationship dynamics and family pressure.
Coping Strategies (Positive and Negative)	Youth reported both adaptive coping (talking to friends, trusted adults, religious leaders, online counseling) and maladaptive coping (substance use, risky sexual behavior, emotional withdrawal). Many described cycling between both.	**Kisumu:** Greater openness discussing both positive and negative coping. Mombasa: Higher normalization of substance use as coping. Nairobi: Silence and internalization of distress were common.	Programs must acknowledge mixed coping strategies and avoid moralizing. Harm-reduction and peer-support models are critical.
Violence, Safety, and Silence	Experiences of physical, emotional, and sexual violence were discussed cautiously. Fear of judgment, retaliation, or stigma often prevented disclosure, even in peer settings.	**Mombasa:** Higher openness about physical and sexual violence. Nairobi: Strong discomfort disclosing abuse. Kisumu: Youth emphasized safety concerns in both home and relationships.	Safe disclosure pathways and trauma-informed facilitation are essential. "Non-disclosure" should be treated as a finding, not missing data.
Help-Seeking and Trust	Youth expressed ambivalence toward formal services. Trust depended more on perceived confidentiality and respect than on professional credentials. Some youth stated they would speak to no one if harmed.	**Nairobi:** Highest reports of having no one to talk to. Kisumu: Greater willingness to engage peer educators and counselors. Mombasa: Mixed trust in clinics, higher reliance on informal networks.	Service design must prioritize trust, confidentiality, and youth choice over purely clinical access points.
Role of Schools and Community Structures	Schools, churches, and community programs were seen as important but inconsistent sources of support. Youth often received information without safe spaces for discussion or emotional support.	**Kisumu:** Strong emphasis on school guidance and counseling teachers. Nairobi: School pressure often exacerbated stress. Mombasa: Religious leaders were influential but not always safe for disclosure.	Strengthen psychosocial capacity within schools and community platforms, not just information delivery.
Digital Platforms and Hybrid Support	Youth valued digital platforms for anonymity and accessibility but emphasized the need for linkage to trusted human support. Online and offline services were seen as complementary, not substitutes.	**Mombasa & Kisumu:** Greater concerns about online embarrassment and misuse. Nairobi: Higher use but cautious trust.	Digital mental health tools must embed safeguarding, privacy, and clear referral pathways to in-person care.
Youth Preferences for Services	Youth preferred services that are youth-led, confidential, flexible, and respectful. Some expressed preference for gender-matched counselors, while others prioritized trust regardless of gender.	**Kisumu:** Diverse preferences around counselor gender. Across sites: Strong preference for peer-mediated entry points.	One-size-fits-all models are unlikely to work. Youth choice and flexibility should be built into service design.

The qualitative and quantitative findings demonstrate that adolescent mental health distress in Kenya is shaped by intersecting economic, relational, social, and digital factors, underscoring the need for youth-centered, trusted, and hybrid models of mental health care.

6

INTERPRETATION OF FINDINGS

The REACH Mental Health findings were interpreted using the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework to understand how observed youth mental health outcomes across Nairobi, Mombasa, and Kisumu are shaped by contextual conditions, system readiness, and youth experiences, and how these factors influence the feasibility, uptake, and durability of youth-centered mental health supports. Rather than treating EPIS as a separate analytic layer, the framework is applied here as an organizing lens to interpret patterns of distress, non-disclosure, coping, and cross-county variation within real-world implementation contexts.

This interpretation integrates quantitative and qualitative findings to move beyond prevalence estimates and toward an understanding of why distress manifests as it does, how youth navigate risk and support, and what conditions must be addressed for effective and sustainable intervention.

6.1 Risk Factors Identified Across Counties (EPIS: Exploration Context)

Across Nairobi, Mombasa, and Kisumu, the findings reveal a convergence of psychological, social, and structural risk factors shaping youth mental health. While the intensity of distress varied by county, the underlying risk profile was broadly consistent and characterized by persistent emotional distress, economic insecurity, exposure to violence, and limited access to trusted support systems. Within EPIS, these conditions define the outer-context realities that establish need and constrain feasible intervention pathways during the Exploration phase.

Economic precarity emerged as a foundational and cross-cutting risk factor. High levels of unemployment and income insecurity, particularly pronounced in Nairobi, co-occurred with food insecurity and persistent symptoms such as fatigue, appetite disturbance, and hopelessness. These patterns suggest chronic stress rather than episodic distress and align with evidence linking material deprivation to diminished coping capacity and sustained emotional burden. From an implementation perspective, economic strain also constrains service engagement, particularly for interventions requiring regular attendance, transport, or time away from income-generating activities.

Exposure to violence and safety concerns constituted a second major risk domain. Experiences of physical abuse, sexual coercion, and online harassment were reported across all counties. Importantly, high levels of discomfort disclosing abuse, especially in Nairobi, indicate that observed prevalence likely underestimates true exposure. Within EPIS, the co-occurrence of exposure and non-disclosure signals low-trust environments that limit detection, referral, and early intervention. Non-disclosure, therefore, functions not as a data artifact but as a structural barrier to care.

Social and relational strain represented a third risk domain. Persistent feelings of having “let their family down,” particularly among youth in Nairobi and Kisumu, reflect strong familial and societal expectations placed on young people amid constrained economic opportunities. These pressures may intensify self-blame and hopelessness while discouraging help-seeking for fear of judgment or perceived failure. Such dynamics further reinforce silence and delayed engagement with support systems.

Finally, digital environments emerged as contextual risk modifiers. Although mobile phone ownership was high, substantial proportions of youth especially in Mombasa and Kisumu reported cyberbullying, embarrassment, and regret related to online activity. These findings indicate that digital access alone does not equate to readiness for digital mental health interventions. Within EPIS, perceived safety, control, and trust within digital spaces are critical determinants of engagement.

Taken together, youth mental health risk in these settings is cumulative and multi-layered, arising from interacting economic, relational, safety, and digital factors. These conditions define the contextual realities within which any intervention must be explored and designed, underscoring the limitations of symptom-focused or single-domain responses.

6.2 Protective Factors and Resilience (EPIS: Preparation Assets)

Despite high levels of distress, the findings also reveal important protective factors and forms of adaptive functioning that serve as implementation assets during the Preparation phase. Across counties, informal social networks, particularly friends, family members, and peer mentors, were the most commonly identified sources of potential support. This highlights the central role of trusted relationships as buffers against adversity and suggests that peer- and community-embedded approaches may be more acceptable than purely clinical or authority-driven models.

Engagement with educational institutions functioned as a partial protective factor. Most youth had attained at least secondary education, and many reported receiving sexual and reproductive health information in school. While schooling did not prevent distress, continued connection to educational systems may provide structure, social interaction, and access to information that mitigate isolation for some youth. From an EPIS perspective, schools represent high-reach platforms whose readiness for mental health support depends on their capacity to ensure confidentiality, psychological safety, and youth-friendly engagement.

Religious and community institutions demonstrated similarly broad reach, particularly as sources of health information. However, the findings distinguish between informational access and emotional safety. While many youths received information through these channels, fewer viewed them as safe spaces for disclosure of distress or abuse. This distinction is critical for assessing system readiness: institutions may be visible and accessible without being prepared to host sensitive mental health interventions.

Youth participation in the REACH MH study itself represents an important preparation asset. Peer-led data collection and self-administered digital tools were associated with willingness to engage when approaches were perceived as respectful, confidential, and non-judgmental. This suggests that participatory and peer-facilitated models may enhance readiness by strengthening trust, perceived relevance, and youth agency.

Adaptive capacity in this context should therefore be understood not as the absence of distress but as the ability to function amid adversity through selective trust, social connection, and continued engagement in education or community life. These assets provide critical entry points for intervention design during the Preparation phase but require deliberate strengthening to translate into sustained engagement.

> What started as mobilization has become a movement. We want mental health program designed with youth, delivered with youth and sustained by youth.
>
> ***Program Officer, Nairobi***

> Young people showed up and responded even to the online question because they saw someone like them leading the process. We built trust in our Nairobi communities.
>
> ***YACH, Nairobi***

6.3 Differences by Age Group and Gender (EPIS: Implementation Dynamics)

Differences by age group and gender reveal important nuances in how risk and protective factors are distributed and how interventions may be differentially experienced during the Implementation phase.

Younger adolescents (15–19 years), though fewer in number, appeared particularly vulnerable to safety-related risks, including sexual coercion and limited autonomy in disclosure and decision-making. Dependence on adults or institutions they may not fully trust can reduce the feasibility of confidential care and heighten disengagement, underscoring the need for carefully designed access points for this age group.

Older youth (20–24 years), who comprised the majority of the sample, experienced greater exposure to economic pressure, relationship strain, and cumulative emotional distress. These patterns likely reflect increased responsibility and societal expectations associated with the transition to adulthood. While need may be higher in this group, competing demands related to income generation and caregiving may constrain sustained engagement in services.

Gendered patterns were evident across multiple domains. Young women consistently reported higher levels of emotional distress, poorer self-perception, and greater exposure to abuse, alongside higher discomfort with disclosure. These patterns are consistent with gendered power dynamics and caregiving expectations and point to the need for gender-responsive and trauma-informed implementation strategies, including discreet access points and enhanced privacy protections.

Young men, while less likely to report emotional distress directly, demonstrated greater involvement in externalizing risk behaviors, including substance use and gang involvement, particularly in Mombasa and Kisumu. This suggests that distress among young men may be under-detected if implementation strategies rely solely on self-reported emotional symptoms. Broader engagement and identification approaches are therefore necessary to avoid inequitable reach.

Without intentional design, these dynamics risk producing uneven coverage, with younger adolescents, young women, and emotionally distressed young men least likely to benefit from standard service models.

6.4 EPIS-Informed Synthesis and Implications

Viewed through the EPIS framework, the REACH MH findings suggest that effective youth mental health interventions in Kenya must be:

- Exploration-informed, grounded in lived realities of economic and social stress, violence exposure, stigma, and digital risk rather than assumed clinical need alone
- Preparation-ready, leveraging peer networks, educational platforms, and digital access while actively addressing trust, confidentiality, and safety gaps
- Implementation-sensitive, responsive to age and gender differences, and designed to minimize barriers related to disclosure, autonomy, and competing demands
- Sustainment-oriented, embedded within trusted community and peer structures and adaptable to evolving youth contexts and technologies.

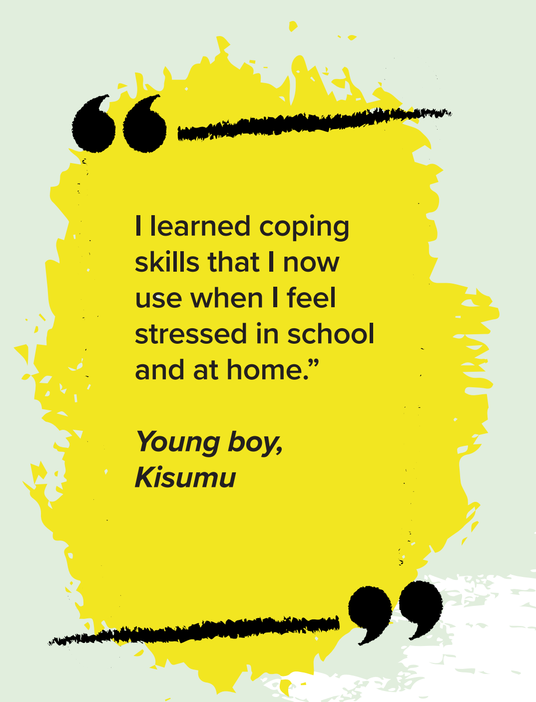
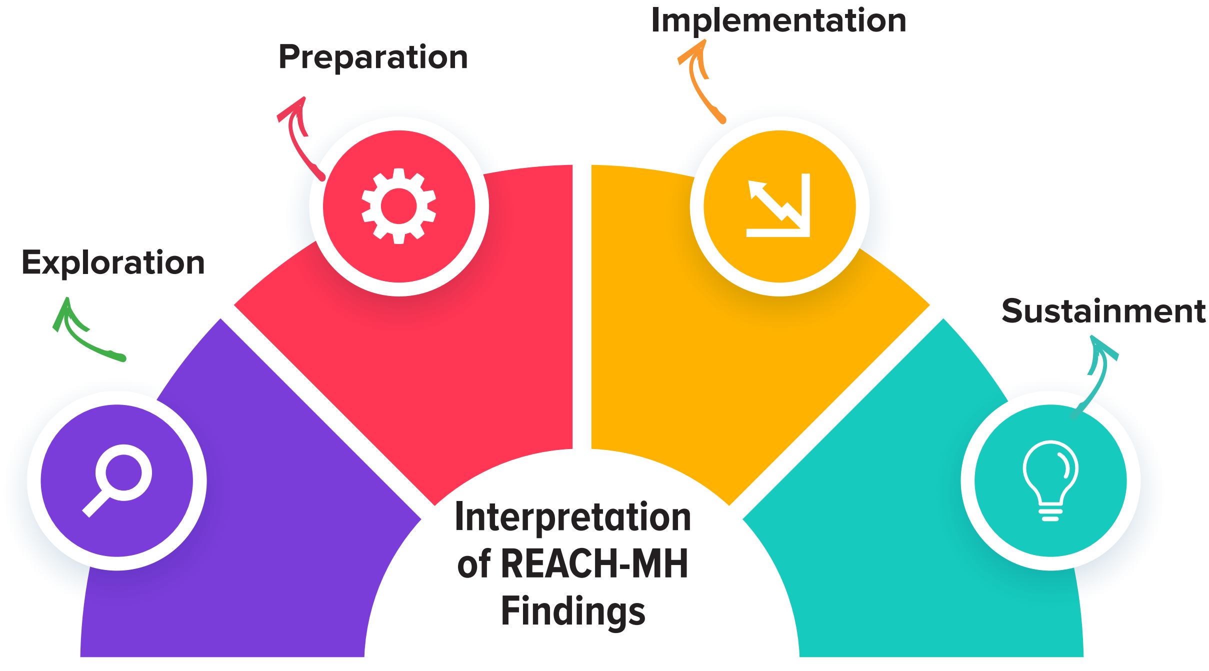


Table 3 : EPIS-Based Interpretation of REACH-MH Findings

EPIS Phase	Key Interpretive Insights from REACH-MH	Implications for Youth Mental Health Programming
Exploration	Youth mental health distress is shaped by cumulative economic hardship, violence exposure, relational pressure, and insecure digital environments. High non-disclosure reflects low-trust contexts rather than low need.	Interventions must be grounded in lived realities and designed for environments where distress is present but hidden. Needs assessment must include trust and safety considerations.
Preparation	Informal social networks, peer relationships, educational settings, and selective digital engagement function as protective assets despite high distress. Youth engagement increases when approaches are participatory and non-judgmental.	Preparation should focus on strengthening trust, confidentiality, and peer facilitation, and on adapting existing platforms (schools, community programs, digital tools) rather than creating parallel systems.
Implementation	Engagement and risk profiles vary by age and gender. Younger adolescents face autonomy constraints, young women experience higher emotional and violence-related burden, and young men may express distress through externalizing behaviors.	Implementation strategies must be age-responsive, gender-sensitive, and flexible, using multiple entry points and detection approaches to ensure equitable reach.
Sustainment	Youth value services that are confidential, flexible, youth-led, and embedded in trusted relationships. Digital tools are acceptable when linked to human support and safeguarding mechanisms.	Sustainable models should be embedded in community and peer structures, allow for adaptation, and integrate digital and in-person support to remain responsive to evolving youth contexts.

Overall, the findings depict a youth mental health landscape characterized by high burden, layered risk, constrained disclosure, and selective adaptive capacity. Distress is widespread and persistent, yet deeply shaped by social, economic, and cultural contexts. Interpreting these findings through EPIS reinforces the need for integrated, participatory, and context-aware approaches that extend beyond symptom reduction and address the conditions that enable or inhibit meaningful engagement and sustained impact.



7

PROJECT CONTRIBUTIONS AND VALUE

REACH-MH functioned as an integrated youth mental health evidence-to-implementation platform, combining youth REACH-MH functioned as an integrated youth mental health evidence-to-implementation platform, combining youth engagement, capacity building, and digital infrastructure to enable scale and sustained impact. Its core contribution lies in demonstrating how participatory data generation, digital systems, and institutional partnerships can be deliberately aligned to move adolescent mental health efforts beyond fragmented needs assessment toward implementation readiness, continuous system learning, and investment viability.

Rather than producing isolated findings, REACH-MH integrated multi-county data generation, youth leadership, county and national partnerships, and digital service linkages into a continuous pipeline for program design, adaptation, and funding decisions—shifting the focus from identifying problems to operationalizing solutions at scale.

7.1 Advancing the Field: Closing the Evidence–Implementation Gap

Globally, adolescent mental health literature repeatedly highlights a persistent gap between data generation and real-world implementation, particularly in low- and middle-income settings. Evidence is often cross-sectional, externally led, and disconnected from service delivery systems, limiting its utility for decision-makers.

REACH-MH directly addressed this gap by embedding community-based participatory research within a digital infrastructure designed for continuity, adaptation, and scale. Youth were positioned not only as respondents, but as co-producers of knowledge through peer-led data generation, interpretation, and dissemination, while counties were engaged as end users of findings rather than passive recipients. This alignment reflects emerging global best practice calling for participatory, technology-enabled mental health systems that translate insight into action.

Critically, the project invested in durable infrastructure rather than one-time outputs. Youth researchers, county partnerships, digital tools, and analytic pathways were intentionally designed to persist beyond the study period, positioning REACH-MH as a reusable platform rather than a closed research exercise.

> **REACH Mental health program provided a timely and practical platform for strengthening adolescent mental health support within Nairobi County. We particularly value the program emphasis on community based participatory models, youth participations and integration within existing county systems. Nairobi county remains committed to supporting scale up and aligning with its Mental health action plan towards 2030.**
>
> ***Nairobi, Mental Health coordinator.***

7.2 A Multi-County, Implementation-Ready Evidence Base

REACH-MH generated one of the few harmonized adolescent mental health datasets spanning Nairobi, Mombasa, and Kisumu, enabling direct cross-context comparison while preserving county-specific nuance. In Kenya's devolved health system, where counties are the primary units of planning, budgeting, and service delivery, this design is not ancillary; it is foundational. The underlying architecture is intentionally modular and adaptable, allowing replication and scale across additional counties and comparable urban settings in low- and middle-income contexts.

At the core of this effort was a purpose-built digital survey platform comprising 13 integrated modules designed specifically for adolescents and young adults aged 15–24. The platform captured mental health symptoms alongside key psychosocial and structural determinants, including family dynamics, schooling, livelihoods, substance use, exposure to violence, sexual and reproductive health, and digital risk environments. This multidimensional design supports a systems-level understanding of youth wellbeing that is rarely achieved through conventional, single-domain surveys.

Feasibility and acceptability were demonstrated through strong uptake during phased rollout and pilot implementation through April 2024. The platform recorded over 3,000 downloads, with nearly half resulting in completed surveys securely uploaded to a central server. This level of engagement demonstrates the viability of smartphone-based mental health data collection in dense urban Kenyan settings, including for sensitive psychosocial content, when paired with youth-centered and peer-facilitated approaches.

The resulting dataset provides planning-grade intelligence across priority domains such as self-harm ideation, food insecurity, sleep deprivation, exposure to violence, substance use, and psychosocial distress. These domains align closely with globally recognized drivers of adolescent mental health outcomes, strengthening the dataset's relevance for county-level programming, national strategy development, and international funding and investment decisions.

VIGNETTE 07

Understanding Young People's Needs: What Are They Calling For? Insights from Kenya's National One2One Youth Hotline

What this study did

This study analyzed call, SMS, WhatsApp, and Facebook Messenger data from Kenya's national One2One youth hotline to understand the health and psychosocial needs adolescents and young people actively seek help for when given confidential, youth-friendly access. Operated by LVCT Health, the One2One hotline is the largest youth-focused hotline in East and Central Africa, providing professional counseling and information on sexual and reproductive health, HIV, gender-based violence, and mental health to over 200,000 users. We examined patterns in topics raised, age and gender of callers, communication channel preferences, and reasons for contact across multiple years, identifying both high-volume issues and emerging or stigmatized topics that young people disclose anonymously but rarely surface in facility-based data. Findings reveal that young people most frequently seek information on relationships, contraception, HIV, puberty, mental health distress, and experiences of violence, with notable gender and age differences in help-seeking behavior and disclosure comfort.

Data from One2One directly informed the design and referral pathways of youth-centered digital initiatives including REACH-MH and the AGILE GBV chatbot, demonstrating how real-time hotline insights can shape implementation-ready mental health and violence prevention platforms.

Implications

Hotline data show that when young people control how, when, and through which channel they seek help, they disclose sensitive issues, mental health crises, violence, and sexual health concerns that remain hidden in facility settings or population surveys. For policymakers, this underscores the urgency of treating youth hotlines and digital platforms not as "nice to have" innovations but as essential surveillance and service infrastructure capable of capturing real-time, youth-prioritized need. The One2One model's stepped-care approach—moving from web information to hotline counseling to face-to-face services—mirrors the systems-anchored design of REACH-MH, reinforcing that effective youth health platforms link digital tools to trusted human support and referral pathways rather than functioning as isolated apps. Integrating hotline insights into county mental health planning, GBV response, and adolescent health programming ensures that services reflect what young people are actually asking for, not what adults assume they need. More broadly, the One2One experience demonstrates that youth-led, multi-channel digital ecosystems can serve as the connective tissue across mental health, SRH, HIV, and violence prevention, creating coherent care pathways for Kenya's young people in a devolved health system.

Recommendations

- Integrate youth hotlines like One2One into national and county adolescent health strategies as core service delivery platforms, not peripheral add-ons, recognizing that many youth prefer anonymous, digital-first entry points over facility-based care.
- Use hotline data systematically to inform policy, program design, and resource allocation, as call and chat patterns reveal youth priorities and emerging needs (such as mental health distress, technology-facilitated abuse, and relationship violence) that traditional surveys and facility records underestimate.
- Strengthen hotline-to-care referral pathways by embedding counselors within multi-sectoral networks (health facilities, mental health services, legal aid, youth-friendly centers) so that disclosures of violence, suicidal ideation, or urgent health needs reliably connect to appropriate follow-up.
- Expand stepped-care models that link digital information (websites, chatbots), hotline counseling, and face-to-face services, allowing youth to move seamlessly across intensity levels based on need—an approach successfully piloted through One2One's integration with REACH-MH and AGILE.
- Invest in continuous capacity building for hotline counselors in trauma-informed care, mental health first aid, GBV response, and LGBTQ+ inclusive counseling to ensure all youth receive affirming, competent support.

Source

Understanding young people's needs: What are they calling for? *The national One2One hotline services in Kenya. Abstract presented at the American Public Health Association Annual Meeting; 2023; Atlanta, GA*

7.3 Youth-Led Qualitative Insight and the Evidence-to-Care Continuum

Quantitative findings were intentionally complemented by youth-led qualitative research, addressing a common limitation in global mental health studies where lived experience is often under-integrated. Structured focus group discussions were conducted with 40 participants in each county, capturing nuanced insights into poverty, family instability, violence exposure, digital pressures, and barriers to help-seeking.

These qualitative findings did more than contextualize numbers; they explained mechanisms, particularly around non-disclosure, trust, and selective engagement with services. Patterns of "not comfortable disclosing" were treated as system signals rather than missing data, offering actionable insight into why formal services may remain underutilized even when available.

REACH-MH further strengthened the evidence-to-care continuum by aligning its analytic agenda with existing digital service platforms, including LVCT Health's One2One chat-based counseling system and Kenya's toll-free 1190 hotline. This linkage demonstrates a stepped-care model in which population-level screening data can inform real-world service delivery, referral pathways, and resource allocation across mental health, sexual and reproductive health, gender-based violence, and HIV prevention.

7.4 Youth Workforce Development and Durable Research Capacity

A central contribution of REACH-MH was the intentional development of a youth research workforce. The project trained and deployed 150 young people across counties to support peer-facilitated, smartphone-enabled data collection. This directly addresses a critical gap in adolescent mental health programming: the shortage of youth-capable research and implementation personnel.

Youth engagement was operationalized through a formal Youth Advisory Champions for Health (YACH) structure, with organized teams in Nairobi, Mombasa, and Kisumu supported by defined leadership, real-time coordination, and structured accountability mechanisms. This moved youth engagement beyond consultation toward operational ownership.

Capacity building extended beyond data collection. A multi-day CBPR training program covered research ethics, epistemology, bias mitigation, community entry, and trust-building in sensitive inquiry. This constituted foundational research training rather than one-off orientation, enabling continued youth-led evidence generation beyond the grant period.

7.5 Bi-Directional Academic–Implementation Learning

REACH-MH established a bi-directional academic–implementation learning platform that moved beyond a single University–implementer collaboration to catalyze wider institutional alignment across Kenya's mental health ecosystem. Initially designed to link Kenyan implementation contexts through LVCT Health and county governments with academia, the University of Maryland, Baltimore (UMB), the platform evolved into a mechanism for expanded partnerships, shared protocols, and coordinated capacity strengthening aligned with health system priorities.

Within the core partnership, two UMB trainees, one medical student and one PhD candidate, used REACH-MH as the empirical foundation for their mental health research, embedded within field-based implementation and mentorship. This ensured that academic inquiry was grounded in real-world service environments, while implementation benefited from analytic rigor, methodological support, and global benchmarking.

Importantly, this learning architecture did not remain bounded within the original consortium. The REACH-MH platform enabled the extension of collaboration to additional national and regional organizations, including Amref Health Africa, through shared learning agendas, joint protocol development, and coordinated submissions for funding and ethical review. These extensions demonstrate that REACH-MH functioned as a convening and translation platform, capable of aligning multiple institutions around common evidence standards and implementation goals. At the subnational level, REACH-MH worked closely with County Health Management Teams (CHMTs), mental health coordinators, and adolescent and youth health focal persons across Nairobi, Mombasa, and Kisumu. County officials were engaged not only as implementers, but as co-interpreters and users of evidence, strengthening alignment between data, planning, and service delivery realities.

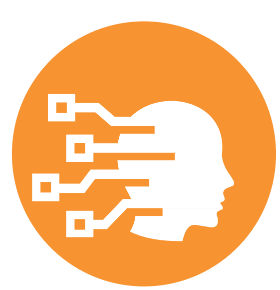
At the national level, the project engaged the Kenya Ministry of Health, including the Division of Mental Health within the Department of Non-Communicable Diseases, to align REACH-MH evidence and approaches with national mental health and adolescent health priorities. This engagement supported coherence with existing policy frameworks and reinforced pathways for scale and sustainability.

These relationships were formalized through Memoranda of Understanding (MoUs) and other binding collaboration mechanisms at both national and county levels, covering areas such as training support, data use, capacity strengthening, and joint learning. By anchoring collaboration within formal institutional agreements, REACH-MH reduced reliance on individual champions and increased the durability of partnerships beyond the life of the project.

Overall, REACH-MH demonstrates how a bi-directional learning model can evolve into institutional spillover, where academic–implementation exchange generates new partnerships, shared protocols, and system-aligned capacity building. This progression distinguishes REACH-MH from projects that limit learning to internal teams, positioning it instead as a platform that strengthens the broader adolescent mental health ecosystem through coordinated, cross-institutional learning.

Mombasa County recognizes the growing mental health needs of adolescents and young people in coastal communities facing social and economic pressures. The Reach program has demonstrated that culturally grounded, youth friendly approaches can enhance awareness, reduce stigma, and strengthen coping skills among adolescents. We appreciate the partnership and look forward to expanding evidence based mental health promotion and research across the county.

Mombasa, AYP and Mental Health Coordinator



7.6 Demonstrating Scalable, Fundable Digital Models

REACH-MH demonstrated the feasibility of deploying a single, offline-capable digital mental health system across multiple counties, directly addressing concerns around fragmentation and site-specific pilots. Offline-first functionality reduced data costs and connectivity barriers, improving completion rates and equity of access.

Peer-to-peer recruitment through youth networks, MindSKILLZ coaches, peer educators, and youth-led organizations expanded reach beyond clinic-based populations. Importantly, the model preserved ethical rigor, consent, confidentiality, safeguarding, and referral pathways while achieving scale.

Rapid learning loops through stakeholder engagement and dissemination ensured the platform remained adaptive rather than static. Integration with Kenya's broader youth digital health ecosystem, alongside parallel innovation efforts such as the AGILE GBV chatbot, reinforced implementation credibility and system alignment.

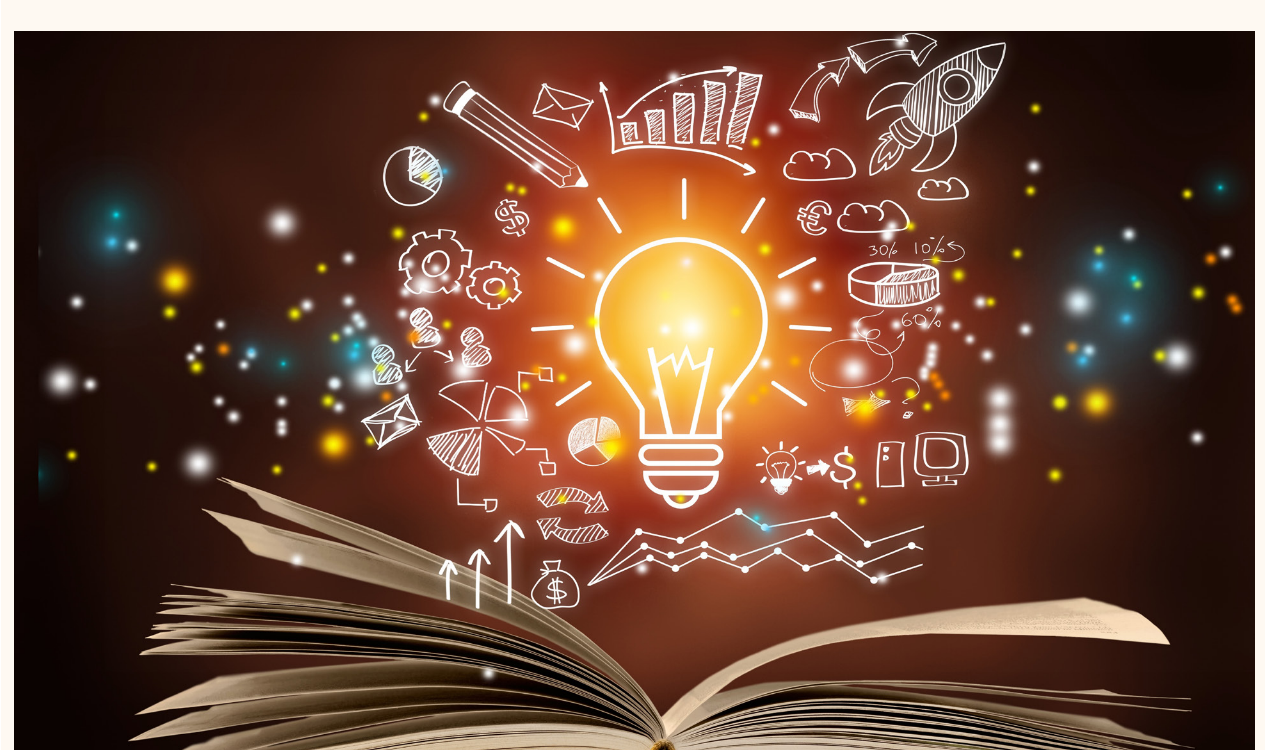
7.7 Investment Readiness and Grant Pipeline Catalyzed

REACH-MH functioned as a de-risking platform for future investment, translating evidence generation and implementation learning into fundable, scale-oriented opportunities. The project directly informed and seeded multiple competitive grant pathways, including USAID, Grand Challenges Canada, the Spencer Foundation, Co-Impact ASPIRE, the Wellcome Trust, and the NIH. This portfolio includes the recently awarded AGILE gender-based violence (GBV) chatbot initiative, which has secured over USD 200,000 in funding.

This emerging pipeline demonstrates that REACH-MH is not an endpoint, but a catalyst for sustained investment and scale. Continued funding does not begin from a greenfield position; it builds on a tested digital platform, a trained and deployable youth research workforce, established county and national legitimacy, and a functioning multi-institution learning network capable of supporting adaptation, expansion, and long-term impact.

7.8 Scholarly Output, Dissemination, and Field Influence

REACH-MH translated investment into sustained scholarly and applied outputs, demonstrating both scientific productivity and delivery capacity. To date, seven peer-reviewed manuscripts have been published across adolescent mental health, digital health, participatory research, gender-based violence, and implementation-relevant domains, with additional manuscripts currently under review or in advanced preparation drawing directly from REACH-MH data and partnerships. These publications reflect deliberate alignment between evidence generation, methodological innovation, and real-world applicability.



Key peer-reviewed outputs include:

- Memiah, P., Wagner, F.A., Kimathi, R., Anyango, N.I., Kiogora, S., Waruinge, S., Kiruthi, F., Mwavua, S., Kithinji, C., Agache, J.O. and Mangwana, W. (2022). Voices from the youth in Kenya addressing mental health gaps and recommendations. **International Journal of Environmental Research and Public Health, 19(9), 5366.**
- Ngũnjiri, A., Memiah, P., Kimathi, R., Wagner, F.A., Ikahu, A., Omanga, E., Kweyu, E., Ngunu, C., and Otiso, L. (2023). Utilizing user preferences in designing the AGILE GBV chatbot. **International Journal of Environmental Research and Public Health, 20(21), 7018.**
- Memiah, P., Lathan-Dye, M., Opanga, Y., Muhula, S., Gitahi-Kamau, N., Kamau, A., and Otiso, L. (2022). Highlighting a digital platform to assess young people's needs: The REACH project. **Adolescents**, 2(2), 150–163.
- Mwavua, S., Ngunu, C., Gitonga, I., Royea, A., Henia, D., Chitayi, B., Memiah, P., and Kumar, M. (2023). Development of a digital mental health platform in the era of COVID-19 in Kenya. **PAMJ–One Health, 11(7)**.
- Memiah, P., Kamau, A., Opanga, Y., Muhula, S., Nyakeriga, E., Humwa, F., Cook, C., Kingori, C., and Muriithi, J. (2020). Using friendship ties to understand intimate partner violence among adolescents and young adults in Kenya. **Interactive Journal of Medical Research,** 9(4), e19023.

Beyond publication, REACH-MH findings achieved high-credibility national and international visibility through dissemination at leading scientific and policy forums, including the International AIDS Society, the American Public Health Association, and the Kenya Psychiatric Association. Importantly, dissemination was conducted not only by senior investigators but also by youth and project team members, reinforcing participatory credibility and authenticity of voice.

At the subnational level, dissemination explicitly engaged county mental health and MHPSS focal persons (Mental Health and Psychosocial Support), embedding findings within existing planning, coordination, and service delivery structures. This approach positioned REACH-MH evidence not as external research outputs, but as decision-relevant inputs aligned with county priorities and operational realities, strengthening prospects for translation into policy and programming.

Finally, REACH-MH established an integrated training-to-publication pipeline in which youth training, data generation, analysis, dissemination, and scholarly output reinforced one another. This pipeline maximized yield from core investments, supported early-career researcher development, and ensured that knowledge production continued beyond a single funding cycle an important marker of durability and field influence.

8
LESSONS
LEARNED

Implementation of REACH-MH across Nairobi, Mombasa, and Kisumu generated critical lessons for designing, deploying, and sustaining youth-centered mental health platforms in urban, resource-constrained settings. These lessons span implementation effectiveness, operational feasibility, and ethical practice, and are directly relevant for future scale and replication.

8.1 What Worked Well

- **Youth-led and participatory implementation strengthened trust and uptake.** Positioning adolescents and young people as peer mobilizers, data collectors, and co-interpreters of findings increased acceptability, reduced barriers to participation, and enhanced the authenticity of data collected. Youth participants consistently expressed greater comfort engaging with peers than with external researchers or formal authorities, particularly when discussing sensitive topics such as mental distress, violence, and sexual health.

- **Digital-first, offline-capable tools enabled reach at scale.** The REACH-MH digital platform demonstrated that smartphone-based mental health data collection is feasible and acceptable in dense urban Kenyan settings when designed with offline functionality, low data burden, and user-friendly interfaces. This approach enabled participation beyond facility-based populations and reduced reliance on continuous connectivity.

- **County engagement enhanced relevance and legitimacy.** Early and sustained engagement with County Health Management Teams (CHMTs) and county mental health focal persons ensured that data collection aligned with local priorities and that findings were perceived as actionable rather than academic. This alignment strengthened ownership and increased the likelihood of evidence uptake in county planning and programming processes.

- **Integration with existing youth service platforms strengthened continuity.** Linkages with established digital and community-based service platforms, including youth hotlines and chat-based counseling services, reinforced an evidence-to-care continuum. This integration demonstrated how population-level data can inform service delivery pathways rather than remaining siloed within research outputs.

- **Hybrid training and mentorship models built durable capacity.** The combination of in-person and virtual training, ongoing mentorship, and field-based support enabled consistent implementation across counties while accommodating logistical constraints. Youth researchers, facilitators, and coordinators developed practical research and implementation skills that extend beyond the life of the project.

8.2 Implementation Challenges

- **Non-disclosure and missing data reflected structural trust deficits.** High levels of "not comfortable disclosing" responses, particularly for violence, sexual experiences, and self-harm, limited precision in estimating prevalence. However, these patterns underscored deeper issues of stigma, fear, and mistrust that cannot be resolved through survey design alone and must be addressed at the system and community levels.

- **Uneven readiness across counties required adaptive implementation.** Differences in infrastructure, partner capacity, and local governance structures meant that implementation intensity and pacing varied across Nairobi, Mombasa, and Kisumu. A standardized platform required flexible operational strategies to accommodate local constraints without compromising core protocols.

- **Balancing scale with safeguarding demanded constant attention.** Scaling youth engagement while maintaining ethical safeguards—particularly around consent, confidentiality, and referral for distress—required continuous supervision and rapid response mechanisms. This was especially critical given the peer-led nature of data collection and the sensitive content addressed.

- **Digital engagement introduced new forms of risk.** While digital tools expanded reach, they also surfaced concerns related to privacy, online harassment, and fear of digital exposure. These risks reinforced the need for clear communication about data protection, anonymization, and safe digital use.

- **Youth workforce sustainability remains a challenge.** Although youth participation was strong, maintaining engagement over time required attention to incentives, workload balance, psychosocial support for peer researchers, and clear pathways for continued involvement beyond short-term project cycles.

The REACH Mental Health program has demonstrated that power of community rooted adolescent responsive approaches to strengthening mental health promotion and early support systems in Kenya. Across Nairobi, Mombasa, and Kisumu, we have seen that when young people are engaged not only as participants but as partners, mental health interventions become more trusted, more relevant, and more sustainable. The integration of youth friendly delivery, safeguarding, and referral pathways has helped normalize conversations on mental wellbeing while strengthening linkages to care for those with acute needs. A key reflection from this implementation is that mental health systems are built through relationships between adolescents and services, between communities and services, and between evidence and policy action. The program; community based participatory research elevated youth voices and strengthened ownership, with youth advisory champions mobilizing peers and transitioning into paid community researcher roles. This represents not only meaningful participation, but a pathway to youth employability and leadership."

Program Manager, LVCT Health

8.3 Key Operational and Ethical Insights

- **Non-disclosure is a finding, not a failure.** Patterns of silence and discomfort provide critical insight into where systems are not perceived as safe. Treating non-disclosure as actionable evidence shifts implementation focus toward trust-building, alternative entry points, and trauma-informed engagement strategies.

- **Ethical practice must be embedded, not appended.** In youth mental health research, ethics extend beyond institutional approvals to day-to-day facilitation practices, language choice, peer dynamics, and referral readiness. Continuous ethical reflexivity is essential, particularly in participatory and peer-led models.

- **Youth choice and control are central to engagement.** Youth consistently emphasized the importance of autonomy in choosing when, how, and with whom to engage. Flexible participation options, anonymous digital tools, and multiple support pathways increased perceived safety and willingness to participate.

- **Hybrid service models outperform single-channel approaches.** Findings reinforced that digital platforms are most effective when paired with trusted human support. Youth viewed online and offline services as complementary, not interchangeable, highlighting the importance of integrated, stepped-care models.

- **Implementation readiness is as important as evidence quality.** High-quality data alone does not guarantee impact. REACH-MH demonstrated that investment in partnerships, capacity, feedback loops, and governance structures is essential to translate evidence into sustained programming and policy action.

REACH-MH has demonstrated that youth-centered, participatory, and digital mental health systems are feasible, acceptable, and implementation-ready in urban Kenyan settings. The next phase focuses on consolidating county uptake, strengthening platform functionality, and positioning REACH-MH as a scalable national and global public good. These pathways emphasize continuity rather than reinvention, building on existing partnerships, infrastructure, and learning.

VIGNETTE 08

Factors Associated with Bullying Victimization among Adolescents Joining Public Secondary Schools in Nairobi County, Kenya: A Cross-Sectional Study

What this study did

This analytical cross sectional study examined the prevalence and correlates of bullying victimization among 539 Form One students in five public secondary schools (one boys', two girls', and two mixed) in Nairobi County, Kenya. Data were collected approximately one month after school entry using the Adolescent Peer Relations Instrument to assess bullying victimization and a structured questionnaire on socio demographic characteristics and mental health, including depression. Generalized linear models with a log link and Poisson distribution were applied to estimate prevalence ratios for factors associated with bullying victimization. The study found that 85.7% of adolescents reported experiencing at least one form of bullying, and that the presence of depression and male sex were significantly associated with higher risk of victimization.

Implications

The very high prevalence (85.7%) of bullying victimization among students just entering secondary school shows that violence is a pervasive part of the school environment and a key driver of adolescent mental ill health. The strong association between bullying and depression suggests that effective adolescent mental health strategies in Kenya must directly address peer victimization alongside individual level support. For policymakers, these results argue for integrated approaches in which school entry screening, anti bullying programs, and mental health services are linked to wider youth focused platforms such as REACH MH, AGILE and the One2One hotline that can provide confidential information, ongoing monitoring, and stepped care referral options for affected adolescents. Embedding school findings within these broader digital and community ecosystems can help counties move from reactive discipline responses toward proactive, cross sector responses to bullying and its mental health consequences.

Recommendations

- Integrate systematic screening for bullying victimization and depressive symptoms into school health and guidance programs at the start of secondary school, with clear referral pathways for students at highest risk.
- Develop and enforce whole school anti bullying policies that address physical, verbal, and relational forms of bullying, with particular attention to boys who showed higher risk of physical victimization.
- Train teachers, school counselors, and peer leaders to recognize signs of bullying and associated emotional distress, respond using trauma informed approaches, and link affected students to appropriate psychological support.
- Strengthen connections between schools, community mental health services, and youth serving digital platforms (e.g., hotlines and apps) so that adolescents who disclose bullying can access confidential, youth friendly support beyond the school gate.
- Include indicators on bullying and mental health in county and national education and health monitoring systems to track trends and evaluate the impact of school based interventions over time.

Source

Mokaya, A. G., Kikuvi, G. M., Mutai, J., Khasakhala, L. I., & Memiah, P. (2023). Factors associated with bullying victimization among adolescents joining public secondary schools in Nairobi County, Kenya: A cross sectional study. African Journal of Health Sciences. [If volume/issue/pages are listed, insert here.] Retrieved from http://repository.kemri.go.ke/xmlui/handle/123456789/1314

PATHWAYS FORWARD: FROM PLATFORM TO SYSTEM IMPACT

9.1 County-Level Translation, Dissemination, and Action

- **County-specific evidence packaging for decision-making.** REACH-MH findings will be translated into tailored county briefs for Nairobi, Mombasa, and Kisumu, highlighting localized risk profiles, priority populations, and actionable entry points within existing health, education, and social service systems. These briefs will be designed for practical use by County Health Management Teams (CHMTs), mental health focal persons, and implementing partners, aligning findings with County Integrated Development Plans (CIDPs) and adolescent health strategies.

- **Participatory dissemination and interpretation forums.** Beyond written products, REACH-MH will convene county- and community-level dissemination forums that present findings in accessible formats such as infographics, short videos, and youth-led presentations. These forums will emphasize dialogue and co-interpretation, enabling counties and communities to jointly identify priorities, validate findings, and translate evidence into programming decisions.

- **Youth-led CBPR structures for sustained local learning.** To sustain participatory engagement, REACH-MH will strengthen Youth Advisory Champions for Health (YACH) through ongoing training in research methods, facilitation, ethics, and advocacy. Counties may establish local research advisory committees comprising youth representatives, implementers, and county officials to guide continued data use, feedback, and adaptation. These structures position youth not only as informants, but as long-term partners in evidence generation and use.

- County-level mental health action planning. REACH-MH data provide a foundation for counties to develop or refine context-specific mental health action plans. The platform can support prioritization of interventions, advocacy for dedicated resources, and the establishment of monitoring and evaluation frameworks to track progress and adjust implementation over time.

9.2 Platform Evolution, Content Expansion, and Inclusive Design

- **From data collection to youth-facing mental health support.** Building on its assessment foundation, the REACH-MH platform can be expanded to include curated educational content on mental health literacy, coping strategies, help-seeking pathways, and crisis support. Interactive features—such as quizzes, chat-based guidance, and moderated peer-support spaces—can enhance engagement while maintaining strong safeguarding protocols.

- **Integration of AI-enabled decision support.** Strategic use of artificial intelligence can support adaptive content delivery, trend analysis, and early signal detection (e.g., rising distress related to food insecurity or violence exposure) without replacing human oversight. AI tools can be used to improve responsiveness, not automate care, reinforcing ethical and participatory principles.

- **Multilingual and disability-inclusive expansion.** To ensure equitable access, future iterations of the platform should support additional languages, including Kiswahili variants and Kenyan Sign Language, and incorporate accessibility features for adolescents with visual, hearing, or cognitive disabilities. These adaptations align with global commitments to inclusive digital health and expand the platform's relevance beyond current populations.

- **Scalable, modular expansion to new geographies.** With its modular design and offline functionality, REACH-MH is well positioned for phased expansion to additional counties and comparable urban settings regionally. Partnerships with organizations such as Amref Health Africa and other implementing agencies can support responsible scale while preserving fidelity to youth-centered principles.

9.3 Policy Alignment, Health System Strengthening, and Investment Opportunities

- **Informing national child and adolescent mental health policy.** REACH-MH findings offer timely, implementation-relevant evidence to support national policy dialogue on child and adolescent mental health. Engagement with national stakeholders—including the Ministry of Health's mental health leadership and relevant divisions—can ensure that youth mental health is embedded within broader child, adolescent, and universal health coverage agendas.

- **Strengthening provider readiness through KAP-informed training.** Future phases can include Knowledge, Attitudes, and Practices (KAP) assessments among healthcare providers to identify gaps in adolescent mental health competence and confidence. Findings can inform targeted training and supervision models that support integration of youth-friendly mental health services within primary care and community platforms.

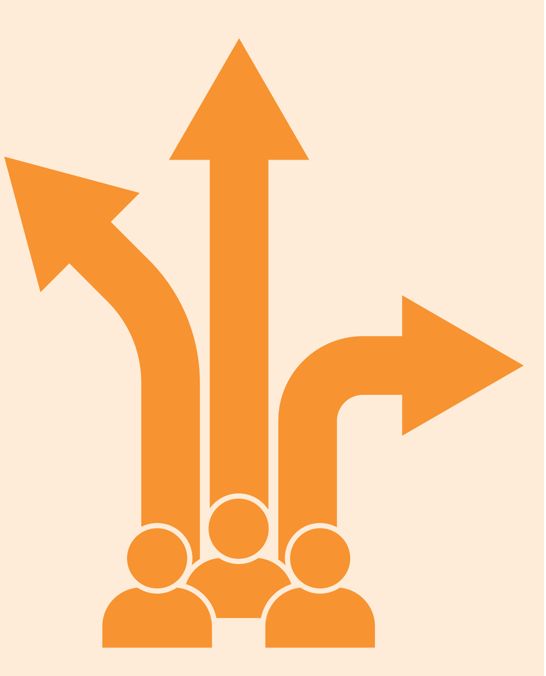
- **Positioning REACH-MH as an investment-ready global platform.** REACH-MH is not a pilot in search of purpose; it is a tested, de-risked platform capable of supporting incremental investment. Funders can support discrete components such as county expansion, AI enhancement, disability inclusion, or provider training without assuming early-stage risk. This modularity supports blended financing models involving government, philanthropy, and innovation funding.

- **Global learning and replication.** Beyond Kenya, REACH-MH offers a transferable model for adolescent mental health systems in low- and middle-income urban settings. Strategic global dissemination positions the platform as a reference case for participatory, digital, and implementation-oriented mental health programming aligned with global evidence and best practice.

Way Forward

The pathways ahead for REACH-MH emphasize translation, inclusion, and scale with integrity. By anchoring action at the county level, evolving the platform to address emerging needs, and aligning with national and global policy and investment priorities, REACH-MH has effectively de-risked scale. The platform has generated multi-county, devolution-ready evidence; trained and deployed a youth research workforce; demonstrated a scalable, ethical, peer-led digital model; embedded evidence within real service ecosystems; and catalyzed a competitive investment pipeline.

Continued investment does not begin from zero. It builds on a tested platform, a trained and deployable workforce, and an established multi-level learning network spanning youth, counties, national institutions, and global partners. REACH-MH is therefore positioned to move beyond successful implementation toward a sustained system-level asset grounded in youth voice, strengthened by technology, and oriented toward long-term impact.



VIGNETTE 09

Correlates of intimate partner violence among adolescents in East Africa: A multi-country analysis

What this study did

This study conducted a secondary analysis of Demographic and Health Survey (DHS) data from 13,165 adolescent women aged 15–24 years in five East African countries—Burundi, Kenya, Rwanda, Tanzania, and Uganda—to identify correlates of intimate partner violence (IPV). IPV was measured as a composite of emotional, physical, and sexual violence, and examined in relation to sociodemographic, income, maternal, sexual, knowledge, behavioral, and partner-related variables. The prevalence of ever experiencing IPV was 45.1%, and higher odds of IPV were observed among adolescents whose first sexual encounter occurred before age 18, who had two or more children, who had ever terminated a pregnancy, whose partners had lower education, or who believed a husband/partner was justified in beating his wife. These regional patterns provide critical context for Kenya focused initiatives such as REACH MH, underscoring how gender norms, early sexual debut, and partner characteristics intersect with adolescent mental health and violence risk.

Implications

The prevalence of IPV among adolescent and young women across East Africa confirms that violence is a pervasive, region wide determinant of poor health, including depression, anxiety, suicidality, and risky sexual behavior. The identified correlates—especially early sexual debut, low partner education, pregnancy termination, higher parity, and acceptance of wife beating—highlight the need for multi level interventions that address both individual behaviors and structural norms. For Kenya and neighboring countries, these findings argue for integrating IPV prevention and response into broader adolescent health and mental health systems, including digital and community based platforms that can provide safe spaces for disclosure, psychosocial support, and referral. Embedding these strategies within national and county plans creates an opportunity to tackle violence and mental health together, rather than as separate policy silos.

Recommendations

- Develop adolescent specific IPV prevention and response policies in East African countries that explicitly address harmful gender norms, early marriage, and early childbearing as structural drivers of violence.
- Integrate IPV screening and counseling into adolescent and youth sexual and reproductive health (SRH) and HIV services, ensuring safe, confidential disclosure pathways and survivor centered referrals.
- Implement comprehensive sexuality education and life skills programs that promote gender equality, challenge attitudes that justify wife beating, and build negotiation and safety planning skills among both girls and boys.
- Target partners' education and engagement—through male involvement programs and community dialogues—given the association between low partner education, acceptance of violence, and adolescent IPV risk.
- Link IPV programming with adolescent mental health and digital initiatives (including REACH aligned platforms and hotlines) to address co occurring emotional distress, trauma, and barriers to help seeking.

Source

Memiah P, Cook C, Kingori C, Munala L, Howard K, Ayivor S, Bianco JA. Correlates of intimate partner violence among adolescents in East Africa: a multi-country analysis. Pan Afr Med J. 2021;40:142. doi:10.11604/pamj.2021.40.142.23139

TESTIMONIAL

Advancing Adolescent Mental Health Through Community-Driven Research and Equitable North–South Scientific Collaboration: The Significance of Amref's Engagement in the REACH Study

Authors: Dr. Samuel Muhula, Yvonne Opanga

Amref Health Africa in Kenya represented by Dr. Samuel Muhula and Ms. Yvonne Opanga is proud to have participated in the REACH (Reaching, Engaging Adolescents and Young Adults for Care Continuum in Health – Mental Health) study led by the University of Maryland, Baltimore in collaboration with partners in Kenya. Our engagement in REACH reflects our deep commitment to advancing adolescent and youth health, particularly in areas that have historically received limited attention within primary healthcare systems most notably mental health. As the burden of depression, anxiety, substance use, trauma, and psychosocial stressors continues to rise among young people, there is an urgent need to strengthen evidence, shift narratives, and embed mental health more deliberately within community and health system responses.

Participation in REACH significantly strengthened our conceptualization of mental health beyond a purely clinical lens. The study reinforced a more holistic understanding of adolescent mental wellbeing one that recognizes the interplay between social determinants, family dynamics, economic vulnerability, gender norms, digital exposure, and access to supportive services. Through the REACH framework, mental health was positioned not only as a treatment issue but as part of a broader care continuum requiring prevention, early identification, linkage to care, retention, and community-based support systems. This continuum approach aligns strongly with Amref's integrated primary healthcare model and has helped refine how we embed mental health within SRHR, youth empowerment, and community health programming.

Particular transformative aspect of this collaboration was the introduction and strengthening of Community-Based Participatory Research (CBPR) approaches. REACH reinforced the principle that adolescents and communities must be active partners in defining mental health priorities, identifying culturally relevant expressions of distress, and cocreating solutions. This approach has helped shift mental health from being externally defined to being locally contextualised and community-owned. It has also strengthened trust, reduced stigma through dialogue, and enhanced youth voice within programme and policy discussions.

The collaboration further deepened our application of Human-Centred Design (HCD) in mental health programming. By leveraging digital tools to engage adolescents directly, we gained nuanced insights into behavioural drivers, help-seeking patterns, stigma barriers, and service gaps. These insights have strengthened our capacity to design adolescent-friendly mental health interventions that are accessible, confidential, and responsive to lived realities. Importantly, the experience reinforced the need to integrate digital mental health innovations ethically, ensuring data privacy, safeguarding, and inclusivity.

REACH also exemplified the power of equitable North–South scientific collaboration. Working with academic and implementation partners fostered mutual knowledge exchange, methodological rigor, and contextual adaptation of mental health research tools. This partnership strengthened Amref's research capacity in behavioral science, digital data systems, and implementation research while contributing African perspectives to global mental health discourse. It demonstrated how collaborative science can bridge global expertise with local realities to generate actionable and policy-relevant evidence.

Beyond the research outputs, participation in REACH enriched Amref's institutional learning platforms. Insights from the study have been shared across technical teams and integrated into program reflection forums, strengthening crosssector learning and informing mental health integration strategies across projects. The experience has contributed to institutionalizing mental health within our broader health systems strengthening agenda, ensuring that adolescent wellbeing is not siloed but embedded within community health, SRHR, and primary healthcare frameworks.

For Amref Health Africa, participating in REACH was more than a research partnership it was a catalyst for strengthening our mental health framework, advancing community-driven science, deepening human-centered innovation, and reinforcing our commitment to youth-responsive, resilient health systems. The study informed integrated, prevention-oriented, and community-anchored mental health approaches across Amref's programs.

ACKNOWLEDGEMENTS

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We also recognize the Youth Advisory Champions for Health (YACH) for their essential role as co-researchers, mobilizers, and interpreters of findings. Their leadership strengthened ethical engagement, data quality, and contextual interpretation throughout the study.

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IN PHOTOS

REACH Background and Timeline

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BALTIMORE

lvcthealth

REACH-MH