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Assessment of Types and Prevalence of Mental Health Inequalities in Samburu East Sub-County, Kenya

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Abstract

Mental health disorders are a leading cause of global morbidity and disability, with the burden disproportionately affecting populations in low- and middle-income countries. Despite increasing recognition of mental health as a public health priority, there remains limited context-specific evidence on the distribution of mental health disorders in pastoralist and marginalized communities in Kenya. The objective of this study is to determine the types of selected mental health disorders prevalent in Samburu East Sub-County, Kenya. A cross-sectional descriptive study employing a mixed-methods approach was conducted among 414 respondents in Samburu East Sub-County. Quantitative data were collected using structured questionnaires, while qualitative data were obtained through key informant interviews and focus group discussions. Quantitative data were analyzed using descriptive statistics, including frequencies and percentages, while qualitative data were analyzed thematically.

Keywords: *Mental health prevalence, depression, stress, pastoralist communities Kenya, anxiety*

1.0 Introduction

Mental health disorders are a leading cause of global disease burden, affecting nearly one billion people worldwide and contributing significantly to disability-adjusted life years (DALYs) [1]. Common mental disorders such as depression, anxiety, and stress-related conditions account for a substantial proportion of this burden, particularly in low- and middle-income countries (LMICs), where health systems are often under-resourced and unable to adequately respond to mental health needs [2].

Despite increasing global recognition of mental health as a critical component of overall health, there remains a substantial treatment and diagnostic gap. It is estimated that up to 75% of individuals with mental health disorders in LMICs do not receive appropriate care, largely due to limited awareness, stigma, and inadequate healthcare infrastructure [3]. Consequently, many cases remain undiagnosed, especially in rural and marginalized populations.

In Kenya, mental health is increasingly recognized as a public health priority; however, the availability of mental health services remains limited. The country faces a significant shortage of trained mental health professionals, with services largely concentrated in urban centers, leaving rural populations underserved [4]. In addition, stigma and cultural misconceptions surrounding mental illness continue to hinder recognition and reporting of mental health conditions.

Samburu East Sub-County, located in northern Kenya, represents a pastoralist setting characterized by arid climatic conditions, nomadic livelihoods, and socio-economic vulnerability. These contextual factors, including poverty, food insecurity, drought, and limited access to healthcare services, contribute to increased psychological stress and vulnerability to mental health disorders [5]. Furthermore, cultural beliefs that attribute mental illness to supernatural causes such as curses or spirit possession may influence how mental health conditions are perceived and reported within the community [6].

While global and national data highlight the growing burden of mental health disorders, there is limited empirical evidence on the types and distribution of these conditions in pastoralist communities such as Samburu East. Most existing studies have focused on urban populations, leaving rural and marginalized groups underrepresented in mental health research.

Understanding the specific types of mental health disorders prevalent in Samburu East Sub-County is essential for informing targeted interventions, improving early detection, and guiding policy and resource allocation. This study therefore aimed to determine the types of selected mental health disorders prevalent in Samburu East Sub-County, Kenya.

2.0 Materials and Methods

This study employed a cross-sectional descriptive design using a mixed-methods approach to determine the types of selected mental health disorders prevalent in Samburu East Sub-County, Kenya. The mixed-methods approach enabled the integration of quantitative and qualitative data to provide a comprehensive understanding of mental health patterns within the study population [1].

The study was conducted in Samburu East Sub-County, located in Samburu County in northern Kenya. The region is characterized by arid and semi-arid climatic conditions, with livelihoods predominantly based on nomadic pastoralism. The area is marked by dispersed settlements, limited healthcare infrastructure, and poor transport networks, all of which influence access to healthcare services and mental health outcomes [2].

The study population comprised of adults based in the community and the healthcare providers who gives services in a variety of local healthcare facilities in the sub county

Including these groups provided diverse perspectives on the identification and understanding of mental health disorders [3].

The formula that was used to determine and calculate the sample population was;

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

$$n = \frac{45,000}{1 + 45,000(0.05)^2}$$

$$n = \frac{45,000}{1 + 45,000(0.0025)}$$

$$n = \frac{45,000}{1 + 112.5}$$

$$n = \frac{45,000}{113.5} \approx 397$$

A minimum sample size of 414 respondents was achieved. Community members were selected using stratified random sampling to ensure representativeness, while healthcare workers were selected using purposive sampling based on their knowledge and experience with mental health issues.

Data was collected using both quantitative and qualitative methods including structured questionnaires which were administered to both the community member and healthcare professionals. Other methods used included the key informant interviews which were conducted with the healthcare workers in obtaining insights on mental health conditions in the community. Using multiple tools enhanced the findings validity through triangulation.

3.0 Data Analysis

Quantitative data collected through structured questionnaires were first checked for completeness, consistency, and accuracy prior to analysis. The data were then coded and entered into Statistical Package for the Social Sciences (SPSS) version 20 and cross-verified using Microsoft Excel to minimize entry errors. Descriptive statistical analysis was performed to determine the types and prevalence of selected mental health disorders. Frequencies and percentages were used to summarize categorical variables, particularly the distribution of mental health conditions among respondents. Results were presented in tables and narrative form for clarity and ease of interpretation.

Qualitative data obtained from key informant interviews and focus group discussions were transcribed verbatim, translated where necessary, and organized for analysis. Thematic analysis was used to identify recurring patterns, perceptions, and explanations regarding mental health disorders within the community. Codes were generated inductively and grouped into broader

themes reflecting lived experiences and contextual factors influencing mental health. Data triangulation was applied by comparing findings from quantitative and qualitative sources to enhance validity and reliability of the results. This approach allowed for a comprehensive understanding of the types of mental health disorders prevalent in the study area and the contextual factors associated with them [1].

Inferential statistical analysis was not emphasized, as the primary objective of the study was descriptive in nature.

4.0 Results

A total of 414 respondents participated in the study. The majority were adults within the economically active age group. Most respondents were engaged in pastoralism as their primary livelihood, with a significant proportion reporting low levels of formal education and limited stable income sources. These socio-demographic characteristics reflect the general profile of the pastoralist population in Samburu East Sub-County. The study identified several mental health conditions affecting the community, with common mental disorders being the most prevalent.

Table 1: Prevalence of Selected Mental Health Disorders

Mental Health Disorder	Frequency	Percentage
Stress	157	37.9
Depression	131	31.6
Substance use disorders	52	12.6
Anxiety disorders	27	6.5
Psychosis	12	2.9
Schizophrenia	9	2.2
Bipolar disorder	8	1.9
Insomnia	18	4.4

The findings indicate that stress and depression were the most prevalent mental health conditions, accounting for more than two-thirds of all reported cases. These were followed by substance use and anxiety disorders, while severe mental illnesses such as schizophrenia and bipolar disorder were reported at relatively low levels. Qualitative data supported the quantitative findings and revealed that mental health disorders were strongly linked to Socio-economic stressors, including poverty, unemployment, and food insecurity. Environmental hardship, particularly drought and resource scarcity. Family and social conflict, contributing to emotional distress Substance use, especially alcohol consumption among youth. Cultural interpretations, where mental illness was often attributed to supernatural causes such as curses or witchcraft

Participants noted that these factors often interact, increasing vulnerability to psychological distress and limiting early identification of mental health conditions.

This study identified a high burden of mental health disorders in Samburu East Sub-County, with stress (37.9%) and depression (31.6%) emerging as the most prevalent conditions. These findings are consistent with global evidence indicating that common mental disorders, particularly depression and anxiety-related conditions, are the leading contributors to disability worldwide, especially in low- and middle-income countries (LMICs) [1,2].

The high prevalence of stress observed in this study likely reflects the socio-economic and environmental challenges experienced in pastoralist communities. Samburu East is characterized by recurrent drought, food insecurity, and limited livelihood opportunities, all of which contribute to chronic psychological stress. Similar findings have been reported in other arid and semi-arid regions, where environmental hardship significantly increases mental health vulnerability [3].

Depression was also highly prevalent, which may be associated with persistent socio-economic deprivation, limited access to essential services, and social isolation. These findings align with the social determinants of mental health framework, which emphasizes the role of poverty, inequality, and adverse living conditions in the development of depressive disorders [4].

Substance use disorders were also reported, particularly among younger populations. Substance use is often used as a coping mechanism for stress and socio-economic frustration, but it further exacerbates mental health outcomes and increases the risk of comorbid psychiatric conditions [5].

Although severe mental illnesses such as schizophrenia, bipolar disorder, and psychosis were reported at lower levels, this may not reflect true prevalence. Instead, it may indicate underdiagnoses, stigma, and limited mental health literacy within the community. In rural and resource-limited settings, severe mental disorders are often underreported due to cultural interpretations and lack of formal diagnostic services [6].

Qualitative findings further highlighted the influence of cultural beliefs, where mental illness is frequently attributed to supernatural causes such as witchcraft, curses, or spiritual punishment. Such beliefs contribute to stigma and delay in seeking formal healthcare services, a pattern widely documented in African settings [7].

Overall, the findings demonstrate that mental health disorders in Samburu East are predominantly common mental health conditions driven by socio-economic stressors, environmental hardship, and cultural interpretations of illness. These interacting factors create a complex mental health burden that requires both medical and community-level interventions.

The study underscores the need for integrated mental health strategies, including early screening, community awareness programs, and strengthening of primary healthcare systems to address the growing burden of mental health disorders in marginalized pastoralist populations.

5.0 Conclusion

This study identified a substantial burden of mental health disorders in Samburu East Sub-County, with stress and depression emerging as the most prevalent conditions, followed by substance use and anxiety disorders. The predominance of common mental health disorders suggests that psychological distress in the community is largely shaped by everyday socio-economic and environmental pressures rather than only severe psychiatric conditions.

The findings indicate that mental health challenges in this pastoralist setting are strongly influenced by interconnected factors, including poverty, unemployment, food insecurity, and recurrent drought. These structural stressors are further compounded by limited access to mental health services, inadequate health infrastructure, and a shortage of trained mental health professionals.

In addition, socio-cultural beliefs significantly influence how mental health is perceived and managed within the community. The attribution of mental health conditions to supernatural causes

such as witchcraft and curses contributes to stigma, delayed care-seeking, and reliance on elders healing systems, which may limit early diagnosis and effective treatment.

Overall, the study highlights that mental health disorders in Samburu East are not only prevalent but also shaped by a complex interaction of social, economic, environmental, and cultural determinants. Addressing this burden requires a comprehensive and integrated response that goes beyond clinical care.

Strengthening mental health services at the primary healthcare level, increasing mental health workforce capacity, and improving community awareness are essential steps toward reducing the treatment gap. Furthermore, culturally sensitive interventions that engage community leaders and elders may enhance acceptance of mental health services and promote early help-seeking behavior.

These findings provide important evidence for policymakers and health planners to prioritize mental health in rural and pastoralist settings, with a focus on equitable access, early detection, and community-based care approaches.

REFERENCES

[1]. World Health Organization. *World mental health report: transforming mental health for all*. Geneva: World Health Organization; 2022. Available from: https://www.who.int/publications/i/item/9789240049338
[2]. Patel V, Saxena S, Lund C, et al. The Lancet Commission on global mental health and sustainable development. *Lancet*. 2018;392(10157):1553–1598. doi:10.1016/S0140-6736(18)31612-X
[3]. World Health Organization. *Mental Health Atlas 2020*. Geneva: World Health Organization; 2021. Available from: https://www.who.int/publications/i/item/9789240036703
[4]. Lund C, De Silva M, Plagerson S, Cooper S, Chisholm D, Das J, et al. Poverty and mental disorders: breaking the cycle in low-income and middle-income countries. *Lancet*. 2011;378(9801):1502–1514. doi:10.1016/S0140-6736(11)60754-X
[5]. Degenhardt L, Charlson F, Ferrari A, Santomauro D, Erskine H, Mantilla-Herrara A, et al. The global burden of disease attributable to alcohol and drug use. *Lancet Psychiatry*. 2019;6(12):987–1012. doi:10.1016/S2215-0366(19)30342-7
[6]. Kohn R, Saxena S, Levav I, Saraceno B. The treatment gap in mental disorders: a review of magnitude, causes, and consequences. *Bull World Health Organ*. 2004;82(11):858–866.
[7]. Ngugi MP, et al. Cultural beliefs and mental health care seeking in African communities: a systematic review. *BMC Psychiatry*. 2021;21:1–12.
[8]. Thornicroft G. *Shunned: Discrimination against people with mental illness*. Oxford: Oxford University Press; 2006.
[9]. Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR, Rahman A. No health without mental health. *Lancet*. 2007;370(9590):859–877. doi:10.1016/S0140-6736(07)61238-0
[10]. World Health Organization. *Investing in mental health: evidence for action*. Geneva: WHO; 2013. Available from: https://www.who.int/publications/i/item/9789241564618