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EXTENT OF IMPLEMENTATION OF THE KENYA MENTAL HEALTH POLICY (2015–2030) IN PUBLIC SECONDARY SCHOOLS IN UASIN GISHU COUNTY, KENYA

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ABSTRACT

The Kenya Mental Health Policy (2015–2030) makes explicit provision for the promotion, prevention, identification and referral of mental health needs in schools, yet the extent to which secondary schools have translated these provisions into practice has not been established. This study evaluated the extent of implementation of the policy in public secondary schools in Uasin Gishu County, Kenya, as the first objective of a wider study on policy implementation and student adjustment. Guided by Bronfenbrenner's socio-ecological theory, the study adopted a pragmatic paradigm and a convergent parallel mixed methods design. From 207 public secondary schools, 21 schools were selected through stratified and simple random sampling, yielding 412 students, 18 Guidance and Counselling Heads of Department, 20 principals and 102 peer counsellors as respondents, together with an independent observation checklist administered in each sampled school. Implementation was measured across six components derived from the policy text: awareness and dissemination, availability of resources, capacity building of teachers, school-based programmes, a supportive school environment, and stakeholder involvement and referral. Implementation was found to be moderate and uneven, rated 2.98 by Heads of Department, 3.08 by principals and 2.73 by students on a five-point scale. Stakeholder involvement and referral was the weakest component on every measure used, and only 14.3 per cent of schools had a specific mental health budget line, 23.8 per cent a standing referral arrangement, and 9.5 per cent a copy of the policy itself. Self-reported provision by school leaders exceeded what independent observation confirmed. Qualitative findings identified inadequate funding, limited teacher training, heavy teaching loads, weak parental involvement, absent referral pathways and stigma as the principal constraints on implementation. The study concludes that the central constraint on implementation is not the absence of the policy but the incomplete translation of its resourcing, coordination and referral provisions into everyday school practice, and recommends joint ministerial implementation guidelines, a dedicated school mental health budget line, and documented school-to-facility referral pathways.

KEYWORDS: Kenya Mental Health Policy, policy implementation, secondary schools, guidance and counselling, mixed methods, Uasin Gishu County

1. INTRODUCTION

Mental health is a core component of overall well-being and a determinant of a person's capacity to learn, work, form relationships and cope with the ordinary demands of life (World Health Organization [WHO], 2021). Adolescence is a period of rapid physical, cognitive, emotional and social change during which young people negotiate identity formation, increasing academic demands and shifting peer and family relationships (Steinberg, 2014). The World Health Organization reports that half of all mental health conditions begin before the age of 14 and three quarters before the age of 24, and that approximately one in seven adolescents experiences a mental health disorder (WHO, 2021). In Kenya, an estimated 13 per cent of adolescents experience mental health disorders, with suicide disproportionately affecting young people (WHO, 2021).

Schools occupy a decisive position in this picture, since they can function as protective environments that build resilience and connectedness or as risk environments that intensify distress (Atilola, 2017). In response to the global mental health burden, the World Health Assembly adopted the Comprehensive Mental Health Action Plan 2013–2020 (WHO, 2013), and, in alignment with this framework, the Government of Kenya developed the Kenya Mental Health Policy (2015–2030), launched in 2016, to provide a comprehensive structure for promoting mental well-being, preventing mental disorders, ensuring equitable access to services and strengthening mental health governance (Ministry of Health, 2015). The policy provides specifically for the integration of mental health services within educational institutions through a three-tier model of universal promotion, targeted early intervention and intensive individualised support with referral, and identifies secondary school students as a priority group (Ministry of Health, 2015).

Despite this framework, mental health difficulties among Kenyan adolescents have persisted, raising questions about implementation. Within Uasin Gishu County specifically, secondary school students have been found to experience elevated psychological distress, including academic stress, social isolation and suicidal ideation (Kilel et al., 2025), and existing county initiatives such as the AMPATH Afya ya Akili Mashinani school programme have reached only a small number of schools (AMPATH Kenya, 2023). Existing Kenyan research has documented the prevalence of adolescent mental health problems and, separately, the effects of guidance and counselling on student adjustment, but has not established the extent to which the Kenya Mental Health Policy itself has been implemented at school level. Studies of the policy have concentrated on the health sector and on county health systems rather than on schools, and no located study examined school-level implementation of this specific policy within Uasin Gishu County.

This paper addresses that gap. It reports the first objective of a wider study on the implementation of the Kenya Mental Health Policy (2015–2030) and its influence on students' adjustment, namely: to evaluate the extent of implementation of the Kenya Mental Health Policy (2015–2030) in public secondary schools in Uasin Gishu County, Kenya.

2. LITERATURE REVIEW

2.1 The Kenya Mental Health Policy and its Provisions for Schools

The Kenya Mental Health Policy (2015–2030) is grounded in Article 43(1)(a) of the Constitution of Kenya (2010), which guarantees every person the right to the highest attainable standard of health, a provision the policy interprets as encompassing mental health care (Ministry of Health, 2015). The policy sets out four interconnected objectives: strengthening leadership and governance for mental health; securing universal access to comprehensive, integrated and high-quality services; advancing mental health promotion and prevention; and strengthening mental health systems through investment in information, research, human resources, financing and intersectoral coordination (Ministry of Health, 2015). The Kenya Mental Health Action Plan (2021–2025) operationalises the policy by embedding monitoring, evaluation and budgeting requirements, including needs-based planning, standard indicators and quarterly reporting by counties (Ministry of Health, 2021).

From the policy's provisions applying to schools, six components of school-level implementation can be derived and measured: awareness and dissemination of mental health information; availability of human and material resources; capacity building of teachers; school-based mental health programmes and initiatives; a supportive school environment; and stakeholder involvement and referral. This structure corresponds to the multi-tiered system of supports used internationally in school mental health, in which academic, behavioural and emotional supports are organised into universal, targeted and intensive tiers (Nitz et al., 2023).

2.2 School-Based Implementation Frameworks and Mechanisms

Research on implementation in school mental health identifies professional development and coaching, fidelity to evidence-based practices, and sustainability under routine conditions as the constructs that determine whether programmes survive beyond their initial phase (Domitrovich et al., 2015). March et al. (2022) found that the sustainability of school-based mental health interventions depends heavily on school-level policy support, stable staffing, leadership commitment and integration into school priorities, and that without these structural supports many interventions fail to survive their pilot phase. Fazel et al. (2020), reviewing school-based mental health programmes in low- and middle-income countries, found that programmes typically follow modules for awareness, prevention, early intervention and referral, but often lack comprehensive coverage and robust implementation structures. Both findings suggest that the presence of a programme is a weak indicator of implementation, and that regularity, staffing and institutional integration are the more informative measures.

Kenya has domestic precedents for embedding health policy in schools. The Kenya School Health Policy requires all schools to implement health-promoting programmes and designates the Ministry of Education and the Ministry of Health as co-coordinators for planning, implementation, monitoring and evaluation (Republic of Kenya, 2018), while the National School Health Strategy establishes a thematic structure covering life skills, child rights, water, sanitation and hygiene, nutrition and disease prevention (Republic of Kenya, 2009). Implementation research on the Kenya Comprehensive School Health Policy found that although the framework was well recognised, its impact was constrained by

weak coordination, limited stakeholder engagement, inadequate resources and the absence of supportive supervision (Wesonga et al., 2014).

2.3 Evidence of Implementation in Kenyan Secondary Schools

Empirical evidence suggests that Kenyan schools have not yet absorbed the reforms the policy envisages. Mwayo et al. (2019) found that secondary school teachers encountered student mental health problems frequently but lacked training, time and referral infrastructure. Studies of student help-seeking indicate that students rely on informal mechanisms rather than structured school services: in Kisii County, only 19.2 per cent of students reported using the school counsellor, compared with 89.1 per cent who turned to parents and 86.8 per cent who turned to teachers (Kilel et al., 2023). Mutemi, Kimiywe and Nyakundi (2023) identify weak governance, limited financial resources and fragmented accountability as constraints on the translation of national health policy into county and facility-level practice. Within Uasin Gishu County, Kilel et al. (2025) report high levels of psychological distress among adolescents, and Too (2020), studying school-based counsellors in the county, found significant inverse relationships between clinical supervision and counsellor compassion fatigue, pointing to a further dimension of capacity that implementation must address.

2.4 Barriers to Effective Policy Implementation

The literature identifies a consistent set of barriers operating at national, county and school levels. Underfunding is the most frequently cited barrier: Marangu et al. (2021) observe that mental health receives a very small share of the national health budget, impeding the recruitment and retention of trained professionals, while at school level mental health activity is typically funded from general school budgets that are already stretched. Kenya has few mental health specialists relative to population need (Ndeti et al., 2018; Mutiso et al., 2019), and within schools guidance and counselling responsibilities are typically assigned to teachers who carry a full teaching load and may have no formal counselling training. Governance capacity is weak at both national and county level, and for schools the critical governance failure is the absence of operational implementation guidance specifying who is accountable and against what indicators performance is assessed. Baffsky et al. (2023), reviewing school-based mental health prevention programmes, identify lack of training, limited administrative support, time constraints, staff turnover and the low prioritisation of mental health relative to core academic goals as recurrent obstacles, together with stigma and confidentiality concerns. Ayiro, Misigo and Dingili (2023) document students' reluctance to seek support because of stigma and fear of judgement.

2.5 Research Gaps

The reviewed literature establishes that adolescent mental health is a substantial concern, that schools are the setting in which it is most efficiently addressed, and that the Kenya Mental Health Policy (2015–2030) makes explicit provision for schools. What it does not establish is the school-level empirical extent of implementation of that specific policy. Available Kenyan studies examine guidance and counselling services or mental health literacy generally rather than operationalising implementation of the policy itself as a measurable, multi-component construct, and studies of the

policy have concentrated on the health sector rather than on schools. No located study examined implementation of the Kenya Mental Health Policy in secondary schools in Uasin Gishu County, notwithstanding the documented adolescent mental health need and active county initiatives against which implementation might be assessed (Mutemi, Kimiywe & Nyakundi, 2023; Kilel et al., 2025). The present study addresses this gap by operationalising implementation as a measurable construct comprising six defined components, drawn from students, Guidance and Counselling Heads of Department, principals and peer counsellors, and corroborated by an independent observation checklist.

3. RESEARCH METHODOLOGY

3.1 Research Paradigm and Design

The study was concerned both with the extent to which the provisions of the Kenya Mental Health Policy had been put into practice, which requires measurement across a substantial number of cases, and with how implementation was experienced by those responsible for delivering it, which requires access to accounts and meanings that measurement alone cannot supply. A pragmatic paradigm was therefore adopted, since pragmatism takes the research problem, rather than a prior commitment to a single epistemology, as its point of departure and supports the combination of quantitative and qualitative methods within a single design (Kivunja & Kuyini, 2017). The study adopted a convergent parallel mixed methods design, in which quantitative and qualitative data were collected during the same phase, analysed separately, and merged at the point of interpretation (Creswell & Plano Clark, 2017). The quantitative strand employed a cross-sectional survey, while the qualitative strand employed a descriptive design analysed thematically following Braun and Clarke (2006).

3.2 Study Area, Population and Sampling

The study was conducted in Uasin Gishu County, Kenya, which contains over 200 public secondary schools spanning national, extra-county, county and sub-county categories, and has documented adolescent mental health need alongside active mental health initiatives that permit implementation to be observed varying across schools rather than simply found absent (Kilel et al., 2025; AMPATH Kenya, 2023). The target population comprised students in Grade 10, Form Three and Form Four, Guidance and Counselling Heads of Department, principals and peer counsellors in the 207 public secondary schools in the county.

The 207 schools were stratified by the six sub-counties, and ten per cent were selected by simple random sampling within each stratum, yielding 21 schools proportionately allocated across the strata. The student sample size was determined using Yamane's (1967) formula for a finite population, cross-checked against Israel's (2009) sample size table, giving a base sample of 381 which, following Zamboni's (2018) recommendation of a modest increase for precision and non-response, was raised to a final target of 441 students, allocated proportionately to the six strata. All 21 principals and all 21 Guidance and Counselling Heads of Department in the sampled schools were included purposively, since each school has only one of each. Six peer counsellors were drawn purposively from each sampled school, two each from Forms Two, Three and Four, giving 126 participants across 21 focus

group discussions. Returns were obtained from 412 students (93.4%), 18 Heads of Department (85.7%), 20 principals (95.2%) and 102 peer counsellors (81.0%), an overall response rate of 90.6 per cent.

3.3 Research Instruments

Implementation was measured through three questionnaires administered to students, Guidance and Counselling Heads of Department and principals respectively, two semi-structured interview guides administered to Heads of Department and principals, a focus group discussion guide administered to peer counsellors, and an observation checklist completed independently by the researcher in each sampled school. The institutional questionnaires addressed the six implementation components derived from the policy text: awareness and dissemination, availability of resources, capacity building of teachers, school-based programmes and initiatives, a supportive school environment, and stakeholder involvement and referral. Items were rated on a five-point Likert scale (Likert, 1932), on which 5 denoted Strongly Agree and 1 Strongly Disagree, and a composite implementation score was computed as the mean of the constituent items for each respondent group. The observation checklist recorded the physical and material resources available for mental health provision, including the presence and privacy of a counselling room, the availability of information materials, the display of referral information, and the presence of peer counselling structures, providing an independent record against which self-reported provision could be checked.

3.4 Validity, Reliability and Trustworthiness

Content and construct validity of the questionnaires were established through expert review and consultation with supervisors, and the instruments were piloted in two schools in the neighbouring Nandi County prior to the main data collection (Cohen et al., 2018; Bryman, 2016). Internal consistency of the scales was acceptable, with Cronbach's alpha coefficients ranging from .768 to .901. Trustworthiness of the qualitative strand was established through triangulation across three institutional respondent groups, verbatim reporting of both confirming and disconfirming accounts, and member reflection during data collection.

3.5 Data Analysis

Quantitative data on implementation were analysed using descriptive statistics, including means, standard deviations and percentages, computed in SPSS version 26, and were compared across the three respondent groups and against the documentary and observation record using Pearson correlation. Qualitative data from interviews and focus group discussions were transcribed and analysed thematically following Braun and Clarke's (2006) six-phase approach, and the resulting themes were integrated with the quantitative findings at the point of interpretation to identify points of convergence and divergence between the two strands.

4. RESULTS

Findings on the extent of implementation of the Kenya Mental Health Policy (2015–2030) are presented from four sources: the documentary and observed record, the perceptual scales completed by Guidance and Counselling Heads of Department and principals, the awareness items completed by students, and the qualitative accounts of institutional respondents.

4.1 Documentary and Observed Record of Provision

Table 1 presents the documentary and observed record of provision across the 21 sampled schools, measuring provision independently of respondent perception.

Provision	Schools with (n)	Per cent	Observed (n)
Written guidance and counselling policy or plan	9	42.9	7
Room used specifically for counselling	16	76.2	14
Counselling room that cannot be overheard	11	52.4	9
At least one formally qualified counselling teacher	14	66.7	14
Timetabled guidance and counselling lessons	8	38.1	8
Specific budget allocation for mental health	3	14.3	3
Written record of counselling sessions or referrals	17	81.0	15
Teacher trained in mental health in the last two years	6	28.6	6
Active peer counselling programme	15	71.4	13
Standing referral arrangement with a health facility	5	23.8	4
Copy of the Kenya Mental Health Policy held in school	2	9.5	2
Written implementation guidance received from MoE or MoH	1	4.8	1

Table 1: Documented and Observed Provision Across the 21 Schools. Source: Field data (2026).

While most schools had a counselling room (76.2%) and written records of counselling sessions (81.0%), significant gaps were evident in areas critical to policy implementation. Only three schools (14.3%) had a specific budget allocation for mental health, only five (23.8%) had a standing referral arrangement with a health facility, and only two schools (9.5%) held a copy of the Kenya Mental Health Policy. Divergence between reported and observed provision was noted in several cases: four schools reported having a counselling room, but observation revealed that it was not private enough for confidential conversations, and two schools reported having a peer counselling programme that observation found inactive.

4.2 Students' Awareness of School Mental Health Provision

Students reported a moderate overall level of awareness of school mental health provision ($M = 2.73$, $SD = 1.30$, on a five-point scale). The highest-rated item was "My school has a counselling office that students can use" ($M = 3.14$, $SD = 1.35$), while the lowest-rated items were the availability of booklets, posters or other mental health materials ($M = 2.52$, $SD = 1.24$) and the privacy of the counselling office ($M = 2.56$, $SD = 1.28$). These findings suggest that while basic infrastructure exists, students perceive significant gaps in information dissemination, privacy and material resources.

4.3 G&C HODs' and Principals' Assessment of Implementation by Component

Table 2 compares the assessment of the six implementation components by Guidance and Counselling Heads of Department and by principals.

Component	G&C HODs Mean (SD)	Principals Mean (SD)	Level
Policy awareness and dissemination	3.12 (1.18)	3.25 (1.15)	Moderate
Availability of resources	2.98 (1.24)	2.90 (1.20)	Moderate
Capacity building of teachers	2.84 (1.31)	3.08 (1.22)	Moderate
Programmes and initiatives	3.05 (1.22)	3.15 (1.18)	Moderate
Supportive school environment	3.18 (1.19)	3.35 (1.14)	Moderate
Stakeholder involvement and referral	2.68 (1.25)	2.78 (1.22)	Moderate
Overall implementation	2.98 (1.23)	3.08 (1.19)	Moderate

Table 2: G&C HODs' and Principals' Assessment of Implementation by Component. Source: Field data (2026).

Both respondent groups rated implementation at a moderate level overall, and both identified “Supportive school environment” as the most favourably rated component (G&C HODs $M = 3.18$; principals $M = 3.35$) and “Stakeholder involvement and referral” as the least favourably rated (G&C HODs $M = 2.68$; principals $M = 2.78$). This consistency indicates that principals and Heads of Department share a similar view of where implementation is strongest and weakest, even though principals' overall ratings were consistently somewhat higher.

4.4 Comparison Across Respondent Groups

Table 3 compares overall implementation scores across the three perceptual respondent groups and the two independent measures.

Respondent group / measure	n	Mean	SD
Students	412	2.73	1.30
G&C HODs	18	2.98	1.23
Principals	20	3.08	1.19
Factual index (0–10)	21	4.67	2.18
Observation checklist (0–22)	21	10.33	4.25

Table 3: Implementation Scores by Respondent Group. Source: Field data (2026).

Overall implementation scores rose progressively from students ($M = 2.73$) through Heads of Department ($M = 2.98$) to principals ($M = 3.08$), suggesting that perceived implementation decreases with distance from the school's administrative leadership. The correlation between G&C HOD and principal scores for the same school was $r = .612$ ($p < .01$), indicating moderate agreement between these two respondent groups, while the correlation between each perceptual measure and the independent factual index was $r = .483$ for Heads of Department and $r = .512$ for principals, indicating that perceptual assessments are only moderately aligned with the documentary and observed record.

4.5 Qualitative Findings on Policy Implementation

Thematic analysis of the interview and focus group data identified seven recurrent themes. Awareness of the policy's existence was widespread, but knowledge of its specific provisions was superficial: of the 18 Heads of Department and 20 principals interviewed, 25 (65.8%) demonstrated only superficial awareness, 8 (21.1%) demonstrated detailed knowledge, and 5 (13.2%) reported no awareness at all.

One principal explained: “I am aware that there is a mental health policy, but I have never actually read the document... we lack specific guidelines on how to implement the policy in schools.”

Existing structures such as guidance and counselling offices were widely present but their functionality was constrained, particularly by privacy: 76.2 per cent of schools had a dedicated counselling room, but only 52.4 per cent of these provided adequate privacy. As one Head of Department reported, “I share the room with the deputy principal's office, which compromises privacy. Students are hesitant to come for counselling when they see others around.” Inadequate resources and funding were identified by 15 of 18 Heads of Department (83.3%) and 16 of 20 principals (80.0%) as major challenges, with mental health activity typically funded from a general school budget already stretched by competing academic priorities. Limited formal training on mental health for teachers was raised by 14 of 18 Heads of Department (77.8%) and 15 of 20 principals (75.0%), with one Head of Department noting that untrained teachers “dismiss students' emotional problems as laziness or indiscipline.”

Only 6 of the 21 schools (28.6%) had a teacher trained in mental health in the preceding two years, and programme regularity varied sharply, from schools benefiting from the AMPATH Afya ya Akili Mashinani partnership to those relying on “occasional talks from guest speakers” with no continuity. Weak stakeholder involvement and referral was identified by 16 of 18 Heads of Department (88.9%) and 17 of 20 principals (85.0%), who described poor parental attendance at school meetings and the absence of a working relationship with external mental health professionals for referral. Finally, stigma was raised in all 17 focus group discussions with peer counsellors and by 12 of 18 Heads of Department (66.7%), with students who visit the counsellor reportedly labelled by peers, discouraging help-seeking.

4.6 Integration of Findings

The quantitative and qualitative findings converge on three points. First, implementation is at a moderate level with basic structures in place but significant gaps, corroborated by both the perceptual measures (students $M = 2.73$; G&C HODs $M = 2.98$; principals $M = 3.08$) and the qualitative accounts. Second, stakeholder involvement and referral is the weakest component of implementation by every measure used, consistent with low scores on the quantitative scales and frequent qualitative accounts of limited parental engagement and weak professional collaboration. Third, resource inadequacy, particularly budget allocation (14.3% of schools) and trained personnel, is a major constraint identified by both data sources.

The two strands also diverge in informative ways. Although 76.2 per cent of schools had a counselling room, student perceptions of its privacy ($M = 2.56$) and qualitative accounts indicate that many such rooms lack adequate privacy and functionality, so infrastructure and functionality are not equivalent. Principals reported higher levels of implementation ($M = 3.08$) than Heads of Department ($M = 2.98$) and students ($M = 2.73$), suggesting that perceived implementation decreases with distance from administrative leadership toward the point of delivery and toward the student. In several cases, schools reported provisions, including written policies, referral arrangements and active peer counselling

programmes, that observation did not confirm, indicating that self-reported provision by school leaders overstates functional implementation.

5. CONCLUSIONS

This study evaluated the extent of implementation of the Kenya Mental Health Policy (2015–2030) in public secondary schools in Uasin Gishu County. The study concludes that the policy has been implemented to a moderate but uneven extent. Basic counselling infrastructure, including a counselling room and written records of sessions, is widely present, but the components requiring dedicated financing, external coordination and documented policy knowledge, namely budget allocation, referral arrangements and stakeholder involvement, remain the least developed. Awareness of the policy's specific provisions, as distinct from awareness of its existence, is limited among the institutional respondents who are responsible for its delivery.

The consistency between the observation checklist, the documentary record and the perceptual scales strengthens confidence in this pattern: self-reported provision by school leaders exceeds what independent observation confirms, indicating that the true extent of functional implementation is somewhat lower than institutional respondents perceive it to be. Implementation also appears to weaken progressively from administrative leadership toward the student, since principals rated implementation more favourably than Heads of Department, who in turn rated it more favourably than students themselves. The central constraint on implementation is therefore not the absence of the Kenya Mental Health Policy, but the incomplete and uneven translation of its resourcing, coordination and referral provisions into everyday school-level practice.

6. RECOMMENDATIONS

Arising from these findings, the following recommendations are made.

1. The Ministry of Health and the Ministry of Education should jointly issue an operational implementation guideline for the Kenya Mental Health Policy (2015–2030) that specifies school-level responsibilities, accountable officers and reportable indicators for each of the six implementation components.
2. County and national education budgets should include a dedicated line for school mental health provision, given that only 14.3 per cent of sampled schools had any specific budget allocation.
3. The Uasin Gishu County Department of Health, in collaboration with Moi Teaching and Referral Hospital, should establish a standing, documented referral pathway between every public secondary school and a named health facility.
4. The Teachers Service Commission and school principals should reduce the teaching load carried by Guidance and Counselling Heads of Department, or provide a second trained officer where school size warrants it.

5. School principals should ensure that counselling space is physically separated from staff and administrative offices to protect confidentiality, since a substantial proportion of nominally available counselling rooms did not meet a basic privacy standard.
6. Schools should extend structured parental engagement in mental health activity, for example through dedicated sessions at existing parents' meetings.
7. The AMPATH Afya ya Akili Mashinani programme and comparable county initiatives should be extended beyond their current pilot schools, given the distinct improvement in mental health literacy and referral awareness reported where such programmes reach a school.

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