CHURCH, FAMILY AND THE PROMOTION OF MENTAL HEALTCARE IN KENYA: TOWARDS A COLLABORATIVE APPROACH

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Abstract

The subject of mental health is global in nature. Various studies have been conducted, especially in the field of.psychology, which areaimed at unearthing the best methodology for tackling the challenges associated with mental ill-healyh. The rise in mental-illness-related acts of violence in Kenya is a matter that has attracted the attention of various stakeholders including human rights advocates, religious organisations, scholars, non-governmental organisations and state agencies, among numerous other interested parties (Nyagah et at, 2015; Mwania et al, 2017). the recent cultic deaths at Shakhahola in the Kenyan coast and which attracted worldwide condemnation, are believed to have been triggered by possible deficiency in the mental health both on the part of the victims and that of the perpetrators. The unfortunate incident was not an isolated incident of fatality did not occur in isolationas many other incidences of cultic-instigated or mental illness related suicides and fatal domestic violennce have been reported in the last several years in Kenya (Sunday Nation, July 7 2024: Saturrday Nation July 6 2024: Daily Nation, july 5,8,9 2024).it was only a peak to many other similar wierd happenings in the country. As the investigations progress on the Shakahola case, most observers are left wondering what became of the institution of the family. The fact that some of the victims were fasted or strangled to death by either the hands or in full knowledge of their parents and pastors - the very people they consider as the primary source of their physical and phsychlogical security and support - raises many questions about the state of mental health fitness within the two basic social institutions in the country. This paper reflects on the challenges facing both the family and the Church in contemporary Kenya and the need for these two institutions to develop mechanisms for mutual inter-party monitoring as a way of preventing, detecting, refering and managing cases of mental illness. The family serves as the captive audience for church membership enrolment. The Church draws its membership and support base from the institution of the family. When the mental health of any member of the family is at risk, the Church must feel that impact and may suffer a redundancy in its ministerial activities. The relationship between the Church and the family is, thus, symbiotic. The family produces the individuals who are then received into Church membership. But the church also provides the family with the spiritual support that the latter requires to operate effectively. This paper is based on the perspective that

Chuch and family (which is the basic unit of society) are mutually interlinked and the health of the one is necessarily involved in that of the other. Hence it calls for greater collaboration between the two institutions in order to perpetuate a spirit of working together (Warambo, 2009) that is necessary to counter the challenge of mental disorder.

Key Words
Church, family, mental welness, mental healthcare workers, collaborative approach.

1. Introduction

There is a connection between church, family and hospital in the nurturing and shaping of individuals into healthy, productive and responsible citizens. The family serves as humanity's nursery bed. It is here that individuals develop social roots and shoots sufficient enough to help them navigate their way through the meanders of life. It is thus the family that serves as the basic supplier of human labour to all other sectors of society including the Church. It is, therefore, for this reason that the nation is compelled to work towards ensuring that a conducive environment is created that can facilitate collaboration between the church, family and mental healthcare workers in the care and nurture of its citizens. Within the family, the nation should strive towards creating structures and programmes that aid in predicting, preventing, treating and managing mental ill-health. This may require investing in programmes that support individuals' ability to explore and exploit legitimate opportunities for personal growth whenever and wherever they are available -for this can inspire them to grow into healthy, productive and responsible adults.

This paper is extracted from a presentation that was made at the 2nd international Conference on Mental health. Health at Kenya Methodist University in Meru, about 200 kms drive from Nairobi. The main theme of the conference was grounded on exploring the connection between spirituality and mental health care. This paper is based on the conviction that there exists a functional correlation between spiritual wellbeing and mental welfare and makes various references, arising from an extensive literature review, to support this view.

2. The interlink between family, church and hospital in regard to mental healthcare in Kenya

Whenever spirituality is mentioned, most people tuen their thoughts to the place of worship, which in this case is represented by the Church. The church and the family are closely inter-connected - and together with the hospital, they form the three basic institutions responsible for the mental healthcare of individuals. This view of spirituality is, of course quite narrow in perspective as as it excludes nonreligious views such as atheism. For even atheists can attest to their own form of spirituality away from belief in a deity. But this is a discussion for another forum. For now, let it suffice to say that christianity propagates a belief in a personal deity and this also resonates with African traditional religious worldview which is popular in Kenya (Mbiti, 1991: Hail, 2009: Theissen, 1982: Philiphs, 1985: Ta'a, 2012).The family serves as the resource base for the Church. It is from the family that the church draws its membership. But the family relies on the Church for

its spiritual nourishment. There is a sense in which the family can be viewed as the primary church while the church is similary viewed as the secondary family.

This presentation is bent on establishing how the relationship between the church and the family plays out either to to boost or to impede mental health and wellbeing. It is my argument that the mental health of individuals is more often than not at the service of both family and church and the way these two institutions coordinate on matters health can either remedy or worsen the mental health of an individual. As the ardage goes, the product is as good as the process. This means that the mental wellbeing of individuals is depended on the smoothness with which the relationship between church and family and especially the interaction thereof is negotiated. But basic in this interaction is the interface between kinship mores amd spiritual demands. Thus, the family passes its moral and ethical lessons but this can only have a positive influence on the individual if they are effectively reinforced by the church. Whereas the family serves as a nursery bed where individuals are planted, the church serves as the watering bucket to supply adequate nutrients required for the individual to grow and develop in a meaningful way.

Church-based interventions for the mental health welfare of the family

In its dealings with the family -especially on matters health - the Church is guided by its divinely sanctioned mandate as the illuminator and preserver of (human) life. In the Gospel according to St. Mathew, the Church is commanded to serve society in a manner akin to that which the salts does to food and to that which the light does to darkness (Mat V:13-14). The social interpretation to this theological obligation of the ecclesia, is four-fold. As salt does to the food, so is the church required to do to society, to: I. Permeat society and ii preserve it. Again, as light does to darkness, the church is to: iii. Illuminate or provide guidance to society, and ii. transform society. These form the four basic components of the church's framework for social involvement. The inference here is that the Church is looked upon to permeat, guide, transform, and preserve the family. This is what I have termed the Spiritual Agency Model for ecclesia-society relationships.

Under this model, it is assumed that the Christian social service delivery system shall be structured in such a manner as to permeat all aspects of family life (including its mental welfare); to guide it (on how to handle mental illness); to transform it (change its perspectives on mental health issues) and to preserve it (device mechanisms for rapid response to mental health issues arising from or within the family). The church views itself as an agency of social transformation. This entails practically engaging with the society through families to inspire a paradigm shift in the way society perceives and responds to mental health challenges (Bosch, 1991).

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4. Role of the family

In the previous section, the role of the church in the promotion of mental health within the family was examined. In this section, the focus is on the role of the family in the quest for mental health wellness. Every human being (including religious leaders) comes from a family set-up (however loosely this is defined) (Addo & Zhang, 2020; Asamoah- Giadu, 2020; Boaheng, 2024). This places the family in a tricky situation. In one hand, the family is the pride of society and this puts pressure on its propensity to not only reproduce but also nurture and mould the character of its members into responsible citizens who can serve the world in various capacities including church leadership (Chang et al, 2011; Brakoniecka, 2024; Cheng & Chang, 2016; Chaudhury et al; Roye et al, 2022). But on the other hand, the rapidly changing social environment leaves the family exposed to factors of vulnerability such as economic, social, political and environmental disempowerment (Mbuthia et al, 2017; Mwania & Njagi, 2017; Oburu ,2024; Nthamburi, 2009 ; Machyo,2009). The family sometimes prone to socio-economic and environmental challenges that may expose its members to unmanageable levels of stress (Mbuthia, et al 2017) that, in the worst case scenario, lead to its disintegration. Disintegration itself may further expose the family to other social ills such as crime, alcoholism, prostitution and drug/substance abuse which in turn intensify its vulnerability to mental health challenges.

Ideally, the family expects to receive support from the government but this support may often fail to arrive or arrive in inadequate measures. The following are some of the basic aspects that government intervention in family affairs is paramount.

i. Marriage

The church demands of its members to enter into matrimony legally(Tough et al , 2017; Okorie, 2024). This is where the state comes in. In Kenya, marriage is certified by the state through the office of the Attorney General. Religious leaders have been given delegated power to preside over and register marriage - which should be between two consenting adults (that is persons aged 18 years and above) and of opposite sex. The Kenyan matrimonial law is strictly opposed to same sex

marriages. This means that pastoral guidance and interaction with a couple begins even at the premarital stage.

There are factors, however, that may militate against a smooth process for those intending to start a family. The process itself requires money even for those who may opt for a non-christian marriage, they still require to pay fees for the certification. It is even worse for christian youth who are required to undertake a church wedding that comes with even greater financial obligations. Most of the youth are financially unstable due to high levels of youth unemployment in this country. This leads to some of them delaying their marriage plans or exploring other options such as the informal (popularly referred to as 'come-we-stay') arrangement, which is not legally recognisable by the church or state. There is also the aspect of same-sex marriages that is outlawed but happens in secret away from the perview of law enforcing agencies. All these situations are capable of exposing the youth to stress and depression.

ii. Childbearing

So much surrounds the issue of reproductive health that this discussion may not exhaust here. Suffice it to say that matters of reproductive health in the family rotate around family planning, antenatal and postnatal clinics, maternity services and mandatory child vaccination services. The government is supposed to avail these services free of charge or at minimal cost but due to collation and other financial malpractices, it is sometimes unable to do so. This leaves parents with a financial burden. Some of them are unable to carry such a burden leading to stress. Inability to access quality maternal healthcare services may in itself compromise the physical and mental health of both child and mother.

Ilii. School

Parenting is a challenging task especially when it comes to education of children. Statutory policies in regard to education are often tied to political interests. When the education fees go high, as it happens from time to time, most parents are unable to sustain their children in school.

Under this trajectory, the Church's involvement in nurturing best practices in the management of mental health fitness within the family should be guided by the following focal points:

i. Preventive

There is need for the spiritual leadership to embrace a proactive approach in dealing with matters of mental healthcare. This is because the church stands to gain when its members are in good mental health. Itnis on these members that it heavily relies in order to fulfill its missionm of proclaiming and teaching the Christian values, healing the sick and helping the needy (Bosch, 1991). Through its functional service delivery points -which include sermons, homilies, teachings and counselling - the Church leadership Haa an opportunity to identify individuals who display such behaviour as is characteristic of mental distress. On making such an observation, they should the prescribe a suitable action towards addressing the situation before it grows out of hand. For those cases that are beyond the expertise of the spiritual leader, the Church should make recommendations for the patient to consult the relevant experts such as psychologists or psychiatrists for further specialised

therapeudicbor medical attention. Insofar as religious leaders form the primary caregiver's resource for mental healthcare especially at grassroot level, every effort should be made to equip them with the requisite skills.

ii. Intervention

In most cases, the factors that expose individuals to mental health challenges are beyond their control. These may range from social, cultural, economic, environmental to even political factors. The spiritual leadership can, for example, intervene to end female genital mutilation, or intervene to have farmers paid their payment arising from sale of agricultural proceeds to cooperative societies and so on. The religious leaders are also in a position to invite experts such as lawyers or medical personnel to come and give amtalk to their congrats on such topics as family law, property inheritance, mental health awareness among other such topics and professionals. It is observable that most mental ill-health cases arise out of situations and hardships as highlighted above - hence, calling a qualified professional to address these subjects to the congrats may be a 'stitch in time that saves nine'. At the level of intervention, the role of the church should be to identify and strive to eradicate all unfavourable conditions within the social-cultural, economic and political environment that may pose a danger to the mental wellbeing of the community.

iii. Treatment

It is important that all those cases that pose as outright mental illness are refreed to appropriate practioners for specialised attention bthe religious organisations run a couple of medical facilities. It is my recommendation that the various faith communities that run medical facilities can collaborate to develop different specialised treatment facilities for varied diseases at different hospitals so as to enhance quality and reduce the cost of treatment. This way, each medical facility will be known for a specific condition and all patients requiring thatbservice are referred there.

iv. Management

This involves cultivation of a conduceful atmosphere for mentally challenged individuals to operate their lives with zero or minimal obstruction (Verger 2009; Zannit & Taylor, 2024; Tough et al, 2017; Yang et al, 2024). Religious leaders should be at the forefront to propagate best practices as far as mental health caregiving is concerned. Resilience building among those affected and their care-giving support system is paramount. This may require appropriate training and sensitisationn strategies by religious leaders targetting members of their respective congreganmtions. This can be achieved through seminars. Workshops, conferences, conventions and symposia, among other such forums.

Through the various church groups, the church is at a better position to offer support system to individuals with mental challenges than any other social institution.

Conclusion

The church the family and the primary health worker form the basic health ecosystem within the community grassroot level. It therefore calls for a proper coordination between these three organs to ensure a disease-free operating environment within the community. Using their privileged positions, religious leaders can lobby for transformation of unfavorable conditions within their areas of jurisdiction. This may include petitioning authorities for unfavourable or punitive policies. Again, through their expertise, the primary health professional can work through churches, schools and barazas to sensitise citizens (which is the summation of families) on healthy behaviour and on how to avoid such conduct as may lead to mental illness or stigmma against those facing mental challenges.

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