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# Caring for the Carers: Protecting the Mental Health and Wellbeing of Kenya's Community Health Promoters

*Evidence from the SHINE study in Nairobi and Kiambu Counties to inform Kenya's Universal Health Coverage and Mental Health agenda*

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## KEY MESSAGES

- **1 in 4** Community Health Promoters (CHPs) in Nairobi screened positive for depression and 1 in 3 for anxiety — a hidden burden inside Kenya's frontline health workforce.
- **Urban CHPs carry up to 5x the stress burden** of their rural peers, signalling that informal-settlement contexts demand tailored mental health support.
- **CHPs are absorbing system costs.** 90%+ report inadequate, unfair stipends and out-of-pocket spending on community members — financial strain that directly fuels distress.
- **CHP mental health is a missing pillar of UHC.** County mental health professionals are not embedded in community health structures, leaving timely intervention opportunities unused.
- **A scalable, co-designed solution exists.** A four-part package (literacy, WHO Doing What Matters, supportive supervision, bulk SMS) is piloted with 500 CHPs and 50 CHAs and ready to scale across Kenya's 107,000 CHPs.

## Why this matters now

Kenya is reshaping primary health care to deliver Universal Health Coverage, with Community Health Promoters (CHPs) at the heart of the strategy. **107,000 CHPs** have been issued kits, equipped with the electronic Community Health Information System (eCHIS), and — for the first time — are receiving a monthly stipend of KSh 5,000 (US$40). Each CHP serves 100 households for prevention, promotion, screening and referral, supervised by Community Health Assistants (CHAs).

These reforms expand reach but also expand load. CHPs now navigate heavier data demands, climate-driven crises (the 2024 floods displaced households they serve), strained referral pathways and household financial pressure — all while supporting communities through their own pain. *Mental health and wellbeing among CHWs is a global blind spot,* and even committed donors note that frontline-worker mental health is one of the most under-funded entry points into resilient primary care.

The **SHINE study** (LVCT Health, APHRC, Liverpool School of Tropical Medicine and BRAC JPGSPH) generated the first mixed-methods evidence base on CHP mental health in Kenya, working alongside the Ministry of Health's **Division of Mental Health** and **Division of Community Health** and the County governments of Nairobi and Kiambu. This brief presents the evidence and a co-designed pathway to act on it.

## Headline findings: a hidden mental health burden

Across both counties, a substantial minority of CHPs are screening positive on the DASS-21 — and the urban informal-settlement burden is markedly higher. **CHPs in Nairobi reported approximately three times the depression, two times the anxiety and five times the stress prevalence of CHPs in Kiambu** (Table 1).

***Table 1. Prevalence of depression, anxiety and stress among CHPs (DASS-21, moderate or above)***

| Indicator (DASS-21, moderate or above) | Nairobi (n=967) | Kiambu (n=269) | Combined (n=1,236) | Nairobi vs Kiambu |
|---|---|---|---|---|
| **Depression** | 26.4% | 8.2% | 22.4% | **3.2×** |
| **Anxiety** | 33.8% | 18.9% | 30.6% | **1.8×** |
| **Stress** | 15.4% | 3.0% | 12.7% | **5.1×** |

***Note:*** *Prevalence is the share of CHPs scoring at moderate, severe or extremely severe levels on the DASS-21 sub-scales. Combined prevalence is weighted by the achieved sample (n=967 Nairobi, 269 Kiambu).*

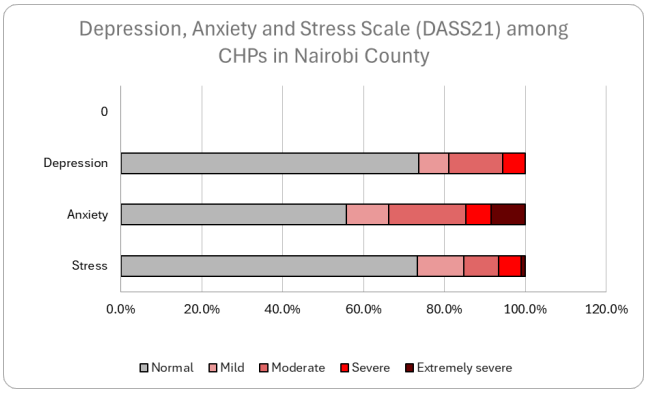


*Figure 1a. DASS-21 distribution — Nairobi (n=967)*

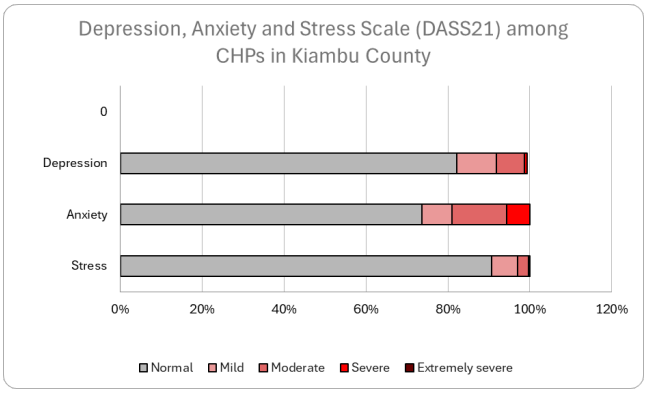


*Figure 1b. DASS-21 distribution — Kiambu (n=269)*

### Work conditions are driving the burden

- **93–97% of CHPs disagree that their stipend is adequate or fair** (Kiambu 95%/97%; Nairobi 93%/93%).
- **92–94% report regular out-of-pocket spending** on transport, airtime and even medical costs for community members they refer.
- **40% of Nairobi CHPs** and **26% of Kiambu CHPs** fear losing their CHP role — amplifying job-insecurity stress.
- **Some Community Health Assistants (CHAs) supervise up to 100 CHPs** — ten times the policy norm of 10 CHPs per CHA — collapsing supportive supervision in the very tier meant to provide it.

## What CHPs are telling us: voices from the frontline

*Across photovoice, life-history interviews and body-mapping, CHPs described how mental wellbeing stressors arise at the intersection of system design, economic precarity, gender dynamics and climate shocks. The themes that emerged most strongly are summarised below, paired with illustrative voices.*

### Workload and data demands

Many CHPs describe long days that bleed into evenings, with eCHIS data targets, late-night calls from community members, and unpredictable referrals stretching them well beyond official hours. Frequent eCHIS downtime, sync failures and phone malfunctions force duplicated work and, in some cases, reduce stipends.

> *"You finish the day exhausted, then at 11 pm a mother calls because her child has a fever. You do not sleep. The next morning your supervisor asks why your eCHIS targets are not yet uploaded."*
>
> — CHP, Viwandani (Photovoice)

### Stipends, out-of-pocket costs and household pressure

CHPs report that the KSh 5,000 monthly stipend is welcomed but inadequate, frequently delayed, and sometimes missed. Many spend their own money to support referrals and transport. Stipends have also created an unintended expectation among some community members that CHPs are now "salaried" and should give more, while a few facility managers add tasks (including cleaning health facilities) outside CHPs' terms of reference.

> *"When the stipend delays, my husband asks what I am doing all day. I have used my own fare to take a sick neighbour to the clinic, and now I cannot pay for my child's school lunch."*
>
> — CHP, Korogocho (Life History Interview)

### Supervision gaps, exclusion and safety

Some CHPs feel excluded from training and decisions, signalling weak communication and strained relationships with overstretched CHAs. Female CHPs report sexual harassment from male community members during household visits — a serious safety and mental-health risk that is not currently addressed in CHP support structures.

> *"When you go alone to a household, sometimes a man will say things that frighten you. There is nowhere to report it that feels safe, so you keep it inside."*
>
> — Female CHP, Lari (Body-Mapping workshop)

### Climate stressors

The 2024 floods displaced households CHPs serve, overflowing sewage raised cholera-outbreak risk, and damaged roads and bridges forced longer routes. CHPs were both first responders and themselves affected.

### Coping: protective and harmful

#### Protective

- Welfare/peer-support groups for emotional and financial help.
- Digital networks (WhatsApp, Facebook, TikTok) for peer learning and solidarity.
- Faith, family and community ties; intrapersonal practices (prayer, music, road trips, silence).

#### Harmful

- Alcohol and other substance use as relief from stress.
- Silence and self-isolation, particularly around harassment and stipend conflict.
- Over-extending personal finances to fill system gaps.

## A co-designed solution, ready to scale

Validation workshops (July 2025) and co-design workshops (August–September 2025) brought together CHPs, CHAs, and policy decision-makers from the Ministry of Health's Mental Health and Community Health divisions and from Nairobi and Kiambu counties. A four-component package emerged, currently being piloted with **500 CHPs and 50 CHAs.**

① **Mental health and wellbeing literacy package** — builds CHP and CHA knowledge of mental health, self-care and stigma reduction.

② **Stress management using WHO's *"Doing What Matters in Times of Stress"*** — a five-week peer-led programme delivered by trained CHP champions for sustained engagement.

③ **Supportive supervision skills for CHAs** — strengthens CHAs to oversee performance *and* wellbeing, with timely referral pathways into county mental health services.

④ **Bulk SMS affirmation system** — motivational messaging linked to local mental health services, scalable to all 12,000 CHPs in Nairobi and Kiambu, and replicable for Kenya's 107,000 CHPs.

## Recommendations

Acting on these findings is feasible within existing Kenyan policy commitments — the **Kenya Mental Health Policy 2015–2030**, the **Mental Health (Amendment) Act 2022**, the **Community Health Strategy** and the **BeWell investment agenda**.

### For the Ministry of Health (Mental Health & Community Health Divisions)

- Adopt CHP and CHA mental health and wellbeing as a costed sub-component of the Community Health Strategy implementation plan, with dedicated indicators in eCHIS dashboards.
- Mainstream Psychological First Aid (PFA), Psychosocial Support (PSS) and mhGAP basics into CHP and CHA pre-service and in-service curricula.
- Issue national guidance embedding county Mental Health Professionals in routine community health activities (monthly meetings, supervision, referrals).
- Develop a national Frontline Health Worker Wellbeing Advocacy Plan to prioritise CHP mental health within UHC budget submissions and donor coordination forums.

### For County Governments

- Pay CHP stipends on time and in full, and review adequacy alongside out-of-pocket reality — stipend predictability is a mental health intervention.
- Enforce the policy ratio of one CHA per Community Health Unit; resource CHAs to deliver supportive supervision, not just performance oversight.
- Protect CHPs from non-CHP duties (e.g. cleaning facilities) and establish a confidential reporting and response pathway for harassment and gender-based violence experienced during household visits.
- Commission county-level CHP welfare/peer-support groups as a formal structure, not an informal one, with linkage to county mental health services.

### For donors and implementing partners (government and philanthropic)

- Co-fund scale-up of the SHINE four-component package across Kenya's 107,000 CHPs — a low-cost, high-leverage entry point into UHC and mental health investment portfolios.
- Invest in CHA supportive supervision capacity and digital wellbeing tools (bulk SMS, peer-support apps) that fit existing community health infrastructure.
- Pool funding for an outcome-based CHP wellbeing facility, aligned with MoH leadership and county delivery, to crowd in philanthropic capital alongside government commitments.
- Support continued mixed-methods learning so that gender, climate and informal-settlement determinants of CHW mental health are tracked over time, generating regional public goods.

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