HERAF
Health Rights Advocacy Forum

MENTAL HEALTH

LAWS AND GOVERNMENT BUDGET ALLOCATION IN KENYA

An analysis of laws, budget allocations for the period 2013/14 - 2017/18 and key influencers of investment decisions in mental health

HERAF
Health Rights Advocacy Forum

Health Rights Advocacy Forum (HERAF)
Ring Road, Kilimani
P.O Box 100667- 00101, Nairobi, Kenya
Tel: +254 735 333 007
Email: info@heraf.or.ke
Website: www.heraf.or.ke
Facebook: Heraf Kenya Twitter: @HERAF_Kenya

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ACKNOWLEDGEMENT

Health Rights Advocacy Forum (HERAF) appreciates all those who contributed to this report in one way or another. This report presents the findings of a baseline study on Mental Health Laws and Government Budget Allocation in Kenya. It examines laws and policies government budgetary allocation and expenditure towards mental health programmes in Kenya. The study was conducted by HERAF with financial and technical support from Open Society Foundation Institute (OSIF) through Open Society for East Africa (OSIEA).

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LIST OF ABBREVIATIONS

COB	Controller of Budgets
CRPD	Convention on the Rights for Persons with Disabilities
CSO	Civil Society Organisations
DALYs	Disability-Adjusted life-years
FBO	Faith Based Organisations
GOK	Government of Kenya
GSK	GlaxoSmithKline
HERAF	Health Rights Advocacy Forum
ICT	Information, Communications Technology
KNCHR	Kenya National Commission for Human Rights
KNH	Kenyatta National Hospital
MAT	Medically Assisted Therapy
MNCH	Maternal, Newborn and Child Health
MNS	Mental health, Neurological, and Substance Use
MOH	Ministry of Health
MSD	Merck Sharp and Dohme
MTEF	Medium Term Expenditure Framework
MTRH	Moi Teaching and Referral Hospital
NACADA	National Authority for the Campaign Against Drug Abuse
NGOs	Non-Governmental Organisations
OAG	Office of Auditor General
OSF	Open Society Foundations
SDGs	Sustainable Development Goals
SPSS	Statistical Package for Social Sciences
TNGB	Total National Government Budget
UHC	Universal Health Coverage
WHO	World Health Organization

EXECUTIVE SUMMARY

Global literature argues that the global burden of mental illness is underestimated to account for 32·4% of years lived with disability (YLDs) and 13·0% of disability-adjusted life-years (DALYs). The rusty estimations is as a result of among other reasons overlap between psychiatric and neurological disorders; the grouping of suicide and self-harm as a separate category; exclusion of personality disorders from disease burden calculations; and inadequate consideration of the contribution of severe mental illness to mortality from associated causes[1].

Despite significant consideration of mental health in the Global Health Indicators and commitments, the global resource envelope for mental health is negligible and there lacks enough commitment among funding and donor agencies to support mental health. The unacceptable apathy of governments and funders of global health must be overcome to mitigate the human, social, and economic costs of mental illness. It is for this reason that HERAF with financial and technical resources from Open Society Foundations (OSF) conducted a baseline study in Kenya to assess the legal framework and extent of government funding to mental health and identify who influences decisions for mental health in Kenya.

The study observed that the Supreme law of the land, the Constitution, recognizes right to health as a fundamental right that all persons including people with mental disabilities should enjoy. According to the Constitution people with mental disabilities have a right to equality and freedom from discrimination, including in accessing healthcare services. It nonetheless, emerged that mental health care services are largely guided by the mental health Act, 1989. This Act was not implemented fully due to lack of political will and budgetary allocations. The Act has now been overtaken by the 2010 Constitution and requires a total overhaul in order to conform to the aspirations of the new constitutional order especially, the rights based framework which is the opposite of the bio-medical model perpetuated by the 1989 Act. Mental health legal framework is complicated further by the numerous legislations that have clauses touching on mental health making it a challenge to reconcile all the provisions for the good of mental health. However, the Health Act, 2017 recognized the need for a separate legislation on mental health. The implementation of the health Act, 2017 should therefore pave the way for enactment of a progressive mental health law.

On regard with international human rights instruments, that are part of Kenya law, under Article (2) (5) and (6) of the Constitution, the United Nations Convention on the Rights of Persons with Disabilities (CRPD) emerged as the best example. The duties and obligations of the government in implementing the Convention are in tandem with the 2015 – 20130 mental health framework hence the government should develop costed mental health plans and allocate resources including financial, technical, and human and infrastructure for mental health care services as required by the Convention. It is the responsibility of the civil society to hold the government accountable including developing shadow reports to mirror governments on status of CRPD progress.

Mental health is marginalized within Kenya's health care system as only about 0.5%[2] of the total national and county health budget is set aside for mental health care. This is far much below the burden of mental illnesses in Kenya with prevalence rates for major mental disorders at 4%.[3] In addition, KNCHR 2011[4] estimates that up to 25% of outpatients and up to 40% of inpatients in Kenya's health facilities suffer from mental disorders.

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1 Daniel Vigo, et al 2016. Estimating the true global burden of mental illness; The Lancet, Psychiatry

2 Kenya National budget estimates 2016/2017: Trend analysis

3 Ndetei D, Khasakhala L, Kuria MW, et al. The prevalence of mental disorders in adults in different level general medical facilities in Kenya: A cross-sectional study. Ann Gen Psychiatry. 2009;8:1. http://dx.doi.org/10.1186/1744-859X-8-1

4 KNCHR 2011. Silenced Minds: The Systemic Neglect of Mental Health System in Kenya. A human rights audit of mental health system in Kenya. Nairobi. Kenya National Commission for Human Rights.

Only at the national government level, is there a budget line earmarked for mental health programmes, which goes into three budget line items. These are the division of mental health, mental health board and Mathari National Teaching and Referral Hospital. At the county government level, none of the 47 counties had a budget line for mental health, including in county referral hospitals.

Despite the low amounts allocated for mental the actual expenditure was more scarcely according to Office of Auditor General Performance Audit Report on Provision of Mental Health Services in Kenya.[5] The report states that, no funds for development were actually disbursed for 2013/2014, 2014/2015 and 2015/2016 financial years while for the recurrent expenditure actual allocation was as low as 28% in 2015/2016 financial year. Poor government budget allocation and expenditure for mental health was attributed to high levels of stigma among decision makers and political leaders, lack of political will to implement fully the existing legal frameworks, and inadequate prioritization of mental health issues as compared to other diseases.

The study observed that the funding levels received in Kenya from external resources including donor community towards mental health is very limited, inconsistent, conditional, and allocated to vertical programs. This finding is consistent with global trends documented in among reports the scoping study on mental health financing by OSF. Lack of resource commitment by donor community is reflective of under-prioritization and presence of weak global financing frameworks that may require reforms to call for systematic commitment to funding mental health.

The study also estimated the level of involvement of CSO in the advocacy for mental health budgets and planning. The results show that generally CSOs have appetite for advocating for budget allocations to health sector at both national and county level. However, very few CSO have an advocacy framework for budget allocations to mental health and very few if any consistently track budget expenditures on mental health.

The study calls for immediate reconsideration of mental health status in Kenya to avert the damaging socio-economic consequences of mental disorders including increased poverty levels, destabilization of families, loss of dignity, and stigmatization. The study makes the following recommendations;

RECOMMENDATIONS

a) **Mental health policies and legislations**: Although Kenya has some polices and legislation supportive of mental health, the current mental health Act no 10 of 1989 is not in tandem with the supreme law (Constitution 2010) making its implementation unrealistic. There is also total lack of the full implementation of the enabling laws on mental health leading to consistent discrimination and violations of the rights of persons experiencing mental ill-health. The national government should ensure a new mental health law is enacted as provided for by the Health Act, 2017.

b) **International and regional obligations on mental health**. The need to advocate and hold the government accountable on international commitments is paramount. Civil society organizations should prepare shadow reports to make comments on progress made by State in meeting international obligations with a focus to provision of comprehensive stigma free mental health services.

c) **Domestic resource flow for mental health.** Kenya does not have a systematic budget planning and allocation to mental health. The funding is either voted in block budget items at national level while at the county level mental health budget plans and allocations is not explicit. There lacks a budgeting framework for mental health. Civil society organisations should advocate for establishment of a national government and county government budgeting framework for mental health.

5 Office of Auditor General, 2017. Performance Audit Report on Provision of Mental Health Services in Kenya. Nairobi. Office of Auditor General.

d) **Prioritization of funding mental health at international level and among donor community.** Data shows that external resource flow for mental health in Kenya and perhaps in developing countries is dismal compared to allocations and commitments made on other health issues yet the prevalence of mental disorders and demand for mental health services is enormous. The Global Financing Framework overstate the need to funding of communicable diseases at the expense of ill-health such as mental disorders. There is need for a robust and consistent advocacy program at international level and among developing partners for greater commitment to funding mental health.

e) **Involvement of civil society organizations on mental health budget advocacy.** Evidence shows that although civil society play a significant role in advocating for higher budget appropriations to health sector at national and county level, they are less involved or lack interest in advocating for higher budget allocations for mental health. There is therefore the need and opportunity of drawing interests among CSOs in advocating for planning, budget allocation and tracking of budget utilization on mental health and issue score cards thereof on the same.

f) **Invest in key influencers of mental health policies and funding.** There is need to develop a mental health campaign and educative programs to reduce stigma on mental disorders and call upon key influencers including the parliamentary committee on health, the Council of Governors Health Committee to demand and influence higher budget allocations for mental health as well as invest in mental health services and programs at community and facility levels.

1.0 Background

The World Health Organization (WHO) defines mental health as 'a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community'. Mental illness on the other hand is a diagnosable condition that causes mild to severe disturbances in thought and/or behavior, resulting in an inability to cope with life's ordinary demands and routines.[6]

The burden of diseases attributed to mental health conditions globally, stands at 14 per cent with 75 per cent of those affected living in developing countries.[7] In sub-Saharan Africa the total burden of disease linked to mental health conditions is about 10 per cent,[8] while in Kenya the prevalence rate of mental health conditions is estimated at 4%[9]. Mental disorders are largely attributed to among other factors poverty, unemployment, internal conflict, displacement, family instability, hunger, chronic diseases such as HIV.[10] Mental health problems are therefore a major contributor to the global disease burden, they are associated with premature mortality and profound socio-economic impacts on individuals including reduced self-worth, lack of dignity, reduced productivity, and they generate substantial costs to the economy including direct medical and home care costs.[11] Despite the evidence of the impact of mental health to the global economy, this has attracted limited attention in global efforts at alleviating poverty through investment in health compared to huge undertaking in communicable diseases programmes.

1.2 Mental Health Situation in Kenya

Data and information on the prevalence of mental disorders in Kenya is currently inadequate. The prevalence of severe mental disorders in Kenya is estimated at 4%[12]. It is also estimated that up to 25% of outpatients and 40% of in-patients in health facilities suffer from some form of mental health conditions according to a report by Kenya National Commissions for Human Rights (KNCHR).[13] Depression, substance abuse, stress and anxiety disorders are some of the common illnesses recorded in hospitals.

Some scholars in health system, have hinted that Kenyans are at risk of other mental disorders because of difficult conditions in the country such as psychosis due to HIV infection, neurodevelopmental disorders and epilepsy due to poor mother–child health, posttraumatic stress disorder due to terrorism and political tensions, and anxiety due to high poverty rates.[14] Indeed, people living in poverty are more vulnerable to mental illness, while those with pre-existing mental illness are more likely to slip into poverty due to their inability to function optimally.[15] Suicide, homicides and violence at household level are some notable cases of attributes of mental disorders in Kenya. This is an indication of dire state of the mental health services in Kenya.

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6 World Health Organization. The world health report 2001. Mental Health: New Understanding, New Hope. Geneva: World Health Organization, 2001.

7 Amuyunzu-Nyamongo, M. (2013). The social and cultural aspects of mental health in African societies. Commonwealth Health Partnerships, 59-63.

8 Stein DJ, Seedat S. From research methods to clinical practice in psychiatry: challenges and opportunities in the developing world. Int Rev Psychiatry 2007; 19: 573-81 doi: 10.1080/09540260701563536 pmid: 17896236.

9 Ndetei D, Khasakhala L, Kuria MW, et al. The prevalence of mental disorders in adults in different level general medical facilities in Kenya: A cross-sectional study. Ann Gen Psychiatry. 2009; 8:1. http://dx.doi.org/10.1186/1744-859X-8-1

10 Ndetei D, Khasakhala L, Kuria MW, et al. The prevalence of mental disorders in adults in different level general medical facilities in Kenya: A cross-sectional study. Ann Gen Psychiatry. 2009; 8:1. http://dx.doi.org/10.1186/1744-859X-8-1

11 Macdaid, D, Knapp M and Raja S. Barriers in the mind: promoting an economic case for mental health in low- and middle-income countries. World Psychiatry. 2008 Jun; 7(2): 79–86

12 Ndetei D, Khasakhala L, Kuria MW, et al. The prevalence of mental disorders in adults in different level general medical facilities in Kenya: A cross-sectional study. Ann Gen Psychiatry. 2009; 8:1. http://dx.doi.org/10.1186/1744-859X-8-1

13 Kenya National Commission on Human Rights (KNHCR). Silenced minds: The systemic neglect of the mental health system in Kenya [Internet]. Nairobi: Kenya National Commission on Human Rights (KNHCR); 2011 November. 73p.

14 National Academies of Sciences, Engineering, and Medicine. 2016. Providing sustainable mental and neurological health care in Ghana and Kenya: Workshop summary. Washington, DC: The National Academies Press.

15 Amuyunzu-Nyamongo, M. (2013). The social and cultural aspects of mental health in African societies. Commonwealth Health Partnerships, 59-63.

Mental health in Kenya has not received its due priority. Unlike communicable diseases and conditions, investments in mental health programmes and services has been completely neglected thereby negating accessibility of quality mental health services. One of the factors that have contributed to low priority, to mental health is the stigma attached to mental disorders. This result to abuse of basic rights for peopl with mental disorders. They are made to loose dignity, subjection to inhuman treatment both at community and health institutions. They are not able to access quality basic health care, cannot engage in useful economic activities such gainful employment.

Due to the low priority accorded to mental health in Kenya, there are few voices advocating for mental health issues including policies, planning and budgeting as compared to other diseases. As a result, despite Kenya having a vibrant constitution that recognizes health as a fundamental human right - Article 43. (1)(a) provides that "every person has the right to the highest attainable standard of health, which includes the right to healthcare services", people with mental disorders are yet to fully leap the benefits of this Constitution. There are concerns that some of the existing health policies including mental health legislations are not in tandem with the Constitution and their implementation has not been successful. Hence contributing to the sorry state of mental health in Kenya.

The other indicator of low priority for mental health is lack of budgets and funding for mental healthcare services at national and county governments levels. The government funding for mental health has substantially been very low. Some analysis has recorded as low as 0.5% of the national government health sector budget which can handily meet the overwhelming needs of the sector. Though allocation could be made, it is worrying that the amount of the budgeted funds that ends been disbursed and spent for the intended purposes is on downward trends. This is further aided by inadequate voices calling for transparency and accountability in governance and decision making processes for mental health. Like, the government, donor community efforts in supporting mental health programmes and services has also been low. There has been a lot of vertical support towards communicable diseases to the detriment of mental health and broader health sector strengthening.

2.0 The Purpose

The main purpose of the study was to establish the legal framework, budget allocation and actual expenditures in support of mental health programmes from government of Kenya for the period between 2013/14 and 2017/18 financial years.

2.1 Specific objective

1. Establish programme and fiscal policies informing mental health programmes and services in Kenya.
2. Analysis of trends in government budgetary allocation and spending on mental health programmes and services.
3. Assess levels of public participation in advocacy efforts for mental health programming, planning and budgeting in Kenya.
4. Identify behind the scene power players influencing government decision making processes that influence mental health budget allocation and expenditure in Kenya.

2.2 Methodology

2.2.1 Data Collection Method

2.2.1.1 Data Search

The research team used the method of literature search to identify relevant legal and policy instruments. This entailed searching for all policies and legislations that have probability of influencing mental health programming including services and funding decisions.

On government budget allocation for mental health programmes and services, the study identified the budget document and procured from the government printer the official recurrent and development budget estimates for period under review. The revised estimates for both recurrent and development

expenditures were also procured from the government printer.

2.2.1.2 Data Sources

- Government of Kenya Ministries' and agencies such as Law Reform Commission
- Books on mental health
- Journals
- Organisational reports
- Research and scholarly works
- Internet
    - Google Scholar
    - Organisation's websites
    - Conferences reports
    - Government's ministries and agencies websites

2.2.1.3 Content Analysis

To assess the suitability of the identified literature, the research team undertook the content analysis. This entailed scanning the identified literature on relevant policies and records on mental health budget and reports. Each of the literature or article was used as the unit of analysis and was scrutinized to assess the text in the article.

2.2.2 Interviews

In assessing public participation in governance, planning and budgeting for mental health programmes and services, the study conducted individual interviews and supplemented with key informant interviews. The targets for the interviews were drawn from non-governmental organisations, faith based organisations, the private sector players, research and academic practitioners, healthcare providers and policy makers.

2.2.3 Data Analysis

The texts were systematically evaluated to make replicable and valid inferences based on the information contained. The information was then used to develop summaries that were presented thematically to inform the content of each social accountability tool. Through the content analysis, organisations that are involved in respective social accountability practices were also identified and sampled.

Specific tools were developed to record and analyse the budget figures. The tools were customised to use excel computer package for more analysis and calculations. Much of the data on budget estimated allocation was analysed from the recurrent and development estimates from National Treasury. This was complemented by studies and reports on analysis of health budgets at national and county government levels by government agencies and other civil society organisations. Data gaps were filled using semi structured interviews with government.

Quantitative responses were analysed using Statistical Package for Social Sciences (SPSS). The data was presented in tables, graphs and pie charts and supported with an interpretation. Qualitative data was analyzed using a theme-content matrix and presented in narratives. Some detailed triangulation of both sets of data helped to clarify observations and firmed inferences and conclusions.

2.2.4 Report Writing

The report was developed logically in line with the objectives of the study. The draft report was shared with the stakeholders from civil society, Ministry of Health and the donor for review and validation. The comments and inputs were used to inform the final report.

2.3 Limitations

The study had intended to analyze the expenditures of the budgeted funds to assess if all the funds were spent as allocated. However, there was no official data availed on mental health expenditure from Ministry of Health and from Mathari National Teaching and Referral Hospital due to bureaucratic and logistical challenges of obtaining the same during the limited time of the study. Also, there was no available secondary data and information on mental health expenditure from the controller of Budgets and the Auditor General. The only data available had not been broken down to lower level budgetary votes for mental health. However, an independent report based on the analysis by Office of the Auditor General provided the grimes of mental health expenditure, though this was not as comprehensive as the study had sought to undertake.

3.0 Key results

This section presents in brief results of study organized by key objectives and sub-objectives

3.1 Policies Guiding Programming, Service Delivery and Budgeting

The study collated and analysed policies informing mental health programming, service delivery and funding.

3.1.1 The Constitution

The Kenya 2010 constitution recognizes right to health as fundamental economic social and cultural right that all persons including most vulnerable groups in the society such as people with mental disabilities must enjoy. Under the Bill of Rights Article (43) (a) “every person is entitled to highest attainable standard of health care services, including reproductive health care”. Highest standard of health care should be interpreted to include mental health services.

Like all other citizens, persons with mental disabilities should enjoy the right to equality and freedom from discrimination. Article (27) (4) notes that “The state shall not discriminate directly or indirectly against any person on any ground including the health status and disability. In addition, the Constitution has devoted Article 54 to reinforce the rights of people with disabilities including mental health. Among the rights Article (54) (1) (a) states that a “a person with disability is entitled to be treated with dignity and respect and to be addressed and referred to in a manner that is not demeaning”. Further as provided for by Article 28, people with mental health disabilities have inherent dignity and the right to have that dignity protected. While Article (29) guarantees all citizens including people with mental disabilities the right to freedom and security. That is, while accessing health services people with mental disabilities should not be denied their freedom through confinement without a just cause, treated in cruel or inhumane manner. The State can therefore be in contempt of the Constitution for failing to invest adequately in mental health infrastructure in order to guarantee access to mental health services. This failure can be termed as discriminatory and demeaning.

To ensure health services are available and enjoyed even at the grassroots levels, the Constitution created a devolved system of government, in which both the national and county governments have responsibility for health care. Under the Fourth Schedule of the Constitution, the national government is responsible for health policy, national referral health facilities, capacity building, and technical assistance to county governments. On their part, the county governments are required to provide health services at the county level including promotion of primary health care. The constitution mandates each county government to plan, budget, implement, monitor, and evaluate county level health care services, including mental health care. County government are therefore required by the Constitution to provide mental health services at the community, primary, general hospital, and at

county referral hospital levels. The national government on its part, is mandated to operate national referral health facilities. Kenya has only one national hospital that offers mental health services; the Mathari National Teaching and Referral Hospital.

Indeed, under Article (54) (1) (b), a person with disability is entitled to access ... and facilities for persons with disabilities that are integrated into society to the extent compatible with the interests of the person. This requirement challenges the bio-medical model that has often been applied to treat mental health problems. Often, this is used to isolate mental health patients furthering their discrimination and stigmatization. Instead, the Constitution observes that there should be more investments towards community based mental healthcare systems.

3.1.2 Mental Health Act no 10 of 1989

Kenya's mental health services are guided by the Mental Health Act no 10 of 1989. The Act was never implemented fully since its passage. For example, though Section 46 outlawed discrimination by insurance companies on grounds of mental disorder[16], interviews revealed a continued violation of this clause by insurance companies. Section 7, which provides for the appointment of district mental health councils was not operationalized too.

The failure to implement the Act fully was blamed on lack of political will. The Minister / Cabinet Secretary in charge of health from giving the commencement dates of the various clauses as provided for by the Act. Lack of budgetary allocation was also blamed for implementation failure. The passage of the 2010 Kenya Constitution dwelt a bigger blow to the Act. It now requires a total overhaul in order to conform to the aspirations of the current constitutional order especially the rights based framework which is the opposite of the bio-medical model perpetuated by the 1989 Act.

There are similar legislations that have complicated mental healthcare services in Kenya as they all have clauses touching on mental health making it a challenge to reconcile all the provisions for the good of mental health. Some of these legislations include the Criminal and Procedures Act, the Penal Code, the Prisons Act, the Children's Act, Sexual Offences Act, The Marriage Act and the Female Genital Mutilation Act. Despite the existence of these numerous legislations patients with mental health challenges have continued to experience human rights violations. Examples of these violations include being restrained and isolated in hospitals, discrimination and stigma, allocation of little resources to mental health care, inadequate investment in research, training, recruitment and retention of mental health workers and general poor mental health infrastructural development in the country.

3.1.3 The Kenya Mental Health Policy 2015-2030

Kenya's Mental Health Policy was launched in 2016 and is currently under implementation albeit in a slow manner. It recognizes mental health as a key determinant of overall health and socio-economic development in the country. This is the key guiding policy on mental health in Kenya and provides a framework on interventions for securing mental health systems reforms in line with the Constitution of Kenya 2010, Vision 2030, the Kenya Health Policy (2014-2030), and the global and regional commitments. The policy further seeks to address the systematic challenges, emerging trends and mitigate the burden of mental health problems and disorders. This includes addressing mental health issues in relation to leadership and governance, health services, human resources, health financing, infrastructure, health products and technologies, health information system and research, advocacy and partnerships.

16 Section 46 (1) Every person in Kenya shall, be entitled, if he wishes, to insurance providing for his treatment as a person suffering from mental disorder and no insurance company shall make any insurance policy providing insurance against sickness, which excludes or restricts the treatment of persons suffering from mental disorder. An insurance company which makes any insurance policy which expressly excludes or puts restrictions on the treatment of any person suffering from mental disorder shall be guilty of an offence

Though the policy is comprehensive, and if implemented fully could drastically change the mental health services for better, it lacks sufficient financial commitments from the government. This is despite the policy commitment that Kenya government will stick to the WHO standards of financial allocation. The policy has neither stated the amounts nor has there been increased budget allocation for mental health in the last five financial years. In an effort to develop adequate human expertise in the mental health sector, the policy recommends training community health workers and general staff in hospitals on mental health.

According to 2017 Performance Audit Report on Provision of Mental Health Services in Kenya by the Office of Auditor General[17] Ministry of Health had commenced the implementation of the Mental Health Policy 2015 – 20130. Then, the Ministry had begun to draft the Mental Health Plan 2017 – 2021. This plan is still at draft level as explained by the mental health directorate.

The other issues that the Ministry was to begin implementation included integration of mental health into the Health Information System (HIS), developement of mental health tools, and monitoring and evaluation framework for mental health services. The policy has also called on the government to develop guidelines and standards on promotion, prevention, care, treatment and rehabilitation of persons with mental neurological and substance abuse disorders. However, by conclusion of the study none of these policy issues had been concluded. This is an indication that the government seems it have not prioritised mental healthcare services.

In particular, the delay in developing guidelines and standards on promotion, prevention, care, treatment and rehabilitation of persons with mental neurological and substance abuse disorders is hurting treatment of substance abuse which has gained unprecedented momentum from devolved county governments with support from the National Authority for the Campaign Against Drug Abuse (NACADA). Counties have domesticated the alcoholic drinks control Act with some notable success including putting in place community based substance, alcohol and drug rehabilitation programs. The approach attempts to build on the community health strategy that begins at community level where community health workers are supported to provide services such as counseling, social and economic support, and referral to county health facilities. These services are however hampered by lack of the prescribed guidelines and standards. As a result, there have been media reports on quality of care been offered by the emerging mental health and rehabilitative programme in some counties. Questions have been raised on value for money invested in these programmes.

3.1.4 The Kenya Health Act, 2017

The Health Act, 2017 was signed into law June 22, 2017 and its operationalization commenced henceforth. The purpose was to establish a unified health system, coordinate the interrelationship between the national government and the county government health systems, to provide for regulation of health care service, and health care service providers, health products and health technologies and for connected purposes. Since the passage of the 2010 constitution the health sector was faced with structural challenges that required a health law in order to align the sector with the Constitution. Delays in enactment of mental health law was blamed on lack of a national health law.

The Health Act, 2017 recognized the need for development of a separate Mental Health Law.[18] This was advocated for by the Directorate of Mental Health, Ministry of Health in order to provide an opportunity to develop an all-encompassing mental health law. Though the Health Act, 2017 did not provide timelines for the enactment of the mental health law, Ministry of Health has commenced the implementation of the Act which should include the process of developing the new legislations.

17 Office of Auditor General, 2017. Performance Audit Report on Provision of Mental Health Services in Kenya.

18 Government of Kenya, 2017. The Health Act, 2017. Kenya Gazette Supplement 101. Nairobi. The Government Printer

The Directorate of Mental Health, Ministry of Health reported that a Technical Working Group had been put in place and was working to fulfill the requirement of the Health Act. The Technical Working Group however, according to the Ministry was yet to commence discussions on whether the Ministry should amend, develop several laws or repeal the existing Mental Health law. However, data from civil society organisations that were interviewed revealed that over the last five years there were attempts to develop a new mental health law. In deed the processes went further and culminated with development of Mental Health Bill, 2014. According to 2017 Performance Audit Report on Provision of Mental Health Services in Kenya the mental Health Bill, 2014 could not be enacted into a law as there was no health law in order to give the basis for enactment of other health laws such as the Mental Health Law. The mental health services and programs largely continue to be guided by the moribund mental health Act of 1989 until Parliament enact a new mental health law.

3.1.5 International Human Rights Instruments

The Constitution of Kenya under Article (2) (5) and (6) recognizes the general rules of the international law as part of Kenya law and any treaty or convention ratified by Kenya as part of law in Kenya. One of the key international instrument that safeguard the right to mental health is United Nations Convention on the Rights of Persons with Disabilities (CRPD). It seeks to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by people with disabilities and to promote respect for their inherent dignity.

The government has the duty to meet all the obligations as provided by CRPD including costed mental health plans and allocate resources including financial, technical, and human and infrastructure for mental health care services. Citizens and stakeholders on their part should be able to work and hold the government accountable in reaffirming that all people with all types of disabilities including mental disorders enjoy all human rights and fundamental freedoms at all times as enshrined in CRPD. The oversight role is to some extent been played by Kenya National Commission for Human Rights (KNCHR), but there is need for the Commission to generate periodic reports that can inform the progress.

Mental and neurological disorders were recognized during the United Nations General Assembly of September 2011 as important causes of morbidity and that they contribute to the global non communicable diseases burden. Governments including Kenya's were called upon to intensify their efforts towards reducing risk factors and creating health promoting environments, strengthen national policies and health systems among others to prevent and control non-communicable diseases including mental health disorders. Mental health care services are still lagging behind with inadequate awareness, stigma and discriminations, inadequate investments and policy frameworks despite existent of this high level political commitment.

Further, in 2015, Kenya joined global community in endorsing the 2030 Sustainable Development Goals (SDGs). SDGs obligates the states to reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being and strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

GOVERNMENT BUDGETARY ALLOCATIONS FOR MENTAL HEALTH

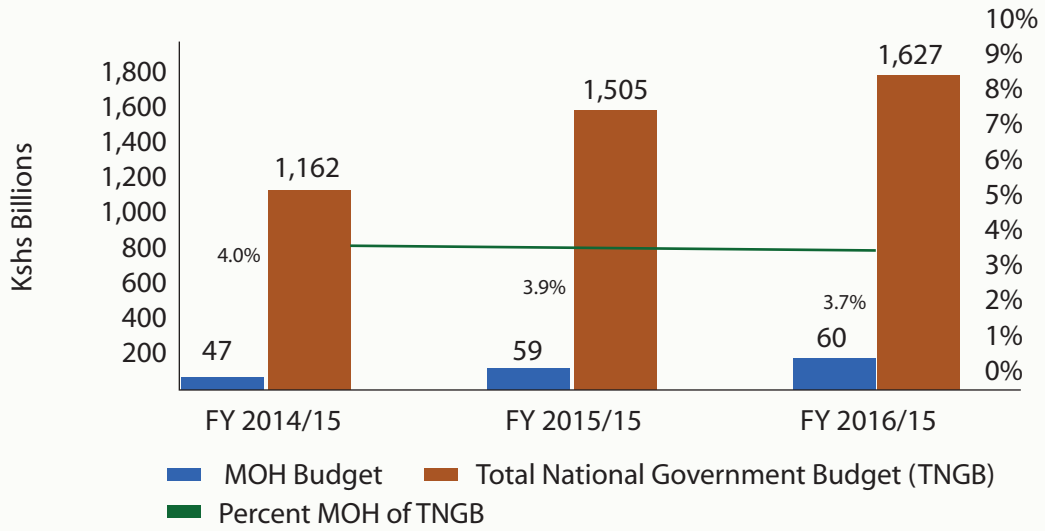
3.2 Government Budgetary Allocations for Mental Health

This section presents the analyses of national and county budgets and allocations to health for 2014/15, 2015/16, and 2016/17 financial years. That is, the amount of funds budgeted and allocated by national and county governments in support of health functions.

3.2.1 National Budget Allocation to the Health Sector

The national government allocation to health sector, according to 2016/2017 health sector budget analysis for national and county government[19] increased gradually between 2014/15, 2015/16 and 2016/2017. An increase was also experienced in the health sector but at only 1.8% compared to national government budget increase of 8%. Indeed, the MOH funding decreased from 4.0% in 2014/15 to 3.7% in 2016/2017 as shown by Figure 1 Below. The marginal increase for health sector compared to national government budget increase could be an indication of the low priority that the national government accorded the health sector although there are counter arguments that most health functions have been devolved to county government.

Figure 1: National Budget Allocation to Health Sector compared to Total National Government Budget



Source: National and County Health Budget Analysis FY 2016/2017

3.2.2 National and County Combined Health Budget

The amount allocated to health sector is determined independently by the national government and each of the 47 counties with the approval from national and county assemblies. As provided for by the Constitution, the national government health budget addresses policy level matters, regulations, trainings and national referral hospital services. County governments on the other hand allocate the funds for healthcare services and infrastructural development. According to the Ministry of Health, National and County Health Budget Analysis Report for 2017/2017[20] financial year, the combined allocation to health in Kenya ranged from 5.5% to 7.7 % between 2013/2014 and 2016/17 as shown in Figure 2 Below. The trend shows some constancy of around 7.5% – 7.7% in the last 3 financial years of combined budget allocation for national and county governments into health sector. This compares with the allocation before devolution in 2012/2013 that stood at 7.8%, an indication that health sector funding over the last five years has relatively remained the same.

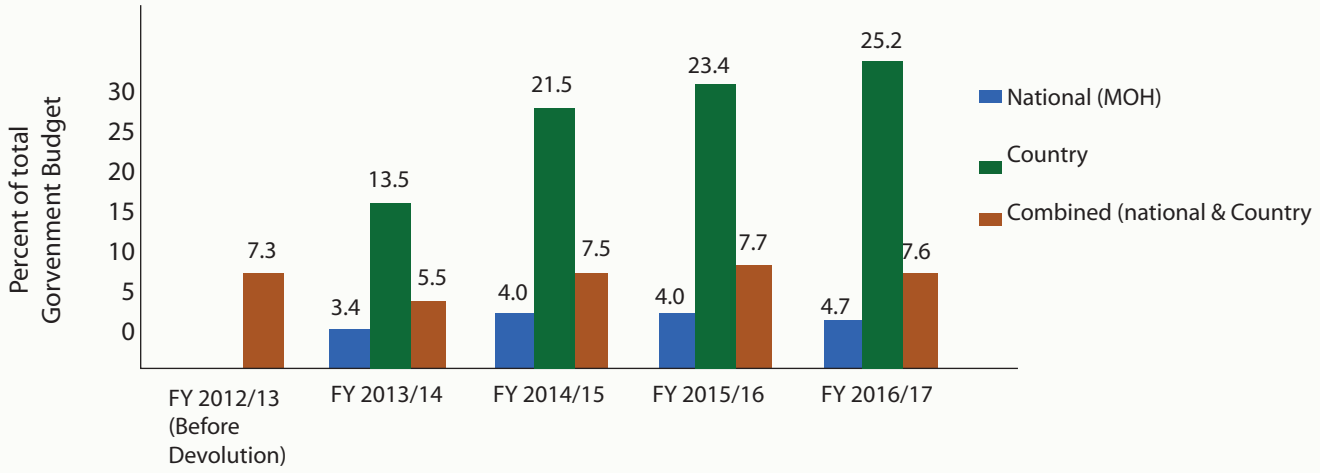
The allocation of national government to health sector has oscillated between 3.4% and 4.0%, a

19 Ministry of Health. 2017. National and County Health Budget Analysis FY 2016/17. Nairobi: Republic of Kenya.

20 Ministry of Health. 2017. National and County Health Budget Analysis FY 2016/17. Nairobi: Republic of Kenya.

trend that can be explained by fact that a lot of health functions have been devolved to county governments. However, the county government allocation for health increased progressively from 13.5% in 2013/14 to 25.2% in 2016/17 financial years. Each county has the autonomy to appropriate total budget allocations by sector.

Figure 2: Trends in Health Allocations as a Percentage of Total Government Budget and Level of Government



Source: National and County health Budget Analysis FY 2016/2017

3.2.3 National and County Governments Budget Allocation for Mental Health

Mental health is marginalized within Kenya's health care system as only about 0.5% [21]of the total national and county health budget is set aside for mental health care as shown in Table 1 below. The figures on total mental health budget is based on the national government budgetary allocation from the budget estimates as there are no mental health budget lines in County government budget an indication of the low priority that county government accord to mental healthcare.

Table 1: % of Total Mental Health Budget Compared to National and County Health Budgets

Financial year	Total health budget including national and county government (Kshs in Billions)	Total mental health budget (kshs in Billions)	Total mental health budget as a % of the total health budget national and county (kshs in Billions)
2013/14	93.08	0.55	0.59%
2014/15	110.14	0.29	0.27%
2015/16	128.89	0.74	0.57%
2016/17	137.05	0.55	0.40%

Source: National and County Health Budget Analysis FY 2016/2017 and Budget Estimates for recurrent and development expenditures

The Auditor General's report observed that even at county referral hospital, it was difficult to itemize and quantify the amount incurred by psychiatric units as they neither make their own budget nor was there direct funding for mental health. Instead they rely on purchases that are done for the hospital as a whole. The assessment of 2017/2018 budget estimates for the county government revealed the same scenario. None of the 47 counties had a budget line for mental health in their health department.

21 Kenya National budget estimates 2016/2017: Trend analysis

Table 2 shows a summary of the budget allocation of the national government to the mental health department over the years under review. The allocation decreased from 1.52% in 2013/2014 to 0.90% in 2016/2017. The allocated amount is far much below the burden of mental disorders and the needs of the community and goes against government's own policy commitments and international human rights instruments.

Table 2: Percentage of National Government Allocation to Mental Health programs

Financial Year	Total allocation for mental health (Kshs in Millions)	Total allocation for MOH (Kshs in Millions)	% allocation of MOH to Mental Health
2013/14	552,170,409	36,281,090,000	1.52
2014/15	294,266,522	47,363,000,000	1.12
2015/16	735,109,730	59,923,530,000	1.23
2016/17	545,315,274	60,269,930,000	0.90

Source: Budget Estimates for recurrent and development expenditures

Most of the government officials interviewed attributed poor budgetary allocation to mental health to lack of full implementation for the existing mental health law, lack of political will and inadequate prioritization of mental health as compared to other illnesses. Table 3 below compares development budgetary allocation by national government to mental health with other programmes.

Table 3: National Government Budget for Development to Mental Health Compared with other Health Programmes IN Ministry of Health

Ministry of Health officials, psychiatrics and civil society members interviewed called for allocation of

	DEVELOPEMENT EXPEDITURE BUDGET				DEVELOPMENT EXPENDITURE %			
Developement Budgets	**2014/15**	**2015/16**	**2016/17**	**2017/18**	%	%	%	%
Curative & Rehabilitative	3,300,000,000	5,370,000,000	0	0	25.4	36.64	0.00	0.00
Spinal Injury Hospital	29,000,000	29,000,000	4,000,000	4,000,000	0.22	0.19	0.07	0.11
Nutrition	681,300,000	442,000,000	860,000,000	67,556,992	5.24	2.93	15.68	1.8
FP, Maternal and Child Health	4,360,000,000	4,348,000,000			33.53	28.86	0.00	0.00
Environmental Health	68,375,000	128,875,000	95,000	50,000	0.53	0.86	1.73	1.33
K.E Programs Immunization	2,860,000	0	0	0	22.01	0.00	0.00	0.00
Malaria Control	1,002,644,732	1,641,799,406	1,078,647,661	1,200,000,000	7.72	10.90	19.68	31.99
TB	395,453,309	590,988,214	1,008,390,474	602,515,900	3.04	3.92	18.38	10.00
Mental Health	51,000,000	31,500,000	30,000,000	75,000,000	0.39	0.21	0.55	2.00
HIV	245,000,000	2,485,203,587	2,409,404,789	1,752,251,523	1.89	10.49	43.92	40.71
GRAND TOTAL	**12,992,773,601**	**15,067,426,207**	**5,485,448,924**	**3,751,324,415**	**100**	**100**	**100**	**100**

Source: Budget Estimates for recurrent and development expenditures

at least 5% of health budget both at national and county government levels, in order to be consumulate with the mental health in Kenya.

3.2.4 Mental Health Budgetary Votes at National Level

The national budget for mental health according to estimates of the recurrent and development expenditures is allocated to three main votes within the Ministry of Health. These are Mathari National Teaching and Referral Hospital, the Division for Mental Health and Kenya Board of Mental Health as indicated in Table 4 Below. It is only Mathari National Teaching and Referral hospital that has a development vote, though in 2013/2014 no allocations were provided for in the estimates.

Table 4: Budget Allocations for Mental Health programs

FY	Vote Head	Amount Allocated		Total Allocation
		Development	Recurrent	
2016/17	Mathari Teaching & Referral Hospital	30,000,000	476,718,877	506,718,877
	Division of Mental Health		33,662,815	33,662,815
	Kenya Board of Mental Health		4,933,582	4,933,582
	Total			**545,315,274**
2015/16	Mathari Teaching & Referral Hospital	101,000,000	578,803,454	679,803,454
	Division of Mental Health		48,746,276	48,746,276
	Kenya Board of Mental Health		6,560,000	6,560,000
	Total			**735,109,730**
2014/15	Mathari Teaching & Referral Hospital	51,000,000	187,960,246	238,960,246
	Division of Mental Health		48,746,276	48,746,276
	Kenya Board of Mental Health		6,560,000	6,560,000
	Total			**294,266,522**
2013/14	Mental Health Services		510,927,227	510,927,227
	Division of Mental Health		41,243,182	41,243,182
	Total			**552,170,409**

Source: Budget Estimates for recurrent and development expenditures

It emerged from the interviews with government officials, that there are other budget lines under the health sector budget that touch on mental health. For example, drugs, non-pharmaceuticals, equipment, human resources and transport but they have no dedicated budget line that can show the amount budgeted for mental health.

According to stakeholder's views during the validation meetings and report by KNCHR[22], stigma and discrimination, poor perceptions and misunderstanding of mental health among politicians and decision makers is responsible for low budget allocation for mental health by government during budget making process. Members of Parliament have done little to influence and allocate more funds towards mental health as they prepare and approve the national budget.

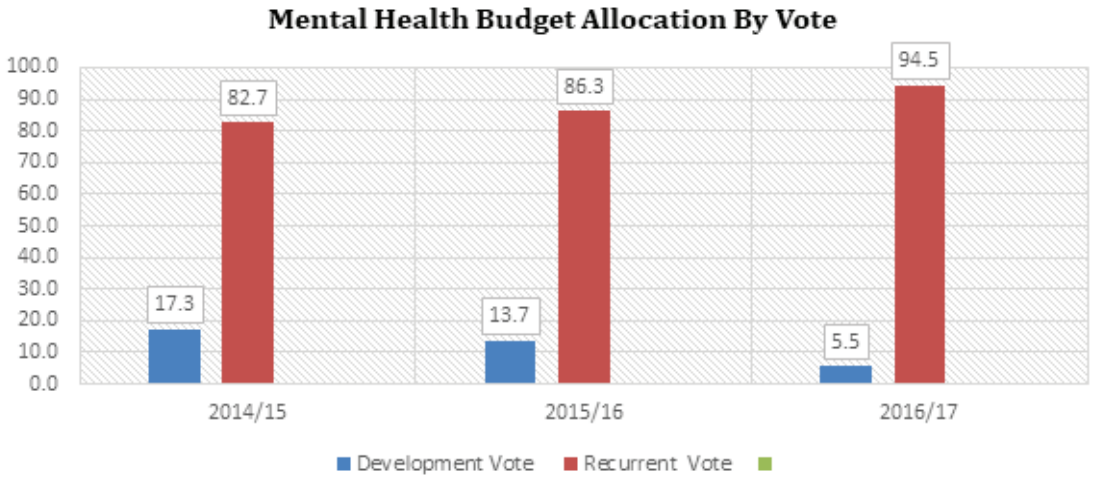
3.2.4.1 Budget allocations by recurrent and development vote

A recurrent budget is an operational budget that tracks ongoing annual revenues and expenses that occur on a regular basis while the development vote is the capital budget used to evaluate potential investments or expenditures for specific projects or purposes and is dedicated to growth. Figure 3 shows the distribution of the mental health budget allocations for the period 2014-2017 by recurrent and development vote.

Figure 3: Mental Health Budget Allocation by Vote

22 KNCHR 2011. Silenced Minds: The Systemic Neglect of Mental Health System in Kenya. A human rights audit of mental health system in Kenya. Nairobi. Kenya National Commission for Human Rights.

Source: Budget Estimates for recurrent and development expenditures



According to the estimates the development vote is far much below the government own commitment of ensuring at least 30% of the budget is allocated and spent in development initiatives. Since 2015, the government of Kenya has invested in macro strategies to manage national budget and debts by among others trimming the recurrent expenditure to 70% against development expenditure of 30%. The ballooning wage bill and low budget absorption rates has threatened the success of this model. The trend is almost the same in the mental health budget allocations despite the dismal allocations.

3.2.5 Mathari National Teaching and Referral Hospital

The study reviewed budgetary allocations for Mathari National Teaching and Referral Hospital, the only national referral hospital under the national government that offers mental health services. According to the hierarchy of Kenya's healthcare system the hospital is at level 6, a facility that is supposed to provide specialized mental healthcare services including integrated preventive and curative services, drug rehabilitation services, forensic services for legal purposes, trainings and research in mental health. It was founded in 1910 during the colonial era as a small pox isolation center but latter on it was used to accommodate patients with mental disorders. According to health sector Health Sector Medium Term Expenditure Framework (MTEF) report for 2017/18 to 2019/2020[23], mental health falls under curative and rehabilitative health programme with Mathari National Teaching and Referral Hospital been the epicenter of mental health services.

Despite the hospital been classified a national referral hospital, the budget allocation does not reflect its full status as a national teaching and referral hospital. Compared to the other National, Teaching and Referral Hospitals, Mathari Teaching and Referral Hospital received meagre budget allocation as compared to Kenyatta National Hospital and Moi Teaching and Referral Hospital as shown in Table 5 and 6 below.

Table 5: Development Allocations to National Hospitals

23 GOK, 2016. Health Sector Medium Term Expenditure Framework (MTEF) Report 2017/2018 – 2019/20.

Vote Heads	Development Expenditure							
	2014/2015	%	2015/2016	%	2016/2017	%	2017/2018	%
Moi T&R Hospital	544,021,896	54.02	166,250,000	23.27	364,021,896	42.93	364,021,896	48.83
Mathari N.T.R.Hospital	51,000,000	5.06	31,500,000	4.41	30,000,000	3.54	75,000,000	10.06
Spinal Injury Hospital	29,000,000	2.88	29,000,000	4.06	4,000,000	0.47	6,000,000	0.80
Kenyatta N. Hospital	383,000,000	38.03	487,750,000	68.26	450,000,000	53.06	300,500,000	40.31
Grand Total	**1,007,021,896**	**100**	**714,500,000**	**100**	**848,021,896**	**100**	**745,521,896**	**100**

Table 6: Development Allocations to National Hospitals

Vote Heads	Reccurent Expenditure							
	2014/2015	%	2015/2016	%	2016/2017	%	2017/2018	%
Moi T&R Hospital	5,256,991,523	36.45	5,244,676,867	35.50	5,033,676,867	39.83	5,638,350,405	36.09
Mathari N.T.R.Hospital	187,960,246	1.30	453,665,436	3.07	476,718,877	3.77	725,436,436	4.64
Spinal Injury Hospital	152,200,243	1.06	367,344,732	2.49	466,276,972	3.69	450,642,090	2.88
Kenyatta N. Hospital	8,824,032,654	61.19	8,707,461,541	58.94	6,661,461,541	52.71	8,807,890,722	56.38
Grand Total	**14,421,184,666**	**100**	**14,773,148,576**	**100**	**12,638,134,257**	**100**	**15,622,319,653**	100

According to the data collected, it was evidenced that the hospital has not lived to its full mandate of a level 6 facility due to inadequate policy, infrastructural development, healthcare workers and funding. The respondents noted that for the hospital to be allocated budget directly, it should have an enhanced legal framework similar to the other two major referral hospitals enabling it to be a semi-autonomous government entity with an independent board of directors and chief executive.

Interviews with hospital management revealed that, the facility is under the Ministry of Health, department of Curative and Rehabilitative Health. An indication that the hospital is allocated budget by Ministry of Health and not direct from the national Treasury. Further interviews with hospital official revealed that there has been recommendations sent to the Auditor General, National Assembly Committee for Health by mental health stakeholders, making justifications on why Mathari National Teaching and Referral Hospital should be elevated to a semi-autonomous government entity.

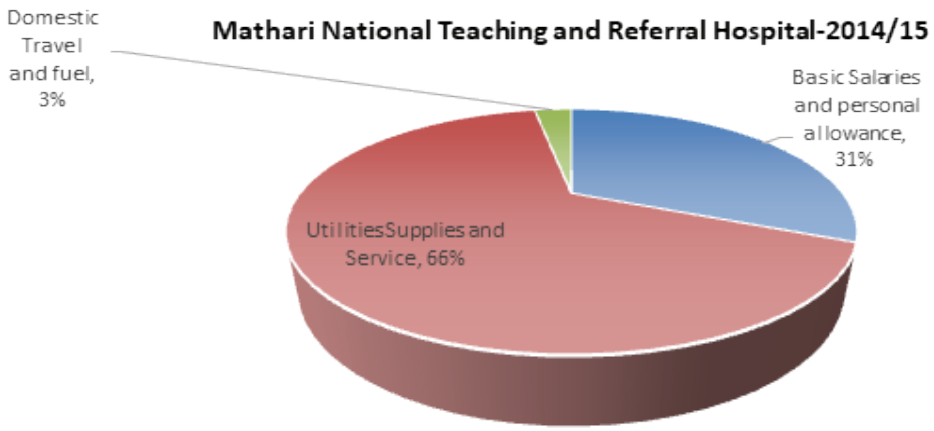
The Office of Auditor General's 2017 Performance Audit Report on Provision of Mental Health Services

in Kenya[24] reported that the head of the hospital, Medical Superintendent reports to at least five different offices. These includes the Cabinet Secretary for Health, The Principal Secretary for Health, Director of Medical Services, Divisional Head, Curative and Rehabilitative Services and Director, Mental Health Division. This reporting structure is too bureaucratic leaving the head of the hospital with little room for decision making. For example, attempts by the research team to access budget and expenditure reports from the hospital proved futile due to clearance and authorization from these offices, which was not forthcoming. No one was willing to take responsibility and provide the authorisation. This is a clear indication that in the government and health sector, there is no one office empowered fully to steer mental healthcare services including providing policy directives. Existence of these many offices could be part of the reasons, mental health is clearly neglected.

3.2.5.1 Distribution for Mathari National Teaching and Referral Hospital Budget

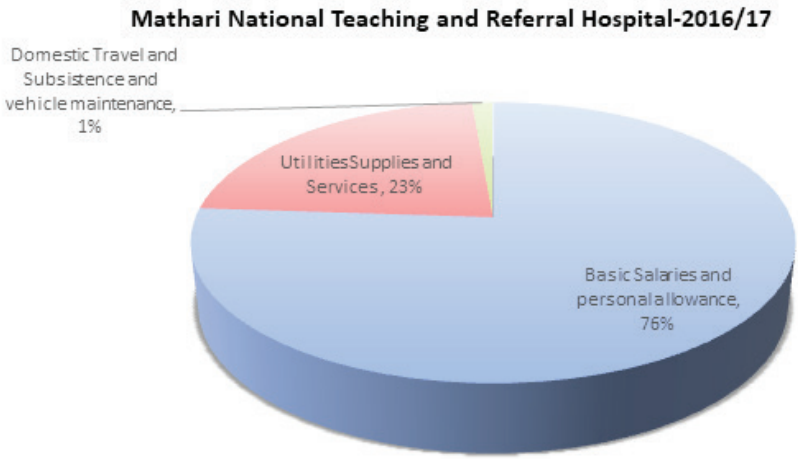
The distribution for Mathari National Teaching and Referral Hospital of the recurrent budget expenditure by line items for the year 2014/2015 are shown by Figure 4 while Figure 5 shows the allocations for the year 2016/17.

Figure 4: Mathari National Teaching and Referral Hospital-2014/15



Source: Budget Estimates for recurrent and development expenditures

Figure 5: Mathari National Teaching and Referral Hospital-2016/17



Source: Budget Estimates for recurrent and development expenditures

The fiscal data shows that more of the recurrent budget was allocated to salaries and specialized materials and supplies.

3.2.6 County Governments Mental Health Budget Allocation The study established that only twenty-

24 Office of Auditor General, 2017. Performance Audit Report on Provision of Mental Health Services in Kenya. Nairobi. Office of Auditor General.

five of the 47 county referral hospitals have psychiatric units. These are Nakuru, Nyeri, Murang'a, Kirinyaga, Machakos, Embu, Kisumu, Siaya, Kiambu, Meru, Isiolo, Uasin Gishu, Kericho, Garissa, Kitui, Nairobi, Narok, Trans-Nzoia, Makueni, Kilifi, Tharaka Nithi, Bungoma, Kakamega, Mombasa and Kisii. These according to Mathari National Teaching and Referral hospital management are mostly reserved to treat those with severe mental disorders and substance use disorders. Nonetheless, majority of cases are referred to Mathari National Teaching and Referral Hospital contribution to congestion. However, the actual budget allocation for the county referral hospitals psychiatric units were not available as none of the 47 counties has a separate budget line for mental health within the county budget.

3.2.3 Disbursement of the Mental Health Budget

One of the objectives of the study was to assess how much of the budgeted mental health budget is actually disbursed and spent as budgeted for. However, this analysis was hindered by lack of primary data from Ministry of Health and Mathari National Teaching and Referral Hospital due to bureaucratic authorisation procedures. Nonetheless, a similar analysis by the office Auditor General in 2017 Performance Audit Report on Provision of Mental Health Services in Kenya[25] shows that not all the budgeted amount are actually disbursed. So astonishing according to the report is the fact that despite there been a budget allocation for development, zero funds were actually disbursed for 2013/2014, 2014/2015 and 2015/2016 financial years while for the recurrent expenditure actual allocation was as low as 28% in 2015/2016 financial year as shown in Table 7 below. According to the report no explanations were provided as to why this was the case.

Table 7: Mathari National Teaching and Referral Hospital Approved Budget Estimates compared to Actual Allocations

	Recurrent Expenditure				**Development Expenditure**		
Financial year	Approved Estimates (Ksh)	Actual Allocation (Ksh)	Variance	% Variance	Approved Estimates (Ksh)	Actual Allocation	Variance
2015/16	453,665,436	127,436,960	326,228,476	72	31,500,000	0	31,500,000
2014/15	187,960,246	134,971,200	52,989,046	28	45,000,000	0	45,000,000
2013/14	510,927,227	185,126,072	325,801,155	64	20,000,000	0	20,000,000
Total	**1,152,552,909**	**447,534,232**	**705,018,677**		**96,500,000**		**96,500,000**

Source: Analysis by Office of Auditor General on GOK Funds for Mathari N.T R. Hospital

The low expenditure for mental health, suggests that priority for the government is low as evidenced by insufficient funding and failure to spend the budgeted for the intended services. This could be attributed to limited appreciation by the government, especially decision makers on prevalence of mental illness in Kenya and its negative on development and economy of the country.

25 Office of Auditor General, 2017. Performance Audit Report on Provision of Mental Health Services in Kenya. Nairobi. Office of Auditor General.

PUBLIC PARTICIPATION IN MENTAL HEALTH PROGRAMMING, PLANNING AND BUDGETING

3.3 Public Participation in Mental Health Programming, Planning and Budgeting

This section documents the level of engagement of public participation in mental health programming, planning and budgeting.

3.3.1 Public Participation in Mental Health Programming, Planning and Budgeting

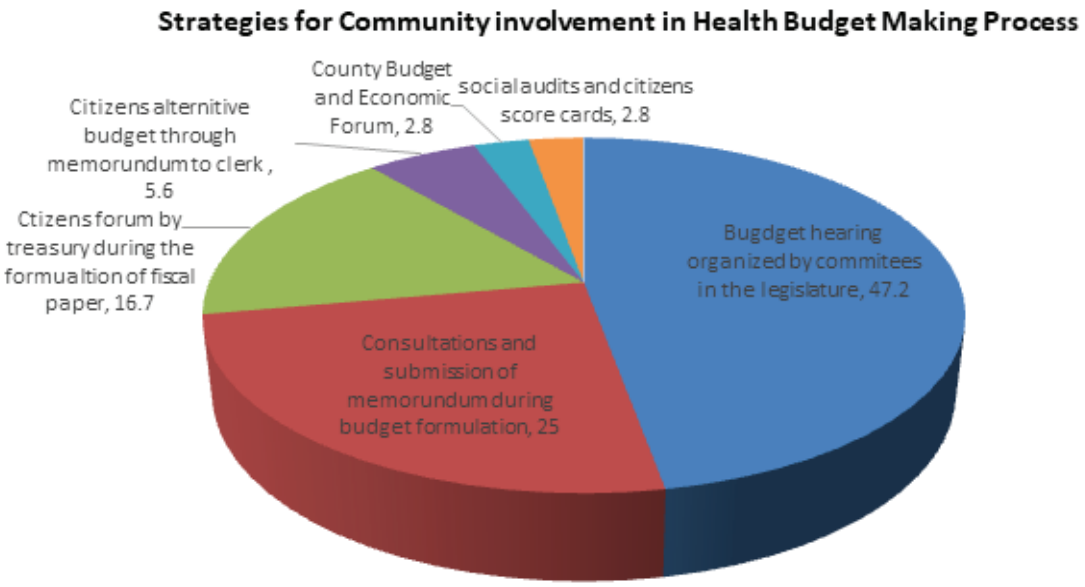
The study sought to explore levels of public participation in the processes of programming, planning and budgeting for mental health in Kenya. Key informant's interviews and document reviews were undertaken with actors involved in mental health activities. A total of 37 actors were contacted and participated in the study. Nearly 40% of the respondents were community based organizations operating at the grassroots level, while about 4 of them were faith based agencies (FBO). One third of the agencies participating in the study were non-governmental organizations. Other actors included disability organizations, self-help groups, research institutions, and academia and humanitarian agencies. Public sector actors such as independent human rights commissions were also interviewed.

The data points to the fact that only 10% of organizations surveyed were involved in advocacy of budgets and plans for mental health. This was in contrast to the high percentage (81%) of organisations interviewed that were involved in policy, budget and planning process for Maternal, Newborn and child health services including reproductive health, and HIV, TB and Malaria prevention programs. It emerged from the data that there is lack of strong civil society voice in engaging with government in planning, budgeting and policy advocacy for mental health.

Participants were asked to state stages at which they are involved in budget making processes at either national or county level. Data indicate less engagement of the communities and grassroots actors in the formative stages of budgeting making processes which is the backbone stage of formulating people centered budget. Indeed, it is at this stage that most behind the scene influencers are able to push for their interests and influence subsequent planning and budget decisions. On the contrary a majority of the organizations (88%) are involved or engage themselves with terminal and last stages of budgeting making process including discussions of the budget just before it's approved by the National Assembly or the County Assemblies. The late engagement with budget making processes denies the local communities from projecting their needs in the budget proposal resulting to rhetoric ritual budget making processes.

The study sought to find out key strategies that civil society organisations including grassroots communities have applied to engage with national and county government during the budget making processes Most recalled strategies were budget hearing sessions (47%) followed by consultations and submission of memorandums to County and National Assemblies (25%) as shown in Figure 6 below.

Figure 6: Strategies for Community involvement in Health Budget Making Process

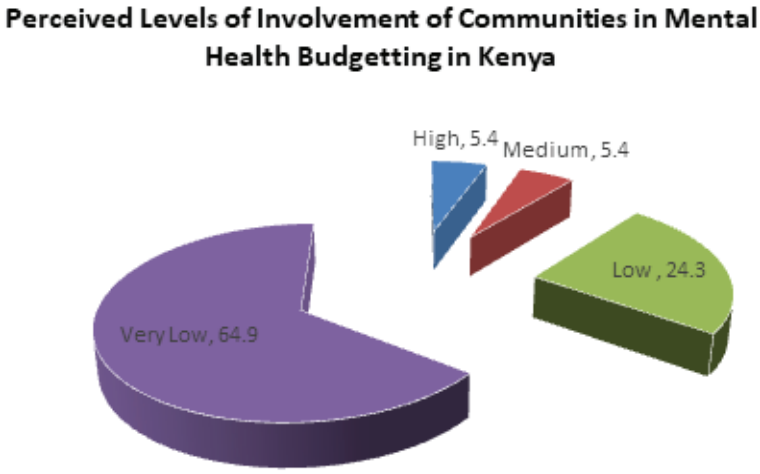


Source: Budget Estimates for recurrent and development expenditures

In-depth analysis of the responses indicates the level of utilization of any of the strategies by civil society organizations to advocate and enhance community involvement and participation in budget making processes is very limited and when it is applied, communities are remotely engaged. That is, despite public announcement for public hearing meetings, the information is often communicated late, no prior documents are shared in advance despite them been bulky, the meeting often begins late, hurried and there is handily any feedback from the government teams. The exercise is therefore more of a gimmick to hoodwink the public that they were consulted but in the real sense all the major decisions had been arrived at and almost concluded. This is intended to blur the public that the constitutional requirements including public consultations have all been met but in the real sense, the public is cheated and taken for a ride.

Using a scalar data point, figure 7 summarizes the perceived levels of involvement of the communities in the mental health budgeting.

Figure 7: Perceived Levels of Involvement of Communities in Mental Health Budgeting in Kenya



The data indicates there that there is very little involvement of the public in mental health budget decision. This attributed to low levels of awareness on mental health, high levels of stigma associated with mental problems and inadequate campaigns at global and national levels around mental health. .

3.3.2 Obstacles to Public Participation

Access to information on mental health by citizens to enable them to effectively participate in decisions making processes remains a major obstacle. The sub-sector was found not truly open to public scrutiny and hence most decisions are made internally. Lack of mental health committees at county government levels locks out the public from decision making structures. The process of accessing information and data is riddled with a lot bureaucracy ranging from Ministry for Health headquarter, (Cabinet Secretary, Principle Secretary and Director of Medical Services), Divisional Head, Curative and Rehabilitative Health, Director, Division of Mental Health to Medical Superintendent, Mathari National Teaching and Referral Hospital.

Under prioritization of mental health. Civil society organisations have other more prioritised health sector interests other than mental health. It emerged that majority (91%) of those interviewed, despite indicating that they had interest in mental health, over 84% of their core activities were in communicable diseases especially HIV, TB, Malaria, maternal and child health programmes. On why community members had little interests in mental health, respondents from civil society revealed that mental health is associated with superstations, bewitchment and other religious beliefs whose explanations are not clear for common citizens. They therefore keep away from discussing matters touching on mental health, thereby stigmatizing the problem further.

Ministry of Health including mental health department at both national and county level were rarely involved in creating awareness among citizens on mental health budgeting and planning. Civil society members interviewed pointed out that other than during the mental health day, rarely do the government including mental health division conduct outreaches or are there public discussion even from the elected leaders. This was found as one of the factors that makes the public to have a low priority of mental health.

Most of the respondents (73%) with interest in mental health did not understand the health sector budgeting process including budget stages and what was expected of them in each of the stages. Unlike other, diseases especially, communicable disease that have strong technical working groups and inter-agency coordination mechanisms that brought all stakeholders together to plan and advocate for their disease component, there was none for the mental health. Key informants further stated that they were only aware of a handful of organisations that track the implementation of health budgets at national and county level. Most of them are interested in HIV, TB, and Malaria, Maternal, Newborn and Child health programmes. There was hardly any in non-communicable diseases. However, the framework for engaging with the government on social accountability has been improved by the 2010 constitution which provides for public participation in all decision making processes in the public sector. CSOs and the public should therefore enhance their capacity and engage effectively with the government on matters of accountability especially, on mental health.

The other hiccup that blur effective participation of civil society organisation in budget making process according to the study was poor coordination and timely follow ups. As a result, sporadic and parallel advocacy actions from civil society riddle the process thereby dimming their voices. In the processes of outdoing each other and seeking for cheap publicity CSOs often contract each other to the advantage of the government. The need to establish a coordination framework that can rally all the interested organisations and stakeholders was called for.

3.4 Agencies outside Government Influencing Budgeting and Planning for Mental Health

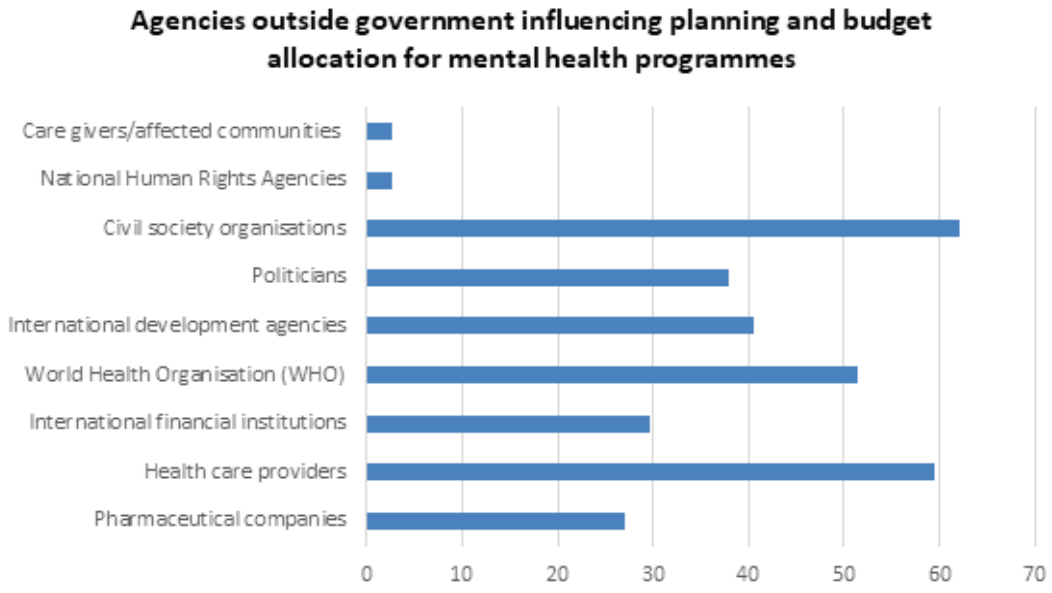
One of the objectives of this study was to identify categories of stakeholders outside government influential in planning, budgeting and funding mental health in Kenya.

3.4.1 Agencies perceived influential on government policy and budget decisions

The results are summarized in Figure 8. The civil society organizations (62%), health care providers (59%), World Health Organization (51%), and international development agencies (40%) are the most common agencies perceived powerful in persuading governments to allocate resources for mental health in Kenya. Other influential organs and agencies include politicians (37%), international financial institutions (29%), pharmaceutical companies (27%), national human rights institutions and care givers and affected communities (2%) respectively.

The study found that ability of civil society organisations both at national and global levels in influencing health decision was rated the highest. Examples were given of how civil society movements were able to lead onslaught into HIV and AIDS policy, programming and funding in all spheres of the economy. At global, national and community levels. The successes witnessed today including reduced stigma, treatment availability and increased funding were attributed to role played by civil society organisations. Mental health been an equally stigmatized disease, civil society movements if well mobilized, coordinated and capacitated should be able to influence mental health decisions to a large extent. This includes ensuring mental health remains an international health concern by piling pressure on the international community and national governments to provide the necessary policy, infrastructural development and adequate funding.

Figure 8: Agencies outside government influencing planning and budget



The role of health professionals and especially psychiatrists was the second in ranking but on further enquiry it emerged that their influence is double edged. While a good number were credited for advocating for the increase in mental health investment in public health sector, an equal number were accused of benefitting from the collapse of public health mental health programmes. They had invested heavily in private psychiatric clinics and hospitals including alcohol and substance abuse rehabilitation centres to an extent the public feels there is conflict of interest. Regarding pharmaceutical and medical equipment companies, key respondents noted that they have a lot of influence in determining availability, accessibility of mental health drugs and equipment thereby influencing mental health services and costs.

3.5 Donor Funding for Mental Health

A scan review on donor funding to mental health programs indicates little or no dedicated financial and human resources. The burden is therefore left to national and county governments and due to competing priorities, the sector is consistently underfunded. This trend is similar at global level. In

their 2018 scoping study designed to engage levels and scope of funding of mental health by funding agencies and development partners, Open Society Foundations (OSF) found and concluded that financing for mental health is notoriously poor, with roughly 0.3% of all global development assistance for health being spent on mental health in 2016 [26]. This is despite the growing prevalence of mental health disorders. Further nearly one half of this funding is channeled through or sourced from NGOs and philanthropies.

Other literature indicates that even where mental health is receiving funding from funding agencies, the resources are marked for short term to medium term interventions, are tied and grounded on some other health programs such as HIV, reproductive health or malaria, or too conditional for the local actors to fully exploit the potential of such a fund. According to KNCHR[27] the funding systems are also not coherent and consistent and often fund selective components of the continuum of mental health thus reducing the desired impact. Most funding further supports uni-sectoral and vertically implemented projects. The continuity of funding is not guaranteed and is not based on long term commitments but on available resources. There is little if any funding allocated to monitoring and evaluation of the mental health programs and even much less is allocated to community based mental health interventions.

In its estimation of external funding of mental health in Kenya, Open Society Foundation through its scoping study of 2018 found out that in 2015, Kenya received approximately USD 328 220 from eight agencies, namely United Kingdom, Finland, Germany, Norway, Canada, Korea, Switzerland and Denmark.[28] The analysis excluded contributions less than USD 100. Compared with incidence and prevalence of the mental health ailments and proportions of resources allocated by funding agencies in Kenya on other health issues, it is clear the levels of support is poor and less targeted. Data gathered through key interviews indicate that children and adolescent mental health needs as well as mental health care for persons with disabilities are routinely underfunded. The key informants however noted a significant growth and interest in donor funding for mental health an initiative that is derailed by lack of national and country level structure supportive of mental health programming.

Data from the Ministry of Health and Mathari National Teaching and Referral Hospital show that mental health programmes and services received support from key partners although at a lower scale compared to communicable diseases. Among these U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and Centre for Disease Control (CDC) were singled out as one of the key influential partners and donors. They have provided support on Medically Assisted Therapy (MAT) at Mathari National Teaching and Referral Hospital. This is the first clinic in Kenya to provide treatment services for people who inject drugs (PWID) who are at increased risk for blood borne diseases like HIV and hepatitis B and C. on her part, DANIDA supported Port Reitz hospital in Mombasa county to construct a building.

Among notable domestic funders included Safaricom Foundation which supported the improvement of Mathari National and Teaching Referral Hospital infrastructural system. This entailed renovation of three wards, purchase of 100 beds, office furniture and upgrading of laundry facilities at the hospital. The other private sector company that has supported the hospital was Cooperative Bank of Kenya.

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26 OSF, 2018. Scoping Study on Mental Health Financing. Open Society Foundations

27 KNCHR 2011. Silenced Minds: The Systemic Neglect of Mental Health System in Kenya. A human rights audit of mental health system in Kenya. Nairobi. Kenya National Commission for Human Rights.

28 OSF, 2018. Scoping Study on Mental Health Financing. Open Society Foundations

Key respondents noted that private sector players especially pharmaceutical industries have a lot of influence in determining availability, accessibility of mental health drugs and equipment. As a result, they influence mental health services and costs. Their donations to mental health care services were said to be very limited in Kenya. Only Philips, GlaxoSmithKline (GSK) and Merck Sharp & Dohme (MSD) according to respondents were known to have made donations towards mental health. Eli Lilly, a global pharmaceutical company had partnership in Kenya and donates products for mental health in Western parts of Kenya.[29] However, the literature search revealed in some developing countries such as South Africa, Pfizer, Novartis, AstraZeneca, Sanofi and Johnson & Johnson were active in mental health initiatives including improving awareness of patients and communities, strengthening patient doctor interactions on mental health, and training healthcare workers. Caution on the role played by pharmaceutical and medical supplies companies in influencing health sector policy decisions was found necessary in order to avoid conflict of interests as they do business directly with the government. Some respondents attributed bio-medical mental health model to have great support from pharmaceutical companies due to high volume of drugs that supply for psychiatric use.

The other organisations that Division of Mental Health and Mathari National Teaching and Referral Hospital identified for supporting mental health programmes and activities included World Health Organisation (WHO), United Nations Office of Drugs and Crime (UNODC), World Vision, Basic Needs, UK, Kenya Red Cross, Kenya AIDS NGOs Consortium (KANCO), MSF Belgium and Friends of Mathari National Teaching and Referral Hospital. There were also the Center for Public Health and Development, (CPHD), Kenya Kamili Organisation, Users & Survivors of Psychiatry Kenya (USPK), Africa Mental Health Foundation, Alzimas and Mental Health Organisation, Help Age International, Caritas, Reason for Hope, University of Washington, University of Maryland and My Mind my Funk. Government institutions that have partnered with the mental health division included National AIDS and STIs Control Programme (NASCOP) and National Agency for Control of Alcohol and Drug Abuse (NACADA).

It also emerged from the literature review that there is growing support to move mental health from the periphery to the center of the global health and development agenda. There have been collaborative efforts between the World Bank Group and WHO to put the mental health agenda at the center of global health and development priorities. WHO, though no data was available on any funding to the mental health, it was credited for influencing the development and launch of Kenya's Mental Health Policy in 2016. The policy provides a framework on interventions for securing mental health systems reforms in line with the Constitution of Kenya 2010. The need to build and strengthen partnership with WHO in order to ensure the policy is fully implemented and subsequent mental law is developed and implemented is paramount. On why development partners have been slow in showing interests in mental health, most stakeholders attributed this to lack of awareness, inadequate data on levels of mental health disabilities and its impact on socio-economic development, lack of global mental health campaigns and advocates that can rally and shape onions of decision makers and policy makers.

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29 Karuranga, S and J.K.Iyer, 2016. Access to mental healthcare: how should pharm companies channel their efforts? Accessed from https://accesstomedicinefoundation.org/media/atmf/2016-Access-to-mental-healthcare.pdf

CONCLUSION AND RECOMMENDATIONS

4.0 Conclusions

According to the assessment of the existing laws and policies on mental health, there is evidence that mental health is recognized by the Supreme law of the land, the Constitution. The Constitution, recognizes right to health as fundamental right that all persons including people with mental disabilities should enjoy without any form of discrimination. Nonetheless, the implementation of the Constitution in health sector has been painstakingly slow to an extent that in almost a decade key legislations especially those touching on mental health are yet to be enacted and implemented. As a consequence, mental health remains largely guided by the Mental Health Act, 1989 which was based on bio-medical treatment model, which has been blamed for most human rights violations that people with mental health disorders have suffered from for a long time. The development of the 2015 – 2030 Mental Health Policy for Kenya and the Health Act, 2017 have paved the way for the enactment of a new mental health law. The new mental health law will be streamlined to the International human rights instruments such as the Constitution, the United Nations Convention on the Rights of Persons with Disabilities (CRPD) which has laid bare the human rights issues that must be upheld for PWD. The implementation of the CRPD is still lagging behind as the country is yet to develop costed mental health plans and allocate resources including financial, technical, and human and infrastructure for mental health care services as required by the Convention. Though it is the responsibility of the civil society to hold the government accountable including developing shadow reports to mirror governments on status of CRPD progress, there are little efforts on this other than by KNCHR.

The national budget allocation on mental health is regrettably negligible and is consistently meant for recurrent costs. The budget votes do not adequately support operationalization of all pillars of mental health as envisioned in the Kenya Mental Health Policy 2015-2030. As a result, mental health is marginalized within Kenya's health care system as only about 0.5%[31] of the total national and county health budget is set aside for mental health care as compared to the burden of mental illnesses whose prevalence rate is estimated at 4%.[32] It is further estimated by KNCHR 2011[33] that up to 25% of outpatients and up to 40% of inpatients in Kenya's health facilities suffer from mental disorders.

Though health services are largely devolved, it was extremely difficult to estimate budget dedicated and spent in mental health as there were no known budget lines on mental health including in county referral hospitals. Only at the national government level, is there a budget line earmarked for mental health programmes, which goes into three budget line items. These are the division of mental health, mental health board and Mathari National Teaching and Referral Hospital. This arrangement calls for concerted advocacy efforts by stakeholder to ensure mental health is provided budgetary vote in all the 47 counties in Kenya.

Despite the low amounts allocated for mental the actual expenditure was more scarcely according to Office of Auditor General Performance Audit Report on Provision of Mental Health Services in Kenya. The report states that, no funds for development were actually disbursed for 2013/2014, 2014/2015 and 2015/2016 financial years while for the recurrent expenditure actual allocation was as low as 28% in 2015/2016 financial year. Poor government budget allocation and expenditure for mental health was attributed to high levels of stigma among decision makers and political leaders, lack of political will to implement fully the existing legal frameworks, and inadequate prioritization of mental health issues as compared to other diseases.

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31 Kenya National budget estimates 2016/2017: Trend analysis

32 Ndetei D, Khasakhala L, Kuria MW, et al. The prevalence of mental disorders in adults in different level general medical facilities in Kenya: A cross-sectional study. Ann Gen Psychiatry. 2009;8:1. http://dx.doi.org/10.1186/1744-859X-8-1

33 KNCHR 2011. Silenced Minds: The Systemic Neglect of Mental Health System in Kenya. A human rights audit of mental health system in Kenya. Nairobi. Kenya National Commission for Human Rights.

The health systems infrastructure including human resources and health facilities are way below to meet the demand level of services in the country. While development partners and other funding agencies are expected to compliment state funding of mental health, Kenya like many countries in the world attracts dismal resources in support for mental health programs. This study shows that the resources committed by the funding agencies are inconsistent and unpredictable.

The resource flow analysis also shows under-prioritization of the mental health by external funding agencies including philanthropic institutions, international funding agencies, bilateral agencies and other donors. The amounts of financial resources injected into the mental health programs in Kenya demonstrates the little interest in mental health among funding agencies. It is however encouraging that private sector actors and agencies such as communications firms have invested in mental health programs.

In estimating the level of involvement of citizens and civil society organizations in mental health budget planning and making, the study established that although citizens are aware that they are entitled to consultation and participation in budget making, they are either never involved or are inconsistently involved in selective stages of budget making. Also although there exists a vibrant civil society organizations advocating for health agenda in Kenya, very few are having full-fledged programs advocating for resource allocation to mental health. The mental health programming by civil societies is therefore disjointed and unidirectional leaving the government to make unilateral decisions on resource allocations to mental health.

The study also identified critical agencies outside government influential to resourcing mental health in Kenya. The civil society organizations, the health care providers preferably through their trade unions and professional associations, World Health Organizations, international development and financial institutions, politicians and pharmaceutical companies are some of the actors. Through their advocacy programs such agencies have the power of pushing government and development partners to allocate desired resources to mental health. Other actors include academia and research agencies who provide critical evidence, profile and case studies about status of mental health. These agencies provide evidence on areas of mental health that deserve priority investment, as well as gaps and opportunities in mental health programming.

5.0 RECOMMENDATIONS

a) **Mental health policies and legislations**: Although Kenya has some polices and legislation supportive of mental health, the current mental health Act no 10 of 1989 is not in tandem with the supreme law (Constitution 2010) making its implementation unrealistic. There is also total lack of the full implementation of the enabling laws on mental health leading to consistent discrimination and violations of the rights of persons experiencing mental ill-health. The national government should ensure a new mental health law is enacted as provided for by the Health Act, 2017. The attempts to develop a new mental health law have been ongoing and this process should be rejuvenated by more civil society movements enjoining the process.

b) **International and regional obligations on mental health**. Assurance of good mental health and delivery of quality affordable and accessible mental health services is recognized as fundamental health right that all persons in Kenya should enjoy. The resource flow analysis indicate that Kenya has not abided itself with some of the international and regional human rights instruments by virtue of not allocating adequate resources for mental health**.** For example, youth and child mental health programming is neglected. The need to advocate and hold the government accountable on international commitments is paramount. However, the modalities for ensuring that is achieved remains a challenge that cab be addressed by formation of loose networks and coalitions. Such movements at national levels with support from international NGOs should be able to support and coordinate civil society actions on compliance of the State with international and regional human rights instruments and obligations including reviewing periodic reports made by the State to examine self-reporting on compliance with international mental health obligations. Civil society

organizations can also prepare shadow reports to make comments on progress made by State in meeting international obligations with a focus to provision of comprehensive stigma free mental health services.

c) **Domestic resource flow for mental health.** Kenya does not have a systematic budget planning and allocation to mental health. The funding is either voted in block budget items at national level while at the county level mental health budget plans and allocations is not explicit. There lacks a budgeting framework for mental health. Civil society organisations should advocate for establishment of a national government and county government budgeting framework for mental health at both national and county government levels. The framework should specify budget allocation and funding mechanisms by national government for national referral hospitals that offer mental health services and respective mental health units in national referral hospitals offering mental health service. Another framework for planning and budget allocation for mental health at county level (facilities in category 1-5) should be defined. These frameworks should be made available to citizens and CSOs to monitor their application.

d) **Prioritization of funding mental health at international level and among donor community.** Data shows that external resource flow for mental health in Kenya and perhaps in developing countries is dismal compared to allocations and commitments made on other health issues yet the prevalence of mental disorders and demand for mental health services is enormous. The Global Financing Framework overstate the need to funding of communicable diseases at the expense of ill-health such as mental disorders. There is need for a robust and consistent advocacy program at international level and among developing partners for greater commitment to funding mental health. Civil society organisations at national levels have the opportunity to collate local evidence on status of mental health and when possible motivate research and academia to invest in operational and actionable research on mental health. The compendium of evidence can be used to design a powerful advocacy program, sensitization programs for civil society organizations and presentations at global and regional conferences. The evidence and advocacy program should also target international NGOS with greatest influence at WHO, World Bank, IMF and EU among other international agencies to advocate for reforms in global funding mechanisms to prioritize mental health.

e) **Involvement of civil society organizations on mental health budget advocacy.** Evidence shows that although civil society play a significant role in advocating for higher budget appropriations to health sector at national and county level, they are less involved or lack interest in advocating for higher budget allocations for mental health. None of the CSOs is consistently involved in monitoring budget allocations and utilizations for mental health. The involvement of CSOs in planning and development of mental health programming is also negligible. There is therefore the need and opportunity of drawing interests among CSOs in advocating for planning, budget allocation and tracking of budget utilization on mental health and issue score cards thereof on the same. On the onset the program need to create awareness among CSOs on value for investment in mental health, the deterioration levels of mental health services in Kenya and consequences of unabated mental disorders including components of mental health such as child mental health prevention programs that are completely neglected.

f) **Invest in key influencers of mental health policies and funding.** Key informant interviews provided an inventory of agencies with greatest influence on policies and funding related to mental health. At domestic level key barriers to advocacy for mental health among health practitioners, politicians, CSOs among others is stigma, ignorance, myths and misconceptions about causes and presentation of mental is orders. There is need to develop a mental health campaign and educative programs to reduce stigma on mental disorders and call upon key influencers including the parliamentary committee on health, the Council of Governors Health Committee to demand and influence higher budget allocations for mental health as well as invest in mental health services and programs at community and facility levels.

Health Rights Advocacy Forum (HERAF)
Ring Road, Kilimani
P.O Box 100667- 00101, Nairobi, Kenya
Tel: +254 735 333 007
Email: info@heraf.or.ke
Website: www.heraf.or.ke
Facebook: Heraf Kenya Twitter: @HERAF_Kenya

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