A qualitative exploration of participants' preferred elements of the 4-week, youth-led, youth-focused, group-based Shamiri intervention: A brief overview

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Abstract

Introduction: *Adolescent mental health challenges have been identified as a public health concern globally, especially in low- and middle-income countries (LMICs), due to the scarcity of services, where help-seeking is often hampered by social stigma. A strategy to increase the availability of services is to implement, brief, stigma-free, and scalable interventions. The Shamiri Intervention (the Kiswahili word for "thrive") is an example of a 4-week, group-based intervention which is implemented via 1-hour sessions within high school settings.*

Purpose*: The present study employed qualitative methods to explore participant feedback on their preferred elements of Shamiri Intervention. The aim is to use the feedback to help to guide and improve intervention effectiveness, acceptability, and appropriateness. The results have the potential to understand better lay-provided mental health service delivery and design among high school students in LMICs, particularly in sub-Saharan Africa.*

Methodology*: The project employed a qualitative phenomenological design to collect participant feedback, and reflective thematic analysis was used to analyze the data.*

Results*: The researchers constructed the following themes to summarize the participants' responses: learning (acquiring new knowledge related to the core components of the Shamiri Intervention, i.e., growth mindset, values affirmation, and gratitude); rewards (e.g., prizes award that encouraged participation); positive interaction (i.e., the peer-lead delivery); and solutions-oriented (e.g., the practicality of the Shamiri Intervention).*

Conclusion*: The preferred components of the Shamiri Intervention were learning, rewards for participation, positive interactions with other people, and the solution-oriented nature of the sessions. The mentioning of the features of the Shamiri Intervention could also suggest that, indeed, they are appropriate for the target population. Additionally, the support for the lay providers is critical in Shamiri intervention cost-effectiveness, accessibility, and scalability.*

Keywords

Mental Health, Kenya, Youth-Friendly, Intervention

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Introduction

Mental health challenges, such as depression and anxiety, among adolescents aged 15 to 19 years have been identified as a global public health concern globally (World Health Organization [WHO], 2017). An even bigger burden is experienced in low and middle-income countries (LMICs) such as Sub-Saharan Africa (SSA) (Vigo, Thornicroft & Alun, 2016), where mental health services are scarce, require expertise and are often lengthy and expensive services (Weiz et al., 2017). The need to seek and provide mental health services is also highly hampered by social stigma (Ndetei et al., 2016), which can be fueled by the fact that traditional mental health care services focus on addressing mental illness.

Among the key proposed ways to deal with mental health challenges burden, especially in SSA, lies in formulating and embracing simple, brief, stigma-free, and scalable interventions (Yotham et al., 2018), which focus on specific psychological processes, offers a key strategy to embrace the scarcity of mental health services. Such programs include the Shamiri Intervention (the Kiswahili word for "thrive"). This character strength intervention anchored on "wise" interventions that seek to change behavior by targeting specific psychological processes for better and improved life outcomes (Walton & Wilson, 2018). The Shamiri intervention is implemented via 4-week, group-based, 1-hour sessions within high school settings. Recent high school graduates aged 18 to 22 are recruited and trained for at least 10 hours to effectively deliver Shamiri Intervention to the students.

Previous research studies indicate that the Shamiri intervention positively impact high school students, such as reducing depression and anxiety symptoms and improving their academic performance and interpersonal relationships (Osborn et al., 2021). The highlighted impact was successfully measured and evaluated by analyzing data from three gold-standard RCTs (Venturo-Conerly et al., 2021). However, the self-reported qualitative data on the program feedback provides insight into the participants' views, thoughts, and feelings about the Shamiri program remains largely unexplored. Thus, this paper explores participants' program feedback on what elements of the Shamiri program students preferred. This will help to guide and improve intervention effectiveness, acceptability, and appropriateness based on the thoughts and feelings of high school adolescents who are the program's target population.

Purpose

The present study employed qualitative methods to explore participant feedback on their preferred elements of Shamiri Intervention. These results are a first step to helping inform and improve the development and implementation of the Shamiri intervention. Further, the results also have the potential to better understand lay-provided mental health service delivery and design among high school students. They can help address the care burden and treatment gap for youth-mental health in SSA.

Methodology

Sample

We used convenience sampling/purposive to target a sample of 413 high-school students (13-18 years) with elevated levels of depression and anxiety as measured by GAD-7 and PHQ-8 to participate in the Shamiri intervention. [For more information on the sample, see Osborn et al. (2021)]. The students were selected from four high schools within Nairobi and Kiambu counties in Kenya. Parental consent was sought for the minors, and written assent was before the students participated in the study. The students were also informed of their right to withdraw from their studies.

Eligibility criteria

To participate in the study, participants were required to meet the following inclusion criteria; aged between 13-18 years old, enrolled in the 4-week Shamiri intervention programs, and able to read the questionnaire and give responses in the English language and have elevated levels of depression and anxiety.

Design

To gather qualitative information, the study adopted a phenomenological qualitative design (Moustakas, 1994). In the study, the students described what they thought or felt was their favorite about the Shamiri 4-week program (post-treatment). To understand their experiences, the data collected was analyzed in a structured way, and the authors developed themes to highlight the essence of students' experiences.

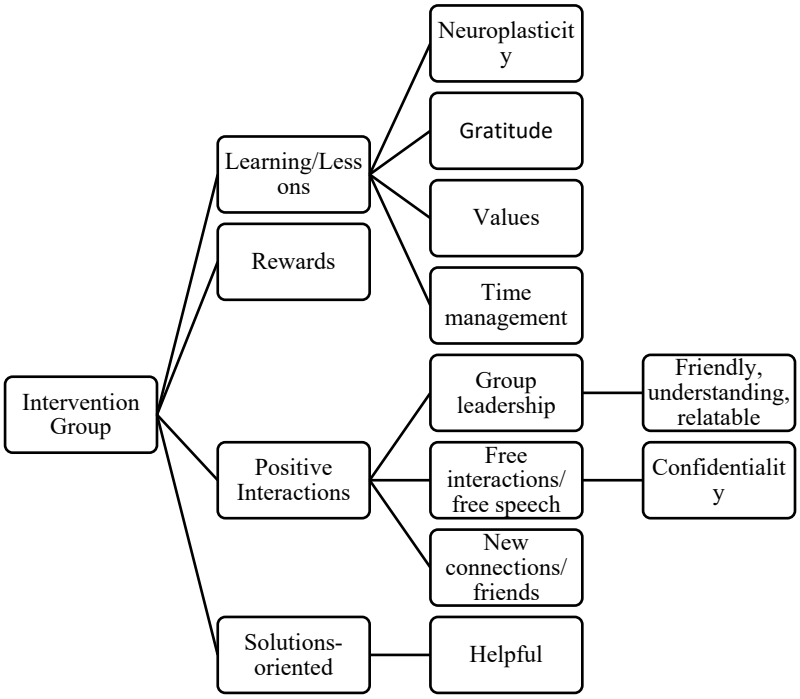
Analysis

The authors employed the six stages of Reflective Thematic Analysis by Braun & Clark (2006; 2019) to analyze the qualitative data. These include familiarization, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and the write-up. The reliability analysis was also conducted to ensure reliable and consistent theme consensus. Two Kappa scores were measured between three coders on two different data sections, at 0.8 and 0.6, indicating good inter-rater reliability.

Further, Lincoln and Guba's (1985) criteria and Creswell's (2018) methods helped guide the reliability and validity of the findings. To achieve

credibility and confirmability, the authors used multiple coders. The large sample size and data saturation supported transferability. The dependability of the results was ensured by a rigorous and detailed thematic analysis process, which is summarized in a thematic map (See Figure 1). Quotes were also reported verbatim to ensure data-driven results. The themes were generated by a multi-cultural group of researchers, each with different experiences and expertise; they met on several occasions to discuss the findings and support ongoing reflexivity.

Figure 1. Thematic Map



Results

The researchers constructed the following themes to summarize the participants' responses. The key themes include learning, rewards, positive interaction, and solutions-oriented.

Learning

Learning themes involved responses directly related to acquiring new knowledge. Several participants endorsed the central components of the Shamiri Intervention, which include Neuroplasticity (growth mindset), Gratitude, and Values. The components of the intervention each made up a sub-theme for this category:

Neuroplasticity

Neuroplasticity (growth mindset) refers to the fact that the human brain can grow, improve, and perform better. Neuroplasticity indicates that humans can learn new things and improve through effort and practice. When people are open to growth, they are not comfortable in one zone; they challenge themselves and see growth opportunities even during difficult situations.

"The study of growth mindset because I grew really." Participant 704

"I was able to learn how the brain works and if you want to you can change things which cannot help you at all." Participant 1592

Gratitude

Gratitude involves embracing feelings of appreciation. Gratitude is not ignoring what we already have, what we are good at, but being thankful for appreciating what we have, being thankful for what we are good at. When embraced, gratitude can improve how a person feels and treats others.

"The fact that there are many things to be grateful for and also that we should not be discouraged but work hard in anything that we do." Participant 1381

Values

Values refer to key ideas that people hold important in their lives. Values guide people in making their decisions, during interactions with other people, as well as achieving important goals in their lives.

"It made me discover that my brain is rapidly growing over time and my attitude determines its nature." Participant 292

Rewards

Rewards encompassed responses related to the prizes awarded to the participants to

encourage more participation and engagement throughout the Shamiri Intervention program. A few students commented that this was their favorite part of the intervention. However, the rewards are not a component of the Shamiri intervention, but a supporting element used to encourage session attendance.

"The part where I won a shirt." Participant 4305

Positive interactions

Positive interactions highlighted the participants' acknowledgement of the group leaders and the peer-led delivery nature of the Shamiri intervention. Several participants commented on the support they received from the group leaders that delivered the intervention. Shamiri intervention is lay-provided, and the lay providers are young people who have recently graduated from high schools, an aspect that allows them to relate well with the participants. The positive interaction's theme was further divided into the following sub-themes,

Peer Group Leadership

Peer Group Leadership involved special acknowledgement to the Shamiri Institute leaders.

"The group leaders were understanding, and they made one to understand everything." Participant 224

"The fact that the trainers are really understanding and can relate to our experiences." Participant 449

"We would get to share ideas as a group about something which helped so much." Participant 801

"The program has really helped me to realize that if I try hard, I will achieve what I am after." Participant 2067

Free Speech

Free Speech some participants specified the importance of having a confidential, safe space to share their experiences without fear that their contribitions would be repeated or feel judged.

"I got a chance to speak my mind, and to learn from others." Participant 793

"I had the freedom to express myself as honestly as I could. I cannot actually tell these to the most trusted friend." Participant 339

"Understanding. Privacy and confidentiality." Participant 732

New connections

New connections captured the participants' appreciation of interacting and connecting with new people. It may indicate strength in the fact that the intervention is delivered by individuals who come from without the school setting– individuals that the students have not interacted with before– which may be an important consideration in the future scaling-up efforts of Shamiri.

"Interacting with new people and growing as a person." Participant 1071

Interestingly, neither Rewards nor Peer Group Leaders are part of the intervention but appear to be an important component of the Shamiri intervention program delivery.

Solutions-oriented

Solution-oriented addressed the responses around the practicality of the intervention. This theme helps describe the impact of the Shamiri intervention. Several participants appreciated the practicality, relatability, and applicability of the intervention.

"Interacting and sharing my problems then getting solutions." Participant 649

"Knowing how to solve a problem. Knowledge of how to achieve my goals and even how to make my worries get over me. Knowing that practice and more practice makes perfect." Participant 9142.

Conclusions

The preferred components of the Shamiri Intervention were learning, rewards for participation, positive interactions with other people, and the solution-oriented nature of the sessions. The first theme consisted of the core components of the Shamiri Intervention (growth mindset, gratitude and values affirmation), which may suggest that the three concepts are appropriate and key character strengths for this population and context. Moreover, the qualitative feedback provides additional affirmation of the ability of these evidence-based therapeutic elements to help deal with many challenges facing the provision of quality mental health care among young people. The mentioning of the Shamiri Intervention features could also suggest that, indeed, they are; a) simple, in that despite being broad, they can be easily understood by the target adolescent population. The simple aspect of the three components of Shamiri Intervention plays a significant role in making the intervention accessible—as it does not require expertise to deliver and can be lay-provided, b) stigma-free—it utilizes simple terms that do not refer to psychopathology, c) scalable—an extended impact of the intervention being lay-provided, thus can be low cost (Osborn and Wasanga, 2020).

Interestingly, the delivery of Shamiri Intervention also appeared to have been significant. For example, the participants seemed to prefer lay providers, who—as mentioned previously—make the intervention provision relatable to high school adolescents and low-cost. Additionally, the positive interactions adopted in the group-led sessions that adopt unconditional positive regard also seemed to impact participants significantly. Positive reinforcement, in the form of prizes/rewards accorded to active participants

who constantly engage and on other merits, did have a significant impact. These highlights are essential because the use of lay providers is key in Shamiri intervention cost-effectiveness, accessibility and scalability. The lay providers (young people with limited mental health training) are readily available in Africa and particularly Kenya. In totality, these aspects—low-cost, scalable, accessible—are important during scaling up mental health care services that can help address the treatment gap to the increasing mental health needs. Additional qualitative studies are required to evaluate further how we can improve the effectiveness and sustainability of the Shamiri Intervention.

Finally, our findings support task-sharing using lay providers (peer leaders) and group-based interventions as an appropriate and cost-effective method to scale-up services in this service. We believe that the preferred elements, i.e., rewards, learning, positive interactions and solutions-oriented, are essential components of the effective youth-friendly intervention in this context.

Conflict of interest

The authors declare that they have no conflicts of interest.

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