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# Community Health Promoters and Mental Health: Skills and Challenges in Luanda Sub-County, Kenya

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## Abstract

Community Health Promoters (CHPs) are community members who are trained to act as a link between formal health facilities and the community. They provide basic preventive, promotive and referral health services in the community. With the increase in mental health-related ailments in the community, there is a need to address the skills gap that may hinder the CHPs from being effective in creating mental health awareness, identifying and making appropriate referrals. This study sought to determine knowledge levels on mental health disorders among the CHPs and also establish awareness and accessibility of resources for effective service delivery. A survey research design using mixed methods was used in this study. Respondents were 180 Community Health Promoters from Luanda Sub-County in Vihiga County, Kenya. A knowledge, attitude and practice questionnaire was used for data collection. Quantitative data were coded and entered into the SPSS software version 29 for analysis. Qualitative data were categorised, thematically classified, and presented using appropriate descriptive terms and sections based on areas of concern. Findings indicated that the majority of the respondents had a secondary level education (65.1%) and had more than 6 years' experience as CHPs (65%). Only a minority (13%) had a good understanding of mental health issues. Most (95%) reported that they had encountered a person with mental health challenges, implying that the prevalence of mental health issues in the community could be high. On skills levels in handling mental health challenges, only 40% rated themselves as good or excellent. The study concluded that the majority of CHPs lacked basic knowledge on mental health, interventional skills and knowledge on referral places for the clients struggling with mental health. There is a need to provide need-based information that will inform intervention programs that will make the CHPs more effective in their work, as well as influence policy that guides their operations.

**Keywords:** *Community health promoters, skills levels, psychosocial challenges*

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## Introduction

In Kenya, Community Health Promoters (CHPs), also known as Community Health volunteers, are community members who are trained to act as a link between formal health facilities and the community. The CHPs are part of the broader Community Health Strategy that was launched in 2006 by the Kenyan Ministry of Health, whose aim was to decentralise healthcare delivery and improve access, especially in rural and underserved areas. They play a crucial role in addressing health disparities by bringing healthcare closer to the community (Ministry of Health, 2006). CHPs are often selected from within the communities they serve and are tasked with providing basic preventive, promotive and referral health services to approximately 100 households each (Ministry of Health, 2006). Their responsibilities include: Working with the Community and Formal Health Facilities; Promoting Health Education by educating communities about health issues, preventive measures, and healthy behaviors; Early Detection and Referral: They are trained to identify health problems and refer patients to appropriate health facilities for further care; Delivery of Basic Health Services: such as administering vaccines, distributing medications, and providing health advice, often within the community setting; Community Engagement and Mobilization: They involve communities in health-related activities and promote health awareness; Monitoring and Evaluation: They collect data on health outcomes and monitor the effectiveness of health programs (Ministry of Health, 2025).

The CHPs in Kenya are trained to address a wide range of public health challenges, including: Disease surveillance and early detection (e.g., malaria, TB), Maternal and child health (MCH services (e.g., immunization, antenatal care), Health promotion and education (e.g., hygiene, nutrition), as well as Environmental health (e.g., waste management and clean water promotion) (Ministry of Health, 2025). The (CHPs) often confront a variety of psycho-social issues in their communities, especially in under-resourced or marginalized settings. The Key challenges in the community include: Mental Health Stigma, where they deal with community stigma around mental illness, which can prevent individuals from seeking care or disclosing symptoms (Marquez & Saxena, 2016). The CHPs also deal with family and community resistance where cultural beliefs and misconceptions may lead to family members denying the existence of mental health conditions, thus limiting support (Patel et al., 2018). However, Many CHPs lack specialized training in mental health, making it difficult to recognize and respond to conditions like depression, anxiety or psychosis (Javadi et al., 2017).

In order for CHPs to be well equipped to deal with psychosocial issues in the community, they need training in several areas, such as Cultural Competence, Basic Mental Health Literacy, Communication and Basic Counselling Skills, as well as Stress Management and Self-Care (Kohrt et al., 2015). Mental health issues in Kenya have become a significant public health concern, with rising prevalence and systemic challenges affecting individuals across various demographics. Approximately 25% of Kenyans experience a mental health disorder at some point in their lives. Just like other regions in Kenya, Western Kenya has a high prevalence of mental health issues, especially depression. The county integrated development plan (2023-2027) shows 1,026 people in Luanda are recorded as living with a mental disability (425 males, 601 females), which is among the highest mental-disability counts among Vihiga's five sub-counties. The Vihiga County Referral Hospital runs a dedicated Psychiatry Services unit (assessment, psychotherapy, medication management; child/adolescent & geriatric tracks), serving the whole county. Vihiga County Referral Hospital lists "basic mental health services - psychosocial interventions" at the primary-care tier (Vihiga County Referral Hospital, n.d.).

Uptake of mental health services in Luanda sub-county is low, with health-facility records compiled by the County and reported in the media indicating that only 345 Luanda residents were seen for psychiatric problems over the five years preceding August 2023, against 9431 patients seeking psychiatric services in the County (Standard media, 2023). While access is improving through screening at primary healthcare and referral care available at Vihiga County Referral Hospital, resource and workforce constraints persist. Kenya still faces a large treatment gap and few specialists, reinforcing the importance of primary-care-based services for sub-counties like Luanda (Kwobah et al., 2023). The study sought to address the skills gap that may hinder the CHPs from being effective in creating mental health awareness, identifying and making appropriate referrals.

## Theoretical Basis

This study was guided by the functional theory of volunteerism, which was developed by Gil Clary and Mark Snyder in the early 1990s (Diaz, J., 2025). The functional theory provides a framework for understanding the motivations behind volunteerism, suggesting that individuals volunteer to fulfil various psychological and social needs. The theory contends that some people engage in volunteerism for social interaction, to enhance self-esteem and for career development. In relation to Community Health Promoters, their motivations to volunteer their services in the community may encourage them to seek more skills, knowledge and competencies that will make them effective in offering psychological and mental health services to their clients. The need to identify mental health challenges and their interventions may motivate the CHPs to pursue more skills through training.

However, when volunteers are primarily motivated by career advancement or social recognition, they may experience frustration if such expectations are unmet, which can lead to reduced engagement, inadequate skill development, or attrition. This kind of mismatched motivation can lead to some of the operational challenges faced by CHPs, such as inconsistent service delivery, limited commitment to specialised training, or difficulties managing complex psychosocial cases. Limited training in mental health issues, coupled with the stigma surrounding mental illness, scarcity of resources, can undermine the CHPs motivation, confidence and effectiveness in offering psychosocial and mental health support in their communities. Therefore, the functional theory of volunteerism supports the study's objective of exploring both the skill levels of CHPs and the challenges affecting their capacity to effectively respond to mental health needs at the community level.

## Methodology

A survey research design using mixed qualitative and quantitative methods was used in this study. The qualitative methods included literature review and interviews. A structured questionnaire was used to collect both quantitative and qualitative data to establish the mental health skills gap among the CHPs. The questionnaire helped to capture challenges faced by CHPs in addressing mental health issues in Luanda Sub-County. The study participants included CHPs in Luanda Sub-County in Vihiga County. Vihiga County has a high prevalence of mental health challenges and, therefore, has been purposively sampled. All healthcare facilities in the sub-county will be selected for the study. There are 1446 CHPs in Vihiga County, with an average of 286 per sub-county. This study targeted 184 CHPs, which was 64% of the CHPs in Luanda Sub-County. The large sample size was proposed for the mitigation of potential non-response bias common in research carried out in the community. A larger sample

size also provides a more accurate and reliable representation of the population being studied, leading to more statistically robust results and reduced margin of error. This increased precision allows for greater confidence in the findings and their generalizability to the broader population.

The sample size was calculated based on Yamane Taro formula (1967) because its accuracy had been shown in cross-sectional studies.

$$n = \frac{N}{1 + (Ne^2)}$$

Where:

n = required sample size N = study population
e = margin of error (set at 0.05)
confidence level- 95%

Where:
N=286
e = 0.05
n=286/1+ (286x0.05x0.05)
n = 167
So, the required sample size = 167 respondents.
Add 10% non-response = 17 + 167 = 184
N = 184

The study included CHPs who were 18 years old and above, were willing to participate in the study, had basic literacy skills (Through formal or informal education) and consented to participate. The study excluded CHPs who lacked basic literacy skills because the training curriculum that would be developed required that participants have basic skills in spoken and written English and Kiswahili. Data collection instruments, a knowledge, attitude and practice (KAP) questionnaire was used to collect data from the CHPs. The self-administration method was used for primary data collection. This was generated from CHPs within Luanda Sub-County. In order to gather this information, the team utilised the questionnaire for CHPs. This helped to elicit information on the prevalence and types of mental health challenges in Luanda Sub-County. Information on any training done for CHPs, and its perceived effectiveness, referral services for mental health, was collected.

Data Analysis was done according to the kind of mental health and psycho-social challenges, level of awareness on mental health challenges, psycho-social interventions and skills gaps in handling them. Quantitative data were coded and entered into the SPSS software version 29 for analysis. Thereafter, the data was cleaned and checked for consistency. Data analysis involved statistical methods such as means, mode and median, percentages and also analysis of relationships among various variables. Qualitative data were categorised, thematically classified, and presented using appropriate descriptive terms and sections based on areas of concern. The final sections of the analysis employed triangulation, where quantitative and qualitative data were presented in a complementary manner. Data analysis paid particular attention to Knowledge, Attitude, and Practice (KAP) of the mental health skills gap and psycho-social challenges encountered by CHPs during their community engagements.

## Analysis of Findings

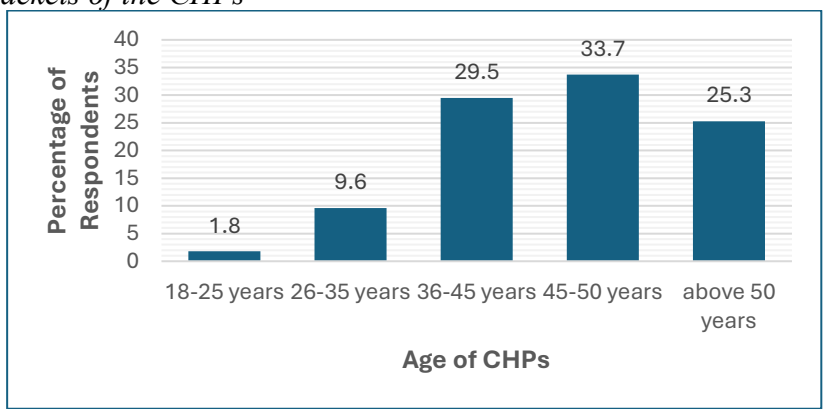
*Demographic Characteristics of Respondents*

This section presents the demographic characteristics of CHPs in the study to understand their profile. These consisted of the respondent's age, gender, level of education, training, marital status, and experience.

*Age of CHPs Sampled*

Figure 1

*Age Brackets of the CHPs*




Source: Research Data (2026)

Most of the community health promoters were either middle-aged or old, with a majority aged between 45 and 50 years (*n*=56, 34%), followed by those aged between 36 and 45 years (*n*=49, 30%) and those above 50 years (*n*=42, 25%). Only one out of every ten CHPs sampled was found to be youthful (*n*=19, 11% of those aged 35 years or below). This is supported by the Functional Volunteerism Theory, which suggests that some people are motivated to volunteer to stay socially connected because most of the CHPs do not have any formal employment, and some have already retired from active employment.

*Gender of CHPs*

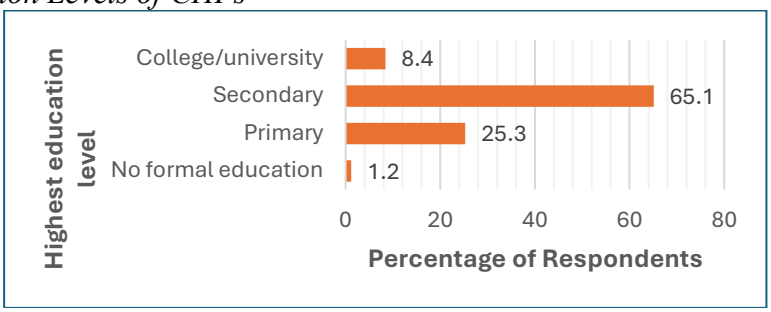
The study found that eight out of every ten CHPs in the sub-county (*n*=136, 82%) were female, relative to only two out of every ten promoters (n=30, 18%) who were male. The results suggested a bias towards female CHPs in the sub-county. These findings are similar to a study by Mwaniki et al. (2025) that found the majority of CHPs were females at 78% compared to 22% men in their study on the CHPs' performance during the COVID-19 pandemic in Machakos County.

*Educational Level of CHPs*

Roughly, two-thirds of the CHPs (*n*=108, 65%) had secondary schooling as their highest educational level, followed by 25% (*n*=42) who had primary education. This implied that nine out of every ten CHPs (90.4%) had either secondary or primary schooling as their highest educational level. Less than 10% (n=14) had college/university education, suggesting CHPs have modest schooling.

Figure 2

*Education Levels of CHPs*




Source: Research Data (2026)

However, according to Rogers, A., & Whembolua, G. L. (2023) though education and literacy are often used in the selection processes of Community Health Workers globally, training and experience outperform literacy and formal education.

*Marital Status*

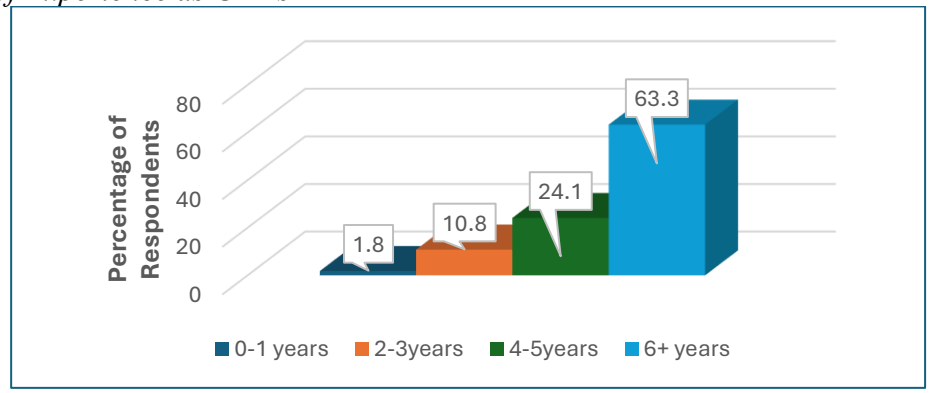
Most CHPs were married (*n*=130, 78%), followed by those who were widowed (*n*=49, 18%). Only seven of them (4%) were single. This was expected as results presented in Figure 1 above showed that only very few respondents were youthful. According to Diaz, J. (2025) a study did in Philippines revealed that both youth and older adults demonstrate general agreeable levels of volunteerism, with youth preferring disaster-related and environmental initiatives, while older people prefer faith-based and community outreach programs.

*Years of Experience*

Results as displayed in Figure 3 showed a progressive increase in the number of CHPs as working experience increased. The experience of most CHPs was six years or more (*n*=105, 63%), followed by 4 – 5 years (n=40, 24%), 2 – 3 years (n=18, 11%), and 0 – 1 years (2%). This showed a reasonably experienced CHP workforce in the sub county. This could arise from the fact that the workers were aged (Figure 1 above). Rogers, A., & Whembolua, G. L. (2023) suggests that experience is an integral part of effectiveness in community health volunteerism. Knowledge levels on mental health disorders among Community Health Promoters.

Figure 3

*Years of Experience as CHPs*



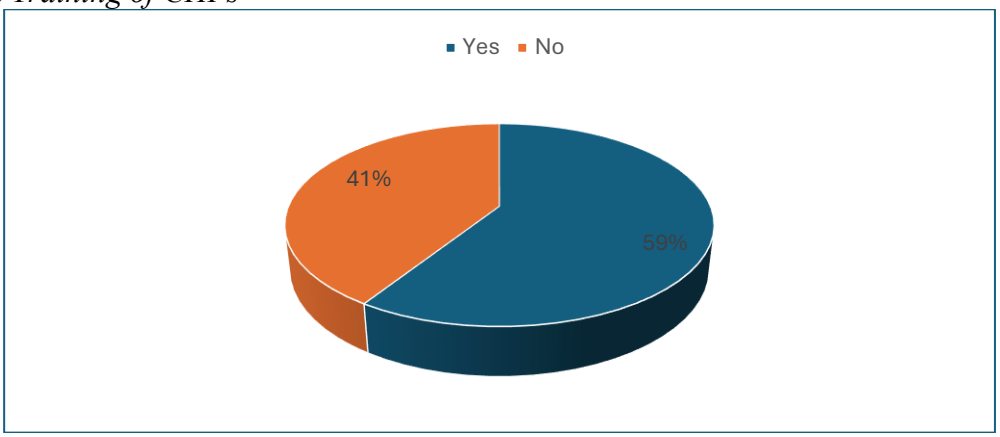

*Source: Research Data (2026)*

*Formal Training of Community Health Practitioners*

Results showed that six out of every ten respondents (*n*=75, 59%) had formal training compared to four out of every ten participants (*n*=52, 31%) who did not. However, unlike other questions, a significant proportion of the sample (*n*=39, 24%) did not answer the answer question.

Figure 4

*Formal Training of CHPs*




Source: Research Data (2026)

Moreover, among those with formal training, not everyone was schooled in community health, with others answering that they trained in mechanics, ECDE teaching, library and information sciences, nutrition, bible college, and malaria management. Given that these fields have little congruence with community health, the results suggested that the actual number of formally trained CHPs in the county could be low. Formal education, knowledge and experience influences performance of CHPs according to (Otieno et al., 2018).

*Understanding of Mental Health Issues*

The participants were asked to rate their understanding of mental health issues such as depression, anxiety, trauma, alcohol and drug abuse. Table 1 displays these results.

Table 1

*Understanding of Mental Health Issues*

| Level of understanding | Frequency | Percent |
|---|---|---|
| Very good | 21 | 12.7 |
| Good | 38 | 22.9 |
| Fair | 53 | 31.9 |
| Poor | 54 | 32.5 |
| Total | 166 | 100.0 |

Source: Research Data (2026)

Most of the respondents (33%) answered that they had a poor understanding of mental health issues, followed by those who said they had a fair understanding (32%), and a good understanding (23%). Only 13% answered that they had a very good understanding. Chi-

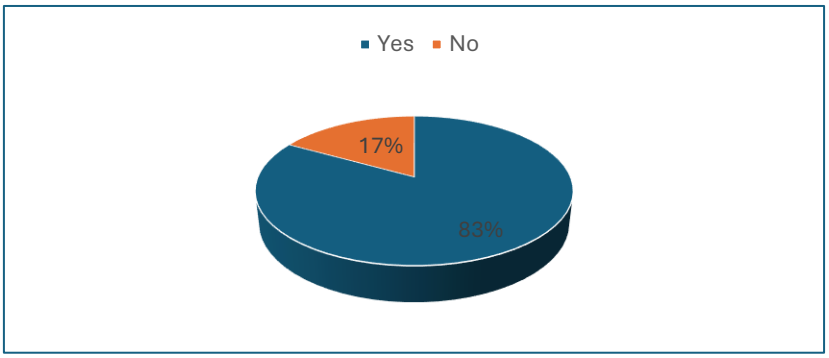
square ($\chi 2$) cross tabulations conducted to test the relationship between the level of understanding and biographical characteristics were all non-significant. The tests revealed that the levels of understanding did not depend upon the level of a participant's education, $\chi^2$ (9) = 8.486, $p$=0.486; gender, $\chi^2$ (3) = 1.797, $p$=0.616; formal training, $\chi^2$ (3) = 2.564, $p$=0.464; experience, $\chi^2$ (9) = 7.126, $p$=0.624; or age, $\chi^2$ (12) = 5.600, $p$=935. This could be caused by the low levels in education and the lack of specialized training in many of them. Marthoenis et al., (2024) emphasize the importance of mental health literacy among female community health workers in their study that was done in India. Without mental health literacy the CHPs may not be effective in handling mental health issue in the communities they serve.

*Signs and Symptoms of Mental Health Disorders*

The participants were asked whether they knew the signs and symptoms of common mental health disorders, and these results are presented in Figure 5.

Figure 5

*Percentage of CHPs aware of Symptoms of Mental Health Disorders*




Source: Research Data (2026)

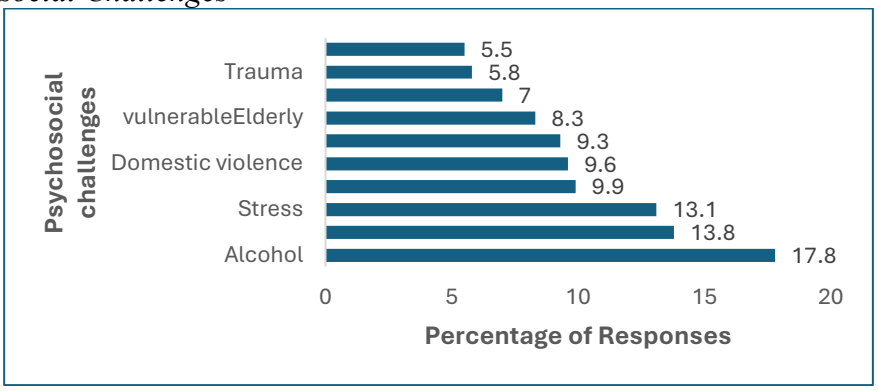
Results showed that eight of out every ten CHPs ($n$=138, 83%) sampled answered that they knew the signs and symptoms of mental health compared to only 17% who said that they did not know. When the respondents were asked whether they had encountered mental health issues in their communities, most of them ($n$=157, 95%) answered that they had while only 5% ($n$=9%) said they had not. This implied that the prevalence of mental health issues in the community could be high. Understanding common mental health disorders and their symptoms is critical for CHPs for proper intervention and referral (Patel et al., 2018).

*Common Psychosocial Challenges in the Community*

The participants were also asked about the most common psychosocial challenges present in their communities. The number of responses for this question was 832, which was more than the number of participants (166) in the study. This was because most respondents said that several psychosocial challenges afflicted their community, that is, the question was a multiple response type. The results showed that the three most important psychosocial challenges in the community were alcohol/substance use (18% of the 832 responses), followed by depression (14%) and stress (13%). The least was anxiety (6%). A cross-sectional survey that was conducted in Mombasa, Kwale and Nairobi counties in Kenya established high prevalence of anxiety disorder, depression, alcohol and drug use disorders, (Mwangala et al., 2025).

Figure 6

*Psychosocial Challenges*




Source: Research Data (2026)

The total percentage of cases was 507.3, indicating that on average, a participant answered that the community has five main psychosocial challenges (507.3/100).

*Skills and Competency*

This section presents the results of CHPs' skills and competency in providing psychosocial support. First, they were asked about how confident they were in providing psychosocial support to individuals in their community, and these results are presented in Table 2.

Table 2

*Confidence in Providing Psychosocial Support*

| Rating | Frequency | Percent |
|---|---|---|
| Very confident | 65 | 39.2 |
| Confident | 64 | 38.6 |
| Not sure | 16 | 9.6 |
| Not confident | 21 | 12.7 |
| Total | 166 | 100.0 |

Source: Research Data (2026)

Results showed that most CHPs (78%) were either very confident or confident in providing psychosocial support to individuals in their community. Only 22% answered that they were not sure or not confident. However, when the participants were asked to rate their current skills in dealing with community members facing mental health challenges, their ratings were found to be lower (Table 3).

Table 3

*Current Skills in Dealing with Community Members with Mental Health Challenges*

| Rating | Frequency | Percent |
|---|---|---|
| Excellent | 28 | 16.9 |
| Good | 39 | 23.5 |
| Average | 68 | 41.0 |
| Poor | 31 | 18.7 |
| Total | 166 | 100.0 |

Source: Research Data (2026)

The study found that only 40% of the respondents thought that they were either excellent or good when dealing with community members with mental health issues, while six out of every ten CHPs rated themselves as either average or poor. The findings suggested a paucity of skills in dealing with mental health issues among the sampled CHPs. The respondents were also asked whether they had received any training in mental health or psychosocial support. Seven out of every ten participants (*n*=119, 72%) answered that they had not compared with 22% (*n*=36) and 7% (*n*=11) who said they had received formal and informal training, respectively. The study also asked respondents about the areas of psychosocial support they needed to be trained in, and Table 4 presents these results.

Table 4

*Training Needs of CHPs in Psychosocial Support*

| Training Needs | Responses | | |
|---|---|---|---|
| | N | % | % of cases |
| Counselling & providing emotional support Identifying mental | 137 | 16.7 | 84 |
| health issues | 126 | 15.4 | 77.3 |
| Dealing with alcohol and drug abuse | 121 | 14.8 | 74.2 |
| Referral systems for mental health services Stress management | 115 | 14.1 | 70.6 |
| Supporting people with trauma experience Crisis intervention | 109 | 13.3 | 66.9 |
| Debriefing | 95 | 11.6 | 58.3 |
| | 62 | 7.6 | 38 |
| | 53 | 6.5 | 32.5 |
| Total | 818 | 100.0 | 501.8 |

Source: Research Data (2026)

The study found that the most critical training needs for CHPs was counselling & providing emotional support (17% of the 818 responses), followed by identification of mental health issues (15%), dealing with alcohol and drug abuse (15%), referral systems for mental health services (14%), and stress management (13%). The least critical were debriefing (7%) and crisis intervention (8%).

*Resources and Support for Effective Service Delivery by CHPs*

This section presents results on the awareness and accessibility of resources for effective service delivery by Community Health Promoters in Luanda Sub-County in Vihiga County.

The participants were asked whether they were aware of mental health services and resources that they could refer community members to. Results showed that slightly more respondents ($n$=95, 57%) answered that they were aware compared to those who said they were not ($n$=71, 43%). The results showed that a significant proportion of CHPs are not aware of any local mental health services and resources. However, when asked whether they had access to resources, eight out of every ten respondents (n=133, 80%) answered that they lacked resources, such as materials and guidelines, that could help them support individuals with psychosocial issues.

Chi-square ($\chi^2$) cross tabulations conducted to test the relationship between biographical characteristics of the sampled CHPs and both the awareness of and access to resources to support individuals with psychosocial issues were all non-significant [Awareness: education, $\chi^2$ (3) = 1.406, $p$=0.704; gender, $\chi^2$ (1) = 0.227 $p$=0.634; formal training, $\chi^2$ (1) = 0.988, $p$=0.320; experience, $\chi^2$ (3) = 5.342, $p$=0.421; or age, $\chi^2$ (4) = 7.451, $p$=0.114; Access: education, $\chi^2$ (3) = 2.985, $p$=0.394; gender, $\chi^2$ (1) = 0.000 $p$=0.985; formal training, $\chi^2$ (1) = 0.441, $p$=0.507; experience, $\chi^2$ (3) = 5.773, $p$=0.123; or age, $\chi^2$ (4) = 5.039, $p$=0.283]. The results showed that awareness of and access to resources to support individuals with psychosocial issues was similar regardless of an individual's education, training, gender, age, or experience. The respondents were asked about the resources that would be most useful in assisting their work and the results are reported in Table 5.

Table 5

*Most Useful Training Resources*

| **Training Resources** | **Responses** | | |
|---|---|---|---|
| | N | % | **% of Cases** |
| Training Materials | 125 | 27.6 | 77.6 |
| Access to mental health | 110 | 24.3 | 68.3 |
| professionals | 93 | 20.5 | 57.8 |
| Technology and digital tools | 125 | 27.6 | 77.6 |
| Network of CHPs | | | |
| Total | 453 | 100.0 | 281.4 |

Source: Research Data (2026)

The most germane resources were found to be training materials (manuals, guides, and videos) and a network of CHPs for sharing experiences (both 28% of the 453 responses), followed by access to mental health professionals for consultation (24%). The least critical were technological and digital tools for mental health support (21%). This could imply a debilitation in digital skills of the sampled CHPs.

*Training Preferences*

The training preferences of respondents are reported in this section. First, the respondents were asked about their most preferred format of training. Table 6 presents these results.

Table 6

*Most preferred format of training*

| **Training Format** | **Responses** | | |
|---|---|---|---|
| | N | % | **% of cases** |
| In-person workshops | 71 | 32.6 | 43.6 |
| Online courses | 20 | 9.2 | 12.3 |
| Community-based learning | 127 | 58.3 | 77.9 |
| Webinars | 0 | 0.0 | 0.0 |
| Total | 218 | 100.0 | 133.7 |

Source: Research Data (2026)

The most preferred format of training was community-based learning, for example, peer support groups (58% of the 218 responses), followed by in-person workshops (33%), and lastly, online courses (9%). Although one of the choices, no participant preferred the use of webinars. By favouring more traditional methods of engagement, such as community-based learning and workshops over modern forums, like online courses and webinars, suggested weaknesses in digital and artificial intelligence skills of the sampled CHPs. When asked how often they would like to receive psychosocial training, most of the respondents (*n*=71, 43%) wanted it every three months, while 28% (*n*=46) and 27% (*n*=45) wanted the training once a month or as needed, respectively. Only four respondents (2%) wanted the training once a year. The results suggest that the sample CHPs prefer training that occurs often.

When the participants were asked about the specific topics they wanted to learn more about during training, the overwhelming answer was on the identification and management of cases of mental health. The second major training need was found to be guidance and counselling. One respondent thus said, "It is important that we get the skills in guidance and counselling so that we can help our community members". The other areas mentioned by several participants were stress management, alcohol and drug abuse, and depression. The lesser pointed training need topics included, technological, digital and networking in the community, domestic violence, reproductive health, health education, crisis intervention, interacting with community members, malaria, tuberculosis, and antenatal care.

*Challenges and Recommendations*

When the respondents were asked about the main challenges they faced in providing psychosocial support to their community, most of them pointed out the lack of financial support, inadequate facilitation, lack of materials, and their lack of requisite knowledge for the job. For example, one participant put it that: *Lack of knowledge and lack of well-being.* Another said: *Lack of materials and equipment. Lack of enough skills.* Another respondent answered: *Lack of materials and support to know how to solve this problem.* The other challenges mentioned included identifying signs and symptoms of mental health, the lack of social support and health for clients, and the lack of access to mental health facilities. For instance, one respondent answered that, "*there are 2 or 3 mental cases in every community and there is a lack of mental health facilities for referrals.*"

The other challenges were the need to understand people in the community, lack of personal protective clothing, lack of transport and airtime, poverty and socio-economic conditions in the community. When the participants were asked about additional support that they needed to

address mental health and psychosocial issues more effectively, most of them pointed out a triad of things: financial resources, facilitation, and increased training. In the words of a respondent: *More training, formation of psychosocial support, and adherence.* Another pointed out: *We need airtime, transport, and uniforms*. Other additional support that respondents said would be pertinent included more empowerment, referral places for community members with health issues, psychologists to be recruited and on standby, and implementation of health education programs.

## Conclusion

The study concludes that community health promoters in Luanda Sub-County have generally low to moderate knowledge of mental health disorders. Although a large majority of CHPs (83%) reported that they know the signs and symptoms of mental health disorders, only a small proportion (13%) rated their understanding as very good, while one-third (33%) reported poor understanding. This suggests that self-reported awareness does not necessarily translate into depth of knowledge or competence. The lack of statistically significant relationships between knowledge levels and demographic characteristics such as age, gender, education, training, and experience indicates that knowledge gaps cut across all categories of CHPs. This points to systemic gaps in mental health training, rather than individual shortcomings.

The findings reveal a discrepancy between confidence and actual skills among CHPs. While 78% of respondents reported being confident or very confident in providing psychosocial support, only 40% rated their skills as good or excellent. The majority (59%) perceived their skills as average or poor, highlighting a significant skills deficit in practical psychosocial support and mental health management. Furthermore, most CHPs (72%) had not received any formal or informal training in mental health or psychosocial support, despite regularly encountering mental health issues in their communities (95%). This demonstrates that CHPs are often expected to address complex mental health challenges without adequate preparation, increasing the risk of ineffective or inappropriate support.

The study establishes that mental health and psychosocial problems are highly prevalent in Luanda Sub-County. Alcohol and substance use, depression, and stress emerged as the most common challenges, with each CHP reporting an average of five psychosocial issues affecting their community. This high burden of psychosocial challenges, combined with limited skills and training among CHPs, suggests a mismatch between community needs and the capacity of frontline health promoters. Vulnerable populations such as children, the elderly, people with disabilities, and survivors of trauma and domestic violence are particularly affected. The study concludes that awareness and access to mental health resources among CHPs are inadequate. Although slightly more than half of the respondents were aware of existing mental health services, a substantial proportion lacked awareness, and 80% reported having no access to essential resources, such as guidelines, manuals, or referral tools. The absence of significant associations between access or awareness and demographic characteristics suggests that resource constraints are structural, rather than individual. This indicates weak integration of mental health into community health systems and insufficient support from the health system.

CHPs demonstrated a strong preference for community-based learning and in-person training, with minimal interest in online courses or webinars. This reflects both limited digital capacity and contextual realities, such as poor internet access and low digital literacy. The priority training needs identified—counselling skills, identification of mental health disorders, alcohol

and drug abuse management, referral systems, and stress management—confirm that CHPs require practical, hands-on, and context-specific training rather than theoretical instruction alone.

## Recommendations

The Ministry of Health, Vihiga County Government, and strategic partners must institutionalize regular, competency-based mental health training for Community Health Promoters (CHPs). This curriculum should prioritize the identification of common disorders, basic counseling, and trauma-informed care, ensuring that training remains continuous and responsive to local psychosocial challenges. To support this, simplified mental health guidelines and standardized job aids, including screening checklists and culturally appropriate educational materials, must be developed and distributed. These resources are essential for enhancing the consistency, confidence, and overall quality of service delivery at the grassroots level.

Effective community care requires the full integration of psychosocial support into routine health activities, such as household visits and outreach, to dismantle stigma and facilitate early case identification. To sustain this, county health authorities should strengthen the structural linkages between CHPs and mental health professionals. By establishing clear referral pathways, assigning sub-county focal persons, and creating dedicated mentorship platforms, the health system can ensure that complex cases are escalated appropriately. This professionalized referral network reduces the clinical burden on CHPs while guaranteeing higher standards of care for the community.

To overcome critical operational barriers, it is imperative that CHPs receive adequate logistical and financial facilitation, including dedicated budgets for transport, communication, and protective equipment. Aligning incentives with these expanded mental health responsibilities is vital for motivation and long-term retention. Furthermore, support programs should adopt community-based and peer-led learning models utilizing role-plays and case discussions to align with adult learning principles. By building robust networks for experience sharing, the state can foster a resilient, mutual-support system that bridges the gap between policy objectives and local realities.

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