# HEALING IS POSSIBLE 2025 CAMPAIGN REPORT

*Mental Health Campaign*
*Ngaru Location, Kirinyaga County, Kenya.*

## JUNE 2025

Prepared By
**James W. Njuguna**
**Dr. Fridah Wachira**
www.convo.africa

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Redefining Healthcare




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***Nairobi, June 2025***

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*This report presents findings, observations, and recommendations from the Healing is Possible (HiP) Project activities conducted in Ngaru Location, Kirinyaga County, in May 2025. The information contained herein is based on community-based mental health clinics, therapy sessions, stakeholder engagement forums, and responses gathered through psychosocial screening tools and questionnaires distributed to participants. Every effort has been made to ensure the accuracy of data and sensitivity in reporting. All individual data has been anonymized to protect the privacy of participants.*

*The views expressed in this report do not necessarily reflect the official policies of any partner organisation, government entity, or affiliate institution. The report is intended for advocacy, awareness, and program development purposes only.*

*Any recommendations provided are based on the specific context of Ngaru and may require adaptation before replication in other settings.*

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HEARTBEATS & HORIZONS

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# Foreword

The month of May 2025 marked a profound chapter in our journey at Convo Africa toward mental health and community transformation. Under the banner of Healing is Possible (HiP), we set out with a simple yet powerful message: **When I Heal, My Community Thrives**. What unfolded in Ngaru location was more than just a campaign, it was a movement. A movement rooted in hope, truth, and the shared belief that mental wellness must be visible, accessible, and embraced at every level of society, and that indeed, healing is possible.

As someone deeply committed to health access, patient advocacy, and the wellbeing of our people, I witnessed first-hand the courage it takes for individuals to confront invisible wounds and break through the entrenched stigma that discourages many from seeking help. Through community dialogues, screenings, and referrals, the HiP campaign redefined how healing is perceived, transforming stigma into strength and silence into bold conversation.

People came out in solidarity to declare that healing is possible. Community leaders stepped forward to learn about mental health, and entire neighbourhoods joined us in dialogue, reflection, and action.

This report captures how we did it, the impact we made, the challenges we encountered, and the lessons we carry forward. It also highlights findings from our research, focused group engagements and the free mental health therapies we offered throughout the campaign. It honours every volunteer, healthcare worker, partners, the Ngaru Location Chief, and community elders who stood with us. Most importantly, it honours those who bravely said, "I need help," those who showed up to walk, the students and teachers who participated, and the wider community that embraced the message.

It is clear that greater investment is needed to train communities, especially local leadership, on mental health, emphasising their vital role in prevention and combating stigma and fostering safe spaces where these conversations can take place without fear or judgement.

To you reading this report, may it stir your compassion, shift your perspective, and inspire your action. Let's normalise mental health conversations and make them welcome in every space. Because healing is not a solo pursuit, it is a shared responsibility. And it is, indeed, possible.

With gratitude and hope,



***Dr. Fridah Wachira, Co-founder & Director, Convo Africa***

HEARTBEATS & HORIZONS

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# About Convo Africa

Convo Africa started with a powerful idea: to create a space where meaningful conversations spark change. What began as a small initiative has evolved into a multifaceted social enterprise with a broad reach across Kenya and Africa. Our early community engagement and media efforts laid the groundwork for a dynamic platform that tackles pressing social challenges and empowers individuals to thrive. Convo Africa now operates as a multifaceted social enterprise with a focus on addressing pressing social issues through a combination of media and community engagement initiatives.

As Convo Africa looks to the future, we remain committed to addressing pressing social issues with renewed strength. We continuously explore innovative ways to expand our reach, engage new audiences, and amplify the voices that matter most. In response to the ever-changing media and technology landscape, we evolve our platforms to ensure our content remains accessible, relevant, and impactful.

## Vision

A world where everyone has access to the information and support they need.
We are committed to sharing credible, up-to-date, and reliable information, as well as offering support on a wide range of social issues.

## Mission

Our Mission articulates the belief that through meaningful conversations, CONVO can help people to learn and grow, build strong communities, and make a positive impact on the world.

Our mission is to create a safe and inclusive space for people to engage in meaningful and thought-provoking discussions about important issues that matter to our community. Open and honest communication is essential for personal growth and for building stronger, more connected communities. We strive to foster empathy, respect, and understanding among people and to be a catalyst for positive change in the world

# 1. Executive Summary

The Healing is Possible (HiP) Project 2025, led by Convo Africa and in collaboration with The Chief, Bethroser, was a community-centred mental health initiative conducted in Ngaru Location, Kirinyaga County, during the month of May, aligning with Mental Health Awareness Month. The project focused on creating awareness, providing access to care, and building community-led solutions around Substance Use Disorders (SUDs), a growing and often misunderstood mental health issue in the region.

Grounded in the theme "Turning Awareness into Action," HiP 2025 combined practical intervention with bold community mobilization. A major highlight of the project was the 10+ kilometre community mental health walk, which brought together over 1,000 participants, including students from public schools and the area TVET institution, church members, professionals, local businesses, and residents. The walk served not only to raise awareness but also to visibly challenge stigma surrounding mental illness and SUDs.

In addition to the walk, the project held a highly impactful leadership breakfast and training forum, attended by 96 grassroots leaders, including the Assistant County Commissioner, Chiefs, Assistant Chiefs, Village Elders (VEs), and Community Health Promoters (CHPs). This forum helped demystify mental health, equipped local leaders with accurate knowledge on SUDs, and clarified their role in prevention, early intervention, and reintegration support.

Throughout the month, mental health clinics were held every Saturday, offering free screenings, counselling, therapy, and psychiatric referrals. A total of 137 individuals accessed these services, many for the first time, receiving support for anxiety, depression, PTSD, grief, and trauma.

The project was made possible through strategic partnerships with NACADA, Mwea Serenity Counselling & Treatment Centre, and Life Alignment Coaching, alongside full backing from the Ngaru Chief, Bethroser, her team of Village Elders, and the broader community. Their collaboration reinforced that community-driven mental health work is not only possible, it's powerful.

HiP 2025 demonstrated that with shared ownership, education, and practical action, stigma can be dismantled, and healing made accessible. It laid the groundwork for follow-up structures, peer-led wellness clubs in schools, and ongoing community outreach under the banner ***"When I Heal, My Community Thrives."***

# 2. Introduction

Mental health remains one of the most under-addressed public health challenges in Kenya, particularly at the community level. Convo Africa's Doctor's Bench Program, through its flagship initiative Healing is Possible (HiP), continues to champion conversations and action around mental wellness, with a strong focus on education, destigmatization, and community-based solutions. In 2025, we expanded our grassroots mental health outreach into Ngaru Location, Kirinyaga County, with a focused campaign during Mental Health Awareness Month in May.

This year's global theme, "Turning Awareness into Action," served as a timely call to deepen our impact beyond awareness, towards sustainable, community-led interventions. In response, we initiated a unique and first-of-its-kind model in the region: a series of community mental health clinics and engagements focused on Substance Use Disorders (SUDs), as well as a large-scale community walk to advocate for greater understanding and support of mental health.

Recognizing that healing does not happen in isolation, we adopted a multi-stakeholder approach by actively involving community elders, the local administration, pastors, Community Health Promoters (CHPs), and medical professionals. Our partnership with the Ngaru area chief, Bethroser, was instrumental. Her endorsement and involvement helped mobilise local structures and build trust within the community.

The initiative was inspired in part by the recovery journey of a resident, whose rehabilitation from substance use revealed both the potential for transformation and the systemic gaps in community-level support. His story galvanised the community and catalysed this project.

This report presents a comprehensive account of the HiP Project 2025 in Ngaru. It documents our planning, partnerships, activities, challenges, outcomes & findings from our survey and experiences,  impact, and the powerful stories that emerged from these efforts. Most importantly, it reflects our conviction that when we heal as individuals, our communities thrive.

# 3. The Problem

According to the National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA), mental health issues in Kenya have reached alarming levels, particularly among the youth. In 2019, mental disorders were the second leading cause of disability among individuals aged 10–24, accounting for 248,936 Disability-Adjusted Life Years (DALYs), or 9.4% of total DALYs in this age group. Substance use disorders alone accounted for 15,022 DALYs.

Specific contributions to total DALYs include depressive disorders (3.1%), anxiety disorders (2.3%), and conduct disorders (1.7%) (The Lancet).

NACADA further reports that among youths aged 15–24 years:
·5.2% (367,608 individuals) currently use alcohol
·3.2% (230,130 individuals) use tobacco
·3.6% (259,954 individuals) use khat
·2.7% (193,430 individuals) use cannabis Additionally, one in every 45 youths in this age group (153,846 individuals) is addicted to alcohol (NACADA).

Despite these concerning statistics, approximately 75% of Kenyans lack access to mental health services. This gap is particularly pronounced in rural areas, such as Ngaru Location, where geographic and economic barriers further restrict access to care. Stigma and lack of awareness prevent many individuals from seeking help, resulting in untreated conditions and an increased risk of self-harm and suicide. Currently, Kenya faces approximately four suicide deaths per day (Ministry of Health Kenya).

The initiative aimed to address these issues by offering accessible mental health support, reducing stigma through community engagement, and ensuring those in need of rehabilitation receive adequate care and reintegration assistance.

Substance use disorders (SUDs) are a growing epidemic, contributing to increased cases of addiction, self-harm, and suicide. Many individuals struggling with addiction lack access to affordable rehabilitation services, forcing them to battle their conditions alone. Without structured intervention, affected individuals face difficulties reintegrating into society, leading to cycles of relapse, family breakdown, and economic distress.

The WHO 2025 Mental Health Policy highlights the urgent need for community-based mental health programs that are accessible, culturally sensitive, and stigma-free. This project seeks to bridge these gaps by fostering community awareness, providing screening and therapy services, and ensuring that individuals in need of rehabilitation receive proper support and reintegration opportunities. By reducing stigma, equipping communities with mental health knowledge, and providing accessible care, this initiative will contribute to national efforts to combat mental health disorders and substance abuse.

## 3.1 Rationale for the Mental Health Walk, Clinics, and Community Study in Ngaru, Kirinyaga County

The decision to carry out a mental health awareness walk, on-site clinics, and a community perception study in Ngaru location, Kirinyaga County, was driven by both urgent need and strategic opportunity.

**A Silent but Growing Burden**

Mental health and substance use disorders (SUDs) have become a rising concern in rural and peri-urban Kenya, yet remain deeply under-acknowledged. In Ngaru specifically, early engagement with local leaders and community groups revealed growing cases of distress, addiction, and family breakdown, but with very little formal support infrastructure or reliable data to guide intervention.

**The survey conducted during the clinic revealed that:**

- 83% of respondents were aware of mental health, but understanding remained superficial and often linked to outdated or stigmatizing beliefs.
- 67% identified alcohol as the most commonly abused substance, followed closely by cannabis, miraa, and tobacco.
- 50% cited peer pressure as the leading cause of substance use, especially among youth and idle young adults.
- Only 44% could name or identify a rehabilitation centre, with many unaware of how to access professional help.

These figures indicate a gap between need and access, both in services and in awareness.

**Why Ngaru? A Strategic and Human-centred Choice**

Ngaru was selected as the focus area because of several key factors:

- It sits at the intersection of rural and urban lifestyles, making it a microcosm of the broader challenges facing many parts of central Kenya.
- Preliminary reports from local elders and health volunteers indicated an increase in youth substance use, family conflict, and school dropout, often traced back to untreated mental health or addiction issues.
- There was a willing and organized local leadership structure, under the stewardship of Area Chief Bethroser, offering a rare opportunity to co-create solutions with strong community buy-in.

**Beyond Awareness: Why a Walk and Clinics Were Necessary**

Mental health remains a heavily stigmatized topic in the area. The symbolic walk was not just an awareness tactic; it was designed as a public statement of solidarity, walking side by side with affected individuals, families, and leaders to dismantle the silence around mental illness and addiction.

The walk, paired with free clinics and screenings, served several functions:

- Provided immediate psychosocial support to individuals in distress.
- Opened space for dialogue and listening, where the community could express lived experiences without fear of judgment.
- Created an entry point for data collection, enabling an evidence-based understanding of local challenges and perceptions.

**A Study Rooted in Listening, Action, and Hope**

The accompanying study was essential not only to diagnose the situation but to build a locally informed foundation for sustained action. The findings confirmed that while challenges are significant, ranging from stigma to lack of services, the community is willing to engage, provided the approach is respectful, inclusive, and action-oriented.

# 4. HiP 2025 Objectives

## General Objective

To raise mental health awareness, destigmatize, prevent, and provide community-based support in Ngaru Location, Kirinyaga County, with a specific focus on addressing Substance Use Disorders (SUDs) as a critical mental health concern.

## Specific Objectives

1. To raise awareness about mental health and reduce stigma around mental health conditions, especially SUDs, through community mobilization and public education.
2. To provide direct mental health services, including screening, trauma and grief counselling, therapy, and referrals through weekly community mental health clinics.
3. To build the capacity of local support structures by training village elders (VEs), Community Health Promoters (CHPs), pastors, and other opinion leaders on mental health, with a focus on understanding, identifying, and supporting individuals with SUDs.
4. To strengthen collaboration between healthcare professionals, community leadership, and civil society in addressing mental health challenges within the community.
5. To promote reintegration and recovery by linking rehabilitated individuals to community support systems and opportunities for income-generating activities.
6. To mobilize the community through a mental health awareness walk that fosters solidarity, encourages public dialogue, and promotes collective action toward mental well-being.
7. Document and Replicate the Model: Develop a comprehensive report on the project's outcomes to create a replicable model for similar initiatives in other regions across Kenya

# 5. Project Design and Implementation

## 5.1. Background and Rationale

The Healing is Possible (HiP) Project in Ngaru Location was born out of a practical need observed on the ground, a need for structured mental health support, particularly in addressing Substance Use Disorders (SUDs), which had become alarmingly prevalent in the area.

The successful rehabilitation of a resident, a middle-aged man struggling with substance use (and potentially another underlying mental health problem), served as a turning point. His recovery revealed both the possibility of healing and the systemic gaps in health care, rehabilitation, reintegration, community understanding, and follow-up care. His journey highlighted the urgency to shift from awareness to action and to develop a localized mental health support model that involved the community directly.

Informed by this insight and inspired by the 2025 Mental Health Awareness Month theme, "Turning Awareness into Action," Convo Africa sought to pilot a sustainable grassroots mental health intervention, starting with Ngaru.

## 2. Stakeholder Engagement

For the project to succeed, community ownership was paramount. We began by engaging the local administration, led by Area Chief Bethroser, whose support was instrumental from the onset. She embraced the vision, facilitated our entry into the community, and ensured the cooperation of local leaders and structures. She invited the Assistant County Commissioner, Mr. Geteya Onchari, who embraced the activities and the walk. We were also able to speak to Nacada, who came to support us and show solidarity.

Key stakeholders included:

- NGAOs (Area Chief & Village Elders): Custodians of local values and conflict resolution processes.
- Community Health Promoters (CHPs): First responders in community health matters.
- Faith Leaders: Trusted voices in guiding values and offering counsel.
- Healthcare Professionals: Medical and clinical officers, Psychiatric nurses, clinicians, counselling psychologists, and clinical psychologists.
- Aligned Life Coaching
- Nacada Kerugoya division
- Mwea Serenity Treatment and Counselling Centre.
- Local business people and schools

This collaborative model ensured that the project was not perceived as an external intervention, but rather a community-led and owned initiative.

# 6. The Impact

The Healing is Possible (HiP) Project in Ngaru stirred a profound shift in how mental health is understood, talked about, and acted upon in the community. What began as a vision to spark meaningful engagement around Substance Use Disorders (SUDs) evolved into a grassroots movement marked by courage, conversation, and collective responsibility.

Throughout the month of May, momentum built steadily, culminating in a powerful visual and emotional statement on 31st May 2025, over **1,000 people** from across Ngaru walked side by side to say: mental health matters here. Students from Kerugoya Central Vocational Training Centre showed up with enthusiasm. We had students from Gakoigo Primary & Secondary School, Ngaru Girls, Kirima Primary & Secondary school, ACK & Catholic Church youth, healthcare workers, professionals, and everyday community members joined hands, hearts, and steps in a 10 KM march to dismantle stigma and invite honest conversations around mental wellness.

At the heart of this movement was Chief Bethroser, the area administrator, whose bold leadership and commitment inspired full participation from her network of village elders. Her office became a central hub for mobilization, not just administratively, but in spirit, she embodied the message that healing is possible when leaders lead with empathy, presence, and action. Her village elders, often the first to encounter cases of distress or substance use, engaged enthusiastically in trainings and dialogues. Together, they helped reposition mental health as a communal, not private, concern.

The mental health clinics, held on three consecutive Saturdays, drew in over **137 individuals** who sat down for screening, counselling, and referrals, all of them experiencing professional mental health care for the first time in their lives. These sessions uncovered deep-seated grief, unspoken trauma, and untreated symptoms of anxiety and depression. Yet, most telling was the readiness with which people spoke, listened, and asked questions. Mental health was no longer taboo. It became something people were willing to understand.

Conversations around SUDs also took a meaningful turn. Previously framed as moral failure or indiscipline, substance use began to be recognized as a health issue, one that requires care, not condemnation. The presence of trained professionals. Youth leaders, pastors, and health promoters reflected on how much they had misunderstood addiction and committed to unlearning and re-learning.

Our partnerships, especially with NACADA, Mwea Serenity Counselling & Treatment Centre, and Life Alignment Coaching, amplified our capacity to respond meaningfully. They brought expertise, resources, and credibility, allowing the community to see that what was happening in Ngaru was not just a campaign, but the beginning of a system, a community health response built on trust, training, and time.

More than anything, what emerged from Ngaru was a collective willingness: to listen differently, to speak bravely, and to act compassionately. The HiP Project planted something deep in the soil of Ngaru, not just awareness, but awakening. And where there is awakening, transformation follows.

# 6.1 Key Findings from the Community Mental Health Clinics

**Community Perspectives on Mental Health and Substance Use in Ngaru**

The following findings are drawn from insights gathered directly from the community, the medics, and a survey from participants who attended the mental health clinics conducted in Ngaru on 10th May 2025. These perspectives reflect the lived experiences and beliefs around mental health and substance use in the area, offering an authentic snapshot of the community's needs, knowledge gaps, and potential strengths for intervention.

**Common Mental Health Conditions and Concerns**
During the clinic sessions, including screenings and informal therapy, it became evident that the most frequently encountered mental health challenges included depression, anxiety, trauma, and substance use disorders (SUDs). A smaller but significant number of individuals exhibited signs of psychosis and moderate to severe stress, pointing to the diverse and often unaddressed spectrum of psychological distress within the community.

**Substance Use: A Growing Concern**
SUDs emerged as a particularly pressing issue. Many respondents either personally struggled with addiction or knew someone who did. The most commonly mentioned substances were:

- Alcohol – the most prevalent,
- Bhang (cannabis) and miraa – widely recognized,
- Tobacco, and in a few instances,
- Prescription drug misuse and inhalants like glue and kuber.

These patterns reflect the accessibility and normalization of substance use, particularly among youth and socially idle populations.

**Perceived Causes of Addiction and Mental Distress**
When exploring root causes of addiction, several recurring themes emerged:

- Peer pressure was cited most frequently, particularly among school-going youth and unemployed young adults.
- Family breakdown, unresolved trauma, and mental illness were also significant contributors.
- Unemployment and idleness were repeatedly mentioned as environmental risk factors that exacerbate vulnerability to both addiction and mental illness.

There was also a spiritual framing in some responses—linking addiction or mental illness to evil spirits, weak will, or moral failure—revealing the need for culturally sensitive mental health education.

**Low Awareness and High Stigma**
A deeply concerning trend across respondents was the low level of awareness around mental health and substance use. Most people rated the community's understanding as low to moderate, with many failing to recognize SUDs as treatable mental health conditions.

Stigma remains a significant barrier. Some participants associated seeking help with being "mad" (wazimu), a perception that isolates individuals in distress and discourages them from accessing care. While some were willing to work or live with someone who had recovered from addiction or mental illness, others still held discriminatory or fearful views, often rooted in cultural or spiritual beliefs.

**Limited Knowledge of Rehabilitation Services**
Knowledge of rehabilitation facilities and services was also very limited. Many respondents were unaware of available centres, including those operating locally, or expressed uncertainty about how to access them. While some named specific centres, such as Mwea Serenity, this was not the norm. The finding points to a serious gap in information flow, referral systems, and public visibility of mental health and addiction recovery services at the grassroots level.

Cost was also a concern raised by some, perceiving rehab as too expensive, despite many expressing willingness to refer others if services were available and accessible.

**Shifting Attitudes and Opportunities for Engagement**
Despite the challenges, the mental health clinic in Ngaru also revealed promising signs of growing openness and willingness to engage. The leadership of Area Chief Bethroser, alongside village elders, played a crucial role in fostering trust and community participation. Their involvement created a supportive environment that encouraged residents to openly discuss issues that are often treated as taboo.

This community response signals a shifting mindset, from viewing mental health as a private or shameful matter to embracing it as a shared community concern. There is clear readiness for more frequent engagements, particularly those that integrate counselling services, youth outreach, public education, and faith-based collaboration.

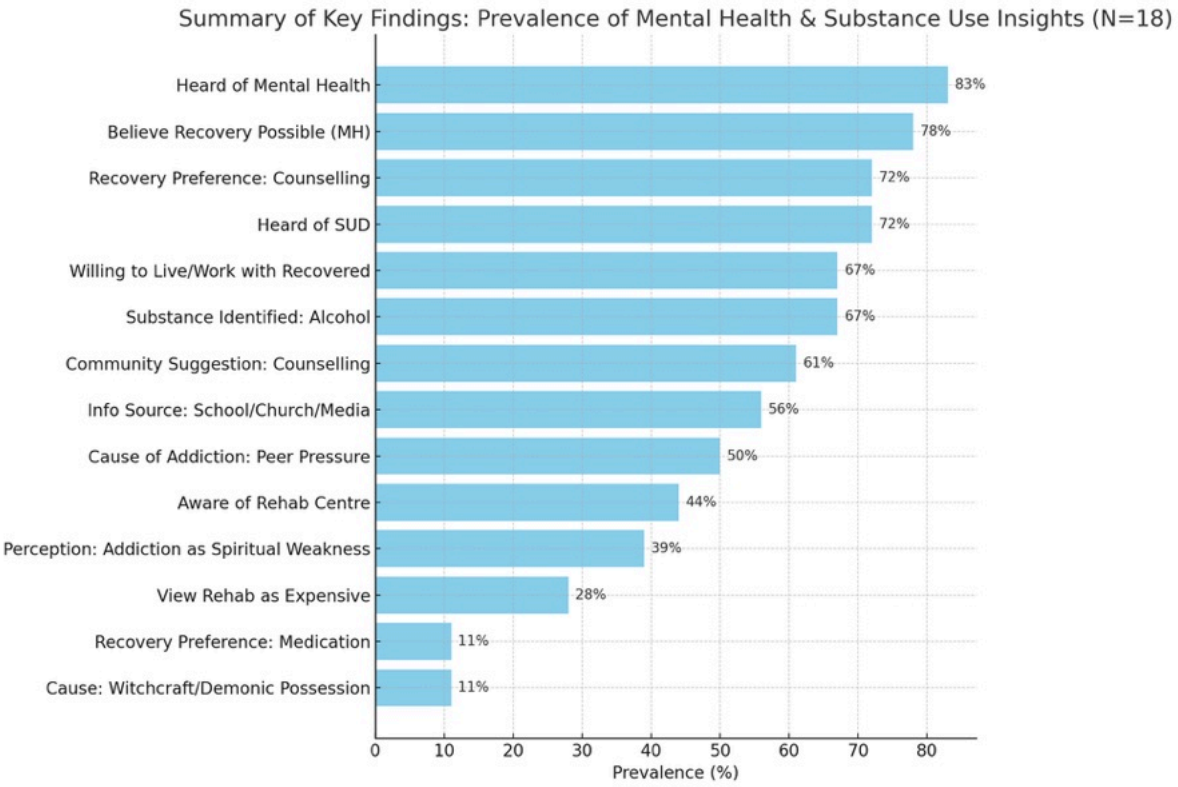
**Table: Key Findings from Mental Health and Substance Use Survey (Ngaru)**

| Category | Key Finding | Insight |
|---|---|---|
| Demographics | Majority respondents are aged 15–55; most are single and Christian | Sample reflects a youthful, religiously Christian population, mostly unmarried |
| Mental Health Awareness | More females than males responded | Gender representation may affect mental health and substance perception patterns |
| | Education varies from none to college; many are in business/farming | Education level may influence awareness sources and perception types |
| | Most have heard of mental health (e.g., 13 out of 16 valid responses = ~81%) | Mental health is a recognized topic in the community |
| | Common info sources: media, church, school (less from hospitals) | Traditional/community channels are more relied on than formal health systems |
| Perceptions of Mental Health | "Madness" and "Depression" are common associations | Public perception still includes stigma and clinical conditions |
| | Commonly believed causes: poverty, stress, drug use, family issues | Socioeconomic and relational stressors dominate public understanding |
| | Most believe people can recover and are willing to work/live with them | Encouraging sign of openness to recovery and reintegration |
| Substance Use Awareness | Awareness of SUD is high (13 out of 16) | Indicates growing recognition of addiction as an issue |
| | Alcohol, bhang, and miraa most cited substances | These are likely the most accessible/abused locally |
| | Friends and stress are top influencers for substance use | Peer pressure and mental health stress are key risk factors |

Table: Key Findings from Mental Health and Substance Use Survey (Ngaru)

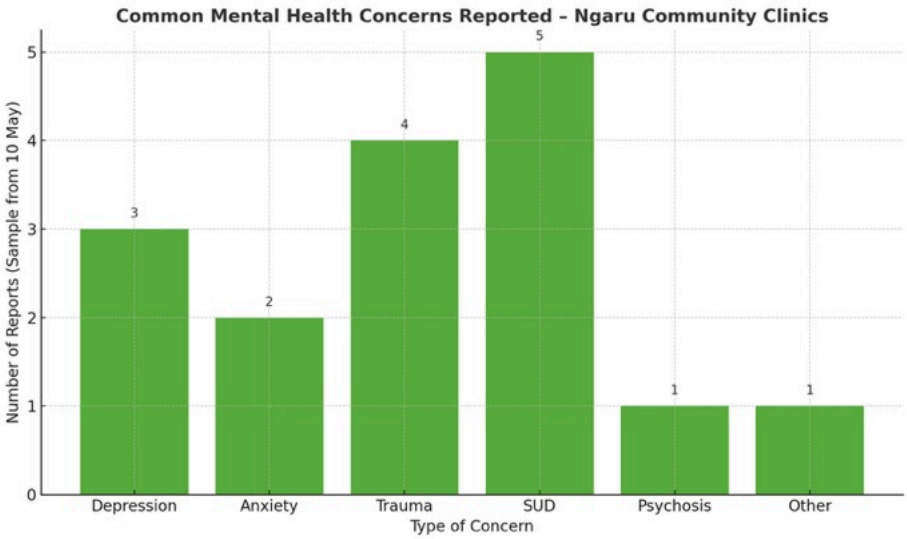
| Category | Category | Insight |
|---|---|---|
| **Causes of Addiction** | Peer pressure, unemployment, trauma, poor parenting most cited | A mix of social and psychological factors seen as drivers |
| **Perception of Addiction** | Mixed: some view as disease, others as spiritual weakness or punishment | Indicates stigma and need for awareness on the medical model of addiction |
| **Recovery Beliefs** | Most support counselling, spiritual help, rehab, and family support | Community sees multi-pronged recovery support as valid |
| **Rehab Awareness and Opinions** | Majority know about local rehabs like *Mwea Serenity*, but many view rehab as expensive | Cost is a barrier; awareness is present but affordability is key |
| **Community Suggestions** | Common proposals: job creation, youth counselling, stricter drug laws, mental health programs | Respondents want practical interventions and community-based solutions |
| **Institutional Role** | Expected roles: awareness creation, enforcement, rehab, youth engagement | Institutions are expected to lead both prevention and recovery initiatives |

Summary of Prevalence Mental Health & SUDs Insights

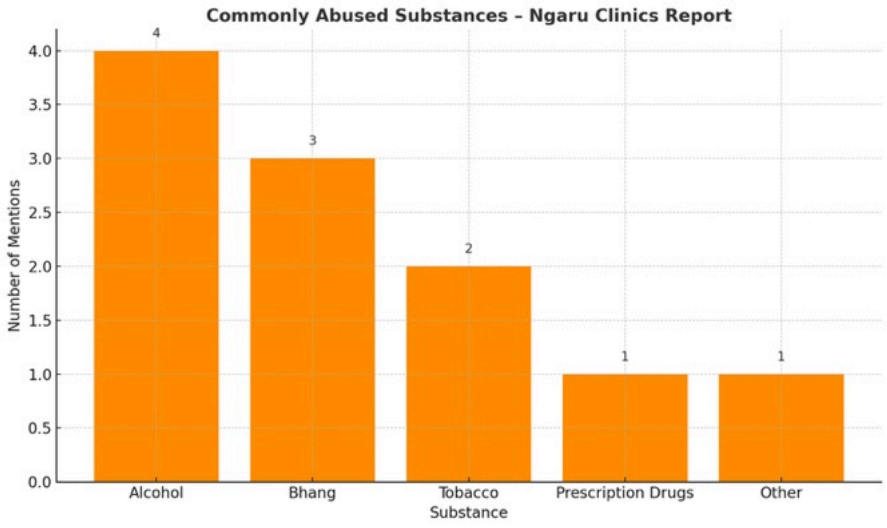



**A summary chart showing the prevalence of key insights from your survey. It highlights what issues are most recognized (e.g., mental health awareness, belief in recovery) and where there are knowledge or service gaps (e.g., medication, spiritual perceptions, rehab access)**

## Common Mental Health  Concerns & Commonly Abused Substance




*The most commonly reported mental health concerns from the Ngaru community clinics. It highlights the prominence of issues like Substance Use Disorders (SUDs), trauma, and depression among attendees.*




*A bar chart showing the commonly abused substances reported during the Ngaru community clinics. Alcohol and bhang (cannabis) were the most frequently mentioned, followed by tobacco and other substances, including prescription drug misuse.*

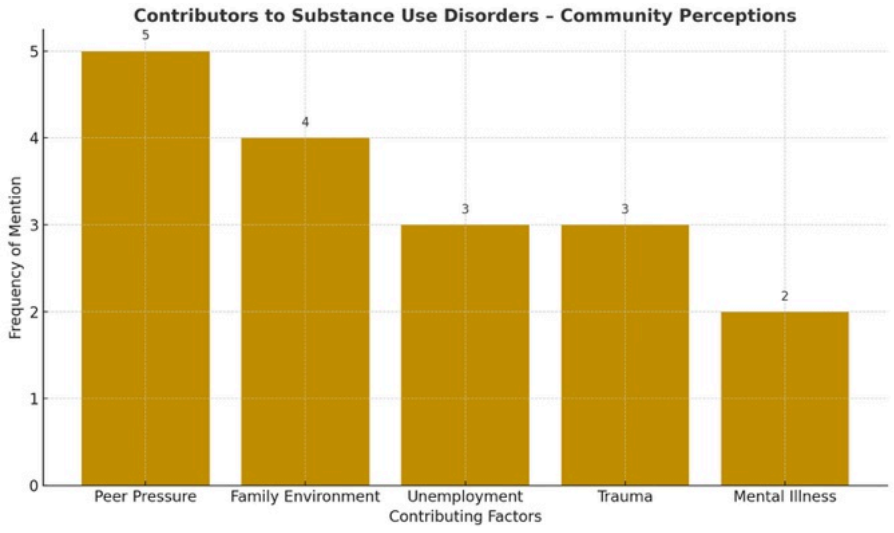
## Contributors to Substance Use Disorders (SUDs)

Findings from the community mental health clinics revealed a clear pattern in the perceived causes of substance use within the Ngaru community. Peer pressure emerged as the most frequently cited contributor to SUDs, particularly among school-going youth and young adults facing social influence and identity challenges.

Following closely were issues related to the family environment, where strained relationships, lack of support, or neglect were seen as common triggers. Unemployment was also a major concern, especially among school leavers and young people unable to transition into productive work or further education. This situation often leads to boredom, frustration, and vulnerability to substance use.

Participants also pointed to unresolved trauma , including grief, domestic violence, and early life hardships , as a factor pushing individuals toward substance use as a coping mechanism. Lastly, underlying mental illnesses, often undiagnosed or misunderstood, were acknowledged by some as being deeply intertwined with addiction, especially when individuals are left without access to psychological care or support systems.

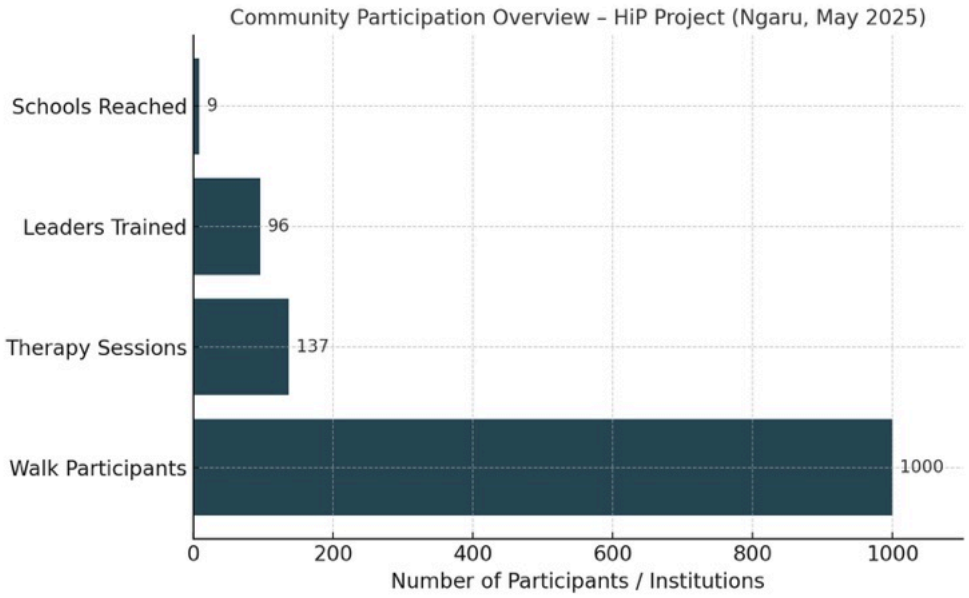
These insights underscore the need for multidimensional intervention strategies that target not only individual behaviour, but also social structures, emotional wellbeing, and economic realities. The community's own recognition of these factors indicates a growing readiness to shift the conversation and response around SUDs from blame to one of understanding and healing.




***The community-perceived contributors to Substance Use Disorders (SUDs) in Ngaru. The chart clearly shows that peer pressure was the most frequently cited factor, followed by family environment, unemployment, trauma, and underlying mental illness.***

## Key Findings from the HiP Mental Health Clinics – Ngaru Location (May 2025)

| Key Finding | Details / Insight |
|---|---|
| **Most Common Mental Health Concerns** | Depression, Trauma, Anxiety, and Substance Use Disorders (SUDs) were the most reported. |
| **High Prevalence of Substance Use Disorders (SUDs)** | SUDs emerged as the most visible issue, especially among young men and school-age youth. |
| **Primary Substances Abused** | Alcohol and bhang were most commonly mentioned, followed by tobacco and prescription drugs. |
| **Main Contributors to SUDs** | Peer pressure was the top factor, followed by family environment, unemployment, trauma, and untreated mental illness. |
| **Awareness Levels on Mental Health and SUDs** | Majority of community members had **very low** or **low** awareness of mental health and SUDs. |
| **Perception of Rehabilitation** | Widespread stigma persists—rehab is often seen as a place for the "mad" (*wazimu*). |
| **Turnout and Participation** | Over **1,000 participants** joined the 10+ KM awareness walk. 137 individuals received therapy. |
| **Community Stakeholder Engagement** | Chiefs, Assistant County Commissioner, CHPs, schools, and churches were actively involved and supportive. |
| **Mental Health as a Hidden Crisis** | Several participants were unaware their symptoms were mental health-related—highlighting gaps in understanding and language. |
| **Need for Youth-Focused Prevention** | Most drug use starts in secondary school settings; early intervention is critical. |
| **Barriers to Seeking Help** | Cost of therapy/rehab, lack of awareness, stigma, and cultural silence were recurring barriers. |
| **Strong Community Readiness** | Enthusiastic participation and willingness to talk about mental health signal a readiness to shift community attitudes. |




## Key Insights and Gaps

| Theme | Observation | Prevalence |
|---|---|---|
| Mental Health Awareness | Strong awareness | 83% |
| Rehab Access | Moderate awareness, strong support | 44–72% |
| Addiction = Disease | Common view | 50% |
| Stigma (madness, punishment, weakness) | Still present | 30–40% |
| Preferred Recovery Method: Counselling | Highly supported | 72% |
| Spiritual Beliefs in Cause/Treatment | Significant | ~40% |
| Clinical Understanding (e.g., medication) | Very low | ~10% |

# 7. Lessons Learned and Challenges

The data collected through community engagements, questionnaires, screenings, and conversations provided both quantitative insights and rich qualitative lessons that speak to the realities on the ground.
The following are key take away lessons learnt.

**1. Mental Health Conversations Are Welcome; When Framed Well**
One of the most encouraging revelations was the community's openness to discussing mental health, provided the approach was sensitive, respectful, and relatable. Despite stigma still lingering in parts of the community, 83% of participants reported awareness of mental health, with many expressing willingness to support or live alongside someone recovering from a mental health condition.

This openness was most evident during facilitated sessions that used clear, non-clinical language. People responded more when facilitators drew on real-life experiences, local references, and inclusive language. These safe spaces allowed participants to talk about personal experiences with depression, anxiety, trauma, and in some cases, psychosis, conditions that had previously gone undiscussed.

***Lesson Learned: People want to talk. They simply need safe spaces, contextual framing, and compassionate facilitators who speak their language.***

**2. Stigma and Low Awareness Are Persistent Barriers**
Although awareness is growing, stigma remains a critical barrier. Approximately 39% of respondents still associated mental illness with "madness" (wazimu), and spiritual or moral explanations, such as punishment or weak will, were frequently mentioned. Additionally, knowledge about Substance Use Disorders (SUDs) as treatable conditions remains limited, with many unaware that addiction is recognized within mental health frameworks.

This stigma discourages early intervention and isolates those affected. Several community members shared that seeking therapy or visiting rehab is often seen as shameful, contributing to silence around suffering and delayed care.

***Lesson Learned: Awareness campaigns must directly address stigma while promoting empathetic, culturally sensitive messaging that repositions mental illness and addiction as health, not moral issues.***

**3. Leadership Buy-In is a Game-Changer**
The support and public presence of Chief Bethroser and her network of village elders played a transformative role. Their active involvement helped normalize the conversation, draw participants, and reduce suspicion or fear. Community members stated they felt "safe" and "invited" when familiar leaders endorsed the event.

***Lesson Learned: When local administration champions a cause, it becomes a shared agenda rather than an external intervention.***

**4. Substance Use is Widespread, Yet Poorly Understood**
SUDs emerged as one of the most pressing issues, with many participants either struggling with addiction themselves or knowing someone who was. Alcohol was the most commonly abused substance (67%), followed by Bhang, Miraa, tobacco, Kuber, and to a lesser extent, prescription drugs and inhalants like glue.

The root causes of substance use were frequently traced to peer pressure (50%), especially among youth, as well as unemployment, family dysfunction, and unresolved trauma. Notably, spiritual interpretations of addiction remained prevalent, complicating public health responses.

***Lesson Learned: The community is ready to view addiction through a health and empathy lens, but requires ongoing reframing of SUDs as treatable conditions, not crimes or personal failings.***

**5. Rehabilitation Services Are Valued But Inaccessible**
Despite strong community support for recovery, with 72% endorsing counselling and 56% supporting rehab, awareness of local rehabilitation centres was low. Only 44% of respondents could name or identify a rehab facility, and many were uncertain about how to access them.

Concerns about cost and privacy were also raised, pointing to the need for community-based outreach and affordable care pathways. Respondents indicated a high willingness to refer others for help if services were more visible and approachable.

***Lesson Learned: There is a clear opportunity to strengthen community-level referral systems, improve visibility of services, and ensure affordability.***

**6. Healing Requires Both Dialogue and Action**
The combination of screenings, open forums, and symbolic actions like the community walk proved highly effective. These interactive experiences helped translate awareness into emotional engagement and public ownership of the mental health agenda.

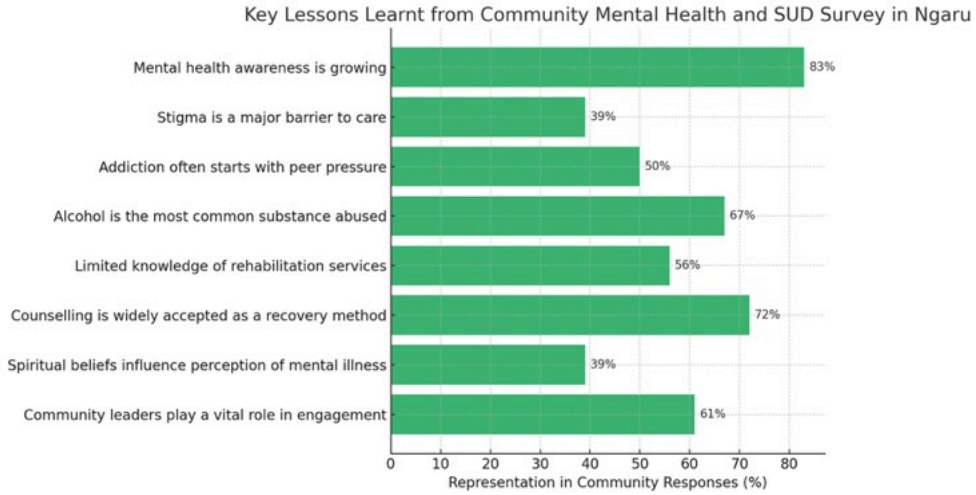
***Lesson Learned: Communities are more likely to internalize change when it includes both education and experiential action, talking and doing, together.***

**7. Spirituality, Culture, and Healing Beliefs Must Be Engaged**
Nearly 40% of respondents described addiction or mental illness through spiritual or moral frameworks, including beliefs in evil spirits, curses, or punishment. While these views can create barriers, they also offer an entry point, particularly through partnerships with faith-based leaders who are respected and trusted in the community.

***Lesson Learned: Interventions must not dismiss spiritual beliefs but rather engage faith leaders and communities in bridging science and culture.***

**8. Partnerships Enhance Quality and Trust**
The involvement of professional partners, including NACADA, Mwea Serenity, and Life Alignment, significantly strengthened the clinic's credibility and impact. These collaborations brought in expert knowledge, access to services, and a sense of professionalism that helped assure participants.

***Lesson Learned: Grassroots mental health work is amplified by strategic partnerships that link community efforts with technical expertise and national policy agendas.***




*The chart above visually presents the key lessons learnt from the mental health and substance use survey in Ngaru. It highlights both strengths, like growing awareness and community engagement and challenges, such as persistent stigma and limited knowledge of rehabilitation services.*

## 7.1 Challenges Encountered

- **Resource Limitations.**

While the project received enthusiastic support, resource constraints, particularly around training, volunteer facilitations, materials, and follow-up logistics, were a consistent challenge. The affected are so engulfed by this problem that they are unable to leave it; it has created a dependence. This requires treatment, and therapy is just one step of the process. These people needed escalation. This highlights the need for better funding and expanded human resources. The community needs more training to help them understand mental health as well as enable them to become key players in finding solutions.

- **Mobilisation Was Hindered by Stigma**

Even with strong support from local leadership (e.g., the Chief, village elders, and school heads), mobilising people for therapy sessions was challenging. Despite public campaigns and door-to-door engagement, attendance from those most in need, particularly individuals struggling with substance use, remained lower than anticipated. Stigma played a significant role, coupled with personal denial and misconceptions about who therapy is "meant for." This indicates a need for alternative mobilisation strategies, including peer-led advocacy, and ongoing normalisation of therapy in everyday community spaces.

- **Deep-Rooted Stigma and Misconceptions**

Stigma emerged as a major barrier to both participation and follow-up. In particular, the widespread belief that therapy is only for the "mad" discouraged people, especially those struggling with substance use, from seeking help. Ironically, many of these individuals admitted a desire to talk and be helped, but could not reconcile that need with the perception that seeking therapy would label them negatively. This fear of judgement, especially in small community settings, limited turnout and delayed necessary interventions. Older generations held tightly to traditional views of mental illness, while younger individuals feared social ridicule. These realities show the pressing need for targeted psychoeducation that reframes therapy as a tool for healing, not shame.

- **Emotional Intensity of Community Cases.**

The therapeutic sessions revealed significant trauma within the community. Many people were facing complex issues, abuse, loss, addiction, hopelessness, and while the clinics offered initial support, some cases required long-term care that is currently unavailable locally. Managing expectations around care and referrals was a delicate process.

- **Follow-Up Gaps.**

After initial screening and therapy, the need for structured follow-up and reintegration support became apparent. Without a clear, resourced plan for continued care, there is a risk that individuals may remain unsupported. This calls for a more robust aftercare model in future phases.

## 8. Recommendations and Way Forward

The Healing is Possible (HiP) Project in Ngaru has demonstrated that when mental health is addressed in ways that are community-led, compassionate, and sustained, change begins to take root. But the work is far from over. The findings from the clinics and the overwhelming turnout for the walk affirm that the community is ready, ready to learn, to unlearn, and to heal. To deepen this impact, several key areas now require our attention and collective action.

First, community education must continue and evolve. One of the clearest insights from the clinics was the persistent misunderstanding of mental health and substance use disorders (SUDs). In many cases, people do not even recognise what they are going through as a mental health issue. Stigma remains deeply entrenched, and in some circles, rehabilitation is still equated with madness. This must change. Conversations on mental health need to become normal in everyday spaces, in homes, schools, churches, chief barazas, and workplaces. These conversations are not just about awareness but about making the community a place where people can speak freely, seek help, and be supported without shame.

From the data gathered and conversations held, it became evident that young people remain especially vulnerable. Most are introduced to drugs by peers, and many during their time in high school. This calls for deliberate, consistent mental health and substance use prevention efforts that focus on youth. Awareness campaigns in learning institutions must be intensified, not just with talks, but through creative peer-led clubs, relatable forums, mentorship, and emotional resilience training. The Convo Wellness Club model already provides a framework for this.

Equally important is reaching out to youth who are not in school, especially those unable to transition into college or formal training. This group often feels forgotten. For them, engagement through Income Generating Activities (IGAs), skill-building programmes, and structured mentorship is critical. By providing opportunity and purpose, we reduce vulnerability to substance use and build a generation that contributes meaningfully to the community.

The role of the family cannot be overstated. Many cases of substance use and mental illness can be traced back to the family environment, conflict, neglect, unresolved trauma, and lack of emotional support. Families must be empowered with the tools, knowledge, and confidence to support loved ones on their healing journeys. This includes addressing the silence, denial, and misinformation that often surround these issues.

A major barrier that surfaced during this project was the community's perception of rehabilitation. The idea that going to rehab means one is "mad" (wazimu) is not only inaccurate, it is harmful. It deters people from seeking help when they need it most. We must change the narrative around treatment. Rehabilitation is a courageous act, a path of restoration. Wherever possible, community-based treatment models should be developed, allowing individuals to heal within familiar environments and with the support of those around them.

We also found that some individuals are willing to change but simply cannot afford formal rehabilitation. These people deserve structured support systems that meet them where they are, offering therapy, follow-up, and accountability while allowing them to continue with their daily lives. Such models are not only cost-effective but deeply respectful of the individual's social and economic context.

A highlight of the project was the 10+ KM community walk, which drew over 1,000 participants, including students, youth, professionals, churches, and leaders like the Assistant County Commissioner and Chief Bethroser. Their presence wasn't just symbolic. It showed the power of inclusive mobilization. Likewise, the leadership training brought together 96 stakeholders—from chiefs and assistant chiefs to village elders and CHPs, creating a unified front in the fight against stigma and misinformation.

This spirit of multi-stakeholder collaboration was the engine behind the success of HiP in Ngaru. Going forward, we must preserve and strengthen these partnerships. Community leaders, schools, churches, health professionals, youth groups, and local businesses must all remain engaged in this journey of healing.

Finally, the Healing is Possible model must not end here. Its grassroots nature, peer-driven approach, and integration of awareness, therapy, and action make it replicable. We must now focus on scaling the model to other communities, adapting it to local contexts while holding firm to its core message: healing is not only possible, it is necessary, it is communal, and it must be sustained.

# Key Findings & Recommendations – HiP Clinics, Ngaru Location (May 2025)

| Key Finding | Insight / Evidence | Recommendation |
|---|---|---|
| **1. Mental Health & SUDs are Prevalent** | Depression, anxiety, trauma, and SUDs were common. SUDs particularly visible among youth. | Continue community-based screening, therapy sessions, and targeted campaigns. |
| **2. High SUD Incidence Among Youth** | Most youth start using substances in high school due to peer influence. | Scale school-based wellness clubs, introduce peer mentorship and creative campaigns. |
| **3. Top Substances Abused** | Alcohol and bhang were most cited, followed by tobacco and prescription misuse. | Develop education materials around these specific substances; partner with NACADA for targeted awareness. |
| **4. Main SUD Contributors** | Peer pressure (most common), family environment, unemployment, trauma. | Engage families, expand youth skill/IGA programs, and train village elders to detect and intervene early. |
| **5. Low Awareness Levels** | Most respondents showed very low to moderate understanding of mental health and SUDs. | Intensify psychoeducation at barazas, schools, and churches. Leverage radio and posters in local languages. |
| **6. Rehabilitation is Stigmatised** | Rehab is often equated with madness (*wazimu*), deterring many from seeking help. | Reframe rehab as a recovery journey; promote success stories and community-based care models. |
| **7. Therapy is Needed but Inaccessible** | Many willing to change cannot afford rehab or therapy. | Set up a follow-up system offering home/community-based therapy and support. |
| **8. Strong Stakeholder Buy-In** | Chief Bethroser, ACC, CHPs, and school heads actively supported the project. | Deepen partnerships and co-develop long-term community wellness strategies. |
| **9. Enthusiastic Community Response** | Over 1,000 joined the walk; 137 received counselling. | Make annual community walks, mobile clinics, and MH weeks part of local planning. |
| **10. Youth Without School Access Are At-Risk** | Many out-of-school youth were idle, making them vulnerable. | Link youth to TVETs and IGAs with integrated mental health education. |

# 9. Conclusion

The Healing is Possible initiative in Ngaru location in Kerugoya was more than an event; it was the beginning of a mindset shift. It proved that when communities come together, stigma can be broken, and mental health can be embraced as a shared responsibility. What began as a call to address mental health became a rallying point for healing, learning, and solidarity.

The walk brought visibility. The mental health clinics offered hope. The conversations sparked reflection. Most importantly, this project reminded us that healing is not just for individuals; it is for families, institutions, and entire communities.

Our work is not finished. The engagement witnessed during the project shows a deep hunger for understanding, support, and sustainable solutions. The presence of youth, elders, school leadership, faith leaders, government officials, and professionals confirmed that healing must be a collective journey.

As we move forward, our commitment remains to educate, mobilise, support, and walk with our people. From school clubs to Saturday clinics, from home-based care to leadership forums, we are building structures that will carry this work forward.

When I heal, my community thrives. This is more than a slogan; it is a promise. A promise we intend to keep.

# Acknowledgements

The success of the Healing is Possible (HiP) Project in Ngaru, Kirinyaga County, was not the work of a single person or organization; it was the fruit of collective effort, sacrifice, shared belief, and unity. We take this moment to sincerely thank everyone who walked this journey with us.

To the entire Convo Africa team, thank you for your resilience, creativity, and relentless pursuit of healing in our communities. Your belief in this mission gave it form and life.

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To our dedicated **Ngaru Location Chief, Bethroser**, and village elders, your ground-level mobilization and belief in this cause made the work not just possible but impactful. To the Assistant County Commissioner, **Mr. Geteya Onchari**, Kerugoya Central Division, thank you for your attendance and endorsement; your presence elevated the message.

We are deeply grateful to the mental health professionals, psychiatric nurses, clinicians, clinical psychologists, and counselling therapists who offered their time and expertise during the clinics. Your presence brought comfort, hope, and healing to many.

A special appreciation goes to **Sharar Kosei,** our lead trainer, whose engaging and informative sessions helped the community better understand Substance Use Disorders (SUDs) as mental health conditions and clarified the critical role of community leadership in prevention and early intervention. His contribution laid a strong foundation for sustained awareness and community-based support.

Convo Africa appreciates Bancy Wachira, your generous hospitality, logistical support, and unwavering commitment from personally driving to pick up people, to ensuring the team was well taken care of, made many moving parts come together seamlessly. You truly embodied what community support looks like, and we are grateful. To Regina Wachira, thank you for your financial support. It was felt deeply, and it helped make a lasting impact.

We thank our partners:
**NACADA,** Kerugoya Division, for their commitment to fighting substance use;
Mwea Serenity Counselling and Treatment Centre, for supporting referrals and guidance; Life Alignment Coaching, for stepping in with practical, people-centred approaches to healing.

We extend our heartfelt appreciation to the Kerugoya Central TVET and the students who showed up in great numbers, walked with us, and reminded us that the future is already engaging.

To the schools who took part and allowed us to reach young minds early, thank you:
Ngaru Primary School, Ngaru Secondary School, Wamugi Academy, Kirima Primary School, Kirima Secondary School, Gatuto Primary School, Gatuto Secondary School and Gakoigo Primary School

Lastly, to the Ngaru community, thank you for showing up, for listening, for being willing to learn, and for beginning the difficult but necessary conversations. Your courage to confront mental health challenges and support one another is what healing looks like in real time.
This project belongs to all of us.

May we keep walking together.

# highlights 2025

## Healing is Possible Campaign







































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