Economic Precariousness, Racialized Gender Inequality, and Child Mental Health Outcomes in Kenya: A systematic Literature Review

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ABSTRACT

Background & research problem: Socioeconomic factors, such as economic precariousness and racialized or ethnicized gender inequalities, have a major impact on children's mental health in Kenya, especially in marginalized communities. Children's mental health challenges are exacerbated by economic instability and structural inequalities, which can result in behavioural disorders, anxiety, and depression. Despite increased awareness of the emerging concerns of mental health among children, barriers such as stigma, financial constraints, and poor infrastructure continue to limit access to care. This systematic review aimed to examine the relationship between child mental health and economic precariousness, evaluate the effect of racial and ethnic gender inequality on mental health outcomes, and investigate barriers to mental health care access.

Results: The findings showed that economic instability causes long-term stress and negative mental health outcomes in children. Furthermore, children from marginalized communities are disproportionately affected by gendered and ethnic disparities, with girls particularly being more affected. Discrimination, limited services in remote locations, and financial challenges are common barriers to accessing mental health care, leading to untreated cases.

Conclusions & recommendations: The study concludes that tackling child mental health issues calls for expanding access to mental health services, promoting equity, and reducing poverty. Enhancing social protection programs, encouraging gender parity through education, and incorporating mental health services into basic healthcare are some of the recommendations by this review. These measures are crucial to enhancing mental health outcomes of children in Kenya.

INTRODUCTION

Racialized gender inequality, economic precariousness, and child mental health outcomes are interrelated global, regional, and Kenyan challenges. In addition to having their roots in socioeconomic structures, these problems are also sustained by structural disparities in opportunity and resource availability (Kirkbride et al, 2024). The rising incidence of mental health disorders in children, especially in underprivileged populations, necessitates a comprehensive enquiry and targeted interventions informed by critical analyses.

Lives of many families across the globe are largely defined by economic precariousness, which is typified by erratic incomes, unstable employment, and limited access to social safety nets. Following the COVID-19 epidemic, economic instability has worsened globally, rendering millions more vulnerable and subjecting them to poverty (Tan et al, 2024). Like many other similar social groups in deprived living environments, women and members of marginalized ethnic groups in Kenya are disproportionately impacted by economic instability, leading to lowered capacity to give their children a socially and mentally secure environment (Onyango & Elliott, 2020). Because they are more vulnerable to the negative effects of poverty, such as food insecurity, poor healthcare, and interrupted education, children who experience this instability often suffer from poor mental health outcomes.

Racialized gender, or gender inequality based on race, compounds the already complex relationship between economic precariousness and child mental health outcomes. Women who belong to marginalized racial and

ethnic groups are faced with the dual burden of being subjected to discrimination on the basis of both gender and race or ethnicity (Showunmi, 2023). This intersectionality can significantly cause restricted access to high quality healthcare, education, and employment prospects. In Kenya, for example, women from marginalized ethnic communities, including pastoralist groups, and those living in rural areas, may be most affected by these inequities (Onyango & Elliott, 2020).

Due to discrimination on the basis of both gender and race, women from marginalized racial and ethnic groups bear a double burden. Because of this intersectionality, people frequently have less access to good healthcare, education, and employment possibilities. These differences are more noticeable for women from marginalized ethnic subgroups, like pastoralist groups, and rural areas in Kenya. As children grow up in surroundings characterized by structural disadvantage and limited support, the cumulative effects of these disparities are likely to be reflected in their mental health and overall well-being (Kirkbride et al, 2024).

Why and How is this A Problem?

The socioeconomic and cultural circumstances in which children are raised have a significant impact on their mental health, but these outcomes can vary from one context to another (Reiss et al, 2019; Olyaeemanesh et al, 2023; Kirkbride et al, 2024). Mental health outcomes in children, including behavioural disorders, depression, and anxiety, are becoming more widely acknowledged as critical public health concerns associated with economic inequalities. However, inadequate infrastructure, stigma, and ignorance impede prompt diagnosis and treatment of mental health issues, depriving many children the assistance they require for overall wellbeing (Mongelli, Georgakopoulos & Pato, 2020). Furthermore, access to mental health services is still very difficult, especially in low- and middle-income economies like Kenya (Rathod et al, 2017; Memiah et al, 2022). The problem could be compounded by gender dynamics, mediated by other crucial social determinants of health such as education access and quality, access to and quality of healthcare, neighbourhood and built environment, and social and community context (Abraham & Walker-Harding, 2022; Kirkbride et al, 2024).

Racialized gender inequality and economic precariousness are enduring issues that disproportionately impact marginalized populations worldwide, with significant effects on the mental health of children. In Kenya, children from marginalized homes are especially susceptible to mental health conditions like anxiety, depression, and behavioural problems due to the country's socioeconomic gaps, which are intricately linked to gender and ethnic inequalities (Memiah et al, 2022).

Even though the value of mental health is becoming more widely acknowledged, little is known about how intersectional inequality and economic instability interact to affect children's mental health outcomes in Kenya. These children's challenges are exacerbated by structural barriers that impede access to mental health care, such as poverty, stigma, and poor infrastructure (Carbonell et al, 2024; Hassler et al, 2024). This knowledge and support gap emphasizes how urgently focused research is needed to guide successful interventions and policy changes.

Although mental health is becoming more widely recognized as a critical public concern, little is known about how economic instability and intersectional inequality affect children's mental health outcomes in Kenya (Kirkbride et al, 2024). In addition, systemic obstacles like poverty, stigma, and inadequate infrastructure make it even more difficult for these children to get mental health care, making their problems worse. This knowledge and support gap highlights the critical need for focused research to guide effective treatments and policy changes.

Research Focus and Objectives

This study attempted to answer the following research questions:

1. How does economic precariousness affect mental health of children in Kenya?

2. To what extent does race or ethnic gender inequality impact mental health of Kenyan children from marginalized communities?

3. What are the likely barriers for the marginalized children in accessing mental health care services, and how do these influence mental health outcomes?

The goal of this research is to understand how the interplay between racialized gender inequality and economic precariousness affects the mental health of children in Kenya. Moreover, the study focused on how structural imbalances and socioeconomic instability can produce an atmosphere that makes children's mental health issues worse, especially in underprivileged social settings. By examining the socioeconomic determinants of child mental health, the study further intended to shed light on how the intersection between poverty, gender, and ethnic disparities influence the psychological wellbeing of children experiencing such dynamics.

Additionally, the study focused on the efficacy, accessibility, and availability of mental health therapies in resolving mental health issues among children from disadvantaged social backgrounds. Given the structural barriers, such as inadequate policy frameworks, limited access to resources, and stigma associated with poverty, there was need for the study to delve into how these can prevent children from accessing adequate mental health care services. By taking a holistic approach, the research hoped to provide insights into the underlying factors that contribute to children's poor mental health outcomes and provide evidence-based suggestions for programmatic and policy changes meant to mitigate these challenges.

Literature Search and Secondary Data Access Techniques

a) Databases and Sources

High-quality data for this analysis was accessed from reputable and reliable academic and professional databases, including PsycINFO, Google scholar, Scopus, PubMed, Taylor & Francis Online, and JSTOR. Other data sources were policy and international reports, such as World Bank, United Nations Children's Fund (UNICEF), World Health Organizations, and Kenya National Bureau of Statistics (KNBS), among others. Furthermore, data was sourced from NGOs' and government agencies' reports on mental health, child welfare, and gender inequality in the Kenyan context.

b) Key Terms, Data Validation and Reliability

A number of key terms and phrases were used to allow comprehensive search, with some of them based on various combinations. For economic precariousness, the terms included poverty, low employment, and economic instability. On racialized gender inequality, some of the key search terms included gender disparity, ethnic inequality, COVID-19, and intersectionality. As a central concept in this analysis, searching relevant literature related to child mental health outcomes involved such terms as anxiety, depression, behavioural disorders, and child mental health. While narrowing down to the specific focus of the study which was the Kenyan context, the word 'Kenya' would be added to the key terms or phrases, such as child mental health in Kenya, socioeconomic disparities in Kenya, among others.

Different strategies were employed to gather valid and reliable data to support a comprehensive analysis of the interplay between economic precariousness and racialized gender inequality, and how they impact child mental health outcomes in Kenya. Priority was given to peer-reviewed journal articles for authenticity, while relevance of the research articles was tested based on their year of publication and content related to the key objectives of the study. For instance, more than 98% of the articles were published between 2020 & 2024, to ensure a reflection of the current trends. Cross-verification of the findings from multiple sources was also necessary to allow consistency and validity. Other validation checks included the authors' qualifications and affiliations to guarantee a high level of expertise, credibility, and scientific rigor involved to produce high quality articles for the purpose of this critical analysis.

c) Analytical Framework and Contextual Data Validation: An Intersectional and Context-Sensitive Approach

In order to enhance methodological rigour, the PROGRESS-Plus framework (place of residence, race/ethnicity, occupation, gender, religion, education, socioeconomic status, social capital, plus age and disability) guided the intersectional analytical lens used in this systematic review. Instead of treating poverty, gender, or ethnicity as distinct variables, using this paradigm during data extraction and synthesis allowed an organized analysis of how racialized/ethnicization gender inequality operates through intersecting social positions. According to Karran et al. (2023), PROGRESS-Plus provides a systematic mechanism for coding and comparing how gender norms, ethnic marginalization, and spatial disparities (such as rural, informal settlements, and arid areas) interact to

influence children's exposure to economic precarity and mental health risks. This approach strengthened internal validity by ensuring that inequities were analytically explicit and consistently assessed across studies.

Additionally, methodological rigour was strengthened by critically evaluating whether primary research used mental health assessment instruments that were validated for Kenyan adolescents rather than relying exclusively on instruments created in the Western context. Research on mental health in Kenya shows that culturally adapted instruments produce more accurate reporting of emotional and behavioural issues among children and teenagers (Nyongesa et al., 2022). As a result, this review acknowledged that failure to contextually validate data could lead to underreporting, incorrect classification, or gender-biased or ethnically-based findings. This step therefore ensured improved this review's conclusions regarding Kenyan children's mental health outcomes in terms of interpretive credibility.

LITERATURE REVIEW

Economic precariousness has been increasing globally, especially in low- and middle-income countries. Characterized by unstable and poor employment environment, low earnings, and limited access to social safeguards, the situation has often left millions of people in strained mental conditions (Koseoglu et al, 2022). The situation was worsened by the COVID-19 pandemic which led to massive job cuts and paralyzed businesses for several people across the world. Economic precariousness has been defined as an intricate phenomenon or multidimensional concept, generally presenting a state of threatening insecurity or risk (Palumbo et al, 2022). Since it can cause food insecurity, income instability, and lack of access to healthcare among other social discomforts, economic insecurity has a substantial negative impact on mental health, particularly in children (van Wijk, de Valk & Liefbroer, 2022).

Intersectionality draws attention to the fact that racial and ethnic marginalization frequently results in heightened disadvantages because of both gender and ethnicity. Racial minority women are disproportionately represented in low-wage, precarious employment worldwide. Their children's mental health is negatively impacted by stress, lower family finances, and a lack of parental support as a result of their limited access to healthcare and education (Golberstein, Wen & Miller, 2020). Studies have further shown that racial and socioeconomic disparities have an impact on mental health conditions in children, including anxiety, depression, and developmental abnormalities (Hoffmann et al, 2022; Leeb et al, 2020). The COVID-19 pandemic in particular made the situation even worse for children's mental health (Lee, 2020). For instance, in the United States, parents and their children faced numerous disruptions in their daily routines as the coronavirus disease pandemic spread throughout, even despite the precautions taken to lessen its effects. While more than 27% of the parents reported worsening mental health for themselves around March 2020, about 15% of their children were reported to be experiencing deteriorating behavioural and mental health (Patrick et al, 2020).

Bai et al (2022) did systematic literature review on the impact of COVID-19 on mental health disorders in children and adolescents in China and noted that the pandemic had a widespread strained influence on young people's mental health in general. Furthermore, there is mounting evidence in the literature that COVID-19 may have detrimental impacts on mental health in both healthy populations and patients. The mental health of people, particularly children and adolescents, is adversely affected by the dramatic changes brought about by COVID19, including social isolation, school closures, and family stress. The situation was among children from communities living in extreme poverty. This review offers insights into the screening methods, preventative strategies, and therapies, as well as summary of the causes, effects, and consequences of the COVID-19 pandemic on children's and adolescents' mental health. The review further recommended that mental health of children and teenagers must be given priority. Additionally, immediate action is required to create a comprehensive and reliable program plan in order to reduce the COVID-19 mental health risks in children and adolescents.

Additionally, research has proven that mental illnesses are stigmatized, which keeps people suffering from such conditions from seeking professional assistance. Racial and ethnic minorities are more affected by stigma compared to the racial/ethnic majorities because the former frequently face additional socioeconomic hardships, such as poverty, and institutional and policy discrimination (Eylem et al, 2020). Then there is the question of gender inequality, with men and women experiencing poverty and mental health-related challenges from rather different perspectives. According to Wanjala (2021), gender inequality is widespread in Africa. However, racialized gender disparity often assumes an ethnic angle, with young girls from different ethnic communities facing different forms of discrimination, vulnerabilities, and mental health stressors.

There are major socioeconomic disadvantages for women, especially those from marginalized ethnic groups. Intrapersonal, interpersonal, institutional, and systemic aspects can organize the distribution of power and resources inequitably across racial, gender, class, sexual orientation, gender expression, and other dimensions of individual and group identity (Banaji, Fiske & Massey, 2021; Shabalala & Campbell, 2023). Such women's children's mental health suffers as a result of the combined burden of gender and ethnic discrimination or disadvantages, which limits their access to resources and makes their household more vulnerable. Another fundamental root cause of mental health inequity, is the unequal allocation of power and resources, including goods, services, and societal attention, which manifest in unequal social, economic, and environmental conditions, also called the social determinants of health (McCartney et al,2021).

Gender Differentials, Adverse Life Experiences, and Child Mental Health in African Context

Child mental health is a serious issue across the world, regardless of markers of social identity such as race, gender, ethnicity, sexual orientation, socioeconomic status, age, religion/religious beliefs, national origin, and emotional, or developmental disabilities and abilities (Town et al, 2021; Kirkbride et al, 2024). In many African countries, children's mental health issues are made worse by the lack of access to mental health services (Hodgkinson et al, 2017; Saade et al, 2023). Negative consequences are caused by a number of factors, including poverty, violence, conflict, and the stigma associated with mental health. Children from underprivileged or ethnically oppressed backgrounds are especially at risk (Aguwa et al, 2022).

In South Africa, Pickstone-Taylo et al (2024) carried out a study on the demographic and mental health profile of the youth in a gender service which featured an African case series. The study was conducted in Cape Town, involving transgender children and adolescents living in poor neighbourhoods and discovered that the participants had unique mental needs, especially informed by their precarious sexual orientation. Furthermore, the findings indicated different dynamics surrounding the socioeconomically disadvantaged youth from a gender perspective. The children involved in the study were bullied primarily because they identified as transgender, or gender-diverse, not exclusively identifying as male or female.

Bullying had become the norm, where this eventually negatively impacted the mental health and general wellbeing of transgender and gender-diverse children and adolescents. Although majority of the parents were helpful, Pickstone-Taylo et al (2024) noted that 90% of the parents specifically relied on gender-affirmative initiatives through which to encourage their children to cope with their mental health issues. These views were a reflection of Nahata et al (2017) who noted that many transgender and gender-diverse children and adolescents had limited access to adequate care against the backdrop of little or no health insurance. When health insurance prevents a marginalized group of young people from accessing healthcare, they are more likely to engage in self-harming behaviours, be stigmatized, and be victimized. Such a situation can easily aggravate their mental health issues.

In the Sub-Saharan African region where several individuals and households are exposed to more unfavourable social conditions, it is almost inevitable that these people will be more vulnerable to mental health issues over their life course (Kirkbride et al, 2024). There is also empirical evidence that many households in Sub-Saharan Africa depend on informal employment, leading to pervasive economic instability. High unemployment and poverty rates exacerbate home stress and insecurity, which affects children's mental health. Studies show that children from low-income families or members of marginalized racial and ethnic groups are more likely to experience mental health problems as a result of institutional barriers to mental health care and education (Hodgkinson et al, 2017; Eylem et al,2020). Economic instability frequently results in child labour and school dropouts, creating generational poverty and mental healthcare deprivation.

In Ghana, Adjorlolo, Anum and Huang (2022) did a general analysis on the adverse life experiences and mental health of adolescents and noted that many adolescents living in Sub-Saharan, and Ghana in particular, are increasingly exposed to adverse life experiences that threaten their mental health. The study looked at the prevalence of negative life experiences, mental health outcomes, and the relationship between negative life experiences and mental health outcomes among school-going teenagers in Ghana, West Africa. The findings showed that compared to boys, girls report more mental health issues. However, the incidence of negative life experiences was similar for both sexes, with the exception of substance abuse and trauma, which were more common among boys. Adverse life experiences had a generally gender-neutral impact on mental health outcomes. For both boys and girls, substance abuse, experiences of victimization, and stress at school are strong

predictors of depressive symptoms. Interventions targeting the adverse life experiences of adolescents would significantly help improve the mental health of boys and girls.

Research has further shown that socially constructed distinctions in status, power, and roles and obligations between men and women, girls and boys, influence how people seek mental health care services, how the health sector responds to these disparities, and how society at large reacts (Tabassum & Nayak, 2021). The utilization of mental health care varies by gender, with female patients consulting mental health experts more frequently than their male counterparts. While gender disparities are more pronounced when it comes to general care, they become less pronounced in specialist or residential care. Lack of need cannot account for the difference in how men and women use mental health services. Rather, this disparity may be informed by behavioural differences between the two genders.

According to Tabassum and Nayak (2021), compared to boys, adolescent girls are far more likely to experience eating disorders, depression, and suicide thoughts and attempts. Furthermore, as opposed to girls, teenage boys are more prone to experience anger management problems, participate in risky behaviours, and commit suicide. While teenage boys are more likely to act out, teenage girls are more likely to experience inward-directed symptoms. As the adolescents move into adulthood phase, substance use disorders and antisocial behaviours are more common in men, whereas depression and anxiety are far more common in women (Colizzi, Lasalvia & Ruggeri, 2020). Additionally, because of biological and genetic characteristics, women are more likely to suffer from anxiety and depression.

Studies have also found out that mood swings are linked to hormonal changes during the menstrual cycle for girls (Ojezele et al, 2022; Handy et al, 2022). The interplay of psychosocial and hormonal factors results in an increased risk of prenatal and postnatal depression, particularly presenting significant risks to teenage mothers. Women may also face significant psychological anguish and disorders as a result of reproductive health issues. Infertility and hysterectomy have been linked to an increased risk of affective or neurotic disorders in women.

In Uganda, Bukenya et al (2022) explored factors contributing to depression, anxiety, suicide risk, and Post-Traumatic Stress Disorder (PTSD) among Ugandan youth (13-25 years) attending vocational training. Both urban and rural young people were involved in the study. The findings noted that almost 50% of the young people said they had moderate to severe anxiety and/or depression. Furthermore, over half of them said they were impaired by anxiety and depression. Almost 25% of the youth thought about or tried suicide. On the PTSD screen, almost half showed favourable results. Food insecurity (56.9%), trafficking (37.9%), severe depression (35.9%), depression-related impairment (56.9%), severe anxiety (26.1%), and anxiety-related impairment (55.6%) were reported among rural female youth. The results further showed that Ugandan youth experienced very high rates of anxiety, depression, suicide risk, and likely PTSD. Young women in rural areas may be particularly vulnerable. It was recommended that youth in vocational training centers require appropriate mental health treatment interventions that can be tailored to their needs. Clearly, this study established that there is a relationship between mental health and poverty levels, hence projecting the youth from rural areas as experiencing higher symptoms of mental health issues compared to those living in urban areas. However, the research fell short of showing how the male students performed vis-a-vis their female counterparts.

In Kenya, Mbithi et al (2023) explored mental health and psychological well-being of Kenyan adolescents from Nairobi and the Coast regions in the context of COVID-19. Child and adolescent psychiatry and mental health. The study used a cross-section survey method to interview adolescents in the ages of 13-19 years from Nairobi, the Coastal regions of Kenya and employed standardized psychological assessment tools for data collection. The study generally noted that despite the high prevalence of adolescent mental health issues and related detrimental effects, these issues have not been well addressed, particularly in sub-Saharan Africa. Additionally, the COVID19 pandemic has put more strain on the mental health of adolescents even today.

In particular, Mbithi et al. (2023) discovered that school-going adolescents had a comparatively lower prevalence of depression (20.6%) than out-of-school adolescents (36.0%). Additionally, adolescents who were not enrolled in school scored far higher on anxiety tests than their peers who were enrolled in school, at 27.7% against. 19.1%, respectively. Compared to their out-of-school peers, adolescents who attended school reported higher quality of life, reduced pandemic anxiety, and fewer emotional and behavioural issues. Living in a risky environment, loneliness, and not attending school are important risk factors for depression. Anxiety was significantly correlated with being older, not attending school, and being in an unsafe environment. High socioeconomic

status, frequent communication with friends, and proximity to parents are also important factors that have a favourable correlation with quality of life. However, this study did not factor in the aspect of gender.

Osok et al. (2018) conducted a cross-sectional study in Kenya, examining the prevalence of depression and associated psychosocial risk factors among pregnant adolescents receiving care at a post and antenatal clinic in Nairobi, Kenya. The study included 176 pregnant teenagers (15–18 years old) who attended the prenatal clinic at Kangemi Primary Healthcare Health Facility. PHQ-9 was utilized to measure the prevalence of depression by utilizing the independent predictors of depression from the psychosocial components that were found to be strongly linked to depression. The findings showed that 32.9% of the 176 participants had positive results for depression. The greatest variation in the caregiver load was attributed to having gone through a stressful life event. This was followed by being young, HIV/AIDS positive, and not having social support for the pregnant teenagers. It was further noted that depression is prevalent among economically-deprived pregnant teenagers in Kenya's poor urban areas. Being young and having HIV were serious risk factors for the adolescent pregnant women. Interventions are required to prevent or mitigate depression in this demographic, with a focus on those who are most stressed. Despite these insightful findings, focusing only on one gender may have rendered the results biased.

Another recent research in Kenya was done by Pinchoff et al (2021) on how COVID-19-related income loss and household stress affected adolescent mental health. Participants in a cross-sectional mobile phone survey were teenagers (10–19 years old) from three urban counties in Kenya of Nairobi, Kilifi, and Kisumu. They were asked about physical and mental health, education, and the effects of COVID-19 on food insecurity, job loss, and healthcare seeking medical. The results showed that more than a third (36%) of teenagers had depressive symptoms, with older boys (15–19 years old) reporting the most. Depressive symptoms, domestic conflicts and aggression, skipping meals, and neglecting medical care were all linked to adult wage pr income loss.

Pinchoff et al (2021) further showed that the odds of adolescents experiencing depressed symptoms were almost 3 times higher if their adult household head reported having depression symptoms and if COVID-19 was causing them to miss meals. It was concluded that food insecurity, household dynamics, healthcare-seeking behaviour, and deteriorating teenage depressive symptoms were all negatively impacted by income loss during the epidemic. The study recommended explicitly addressing adolescent mental health, possibly through community-based psychosocial programming, school-based psychosocial programs, or cash transfers. Despite reliable results by this research, comparing findings of different previous studies through the current critical analysis has greater potentials to address existing knowledge gaps on the subject of economic precariousness and child mental health care.

Social Constructionism and Gendered Child Mental Health-Seeking Behaviour

While poverty and economic precariousness have generally been associated with health seeking behaviour among men and women or boys and girls living in disadvantaged social environments, there are social and cultural factors that must also be explored. Social constructionism posits that people's perceptions of the world, including ideas about health and illness, are shaped by cultural norms, values, and beliefs. Attributed to sociologists Peter L. Berger and Thomas Luckmann, where the concept was introduced in their powerful book *"The Social Construction of Reality: A Treatise in the Sociology of Knowledge"* in 1966, social constructionist perspective emphasizes gender roles and expectations in influencing mental health-seeking behaviour (Stănciulescu, 2024). Social norms often place different demands on boys and girls in terms of coping strategies and emotional expression.

Related to mental health-seeking behaviour, social constructionism highlights the way cultural and societal norms impact how boys and girls view and react to mental health issues (van Riel, 2016). According to traditional gender norms, men are typically expected to be strong, self-reliant, and emotionally stoic, while women are meant to be expressive and nurturing. Because getting treatment for mental health issues may be interpreted as a sign of weakness or failure, these stereotypes can deter men or boys from seeking help lest they betray their masculinity (McKenzie et al, 2022). However, emotional expressiveness and relational support associated with femininity may encourage girls to discuss their emotions and ask for support from family, friends, peers. or experts. Notably, certain cultural expectations for girls, such as attractiveness or appearance, behaviour, and caregiving responsibilities, can increase girls' susceptibility to mental health issues like anxiety and depression (Stănciulescu, 2024).

According to Subu et al (2021), people with mental health issues may experience prejudice and discrimination because mental illness is often stigmatized. Men are more susceptible to this stigma, for fear of being viewed or labeled as mad or mentally incapable of performing their 'manly' responsibilities. This has forced some men to opt for informal mental health coping mechanisms, such as exercising, indulging in excessive taking of alcohol for escapism, or completely avoiding talking about emotional issues. But, while girls are more likely to seek out mental health care from both official (therapists and counselors) and informal (friends and family) sources, stigma can still be a big barrier for them. This may especially be the case in cultures where mental health problems are seen as a weakness that affects people of all genders (McKenzie et al, 2022).

Stănciulescu (2024) further observed that boys are trained to value independence and self-sufficiency, which makes them less likely to admit when they have mental health issues or ask for assistance. Girls are more likely to seek treatment because they are trained to value relationships and emotional transparency. Yet, they may also be more stressed and subjected to emotional anguish. The way mental illness is diagnosed and treated can differ depending on the symptoms that men and women exhibit. For instance, internalizing behaviours like anxiety and depression are more common in women, whereas externalizing behaviours like aggression and substance abuse are more common in men, especially adolescents.

FINDINGS AND DISCUSSION

This analysis intended to address three specific objectives, which also triggered related pertinent research questions.

Effect of Economic Precariousness on Child Mental Health

Economic precariousness, which is defined by poverty, unstable income, and limited access to basic essentials, has a major effect on Kenyan children's mental health. Studies indicate that children from low-income families are more likely to experience behavioural, emotional, depression, and anxiety problems (Hodgkinson et al, 2017; Kirkbride et al, 2024). Families experiencing economic instability frequently experience chronic stress, which can create emotionally harmful conditions for children over time. Furthermore, children from these households are more likely to face food insecurity, substandard housing, and poor access to healthcare and education, with all of these emerging as critical factors that determine mental health.

Economic precariousness causes stress that impacts children and their caregivers, frequently resulting in strained parent-child relationships or interactions. Financially stressed parents tend to find it difficult to offer emotional support to their children, which exacerbates mental health problems in children. Furthermore, families are frequently unable to seek professional mental health care due to strained or lack of financial resources, which can lead to the children's mental health issues unaddressed. Improving the mental health outcomes of children requires addressing economic issues through social safety nets, community support programs, and focused poverty alleviation projects. Yet, all these can prove untenable, especially in communities which have experienced generational poverty and limited employment opportunities over the years (Colizzi et al, 2020).

Table 1: Effect of Economic Precariousness on Child Mental Health in Kenya

Dimension of Economic Precariousness	Key Findings / Statistics	Source(s)
Household Poverty	Compared to children from wealthier homes, children from poor households exhibit noticeably greater levels of emotional distress, anxiety, and depressive symptoms	APHRC (2022); KNBS (2023)
Food Insecurity	Children and adolescents who live in food-insecure households are more likely to experience stress, behavioural problems, and poor psychological health.	KNBS & UNICEF (2023); WHO (2023)

Out-of-Pocket Health Costs	Less than 12% of adolescents with mental health needs receive any formal care due to financial hurdles, which disproportionately impacts low-income households.	APHRC (2022); MoH (2024)
Parental Unemployment & Informal Work	Harsh parenting practices, increased family stress, and poorer outcomes for children's mental health are all associated with parental job uncertainty and informal income sources.	KNBS (2023); UNICEF (2024)
Urban Informal Settlements	Children who live in informal settlements are more likely to experience economic pressures, violence, and overcrowding, with all these linked to increased psychological distress.	APHRC (2022); WHO (2024)

Tabulated Data Sources: (KNBS & UNICEF, 2023; MoH, 2024, APHRC, 2022; UNESCO, 2024)

Evidence from the summarized tabulated findings indicates that economic precariousness, which manifests through poverty, food insecurity, and financial barriers to care, is a major driver of children's mental health in Kenya. Children from low-income and informal-settlement households are more likely to experience psychological distress. Similarly, such children have significantly limited access to mental health care, which perpetuates vulnerability cycles. These findings demonstrate the need for integrated economic and mental health measures, such as social safety nets and financial protection, to mitigate mental health risks among marginalized children.

Impact of Ethnic and Racial Gender Inequality on Child Mental Health

In Kenya, gender disparity based on race and ethnicity has a major impact on children's mental health, especially for those from underprivileged backgrounds. According to the Kenya Institute for Public Policy Research and Analysis (KIPPRA) (2024), majority of girls from these groups have less access to social, healthcare, and education opportunities due to the dual burden of discrimination on the basis of both gender and ethnicity. Lower self-esteem and increased stress and anxiety are common outcomes of this complex phenomenon. Despite enjoying the benefits of male privilege, boys also tend to experience social pressure to adhere to rigid gender norms, which can result in suppressed emotional expression and untreated mental health conditions (Memiah et al, 2022; Abraham & Walker-Harding, 2022).

The kind of support that children receive in marginalized communities is often determined by established gender roles. Boys may experience societal pressure to suppress vulnerability, which results in internalized stress. Furthermore, girls may be subjected to early marriage or gender-based violence, which has a serious negative impact on their mental health (Burgess et al, 2022). These issues are exacerbated by the intersection between gender inequality and ethnic prejudice, with structural impediments and systemic barriers denying children equal access to mental health care resources. Addressing these imbalances may require targeted interventions that emphasize advancing of gender equity and offering culturally sensitive mental health services.

Table 2: Summary of Impact of Ethnic and Racial Gender Inequality on Child Mental Health in Kenya

Dimension of Inequality	Key Findings / Statistics	Source(s)
Ethnic Marginalization & Place	Adolescents from historically marginalized areas/communities report significantly higher psychological distress and lower mental health services access compared to urban peers, e.g. in ASAL	KNBS & UNICEF (2023); MoH (2024)
Gender Disparities	Girls report higher rates of depressive symptoms and anxiety compared to boys, partly linked to gender norms, early caregiving roles, and exposure to gender-based violence.	APHRC (2022)
Ethnicity × Gender Intersection	Girls from minority ethnic groups face compounded risk due to cultural norms limiting mobility, voice, and health-seeking autonomy, leading to delayed or foregone mental health care.	MoH (2024)

School-Based Discrimination & Bullying	Ethnic bullying and gender-based discrimination in schools are associated with increased emotional distress, absenteeism, and reduced help-seeking among affected children.	APHRC (2022); UNESCO. (2024)
Stigma and Social Norms	Mental health stigma is stronger in some ethnic communities and is more restrictive for girls, discouraging disclosure and formal service utilization.	KNAMHS (APHRC, 2022)

Tabulated Data Sources: (KNBS & UNICEF, 2023; MoH, 2024, APHRC, 2022; UNESCO, 2024)

Summary of evidence in table 2 suggests that rather than acting as separate determinants, gender inequality and ethnic marginalization interact to increase mental health risks among Kenyan children. Due to interrelated issues such poverty, stigma, discrimination in schools and communities, and rigid gender norms, girls from minority ethnic communities face disproportionate psychological distress and limited access to care. These findings highlight the importance of intersectional, equity-focused mental health therapies that concurrently target ethnic and gender inequities.

Barriers to Mental Health Care and Service Access for Marginalized Children

In Kenya, like in many other countries in Sub-Saharan Africa, stigma, ignorance, limited mental health infrastructure, and financial constraints are some of the barriers that prevent marginalized children from accessing mental health care (Carbonell et al, 2024). In rural and marginalized communities, mental health stigma is still widespread, where seeking mental health care is sometimes viewed as a sign of failure or weakness. Furthermore, there is a serious shortage of mental health specialists, with a greater percentage of those available concentrated in urban areas where they are not easily accessible to severely underprivileged rural communities. Access is further restricted by financial limitations, since many marginalized rural families cannot afford the accompanying transportation expenses or the cost of mental health care (Burgess et al, 2022).

Children from marginalized communities are disproportionately affected by lack of easily accessible and affordable mental health services, which can result to poorly managed or in untreated mental health disorders (Kirkbride et al, 2024). Hodgkinson et al (2017) further observed that early indicators of distress can be typically overlooked or go unnoticed due to lack of school-based mental health programs for children to be taught and sensitized on how to manage their mental health. The stigma associated with mental health sometimes discourages families from seeking help and treatment for psychological problems. In order to overcome these obstacles, studies have recommended investments in developing mental health infrastructure, especially in rural regions, and to launch awareness efforts that combat stigma (Mongelli et al, 2020; Colizzi et al, 2020). Access and outcomes can also be enhanced by community-based interventions, such as training educators and community health workers and incorporating mental health services into primary health care systems.

Critical insights into structural impediments affecting children's mental health, which are often underrepresented in peer-reviewed studies, are provided by grey literature from Kenyan government agencies and nongovernmental organizations. According to recent reports from the Kenya Ministry of Health (MoH) and the Kenya National Bureau of Statistics (KNBS), there is persistent shortage of mental health specialists for children and adolescents, especially in economically disadvantaged and arid and semi-arid areas. Despite the rollout of the National Suicide Prevention Strategic Plan (2021–2026), and the Kenya Mental Health Action Plan, there are still significant implementation gaps, especially at the county level. Inadequate funding, weak referral systems, and continued concentration of services in urban areas at the expense of rural areas or devolved governance institutions still remain a big challenge (MoH, 2024; KNBS, 2025). Children from low-income households are disproportionately affected by these structural limitations, since they are more vulnerable to economic precarity, school dropout, and exposure to household stressors where they lack adequate psychosocial support.

According to recent population-based research, only a small percentage of teenagers with serious mental health needs receive care and treatment. In their recent review of the *National Adolescent Mental Health Survey* data, Wahdi et al (2025) reported that less than 12% of Kenyan adolescents with mental disorders accessed counseling or support services in the previous year. This implies that more than 85% of these adolescents did not seek or

receive formal assistance despite their obvious need. Further statistics by the Kenya Ministry of Health (2021) shows that less than 13% of Kenya's health facilities provide mental health services, and the majority of specialized care is still concentrated in urban referral hospitals. This severely limited mental health infrastructure nationwide exacerbates this service gap, making access especially challenging for children from low-income rural households who already face greater burdens of poverty and multidimensional deprivation.

Reports by NGO and international agencies further highlight the intersection of racialized gender inequality with service access barriers. Recent community-based assessments carried out in rural Kenyan counties by organizations such as the World Health Organization, and the Kenya Adolescent Mental Health Group document the uneven uptake of "task-sharing" mental health interventions rural communities (WHO, 2024; Kenya Adolescent Mental Health Group, 2023). This is where cultural stigma, gendered caregiving responsibilities, and ethnic marginalization limit service utilization among children and adolescents.

Table 3: Summary of Barriers to Mental Health Care and Service Access for Marginalized Children in Kenya

Barrier Type	Key Statistics / Findings	Source(s)
Low Service Utilization	About only 8.7% of Kenyan adolescents accessed any mental health support or counselling in the past 12 months; most (34.2%) sought help from religious/faith leaders rather than medical specialists.	Kenya National Adolescent Mental Health Survey (KNAMHS) found <10% service use.
Unmet Need for Care	Among adolescents with a mental disorder, roughly 11.9% received services; over 85% did not get support at all.	National Adolescent Mental Health Surveys across multiple LMICs including Kenya.
Workforce Shortage	Kenya has very few specialists, about 54 psychiatrists & 418 psychiatric nurses for >50 million Kenyans, with even fewer child/adolescent specialists.	WHO / Kenyan health workforce data.
Stigma and Literacy Issues	Many families prefer tackling mental health concerns themselves; lack of mental health literacy and stigma noted as main barriers among caregivers.	**FINDINGS** from K-NAMHS and health systems research.
Cost and Accessibility	Many people were deterred from seeking formal care by high costs of consultation and medicine; transportation costs and the distance to institutions continue to be significant barriers.	Study at Mathari National Teaching and Referral Hospital by Victor et al (2022).

Tabulated Data Sources: (Wahdi et al, 2025; Marangu et al, 2014, Kenya Adolescent Mental Health Group. 2023; Victor et al, 2022; APHRC, 2022)

According to the statistics in table 3, very few Kenyan children and adolescents who require mental health care, especially formal clinical care, actually receive it. For instance, research by the African Population and Health Research Center (APHRC) revealed that less than 10% of teenagers said they had used any mental health services in the previous year. At the same time, most of them opted to turn to religious or community leaders for assistance rather than from qualified medical experts (APHRC, 2022).

The severe shortage of mental health experts is a critical structural barrier. Specialized care for children and adolescents is often unavailable outside of major urban centers due to the country's small number of psychiatrists and psychiatric nurses (Marangu et al, 2014). This labour constraint compounds financial and geographic barriers, where high costs for clinic visits, medicines, and transport make formal services less affordable for families in poorer, remote locations (Victor et al, 2022). The findings in the table further demonstrate that help-seeking is further hampered by stigma and low mental health literacy. The importance of community education and culturally sensitive outreach is highlighted by the fact that many primary caregivers either prefer to handle

issues within the family level or are unsure of where to seek assistance (APHRC, 2022). Collectively, these findings show how social barriers, poor service infrastructure, and economic exclusion intersect to restrict marginalized children's access to mental health care. This highlights the need for targeted investment in child-friendly, community-based mental health services as well as policy actions.

CONCLUSION

Economic precariousness is a significant contributing factor to children's poor mental health outcomes in Kenya. Because of the instability and deprivation that come with poverty, children from low-income households are more prone to suffer from chronic stress, anxiety, and depression. These mental health issues are worsened by limited access to basic necessities like food, healthcare, and education. In order to mitigate the negative impacts of economic instability on children's mental health, it is imperative that poverty alleviation initiatives and social safety nets are implemented.

Mental health of children from marginalized communities are disproportionately affected by racial and ethnic gender disparity, where girls are particularly faced with poverty-gender compounded challenges. Systemic discrimination and gendered expectations lead to increased psychological suffering, including anxiety, low self-esteem, and trauma from events like early marriage or gender-based abuse. Social pressure to adhere to strict masculine standards prevents boys from expressing their emotions or promptly asking for help. In order to address these disparities, comprehensive policies that promote gender and ethnic equity are needed. Additionally, there is need for culturally sensitive mental health interventions that address the special needs of underprivileged children.

Financial limitations, stigma, and inadequate mental health infrastructure and resources are some of the barriers that keep marginalized children from receiving the mental health care they need. Many children in rural and marginalized communities lack timely and sufficient help due to pervasive social stigma and the concentration of mental health services in urban areas. These obstacles result in untreated mental health issues, which may adversely or negatively impact the children’s growth and general wellbeing over their life course. In order to overcome these obstacles, there is need to implement community-based mental health services, expand mental health infrastructure, and deal with stigma through awareness campaigns and initiatives.

The findings demonstrate the intricate interplay between economic precariousness, gender and ethnic disparities, and barriers to mental health care in influencing children's mental health outcomes in Kenya. A multifaceted strategy for addressing these issues will be imperative, including poverty alleviation, promoting gender and ethnic parity, and enhancing availability of affordable, and culturally-sensitive mental health care services. The findings further underscore the pressing need for comprehensive approaches to address structural and socioeconomic determinants of children's mental health in Kenya. Policymakers and key stakeholders may foster a more conducive atmosphere for children's mental and emotional health by addressing economic precariousness, advancing equity, and enhancing access to mental health care services.

RECOMMENDATIONS

Based on the findings and conclusions, it is imperative to employ an integrated approach to focus on the structural and socioeconomic factors influencing children's mental health in Kenya. Targeting disadvantaged households, the government and stakeholders should improve social protection programs including food security initiatives and cash transfers to mitigate the effects of economic precariousness. Policies that support gender equity and inclusivity are necessary to address racial and ethnic gender disparity. These policies may include empowering underprivileged girls through education and putting in place community-based initiatives to challenge punitive gender norms, to both boys and girls. Tailored programs and initiatives should also be instituted for the boychild to avoid skewed empowerment of girls alone.

To remove barriers to accessing mental health care, mental health services should be decentralized and integrated into primary healthcare systems, with an emphasis on rural and underserved communities. Campaigns to reduce and mitigate stigma will be important to enhance mental health education in communities and schools to also motivate children and their caregivers to seek intervention. Together, these initiatives can help establish a supportive environment that improves mental wellbeing of children in Kenya.

This systematic review highlights task-sharing as one of the most practical and scalable approaches to bridging the gaps in child and adolescent mental health care in Kenya. Training non-specialists, such as community health volunteers (CHVs), teachers, and lay counselors, can greatly increase access to basic psychosocial support in resource-scarce environments while reducing the stigma associated with specialist-led services.

Similarly, new policy and practice trends highlight the need to incorporate Kenyan adolescents lived experiences into research and service design, especially through peer-led interventions and adolescent-friendly spaces aligned with local social realities. Incorporating youth perspectives enhances cultural relevance and service uptake while addressing stigma and gendered barriers that prevent marginalized groups from seeking assistance. This strengthens the policy relevance and translational impact of future reviews and primary studies.

Implications for Policy and Practice

This review emphasizes the need for mental health parity within Kenya's Universal Health Coverage (UHC) benefit package in order to ensure that protection extends beyond clinical availability to affordability of services. It also recommends integrating mental health literacy into the school curriculum as a preventative measure to address stigma, ethnic bullying, and gender-based discrimination at an early age. This would position education as an affordable, population-level mental health intervention, aligned with Kenya's present and future socioeconomic policy objectives, goals, and priorities.

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