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Identifying Community-Sourced Implementation Strategies for Delivering a Task-Shared Mental Health Intervention for Fathers in Kenya

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Abstract

Background: To design accessible interventions, understanding how best to implement them in context is essential. Strategies that reflect community perspectives may be most relevant and impactful. This study aimed to identify and specify community-sourced implementation strategies for delivering a mental health and alcohol use intervention for fathers in Kenya and to map them to the Expert Recommendations for Implementing Change (ERIC) taxonomy.

Method: In Eldoret, Kenya, focus groups (seven groups; 31 participants) and key informant interviews ($n = 18$) were conducted with hospital leaders, policymakers, mental health providers, community leaders, fathers, lay providers, patients, and men currently experiencing mental health and alcohol use challenges. Data were analyzed using the framework method to generate high-level codes, followed by a second phase to extract, specify, and review implementation strategies.

Results: Community members identified lay providers recruited from the community as a promising delivery approach, with professional providers contributing to linkage to care and support for more acute needs. Engagement of community leaders and leveraging existing infrastructure were seen as key to enhancing implementation and reach, particularly among men. Multiple delivery settings (e.g., church, hospital, school) were considered acceptable depending on patient preference. A total of 25 unique community-sourced strategies were identified: three directly matched ERIC strategies, 19 were adapted, and two were unique to the community context.

Conclusions: This study identified locally grounded implementation strategies to guide early-stage intervention delivery for fathers in Kenya. Findings contribute to the growing body of implementation science in non-Western contexts and highlight a participatory approach for identifying and specifying strategies relevant to local systems and populations.

Plain Language Summary

This study explored how to deliver mental health and alcohol use treatment to Kenyan fathers based on community and father input. Key strategies included using local helpers, familiar spaces, and engaging leaders. Findings emphasize co-design and context-based delivery to make interventions more accessible, relevant, and ready for testing.

Keywords

implementation strategy, Kenya, fathers, mental health intervention

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Introduction

Depression and alcohol use contribute significantly to global mortality (Chisholm, 2004; Griswold et al., 2018). Alcohol use, often co-occurring with depression, disproportionately affects men, with serious consequences for their health and relationships (McHugh & Weiss, 2019; Solis et al., 2012). Among fathers, these challenges can undermine family well-being and increase the risk of youth mental health problems (Andreas & O'Farrell, 2007; Chweya & Auya, 2014). Despite these cascading effects, fathers remain understudied in family-focused research and, like men more broadly, are often difficult to engage in treatment (Panter-Brick et al., 2014).

In Kenya, the prevalence of alcohol use disorders among men is seven times higher than among women (Jenkins et al., 2012; NACADA, 2017). Although interventions exist, access remains limited; only a small proportion of individuals with alcohol use or depression receive care (Aguwa et al., 2023; NACADA, 2017). National protocols and treatment centers are in place (Jaguga & Kwobah, 2020), but unmet need remains high—a pattern seen globally (Wainberg et al., 2017). Barriers such as limited resources, low awareness, and gendered norms further constrain care access for men (Abubakar et al., 2013; Berger et al., 2013; Vogel et al., 2011). These norms can discourage help-seeking and inhibit acknowledgment of distress. There is a pressing need for interventions that target father alcohol use and depression and that consider implementation strategies to address these help-seeking barriers (Patel et al., 2020).

To address these intersecting challenges, a team of Kenyan and US-based clinician-researchers co-developed a five-session intervention for fathers, titled *Learn, Engage, Act, Dedicate* (LEAD), grounded in formative research and existing evidence (Giusto et al., 2022). Delivered by peer-father counselors, LEAD showed promising pilot results in reducing alcohol use and depression and improving family functioning (Gusto et al., 2021, 2022).

At this early stage, identifying strategies for sustainable delivery is critical. Integrating implementation design with intervention development may lead to a more scalable package for future testing (Hailemariam et al., 2019). This study explores community-identified implementation strategies for LEAD delivery, with the goal of informing future scale-up. This aligns with calls from the Lancet Commission to embed implementation in all research phases and replace linear models with integrated, co-produced approaches (McGinty et al., 2024). By sourcing strategies from community members and individuals with lived experience, we aim to enhance intervention relevance, sustainability, and community engagement; key tenets of participatory research (Goodman et al., 2020; Israel et al., 1998; 2015; Triplett et al., 2022; Giusto et al. 2024)

A second goal of the study was to specify and match community-sourced strategies with the Expert Recommendations for Implementing Change (ERIC) taxonomy (Powell et al., 2015; Proctor et al., 2013), contributing to clearer conceptualization of implementation strategies, particularly in LMIC contexts like Kenya. This process can enhance the precision of strategy selection and adaptation while supporting identification of contextually and culturally appropriate approaches. Aligning community-identified strategies with established frameworks like ERIC also enables more systematic assessment of implementation fidelity and effectiveness and extends the conceptual application of implementation science to non-Western settings (Lovero et al., 2023). Mapping local strategies to a widely recognized classification system promotes a common language for researchers and practitioners to discuss, replicate, and scale effective implementation practices across contexts. This, in turn, facilitates cross-study comparisons and strengthens the global evidence base on how to implement and sustain interventions.

Method

Study Approach

To identify and describe promising implementation strategies, we conducted key informant interviews and focus group discussions with diverse participants in Eldoret, Kenya. These data were collected as part of a larger qualitative study examining factors influencing the delivery of LEAD. Interview guides were informed by the Consolidated Framework for Implementation Research (CFIR) and the Integrated Sustainability Framework (ISF), and included questions about strategies to overcome delivery barriers, leverage opportunities, and build on system strengths across domains outlined by CFIR and ISF. For example, questions related to delivery settings included asking: "If *there was a program to help with these problems, tell me where people should meet to talk about these problems and learn new skills? Why? Tell me where would be bad places to meet? Why?'* Participants were also asked to provide examples of successfully implemented programs in the area, as well as reflect on who might be best to deliver treatment, where, and in what ways. Focus groups and key informant guides assessed the same domains with questions tailored to reflect who was being interviewed (e.g., mental health providers were asked how a father might find their services, while a father was asked who they might reach out to when in need of support). A copy of all the interview guides is available in Giusto et al., 2023.

Setting

The study was done in collaboration with Moi Teaching and Referral Hospital (MTRH), as well as AMPATH, a service and research organization including MTRH and a consortium of North American schools in partnership with the Kenyan Ministry of Health. Research was conducted in Eldoret,

Kenya. Eldoret lies within the Rift Valley Province. It is a peri-urban community and the fifth most populated area in Kenya. All study procedures were approved by the Institutional Research and Ethics Committee at Moi Teaching and Referral Hospital and the Institutional Review Board at New York State Psychiatric Institute.

Participants and Recruitment

Individuals from diverse sectors and with varying levels of engagement with fathers and/or mental health and alcohol use were invited to participate. Participants included policymakers, community leaders, hospital leaders, mental health and alcohol use providers (referred to as providers), lay counselors who previously delivered the LEAD intervention (past LEAD providers), fathers who had received LEAD counseling (past LEAD patients), and men currently receiving treatment for alcohol use in the area (current patients). Recruitment efforts aimed to ensure representation across genders, roles, and geographic areas. A total of 49 individuals participated in focus groups or key informant interviews (KII). KIIs were conducted with hospital leaders ($n = 5$), community leaders ($n = 4$), policy makers ($n = 3$), previous LEAD patients ($n = 3$), and previous LEAD lay providers ($n = 3$). Community leaders ($n = 4$), mental health and alcohol use providers ($n = 21$), and current patients ($n = 6$) participated in separate focus groups. In total, seven focus groups were conducted (31 participants) and 18 key informant interviews. (We do not report specific demographics to protect confidentiality) These target numbers for sample size (i.e., for key informant interviews) were set a priori in alignment with other similar studies employing key informant interviews and focus groups to explore such outcomes (Hennink & Kaiser, 2022) and guided by principles of saturation and information power recognizing that sample adequacy is determined by the richness of the data in relation to study aims, the specificity of the sample, and the quality of dialogue with participants (Malterud et al., 2016). We anticipated that perspectives across diverse individuals (e.g., policymakers, providers, community leaders, patients) would generate sufficient information power for identifying a broad range of strategies while an iterative coding process allowed us to assess saturation and ensure no new major themes were emerging during analysis.

Recruitment procedures varied by participant. Leaders and providers were identified by study staff and leadership based on their experiences in the mental health field. Local staff approached leaders and providers to describe the study, assess initial interest, and obtain consent verbally or in person. Fathers who previously received an alcohol use and depression program were identified based on previous study records (only those who indicated openness to future contact). From this list, men were randomly assigned an order in which to be called and then called by a local research assistant to assess interest in participating; RAs met with participants in person to obtain written consent. Current patient participants were recruited from local substance use groups and a clinic supported by MTRH. These men were eligible if they were fathers reporting problem drinking as assessed by the Alcohol Use Disorder Identification Test and reported alcohol use in the past two months (Atkins et al., 2021; Babor et al., 2001). Men were approached by study staff to see potential study interest, complete screening, and if eligible, obtain written consent. Recruitment was done on a rolling basis until at least five fathers were recruited. Regardless of eligibility men continued to receive care where they were receiving services.

Procedures

Local research assistants conducted interviews and collected data with support as needed from the onsite investigator. Each of the interviewers had at least their Bachelor's degree in Psychology (equivalent to a US Masters of Clinical or Counseling Psychology) or a Master's in Psychology. For hospital leader and policy maker interviews, the second author, a psychiatrist attended interviews as was appropriate for the setting. Each of the interviewers was trained in qualitative interviewing as well as qualitative coding and analysis. Interviews and FGDs were conducted in either English or Swahili depending on participant preferences. KIIs and FGDs were audio recorded. Interviews lasted around 45 min and focus groups ranged from 2 to 3 h. KIIs with leaders occurred in person and virtually. Interviews and focus groups with other participants occurred in a private office area near MTRH. Data were transcribed verbatim from recordings into English by RAs; for words that had no direct translation from Swahili to English, the Swahili word was maintained in transcription. RAs were all fluent in both Swahili and English with extensive experience with cultural translation and transcription.

Analysis

Qualitative data analysis followed two phases with multiple steps guided by the framework method (Gale et al., 2013). Phase 1 focused on organizing and synthesizing data by high-level codes guided by the CFIR and ISF. Phase 2 focused on codifying, extracting, and operationalizing specific implementation strategies from Phase 1 summaries and codes with review of transcripts.

In Phase 1, a team led by a US-based psychologist and Kenyan psychiatrist engaged in an inductive and deductive coding process. Per the framework method, this began with transcription, then reading and familiarization with transcripts with general memoing of themes and team discussion. Next, a random sample of KII and FGD transcripts was selected, divided, and coded using inductive codes.

Iterative discussions of coding informed initial codebook development with inclusion of deductive codes as they arose. Transcripts were then independently coded until 80% agreement was met across coders with refinement of the codebook based on consensus discussions; discussed transcripts in which 100% consensus were reached were retained for analysis (i.e., not re-coded). After agreement was reached, transcripts were independently coded using NVivo 12.0 software. Lastly, we interpreted the data synthesizing and summarizing themes within each code and charting by theme and participant. This resulted in summaries of each code.

In Phase 2, we focused on extracting implementation strategies and specifying strategies based on the ERIC taxonomy as well as recommendations for strategy specification (Powell et al., 2015; Proctor et al., 2013). A Kenyan psychiatrist, US-based psychologist, and US-based research assistant reviewed summaries and extracted implementation strategies. Implementation strategies were operationalized as actions that aid in sustainable treatment delivery, including but not limited to screening, recruitment, training, and engagement. Next, these were reviewed with the full team, discussed, and refined. Summaries and transcript data were then re-reviewed to ensure all strategies were captured. Strategies were matched to existing ERIC taxonomy classifications when possible, and strategies were operationalized based on actor, action, action target, temporality, dose, outcome affected, and justification (Proctor et al., 2013). Initial matching and specification was conducted by a trained RA with lead author guidance. Strategies were then reviewed and discussed by the lead author, an implementation expert, and second implementation expert for accuracy or clarification to reach consensus on all codes. Data were re-reviewed as needed. Through iterative discussions, we resolved discrepancies, refined interpretations, and ensured that each mapping decision reflected both fidelity to community input and theoretical coherence with the ERIC framework. We opted for consensus coding in this process to prioritize depth of understanding and reflexivity over mechanical agreement (Saldaña, 2021). Notably, during the coding process, some community-sourced strategies did not match existing ERIC strategies but maintained conceptual similarities. In these cases, we chose to adapt the existing ERIC strategy to describe the community-sourced strategy versus noting the case as a non-match. Therefore, in addition to specification, data includes what community-sourced strategies matched ERIC, which did not, and which were adapted.

Results

We first present a summary of implementation considerations and strategies for delivering LEAD organized by who is best to deliver LEAD, where it is best to deliver, and how it is best to deliver. In this section, Table 1 includes illustrative quotes based on each theme. Then we summarize community-sourced strategies operationalized and matched to ERIC strategies (Table 2).

Community-Sourced and Identified Implementation Considerations

Who Is Best to Deliver Treatment

Lay Providers. Across the FGDs and KIIs, almost all participants emphasized advantages of having lay peer counselors recruited from local communities be a part of implementation. Participants noted that peers might include other fathers as well as men with lived experience with alcohol use and/or depression. Social proximity and shared experience were noted as potentially improving implementation reach, acceptability, and engagement by helping fathers feel more comfortable participating. Policy makers, hospital leaders, and community leaders specifically noted increased comfort may be facilitated by reducing stigma barriers.

Past LEAD patients also noted a preference for community-based lay providers as opposed to mental health professionals noting they might be more accessible. One past patient reported, "hospital person is also okay but the problem might be time because I might need to go for my casual work so I prefer someone from the community."

Lay Provider Recruitment. To recruit lay providers, participants suggested engagement with different community leaders, sectors, and organizations. Recruitment from community spaces, such as places of worship, was specifically noted as suitable. A policy maker also emphasized benefits that come with recruiting providers from churches noting "we build them [counselors] to a level where they are able to identify someone who has mental issue… then we [could] put them into groups ….We [could] talk about it so that everybody accepts."

Some interviewees, including hospital leaders, highlighted the potential of recruiting peer counselors from the patient-population's own community. Community-recruitment was noted as promising given the potential similarity of patient and counselors cultural and social values that might enhance patient treatment engagement. Other participants noted that recruitment of counselors who would not be known to patients (i.e., outside their community) might be more acceptable to some fathers. One provider explained that the disadvantage of recruiting peer counselors from the same community is that "the privacy of the client is not maintained… and could possibly bring about disagreement within the community." When discussing recruiting men from local communities as counselors, much of the "how," that is, strategies to identify, engage, and train men, centered on work or engagement with the community versus formal hospital systems. The benefits of working with peer father counselors was often noted as an alternative to healthcare workers in part due to scarcity of providers and potential stigma or fear visiting healthcare providers.

Table 1. Illustrative Participant Quotes.

Theme	Illustrative quote
Importance of peer providers and social proximity	"*It will be very good because one father talking to the other father, they get along well, it will be very easy unlike a boy counseling an old man. The old man will not really concentrate; he will feel that he is the one to talk to, to guide the boy. But if they are feeling that we are all fathers, then that puts us at the same level. Then this person knows he is ready to listen to me or to learn from me or to expose himself and his feelings to me.*" −1501 Past LEAD Provider KII
	The testimony he [father who experienced alcohol challenges] is giving out is what he has personally passed through it. They have also witnessed what he has passed through. The only difference is that this professional comes and [gives an] overview of what he has been studying but when you compare with this father of the community; he has more experience than the professional… When we talk about calls and experience, the father in the village beats him. − 702 Current Patient FGD
Quality of lay-providers for recruitment	*"Counselors who are very sensitive with the language they are using. The counselors who are sensitive to the culture they are going to work in, you see this counselor does not have to be from that area that they can be professionals who respect different cultures and those who are willing to learn and to grow and to just serve. They have the passion to serve. People who are not motivated by the kind of the money they are earning or the allowances they are getting. But people who are looking out to make an impact on men who are struggling with mental issues and alcoholism."*—1102 Policy Maker KII
	"It depends on the character and the perception within the community and…for example in the community I might have had a quarrel with you and now you want to be counseled by me, it will be a problem between us. But if I have cordial relationships with everybody, people know me as a good father, as an example, I do not have quarrels, fights with the community members then it would be very easy for me to work with them."—1502 Past LEAD Provider KII
Benefits of healthcare providers	"*I tend to think that the health worker will be objective as compared to the community person. … the community person knows so much about this person and might not, it is not like a blank state, for a health worker, you might not know this person, you are learning this person, what information you are getting, you work with what is coming on your plate. It also enables you to feel the patient as compared to someone who knows already knows all the bad things and does not know the inner issues.*"—402 Mental Health Provider FGD
Benefits of working with lay-providers and healthcare providers	*"I think we need both. Both the community leaders and the hospital [providers] because some of the issues that will be identified at the community level will require referral to the hospital. We need a system whereby the services offered in each entity are intertwined with what is being offered in the other entity. The community knows that they can do up to here and what is remaining can be referred to the hospital and when the hospital is done with these people, they refer them back to the community for continuation of the program. So we really need both the community, we need the NGOs, we need the MBOs, we need the hospitals."*—1203 Policy Maker KII
Benefits of a hospital setting for delivery	*"The good thing about the hospital is that the health of this man will be managed. He will be diagnosed and will know what they are dealing with. Maybe a man will come there with pressure and before he is given the service, even before he is treated when he is checked with the machine he will go home happily. When they are given water, even the normal water, the water from the hospital is different because they will go saying that the water helped him so much."*—1102 Community Leader KII
Overcoming hospital setting disadvantages	*"I don't know how we will even rebrand our facilities to destigmatize the services offered in those facilities so that when I walk to [Psychiatric] Hospital, I feel so safe, I feel so unjudged just like I enter [General] Hospital. The dignity of me going to [General] Hospital …should be the same level [as] going to [Psychiatric] Hospital. Are we going to rebrand the hospital, are we going to rename them especially the psychiatric hospital so that if you hear that [X-person] has gone to [Psychiatric] hospital is fine, he has gone to seek for medical services and it is okay."*—1202 Policy Maker KII
Benefits of community setting delivery	"*It is within the religious setting that we can actually be ourselves. These are the places where you can really pour our heart to the higher power and you feel so safe…we have small fellowship groups where people can really bond and just identify and support each other who are struggling with different issues. In those … groups we are able to really talk about issues that affect men directly, discuss them openly, so that we destigmatize the mental issues*

(continued)

Table 1. Continued.

Theme	Illustrative quote
	affecting men, then we will have a church that is more informed, a church that is more willing and open to support men struggling with alcoholism or mental any other mental issues."—1205 Policy Maker KII
Community leader support of men's engagement	*"It is also important to check on them in two weeks, in a month and ask them how is it going, what is going on or if it didn't help… Do not leave them, just call him and ask him 'did you meet with so and so, how did it [go], are you okay. If you need something, let me know, I am here for you, if you need someone to talk to, let me know I am here for you. if I can't talk to you, I will find someone to help you', whatever the outcome, assure him that you are with him even if you feel that he is at the edge …, I will be there for you. Do not make him feel like you have helped me today and tomorrow when I come to you are a bother."*—101 Community Leader FGD
Financial and vocational incentives on engagement	*"Like in [a specific county] I know… the brewers are getting funded to start dairy farming or poultry farming so that you have denied me my source of income which is brewing but now you have given me a cow, I can sell milk, I can sell manure, I can use the manure to do my kitchen garden and sell Sukuma wiki."*—1202 Policy Maker KII

Note: FGD = focus group discussion; KII = key informant interview.

Participants also pointed to specific qualities to screen and recruit for when selecting lay counselors from the community. They were noted as both qualities implementers should look for as well as qualities that lay providers might be more likely to possess. Qualities that interviewees suggested included "warm and jovial personalities," men who "keep promises," "chose their words wisely," and are "punctual." Interviewees noted these qualities could facilitate trust for men to feel supported and be inclined to engage. Past providers and mental health practitioners also reported that selecting and training peer counselors to use good communication skills and "practice good character" particularly around confidentiality would enable better understanding with fathers. Father's currently experiencing alcohol use and mental health challenges also echoed these qualities. One current patient reported, "That person should be a role model, people should know him as a person with good behaviors. When such people come to you and tell you something, you listen carefully."

Hospital or Professional Providers. Hospital-affiliated individuals and professional providers were also identified as promising candidates. Mental health professionals noted the benefits of recruiting healthcare professionals from the hospital. One reason being that fathers would feel more comfortable participating if counseled by people they do not know personally. Mental health professionals and past providers also noted that healthcare workers' professional positions would make them less likely to convey judgmental attitudes and possess training in confidentiality. This might reassure fathers that they can fully disclose challenges. A past LEAD provider reflected on this idea saying: "Somebody who works at the hospital …men might be most comfortable talking to, as compared to someone from a school, a church, a peer or someone else." Additionally, a policy maker and hospital leader noted there may be existing government funding and training support for healthcare workers.

Together. Interviews also noted that lay providers from the community and professionals could work together. One current patient reflected, "It [the counseling of fathers] needs the presence of a professional together with this person chosen in the community." Participants noted that professionals can provide high-level training and information to communities, and lay providers can counsel. Participants also reflected the need for different providers to work together to link patients to care in hospital and community settings. One policy maker remarked that lay providers and hospital providers are needed to build a fluid linkage and referral system to meet the need of fathers (Table 1).

Where to Deliver Treatment. Recommendations on where to deliver LEAD varied. However, when considering location, participants typically focused on certain qualities such as spaciousness, safety, comfort, and accessibility. Most participants noted feeling safe, secure, and unjudged may motivate fathers to show up and participate. A mental health provider, for instance, revealed that "we better bring [men] to the place they will be comfortable, a position where he will learn our goal and he will be free."

Locations for delivery were discussed either within the healthcare system or within the broader community. Interviewees suggested the hospital and/or local community venues might be appropriate. Community leaders, current patients, and past LEAD patients often focused on the importance of community settings. Providers, policy makers, and hospital leaders often noted the usefulness of both community settings and leveraging hospital resources. This included working with existing providers to support aspects of delivery (e.g., supervision) and providers' ability to prescribe medication and manage higher acuity challenges.

Table 2. Community-Sourced Implementation Strategy ERIC Matching and Specification.

ERIC strategy	ERIC strategy description	New or adapted strategy code	Community-sourced strategy description	Actor	Action	Action target	Temporality	Dose	Outcome affected	Justification
Involve patients/ consumers and family members	Engage or include patients/consumers and families in the implementation effort	NA	Involve family members in recruitment and help seeking	Implementers	Include family members in efforts to recruit and identify men for treatment	Patient/ participant	IP	Continuous	Reach	Having the mothers and children present may help fathers feel inspired to change their behaviors.
Promote adaptability	Identify the ways a clinical innovation can be tailored to meet local needs and clarify which elements of the innovation must be maintained to preserve fidelity	NA	Shorten the intervention	Implementers	Intervention with 5 sessions or less	Patient/ participant	PP	Continuous	Acceptability; satisfaction; reach	This will motivate fathers to participate and not feel pressured to commit to long-term engagements.
Create new clinical teams	Change who serves on the clinical team, adding different disciplines and different skills to make it more likely that the clinical innovation is delivered (or is more successfully delivered)	NA	Involve male community members in implementation	Implementers	Include male community health workers to potentially supervisor or provide treatment or identify and refer men to LEAD	Patient/ participant	PP	Once	Reach; patient-centeredness	Fathers will be more willing to engaged in treatment and listen to advice/support from men from the community because of their similar prioritized views, challenges and understanding.
Change service sites	*Change the location of clinical service sites to increase access*	*Select site for intervention implementation—ADAPTED*	Deliver the intervention in a hospital setting	Implementation Staff	Conduct the intervention in a hospital setting	Healthcare providers	IP	Once	Appropriateness; reach; patient-centeredness; acceptability	Carrying out the intervention in a hospital setting may enhance patients' trust and willingness to participate in the intervention because of the safe, comforting environment and being surrounded by skilled, professionally trained health care providers.
Change service sites	*Change the location of clinical service sites to increase access*	*Select site for intervention implementation – ADAPTED*	Deliver the intervention in community setting	Implementation Staff	Conduct the intervention in a local community setting (e.g., Churches, other place of worship, schools)	Community healthcare workers	IP	Once	Appropriateness; reach; patient-centeredness; acceptability	Carrying out the intervention in a local community setting may help to remove barriers to participation (e.g., distance, transportation costs) and facilitate a comfortable environment that is familiar to participants.
Change service sites	*Change the location of clinical service sites to increase access*	*Choose location of clinical service sites to increase access and engagement—ADAPTED*	Choosing a spacious, safe place to deliver intervention	Implementers	Carrying out intervention in a place (e.g., church, school, hospital, village, men's homes) that is safe, spacious and comfortable	Patient/ participant	PP	Once	Appropriateness; reach; patient-centeredness	Feeling safe and secure will motivate fathers to participate. Also going to a place that is easily accessible will prevent attrition by reducing travel costs, time, etc.
Involve patients/ consumers and family members	*Engage or include patients/consumers and families in the implementation effort*	*Engage or include families in the individual intervention—ADAPTED*	Involve family members in intervention	Implementers; Providers	Include some group sessions with family members (e.g., wife and child)	Intervention	IP	Once	Acceptability; patient-centeredness; effectiveness	Inclusion of the wife or child in a session may bring "positivity" or increased engagement in the intervention
Alter incentive/ allowance structures	*Work to incentivize the adoption and implementation of the clinical innovation*	*Provide financial support to participants—ADAPTED*	Financially support participants	Implementers	Buy gifts for fathers and their families who attend.	Patient/ participant	IP	Once or Continuous	Adoption; satisfaction; reach	This will incentivize fathers to continue the sessions (i.e., increase demand) and prevent attrition.
Alter incentive/ allowance structures	*Work to incentivize the adoption and implementation of the clinical innovation*	*Provide vocational skills or resources to participants—ADAPTED*	Add vocational skills training or job resources to participants	Implementers	Give fathers the training, education and/or other capital to help secure an occupation/employment and sustain themselves and their families.	Patient/ participant	IP	Once or Continuous	Reach; satisfaction; patient-centeredness; sustainability; effectiveness	Providing participants with the vocational skills and/ or resources during treatment will incentivize fathers to attend and increase effectiveness of treatment post-intervention .
Alter incentive/ allowance structures	*Work to incentivize the adoption and implementation of the clinical innovation*	*Provide financial support to lay counselors—ADAPTED*	Financially support providers	Implementation Staff	Provide monetary incentives to lay counselors to compensate them for their work/service in delivering the intervention.	Lay Counselor	IP	Once or Continuous	Adoption; satisfaction; sustainability	Incentivizing lay counselors with financial support will ensure their continued participation and motivation in the successful delivery of the intervention.
Recruit, designate, and train for leadership	*Recruit, designate, and train leaders for the change effort*	*Recruit community leaders to recruit and follow-up with patients—ADAPTED*	Engage community leaders to recruit and continually engage with patients	Implementation Staff	Identify and train community leaders to recruit and follow-up with potential patients	Community Leaders	PP; IP; MP	Once (recruit); Continuous (follow-up)	Reach; acceptability; satisfaction; sustainability	Community leaders are well connected in their communities and can increase identification, recruitment, and delivery of treatment, leveraging naturally occurring follow-up and contact.
Tailor Strategies	*Tailor the implementation strategies to address barriers and leverage facilitators that were identified through earlier data collection*	Tailor Strategies: Patient-choice—*ADAPTED*	Provide options for intervention delivery sites	Implementers; Counselors	Give patients options of potential treatment delivery locations that they chose from	Patients	PP	Once	Reach; acceptability; patient-centeredness	Patients may find different delivery sites more or less stigmatizing, providing a choice in delivery increases potential patient engagement through providing a choice and choice of a least stigmatized location.
Revise	*Shift and revise roles among professionals*	*Revise Professional Roles:*	Recruitment & Selection of	Implementation Staff	Recruit and train lay counselors who have also experienced alcohol use or	Lay Counselor	PP	Once	Reach; patient-centeredness; acceptability	Counselors with lived experience can build trust

(continued)

Table 2. Continued.

ERIC strategy	ERIC strategy description	New or adapted strategy code	Community-sourced strategy description	Actor	Action	Action target	Temporality	Dose	Outcome affected	Justification
Professional Roles	*who provide care, and redesign job characteristics*	*Task-sharing—ADAPTED*	Peer Counselors with Lived Experience		depression and may be in recovery to deliver treatment.					more quickly with fathers experiencing these problems.
Revise Professional Roles	*Shift and revise roles among professionals who provide care, and redesign job characteristics*	*Revise Professional Roles: Task-sharing—ADAPTED*	Recruitment & Selection of Peer Counselors with Social Proximity	Implementation Staff	Recruit and train lay counselors who have share social proximity to participants such as being men and/or fathers.	Lay Counselor	PP	Once	Reach; patient-centeredness; acceptability	Having other men or fathers deliver the treatment will increase acceptability for men to engage in the treatment and come to treatment.
Revise Professional Roles	*Shift and revise roles among professionals who provide care, and redesign job characteristics*	*Revise Professional Roles: Task-sharing—ADAPTED*	Task-sharing: Recruitment & Training of Existing Healthcare Providers	Implementation Staff	Recruit and train existing lower specialized healthcare providers to deliver treatment in order to maximize the efficient use of resources.	Healthcare Provider	PP	Once	Reach; patient-centeredness; acceptability	The systematic delegation of tasks to less specialized healthcare providers will maximize efficiency by distributing time, money and resources in such a way that healthcare providers can deliver their services more effectively.
Ongoing Training	*Plan for and conduct training in the clinical innovation in an ongoing way*	*Ongoing Training in Core Competencies—ADAPTED*	Train peer providers in confidentiality and good communication	Implementation Staff	Train healthcare providers to practice confidentiality of patient information and engage in effective communication skills (e.g., active listening, empathy, non-verbal, visual).	Healthcare Provider	PP	Once	Reach; patient-centeredness; acceptability	Having providers trained in practicing confidentiality and good communication ensures that patients are being treated with respect and dignity.
Revise Professional Roles	*Shift and revise roles among professionals who provide care, and redesign job characteristics*	*Revise Professional Roles: Task-sharing—ADAPTED*	Work with community health workers to reach community at little cost to participants	Implementation Staff	Train and incentivize community health workers to identify participants and deliver care in such a way that prevents participants from going out of their way.	Community Health Workers	IP	Once; Ongoing	Reach, patient-centeredness, acceptability	Having community health workers recruit, identify and select participants in the community may help to reduce barriers to participation, such as time, financial costs and transportation issues.
Revise Professional Roles	*Shift and revise roles among professionals who provide care, and redesign job characteristics*	*Revise Professional Roles: Task-sharing—ADAPTED*	Partner and train community leaders to identify and recruit participants	Implementation Staff	Collaborate with and prepare community leaders to appropriately identify and recruit participants eligible for the intervention.	Community Leaders	PP; IP	Once; Ongoing	Reach; patient-centeredness; acceptability	Working closely with the community leaders and training them on recruitment, identification and selection of participants will ensure that as many eligible participants are included in the intervention, thus meeting the local needs of the community.
Revise Professional Roles	*Shift and revise roles among professionals who provide care, and redesign job characteristics*	*Revise Professional Roles: Task-sharing—ADAPTED*	Recruitment & Selection of Counselors: Positive Qualities	Implementation Staff	Recruit and engage counselors to develop positive characteristics in preparation for successful delivery of the intervention (e.g., warm welcome; being on time; jovial personality; keeps promises).	Lay Counselor	PP	Once	Reach; patient-centeredness; acceptability	This will create an environment of trust where men can feel supported and feel inclined to participate.
Tailor Strategies	*Tailor the implementation strategies to address barriers and leverage facilitators that were identified through earlier data collection*	*Tailor Strategies to Counselor Qualities—ADAPTED*	Recruitment & Selection of Counselors: Unknown community member	Implementation Staff	Recruit counselors from the community & unknown to the participant	Lay Counselor	PP	Once	Reach; patient-centeredness; acceptability	This will get fathers collaborating with people with similar social/cultural values, which makes it easier to build a trusting, meaningful connection. Counselors should be unknown to participants to ensure privacy and comfort sharing information.
Tailor Strategies	*Tailor the implementation strategies to address barriers and leverage facilitators that were identified through earlier data collection*	*Tailor Strategies to Counselor Qualities—ADAPTED*	Selection of Counselors: Personal Qualities	Implementation Staff	Recruit & select understanding, sensitive counselors (e.g., practicing good character and leadership)	Lay Counselor	PP	Once	Reach; patient-centeredness; acceptability	Recruiting sensitive counselors with good character/ leadership will allow for better understanding and communication so fathers don't feel judged.
Ongoing Training	*Plan for and conduct training in the clinical innovation in an ongoing way*	Ongoing Training in Core Competencies —*ADAPTED*	Training of Counselors	Implementation Staff	Train lay counselors to develop core competencies (e.g., using sensitive language) that will be conducive to the intervention's success.	Lay Counselor	PP	Once	Reach; patient-centeredness; acceptability; effectiveness	Training counselors in "sensitive language" or non verbal and verbal communication skills will aid in delivery of the treatment.
NA	NA	Stigma Reduction	Rebranding typically stigmatized settings like hospitals	Policy Makers & Hospital Leaders	Change or update the quality of the implementation setting in order to reduce any associated stigma and enhance its dignity/reputation.	Patient/ participant	IP	Once	reach; patient-centeredness; acceptability	"Rebranding" the setting to reduce stigma will ensure that participants can feel more welcomed and comfortable accessing that particular location.
NA	NA	Community sustainability	Create peer support patient networks following treatment completion	Implementers & Patients	Create peer support groups with men who complete the program and connect fathers to these groups after completing the intervention	Patient/ participant	IP	Continuous	Acceptability; satisfaction; patient-centeredness; sustainability	Support groups will help fathers to stay empowered to make positive behavior changes and connect with others which can increase the acceptability of the program and lessons of the program.

Note: ERIC = expert recommendation for implementation change; IP = implementation phase; PP = preparation phase; MP = maintenance phase. Italicized indicates adapted strategies.

Hospital Setting. Participants noted several strategies to facilitate hospital delivery and potential advantages for sustainable delivery. First, the presence of trained, professional staff and availability of resources (e.g., medicine, food, water) in hospitals contributes to the sense of security which may ease fathers' tensions. Additionally, the ability to refer to other providers in the hospital systems if other challenges arise (e.g., illnesses, acute problems) was seen as beneficial.

Disadvantages to hospital delivery were also identified. These included potential stigma, transportation barriers, and fear of medical settings. Stigma specifically related to gender norms emphasizing help-seeking as weak for men was noted as a potential disadvantage to hospital delivery. Some participants noted fathers might worry their reputation could be diminished if someone in the community found out that they have visited a specific hospital for treatment. Another noted disadvantage was fear that medical settings might evoke. Fathers may be reluctant to seek services if they think that they will receive physical treatment rather than counseling. One community leader described this saying: "In the hospital someone will [think] that he is sick and there are other men who fear injection and drugs. They [think] that they are going to get treatment and not to be counseled, [and] they may say no, next time." Mental health stigma was also cited as a potential factor that can interfere with hospital delivery. Strategies to overcome these barriers included potential re-branding of services. Another strategy for overcoming this barrier noted by a hospital leader was to help create a welcoming environment in the hospitals. They describe the differences between the atmosphere of the mental health-focused hospitals in Kenya versus those abroad, stating that the latter have "patients who come in there and they are comfortable, they are not stigmatized. They look like five-star hotels, so if we can provide … treatment with dignity, it could be easier for anyone to walk in." Further, lack of transportation services was a noted barrier to delivery that could be overcome by working with community health care workers.

Community Setting. All participants noted advantages to engaging the community fully or in some capacity as an approach and location to deliver LEAD. Participants highlighted the potential of community leaders to aid in identification and recruiting participants given their understanding of community members and existing roles and relationships in the community that naturally facilitate help sharing. For instance, one hospital leader noted that "if we could train people who are most likely the recovered … who will go back to the community to identify clients … I think that would work best. Because they also identified people who have been through it before. It is easier for them to connect and to agree to come even taking away the stigma issue because there is the stigma of there is another man who wants to help me and why not?" Current patients further emphasized community delivery may increase accessibility noting, "If it will happen in the community, it will be easy for them to come."

When asked to compare potential delivery in a hospital versus a community setting, participants noted the relative benefits of the community with one hospital leader noting the following: "Churches will help us more [than hospitals] because they have the pastors and the leaders who are living in the community. If we use the religious leaders and use the county leaders, it will work very well. Then we will have the trained people who will be supporting them in units like if I am trained here to support somewhere, I will be going round." When asked not to directly compare, participants noted the importance of both the community and hospital to reach fathers and deliver treatment sustainably.

Specific to physical locations of delivery, communal settings, places such as schools, community gathering centers, and religious structures were noted as potential locations. Conversely, some participants noted difficulties with the church for treatment delivery. Specifically, a current patient reported some will refuse to go as they do not want to be judged. He noted: "When you call for a meeting in the church, people will go and there are those who will refuse to go. Those who are near will agree to go because they know that there is singing and there are those who will refuse to come saying that they will get the preaching about stopping alcohol". Therefore, an approach to identify multiple possible delivery locations and provide participants a choice for where they attend may be one strategy to determine location.

How to Deliver LEAD. Recommendations for how to best deliver LEAD focused on how to meaningfully engage, retain, and sustain fathers in treatment to ensure improved reach, acceptability, patient-centeredness, and clinical outcomes. Here, results focus on strategies related to the innovation -LEAD- that participants noted as potentially enhancing both implementation and clinical outcomes. These included family inclusion, increasing financial support, and using peer support groups for sustainment and engagement.

Including natural supports. Some participants reported fathers may feel more motivated and hold themselves accountable if sessions included family members, which may support acceptability and reach. Other participants, including current patients, indicated including family members in treatment might deter engagement and openness in sessions. A current patient reflected on this, "It is possible [for family members to join sessions] but most men do not want their issues to be known. They think that when the mother learns about it, it becomes a problem". Related, participants' noted community and religious leaders might support men's engagement in LEAD once beginning treatment.

Increased Financial Support. Interviewees reported providing financial support to fathers and counselors might increase engagement, acceptability, and adoption. For example, a current patient reflecting on what may increase likelihood of reaching fathers noted that "nowadays people work and at the end of the day they need pay… a person may want to do that work but they reach a point they think of what they will get at the end of the work." Participants reported financial support can extend beyond money and items of monetary value, such as school items for youth to include empowering men with vocational skills and knowledge to build entrepreneurial ventures (e.g., starting their own businesses). For instance, one community leader noted the following: "If this [person has] come to you from drinking and you have …engaged him, it is good to have mechanic there and train him and build a garage for his mechanic work, if he is a shoe shiner, give him shoe polish to start his work, stop thinking about … drinking of alcohol." Past LEAD providers mentioned that financial hardship is a barrier to fully participating in such interventions, therefore incentives for empowerment programs might increase reach and potential clinical outcomes. The past provider reported: "I felt that [one patient] was anticipating more– be it finance[es] or empowerment in a certain way so when we came … I felt that at the end he was bored…maybe the expectations that he had was more materialistic and that [was] a barrier." Policy makers also spoke about financial support influencing clinical effectiveness by helping replace alcohol related income activities with microfinance on entrepreneurial activities as well as build confidence in ones' self (Table 1).

Adding Peer Support Groups. Most interviewees expressed that a strategy to increase LEAD sustainability could be creating and connecting fathers to peer support groups following LEAD completion. Creating groups of peers who completed the program and continue to meet was tied to maintaining relationships and sustaining changes. In addition to sustaining clinical outcomes, an ongoing presence in the community might enhance the long-term presence of the program in the area.

Identifying, Specifying, and Matching Community-Sourced Strategies to ERIC

A total of 25 distinct strategies were identified in the data. Table 2 describes the identified strategies, their ERIC-match, when applicable, and specification. Three of the strategies clearly matched ERIC strategies and definitions; nineteen had conceptual similarity but were adapted to better reflect the noted actors or actions identified by participants; two were unique to community-reported delivery. The two distinct strategies included stigma reduction strategies (e.g., rebranding) and creating peer-led patient support networks, which were classified as a community-based sustainability strategy. Most adapted classifications centered on the ERIC strategy 'Revise Professional Roles,' which was adapted to 'Revised Professional: Task-Sharing' to emphasize a focus on non-medical settings and task-sharing (i.e., training new non-specialists or lay individuals in new roles as opposed to existing professionals). Most strategies were linked to treatment reach, patient-centeredness, and acceptability.

Discussion

Many strategies and considerations for implementing LEAD in Eldoret, Kenya emerged from the perspectives of community members, hospital leaders, patients, providers, past LEAD patients and past LEAD providers, and policy makers. Strategies varied depending on contextual considerations. Working with communities and community members to deliver treatment encompassed many promising strategies for delivery. The use of peer-providers—men with similar lived experience- was also seen as a valuable for reach and implementation by all participants.

Community-focused strategies were mentioned by all participants and especially emphasized by patients, community leaders, and mental health providers. When mapped to the ERIC taxonomy, 19 existing strategies required adaptations, three matched directly, and two were specific to this study. These will inform a hybrid implementation-effectiveness pilot based on feasibility, context, and partner input. Findings clarify implementation strategies relevant in LMICs —particularly for engaging men, who are often underserved in mental health care and contributes to approaches that integrate community voices into implementation planning (McGinty et al., 2024; Ramanadhan et al., 2023)

Results provide a menu of strategies based on lived experience (e.g., delivery location, providers, and format). Offering a menu rather than a fixed plan enhances adaptability to the needs of community members while remaining rooted in community input and implementation science. Adaptability to the needs and values of communities, patients, providers, and local partners (e.g., institutions, advisory boards) is a cornerstone of participatory community-engaged research methods (Israel et al., 1998; Payán et al., 2022; Wallerstein et al., 2015). Because one size often does not fit all, a menu of context-sensitive strategies supports informed decision-making and adaptation throughout implementation. Flexibility allows the intervention and implementation plan to evolve in tandem during early piloting, ultimately producing a refined, contextually grounded strategy menu (Nilsen & Bernhardsson, 2019; Rudd et al., 2020). For this program, the research team and local partners will begin with a tentative implementation approach based on these findings, to be reviewed with a community advisory board and work with counties in Eldoret that indicate a desire for this programming and research. As we move into a larger pilot trial, we will explore implementation processes and refine our approach

using the menu. A pilot will allow us to test the feasibility and acceptability of options and determine whether specific strategies should be retained, removed, or adapted. Future studies might adopt a more targeted implementation science question to evaluate how best to use strategy menus. Building a larger pool of locally identified strategies provides one example integrating intervention and implementation science early in the process. Future research could explore the usefulness of this approach compared to more static implementation plans.

One challenge was balancing community-sourced strategies with classification systems like ERIC. This likely reflects two factors. First, in LMICs where infrastructures are limited, implementation planning often involves exploring and identifying potential delivery pathways rather than selecting a defined setting. Therefore, implementation planning might often relate to exploring and determining potential strategy pathways (i.e., comparing and contrasting) versus planning for a specific delivery setting. Although not all strategies matched ERIC one-to-one, many overlapped conceptually with only minor adaptation; similar to findings from a review showing 88% of ERIC strategies have been used in LMIC implementation (Lovero et al., 2023). Second, we considered both the intervention and implementation concurrently. Although implementation science often adapts interventions as an implementation strategy, it less often focuses on considering both implementation and intervention relevance at the outset of treatment design (Brownson et al., 2021). For example, including vocational work in the intervention itself was seen as a way to increase reach and acceptability as well as improve clinical outcomes.

Most adaptations centered on better emphasizing task-sharing within the existing taxonomy including aspects of recruiting, identifying, selecting, and training counselors. These were strategies noted by all participants. Future research should explore whether these approaches are specific to this study or generalizable to other Kenyan or resource-constrained settings. Regardless, systematic specification supports contribution to strategy compilations like ERIC, enhances cross-study comparisons, and informs replication (Perry et al., 2019; Proctor et al., 2013). For instance, a recent study adapted the existing ERIC compilation to be sustainment specific, highlighting how existing compilations can be built upon suing systematic specification (Nathan et al., 2022).

Lastly, our approach reflects participatory and community-centered approaches in implementation science (Ramanadhan et al., 2023). Despite implementation science historically not meaningfully engaging partners (Triplett et al., 2022), there have been efforts to embed more participatory approaches. This has included empowering partners to co-specify implementation strategies and mechanisms (Moore et al., 2025) and develop a compilation and pragmatic implementation strategy selection process (Balis et al., 2024). Our study adds to this growing body of work by demonstrating how community voices can be used to inform strategy specification and adaptation in LMIC contexts. Our qualitative formative work also allowed us center community member voices at the early stages of intervention refinement. In this case, sourcing potential strategies went hand in hand with attempting to design an intervention that community members will use as opposed to selecting an intervention first then getting community members to use. As implementation science is integrated and embedded earlier in development to implementation pipeline more strategies will likely emerge (McGinty et al., 2024), thereby furthering efforts to advance health equity (Ramanadhan et al., 2023). Future work might consider how to more explicitly use implementation frameworks, models, and theories to both partner deeply with community members and inform how to develop treatments with access and implementation in mind (Brownson et al., 2021).

More broadly, our findings underscore the potential for implementation science to build *practice-based evidence* by grounding strategy development in community perspectives. Frameworks such as ERIC are essential for systematically specifying and comparing strategies across studies, and future work can extend their value by pairing them with community-informed approaches. This combination allows researchers to move beyond documenting "what works" to examining *what works, for whom, and in which contexts*. Advancing this dual focus can strengthen both practice and science by ensuring that implementation strategies are contextually relevant, equitable, and sustainable.

Limitations

The study has limitations. Coding was comprehensive but strategies may have been missed, and coding errors are possible. Additionally, although local simultaneous translation and transcription is common in global work, it may introduce bias if translators inadvertently interpret rather than directly translate. ERIC matching posed challenges given differences between theoretical categories and real-world interpretations. Alternative expert coders might have mapped strategies differently. We share this limitation to encourage discussion about matching frameworks rather than overemphasize theoretical fit. Lastly, a more diverse, including family members and previous study participants, could have yielded additional perspectives.

Conclusion

This study identified and specified community-driven implementation strategies for delivering a father-focused intervention addressing depression and alcohol use in Kenya. Sourcing a flexible strategy menu enhances the potential for scalable, sustainable delivery. Findings contribute to a growing literature on integrating implementation science throughout research (McGinty et al., 2024).

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Informed Consent Statement

Informed consent was obtained from all subjects involved in the study.

Institutional Review Board Statement

The study was conducted in accordance with the Declaration of Helsinki and approved by the Institutional Review Board at New York State Psychiatric Institute (Protocol 8084, Date Approved 29 October 2020) and the Institutional Ethics Review Committee at Moi Teaching and Referral Hospital (Approval Number 0001138, Date Approved: 10 December 2020).

Author Contributions

Conceptualization: AG, FJ.; Methodology: AG, FJ, MW; Original drafting: AG, MG, FJ; Supervision: AG, FJ, WR, M.L.W.; Project Administration: AG, FJ, WR, MK; Analysis: AG, FJ, NT, HR-E-Q, DA, MK, AG, NT, HR-E-Q, MW, FJ, and MG. All authors reviewed and edited the manuscript. All authors have read and agreed to the published version of the manuscript.

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Data Availability

Please contact the first author if you are interested in learning more about the qualitative data (ali.giusto@fiu.edu)

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