HERAF
Health Rights Advocacy Forum

Community Report Card on the Status of Mental Health Services in Nyeri County.

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LIST OF ABBREVIATIONS

CCPR	Convention of civic and political rights
CHMT	County Health Management Team
CHV	Community Health Volunteer
CIDP	County Integrated Development Plan
CRH	County Referral Hospital
CRPD	Convention on the right of persons with disability
CSO	Civil Society Organization
FGD	Focus group discussion
HCW	Healthcare Worker
KEML	Kenya Essential Medicine List
KMHP	Kenya Mental Health Policy
KPI	Key Performance Indicators
NCD	Non Communicable Disease
NCPWD	National Council for Persons with Disability
NHIF	National Hospital Insurance Fund
PHC	Primary Health Care
WHO	World Health Organization

1.0 INTRODUCTION

1.1 Background

The prevalence of mental health challenges is estimated to be around 15% of the world population with more than 1 (one) billion individuals are vulnerable to mental health disability according to World Health Organisation (WHO)[1] report on the mental health disability. Precisely, WHO[2] further estimates that about 450 million individuals are living with a mental or neurological condition whilst two-thirds of these people will not seek professional medical help, largely due to stigma, discrimination and neglect. Mental health is conceptualized 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.

In Kenya, the Ministry of Health[3] estimates that 1 in every 4 Kenyans suffers from mental ill health in their lifetime, which translates to 12 million Kenyans who will need medical attention. It is estimated that up to 25% of outpatients and up to 40% of in-patients in health facilities suffer from mental conditions. Further, the probable prevalence of psychosis in Kenya is at an average of 1 % of the population. According to WHO (2017)[4], Kenya is ranked as the sixth among African countries with high rates of depression. Additionally, KNCHR[5] estimated that six million in Kenya are suffering from common mental conditions such as depression, substance abuse, stress and anxiety. Despite the presence of these mental health challenges in Kenya, presence of COVID-19 has seriously escalated mental health challenges in Kenya subjecting individuals to depression, anxiety, stress among other mental health conditions, as a result of economic difficulties, bereavements, fear of the disease among other factors.

The enactment of the Kenyan Constitution 2010 saw the formation of two tiers of government consisting of the national and the county government. Additionally, the Constitution has witnessed the devolution of health programs to the County government, including mental health services.

1.2 Objective of the community report

The main purpose of the community report was to track the government's compliance with international, regional and national policies, commitments, budget allocations and service delivery on mental health in Nyeri County.

1.3 Methodology of a Report Card Generation

HERAF with the financial support of OSIEA rolled out an 18 month project aimed at "Improving Mental Health Legislation, Financial Investments and Accountability in Kenya". The project was implemented in Nyeri, Embu and Nairobi Counties from June 2019 to March 2021. Primarily the project would promote the participation of CSOs and organizations of people with lived experience of mental health problems in improving mental health law, financial investments and social accountability in Kenya. The key objectives being:

1. World Health organization (2001). The world health report 2001: Mental Disorders affect one in four people. www.who.int
2. WHO.(2013).Mental health action plan 2013-2015
3. Ministry of Health.(2020). Taskforce report on mental health.
4. WHO.(2017).Depression and other common mental health disorders: Global health estimates.www.who.int
5. Kenya National Commission on Human Right. (2011). Silenced minds: The systemic neglect of the mental health systems in Kenya. www.knchr.org

1. To promote participation of civil society and organizations of people with lived experience of mental health problems in review and development of new mental health legislation in Kenya

2. To empower CSOs of people with lived experience of mental health to participate in planning and budgeting for mental health at MOH, national and county levels

3. To track government's accountability to international and national commitments, policy and budget implementation for improved mental health services in Kenya

The primary targets of the project were persons with mental health issues (disability or illness), their families and care givers, Civil Society Organizations, County Government of Nyeri, National Government, Ministry of Health and other actors in mental health including public and private service providers, religious institutions.

In Nyeri the project held an inception meeting with the CHMT to foster buy in and partnership in implementation; follow up engagements were geared toward mapping CSOs of persons with psychosocial and cognitive disabilities and other CSOs working or interested in mental health. The project would hold strategy laying meetings to adopt the best approach in mental policy and budget advocacy, conduct capacity training workshops targeting various stakeholders and engage through written and oral submissions in the county planning and budgeting processes. Round table engagement with CSOs network, service providers, county officials and representatives of key national government departments would be targeted to synergize mental health interventions.

To track government's accountability to international and national commitments, policy and budget implementation for improved mental health services in Nyeri County; the project trained stakeholders on social accountability and oriented a lead team comprising of project staff, community members and CSOs on social accountability tools.

In this community report five public health facilities were selected through sampling of facilities with high mental health workload. The targeted health facilities were County Referral Hospital, a level 5 hospital that hosts the only mental health inpatient facility, Karatina sub-county hospital the only other facility with a consultant psychiatrist and a full time outpatient clinic, Kiamabara, Karaba, and Belle-view health centers that have HCWs trained on mental health and have support groups of persons with the lived experience of mental health linked to the facilities. For data collection, focus group discussion (FGD) was adopted in the collection of qualitative data. There were a total of sixteen FGDs conducted across the four healthcare facilities. Bureaucratic challenges within the health management structure of Nyeri County referral hospital made it difficult to carry out the FGD within the facility. The participants for the FGDs consisted of HCWs, CHVs, CHMT/hospital board, patient support and service users.

FGDs with each stakeholder group were held independently for instance at the facility level FGDs with HCWs, HFMC, CHVs, caregivers and persons with psychosocial or cognitive disabilities were scheduled at different times/days and conducted separately. This would create confidence in the neutrality of the process; eliminate the threat of coercion, intimidation or possible reprisals especially where feedback given was not necessarily positive and ensure stakeholder feedback was not lost in consolidated scoring. Participants were urged to provide non-confrontational and unbiased feedback and where possible suggest how to address emerging gaps.

2.0 STATUS OF MENTAL HEALTH IN NYERI

2.1 Nyeri County

Nyeri County is one of the 47 counties in Kenya located in the densely populated fertile central highlands. It is situated about 150 km north of Kenya's capital Nairobi and sits on a surface area of approximately 3337.10 km2.The county borders Laikipia county to the north, Kirinyaga county to the east, Murang'a county to the south, Nyandarua county to the west and Meru county to the northeast. There are 8 sub-counties in the county namely: Kieni East, Kieni West, Mathira East, Mathira West, Nyeri Central, Mukurweini, Tetu, and Nyeri South. The county has 125 public health facilities comprising of 5 hospitals, 31 health centres and 89 dispensaries, 251 community units and 1 rehabilitation centre.

2.1.1 Situation of Mental Health

Table 2.1 Mental Health Situation

INDICATOR	CHMT	HCWS	CHVS	CITIZENS/ SERVICE USERS/ PATIENT SUPPORT	REASONS/COMMENTS
How is the situation of mental health (people with psychosocial, intellectual or cognitive disabilities) in community? Give examples of mental health cases- rank from high to low.	Average	poor	Very poor	Very poor	• High unreported cases of domestic violence within the community • Increase in the number of youths abusing drugs and alcohol • Increased cases of people killing themselves • The number of patients taking psychotropic drugs has increased.
How are people with psychosocial, intellectual or cognitive disabilities often perceived by society? *(What are some common labels or abusive words used in relation to people with psychosocial, intellectual or cognitive disabilities?)*	Very bad	Very bad	Very bad	Very bad	• Associated with witchcraft, curse, and theft. • The are labeled as users of drugs and alcohol. • They are mad people: Wenda wazimu, aguruki, mundu wa ngoma. • They are considered a nuisance and bothersome.
People with psychosocial, intellectual or cognitive disabilities face many barriers and forms of discrimination which prevent them from participating in society (give examples of physical, attitudinal, communication, social, practices –violence, coercion and abuse -or legal barriers.)	Very bad	Very bad	Very bad	Very bad	• They lack basic need provision such as shelter, food & clothing • Seen as lesser human beings. • Beaten and chased away in social gatherings • Sexually violated. • Denied inheritance of properties such as land • Discriminated against when it comes to marriage:- considered unable to take care of the family, should not have children, etc

2.1.1.1 Situation of Mental Health

Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.[6] The mental health taskforce (July 7, 2020) estimated that in Kenya, one in every ten people suffer from a common mental disorder. The number increases to one in every four people among patients attending routine outpatient services. Depression, anxiety and substance use disorders are the leading mental illnesses diagnosed in Kenya. Alcohol is the commonly abused substance especially among youth 18-29 years old.

In Nyeri County the number of people suffering from mental illness is largely unknown however it is estimated that 25% of outpatient clients and 40% of inpatient clients suffer some form of mental illness[7]. Available disease surveillance data indicate a high incidence of suicides especially among men below the age of 35 years. On the other hand, hospital data indicates commonly treated illnesses of drugs and substance abuse psychosis, bipolar disorder, schizophrenia and stress related psychosis.

2.1.1.2 Community Perception of Persons with Mental Health Disabilities

Over time most of the persons with psychosocial and cognitive disabilities have been viewed negatively in the community. These perceptions permeate family/household, schools, religious gatherings and workplaces. It emerged from the discussion that these perceptions were directly linked to numerous barriers faced by persons with mental health and cognitive disabilities curtailing the enjoyment of their human rights. The negative perceptions manifested themselves in various forms as described by WHO[8].

- Being treated as "abnormal" or different from the rest of society. For example, people avoided associating with persons with mental illness since the condition is often associated with witchcraft or curses meted on people who have stolen or refused to adhere to some socio-cultural practices. Most of these practices revolved around dowry payment where failure to adhere would be said to result in abnormal traits including mental or cognitive disabilities.

- Being treated as "incapable" e.g. not capable of working, of having responsibilities, of judging situations, of knowing one's best interest, or of making decisions. Caregivers often made decisions for persons with disability including ownership of property, establishing families and even on care and treatment options. The notion of female sterilization among women with psychosocial or cognitive disabilities is seen as an acceptable birth control method usually at the behest of the family, community or caregiver. The justification is that these women are incapable of caring or providing for their children.

- Being labelled and bullied has consequences on one's identity and perception by society. Persons with psychosocial and cognitive disabilities were often referred to in derogatory terms wenda wazimu, aguruki, mundu wa ngoma all translated to mean "mad people". Youth with mental health issues are often labeled as drug users; community members attribute mental health issues among the youth to lifestyle choices aided by access to cheap and illicit alcohol, betting and proliferation of seemingly social drugs bhang, khat and kuber among others.

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6. WHO: 2018
7. KNHCR: 2011
8. WHO, Quality Rights: https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools

- Facing dehumanizing and unpleasant attitudes or objectified. Commonly treated as persons without feelings, incapable of feeling pain or deserving a good life. They are poorly fed, live in squalid conditions or on the streets, are overworked, underpaid or not paid and undue physical violence is meted on them. Mistrust, fear, exclusion and rejection are more negative attitudes they have to contend with.

2.1.1.3 Barriers and Discriminations

Persons with psychosocial and cognitive disabilities face multiple barriers. WHO defines barriers as factors in a person's environment that, through their absence or presence, limit functioning and create disability. These include aspects such as physical inaccessibility, lack of relevant assistive technology (assistive, adaptive, and rehabilitative devices), negative attitudes of people towards disability, services, systems and policies that are either nonexistent or that hinder the involvement of all people with a health condition in all areas of life."[9]

1. SOCIAL BARRIERS

A. Stigma and Discrimination

Stigma and discrimination in mental health refers to negative perception and negative treatment because of mental illness, it can worsen mental health problems and prevent people from seeking help when needed. Stigma may result from lack of awareness and the nature or complications of the mental illness. At the household level persons with psychosocial and cognitive disabilities are often bullied, verbally and physically assaulted; this is manifested in isolation, denial of basic needs and neglect.

As a result persons with mental disorders often suffer shame, hopelessness that may also result in self stigma. This negative perception and treatment permeates community settings leading to further isolation and exclusion from normal social activities for instance savings and credit self-help groups, commonly known as chamas (Welfare group), community dialogue or public barazas. A middle aged lady said in her chama her opinion is usually disregarded with a curt comment of "you should leave the meeting and go take your meds" She said the hardest part is explaining to her children why people refer to her as mad yet she rarely has relapses.

The high level of stigma affects the ability to earn a living in a rural economic environment where most young people depend on casual labour and even when one lands a "job" the incidence of exploitation is high. Often times they get paid in meals - tea, worn clothes regardless of the volume or value of work put in.

B. Lack of Social Protection

Persons with lived experience of mental health have limited access to income either through employment or other income generating activities, partly attributed to stigma toward mental illness and limited capacity to be gainfully engaged due to relapse and effects of medication. Some of the care givers had been able to access bursaries for children in their care whose parents have mental health issues they felt that the government social protection programme for the elderly, PWD, orphans and vulnerable children should but expanded to cater to persons with mental illness. This would supplement household budgets especially in access to drugs since the burden of care lies solely on the caregiver.

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9. World Health Organization, International classification of functioning, disability and health. Geneva: 2001, WHO. p. 214

C. Economic Exploitation

Care givers lamented the level of economic exploitation for the few who are able to access work; one mother told of an incident where a neighbor would entice her daughter to fetch 3 20-litre jars of water for a mug of tea. These were common scenarios in the villages where most are overworked and underpaid or paid in kind usually in food or clothes. Employers were said to be unwilling to accommodate needs of persons with psychosocial disability and often labeled them as unfit to work.

Influx of trade in illicit goods and drugs has seen most of the mental health clients used as mules as they are less likely to fall under the scrutiny of security forces. It emerged that persons with mental illness living on the streets would often be used by people trading in illicit drugs to distribute to pre-arranged drop off points since law enforcers were less likely to frisk them.

D. Limited support systems for care givers

Support systems for persons with lived experiences and their care givers should entail access to community services and support that promote debriefing and stress management, provide insights and plug in points for access to opportunities, care and support. Ideally psychosocial support groups may be formed out of the initiative of beneficiaries or by a third party to align support through community networks. While such formations existed in Nyeri County with some level of functionality for service users, there were none for caregivers. Some of the shared experiences pointed to a feeling of loss of control, loss of a beloved child (to illness) and emotional exhaustion. “I wish my daughter had a child before illness struck, her life would serve a purpose. Sometimes she feels so distant it’s as if she is not here (dead)”, mother to a middle aged woman battling depression and physical disability.

It emerged from the report that there was need for strong psychosocial support mechanisms at the community level with clear linkage to the health system for psychological and psychiatric support services.

2. LEGAL BARRIERS

Persons with psychosocial and cognitive disabilities have the right to exercise legal capacity, the right to personal liberty and security of person (Articles 12 and 14 of the CRPD). Discussions with persons with the lived experience and caregivers revealed that persons with psychosocial and cognitive disabilities faced serious impediments to enjoyment of rights including:

a) **Disinheritance.** Parents and siblings question the ability of persons with the lived experience and caregivers to utilize or safeguard inherited resources. This resulted in destitution of persons with mental illness upon the demise of the care giver usually the parent.

b) **Lack of satisfactory legal redress from law enforcers.** Complaints raised by persons with psychosocial and cognitive disabilities especially on physical abuse, disinheritance and neglect were often disregarded and considered as “not true”.

c) **Right to establish a family.** It was revealed that there were negative perceptions marrying or getting married to a person with lived mental health experiences would transmit the illness to the other family. Hence, few were willing to encourage such relationships. Families worried that they may carry the burden of the new family including bringing up and educating their children. It was assumed parents with psychosocial and cognitive disabilities were more unlikely to access and sustain gainfully employment. Where persons with psychosocial and cognitive disabilities went ahead to establish

families and were self-reliant, biases in distribution of family property were reported. Discriminatory laws like the Matrimonial Clauses Act, Cap. 152 that cites unsound mind as a basis for dissolution of marriage was often quoted as a basis for deterrents.

d) **National registration.** It was revealed that most of the persons with psychosocial and cognitive disabilities were not registered by the national government. Hence, they did not have national identity card other than those that developed mental health disabilities in their adulthood. Many missed out on the opportunity for registration due to unmanaged mental illness and neglect. Destitution was also highlighted as a reason for failure to register due to inadequate tracing of the background of persons with psychosocial and cognitive disabilities living in the streets. Though there existed delegated legal capacity in the form of primary care givers, it was at their discretion to ensure persons psychosocial and cognitive disabilities not registered are duly registered. Such care givers should be empowered to ensure they actually facilitate registration to all at all times. It further emerged that, Nyeri County Department of Social Services had undertaken to ensure the registrar of persons issued street families with national identity cards.

e) **Right to vote.** Persons with psychosocial and cognitive disabilities were rarely registered for voting. This was partly attributed to lack of national identity cards a prerequisite document for voter registration. In addition, the legal requirement that one "be of sound mind" is deterrent to the right to vote. However, according to the Mental Disability Advocacy publication "Right to Legal Capacity in Kenya[10] as long as persons with psychosocial and cognitive disabilities *"lives in the community (not in a psychiatric facility during voters registration or election day); is interested in politics and is supported by his or her family or an NGO to provide support; the polling station officer does not perceive the person to be of "unsound mind"; and the person can physically access the polling station and can physically write, or have someone else mark an "X" on the ballot paper"* can exercise their political rights.

f) **Participation in decision making process including public hearing forums.** It emerged the County government did not include persons with psychosocial and cognitive disabilities in decision making processes. The design of public consultation and hearing forums were massive engagements and not specific to stakeholder category. As such persons with psychosocial and cognitive disabilities felt not comfortable or welcome due to community attitude, stigma to engage in such public forums. In the past partners working in mental health mobilized persons with psychosocial and cognitive disabilities to attend budget forums.

3. PHYSICAL ABUSE AGAINST PERSONS WITH MENTAL HEALTH DISABILITIES

There were various forms of physical abuses against persons with cognitive and mental health disabilities at household/ family, community, health facility and workplace place levels. Most of these abuses were reported to start at family/household levels where due to inability to care for persons with cognitive and mental health disabilities, including getting them the help they need, shame and fear of ostracism associated with mental illness often led to neglect and abuse of persons with mental health illness. Physical restraint including chaining or caging to prevent some persons with serious mental health illnesses from wandering away, prevent them from harming/injuring themselves or others often resulted in physical injuries/wounds. These abuses remain a hidden secret at family/household level according to a CNN documentary of 2011[11] "hidden secret" of persons with psychosocial and cognitive disabilities.

10. http://mdac.org/sites/mdac.org/files/mdac_kenya_legal_capacity_9apr2014_0.pdf
11. http://edition.cnn.com/2011/WORLD/africa/02/25/kenya.forgotten.health/

This abuse is escalated at the community level and is often times extreme and unwarranted. A care giver told of how her youthful son was beaten up by a mob and admitted in hospital. Amidst rising reported incidents of violence and murder in the community, there were growing numbers of unreported cases of abuse among vulnerable populations especially the mentally disabled or mentally ill. Care givers noted that there was laxity among security personnel especially at the local administration offices in dealing with perpetrators of abuse. This raised concerns over how to protect the rights of these vulnerable populations.

Other incidences of physical abuse reported as rampant at household and community levels included:

- Physical beatings and flog matching whenever they were suspected of mistakes.
- Often ostracized and chased away from the household.
- Sexually harassed and raped. For example several mothers with mental health illness are sexually assaulted, exploited or raped. A number of them were often seen with infants on the streets and markets.

4. VIOLATIONS RELATED TO COMMUNICATION

a) Persons with mental health disabilities were hardly informed on any important events, meetings or gathering at family/household or community levels. Whenever, they were lucky, their voices and opinions were rarely considered in decision making.

b) Negative attitude from health care workers. It emerged from persons with cognitive and mental health disabilities that they were often treated differently “as though we are not people”. This was despite being conscious enough to respond to the clinician’s questions or provide feedback on effects/side effects of facility preferred treatment. The negative attitude from health care workers was partly be attributed to lack of psychiatric training among most nurses and clinical officers, misconceptions or stigma and discrimination associated with mental illness.

c) Not receiving information in an understandable way (for example, use of Braille for people with visual impairments or easy-to-read information for people with learning difficulties).

d) The tone of communication. Not been spoken to in simplistic language or in a condescending tone.

e) Not being listened to by practitioners, family members or others.

f) Having one’s differing opinion, perspective or view considered as a “symptom of illness” or “lack of insight”.

2.2 Mental Health Policy

The Kenyan Constitution Article[12] 43 (1) (a) provides that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care. Article 43 (2) also provides that a person shall not be denied emergency medical treatment. Mental health being key part of health the legal bench mark for service provision in entrenched in Article 43. Additionally, all general hospitals are gazetted to treat and admit persons suffering from mental disorders in accordance with section 9 of sub-section 2 of the Mental Health Act 1989[13]; Cap 248 of the Laws of Kenya.

12. The Kenya constitution 2010
13. Mental Health Act (1989) chapter 248.www.kenyalaw.org

To ensure effective running of mental health services in accordance with the Constitution, the Kenya Mental Health Policy 2015-2030 was enacted where the National Government was to be responsible for health policies, capacity building and offer technical assistance to the counties; whilst the counties were responsible for county mental health facilities and ensure an effective mental health referral system. Additional effort to enhance mental health policy in Kenya is evident in introduction of the Amendment Bill of 2018 which is meant to repeal the Mental Health Act of 1989.

Kenya being part of the international community, it has signed several treaties which are legally binding within the Kenyan legal system. Some of the these treaties in relation to mental health policies include: The convention on the right of the child article 23 which recognizes the right of the mentally or physically disabled child to enjoy full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community. The Convention of civic and political rights (CCPR)[14] article 7 focuses on the ban of torture or cruel, inhuman or degrading treatment of persons. The convention on the right of persons with disability (CRPD)[15] emphasizes on prohibition of discrimination on the basis of disability and guarantee of equal protection to persons with disabilities (article 5), right to employment and to gain a living (article 27), equal rights for persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit (article 12); and right to the full enjoyment of life on an equal basis with others (article 10);among other rights.

Despite all these legal frameworks and policies that work to promote human rights approach in mental health services, Penal Code section 226 still criminalizes suicide attempt in Kenya. This piece of legislation does not underscore the idea of suicide or suicide attempt as a mental health disorder which requires psychosocial and pharmacological interventions.

14. International Convention on Civic and Political Rights. Retrieved from: www.ohchr.org
15. United Nations. (2007).Convention on the right of persons with disabilities. www.un.org

2.2.1 Findings on mental health policy

In line with the mental health policy, table 2.1 shows the summary of focus discussions responses as was given by various respondents.

Table 2.2: Responses on Mental Health Policy in Nyeri County

INDICATOR	CHMT	HCWS	CHVS	CITIZENS/ SERVICE USERS/ PATIENT SUPPORT	REASONS/COMMENTS
Existence of a national mental health policy that is in line with international human rights instruments.	Average	Average	Very poor	Very poor	• It is known among the mental health workers but not disseminated. • Other HCWs have not heard or read the policy document. • CHVs and service use have never heard of it.
Existence of a national mental health law that is in line with international human rights instruments.	Poor	Very poor	Very poor	Very poor	• Only known among the mental health workers but have not been disseminated. • It is not available among the HCWs or the community at large.
Existence of mental health committee/Technical Working Group at county level that provides technical support / oversight to mental health at county level	Poor	Very poor	Very poor	Very poor	• None is existing • Coordination is done through health governance structure

2.2.1.1 Mental Health Policy

The community report sought to establish the implementation status of the national mental health policy that is in line with international human right instruments within the county government health structure. The result showed that County Health Management Team (CHMT) was aware of the Kenya Mental Health Policy 2015-2030[16]. However, it had not been disseminated to other HWCs. Kenya Mental Health policy was well understood by HCWs directly involved in mental health but HCWs working under other programs such as MNCH, HIV/AIDS, and others had no knowledge of the existence of the policy. The knowledge gap among HCWs on mental health policy result to lack of or poor integration of mental health in other health programs within a healthcare facility. Minimal dissemination had been done by CHMT via whatApp platform to a few HCWs. Other respondents were not aware of the mental health policy or the existence of any national mental health law that is line with international human rights.

16. Ministry of Health(2015). Kenya mental health policy 2015-2030. https://www.health.go.ke/

2.2.1.2 National mental health law

The Mental Health Act, 1989 that currently guides mental health service delivery is outdated and not in tandem with the Constitution, the mental health policy and international human rights instruments. These shortcomings were identified and the country commenced a process to amend or develop a new law.

On the County stakeholders' involvement in the review of the Mental Health Amendment Bill, it was established that there was no certainty on the existence or participation in this process at County level. However, it was noted that some CSOs upon mobilization, information awareness and capacity strengthening participated in several public hearing forums organized by National Assembly and Senate on the Amendment of the Act.

Among the community members at large, it emerged that most of them had not engaged in the review of the Bill. Some of the reasons given for lack of participation included lack of information or notifications of the meetings, not sensitized on the content of the Bill and its importance. There were also citations of logistical challenges such as lack of transport reimbursement. This logistical challenge according to community members could be cured by delocalizing public hearing forums to ward and community levels, closer to the people.

2.2.1.3 Leadership and coordination

Mental health leadership referred to provision of guidance and direction towards improving mental health policy and legal framework, funding and service delivery while guaranteeing accountability for the entire process. The Kenya Mental Health Policy 2015-2030 defines key priority actions towards achievement of optimal mental health systems reforms, the policy is to be implemented in line with the distinct functions of the National government and devolved units. One of the intended significant reforms was the amendment of mental health Act to establish the County Mental Health Council that shall provide oversight to mental health at county levels.

Feedback on leadership and coordination showed that there was no existence of a mental health committee/ Technical working group at county level that provided technical support or oversight of mental health. Mental health leadership, governance and coordination was said to be aligned to the health leadership, governance and management structure from Level I to Level 5. The CHMT was keen on establishing technical working or mental health council.

2.3 Mental Health Financing

Kenya is among the 28% of WHO member states countries that do not have a separate budget for mental health[17]. Evidently, mental health budget is estimated to be around 0.5% of the total national and county budget allocations[18]. Despite, health being a devolved function, there were no dedicated budget lines within the county government budget for mental health services. However, there were other budget lines under the health sector budget that touched on mental health. For example, drugs, non-pharmaceuticals, equipment, human resources and transport but they had no dedicated budget line that could show the amount budgeted for mental health.

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17. WHO.(2013).Mental health action plan 2013-2015
18. Kenya National budget estimates 2016/2017: Trend analysis

The report sought to explore levels of mental health financing as indicated in Table 2.4 below.

Table 2.3 Mental Health Financing

INDICATOR	CHMT/ HMT	HCWS	CHVS	SERVICE USERS/ PATIENT SUPPORT	REASONS/COMMENTS
Existence of costed mental health plan at the county level to support implementation of mental health initiatives.	Poor	Very poor	Very poor	Very poor	• No plan • No priorities • There is no mental health data available for evidence based decision making however mental health service provision is largely integrated in curative and rehabilitative services. The component of preventive/ promotive mental health services is largely community driven and dependent on partner support for instance Caritas, World Vision and HERAF.
Mental health included in County Integrated Development Plan and Annual Development Plans	Poor	Very poor	Very poor	Very poor	• Mental health not explicitly indicated in CIDP and ADP unlike other NCDs of diabetes, hypertension and cancer despite the high incidence
Existence of a separate budget line for mental health services in County government approved budgets	Very poor	Very poor	Very poor	Very poor	• No separate budget line for mental health at the county including at the facility level. However, at the facility level the service provider can order drugs at their discretion. • At facility level there exists vote heads for commodities, the high cost of psychotropic drugs (especially medicate) against limiting drawing rights lead to low prioritization of some MH commodities.E.g. modecate single dose costs Ksh. 150, one client may use 3 or more in a month on the other hand a pack of Amoxil 500s may cost Ksh. 1,500 for a total 33 doses; the service provider may be inclined to order the later and provide to more clients.

INDICATOR	CHMT/ HMT	HCWS	CHVS	SERVICE USERS/ PATIENT SUPPORT	REASONS/COMMENTS
All mental health services at primary, county referral and national teaching and referral hospitals are paid for in full by insurance service providers – National Hospital Insurance Fund (NHIF)	Average	Average	Average	Average	• Partial payment because of frequent stock out of mental health commodities and drugs at level 4 and 5 HCF • Primary health care facilities offer free services; • Mental health services like all other services are free at primary health care level. At hospital level service users with NHIF cover enjoy available services within the NHIF terms and conditions. There are still incidences of out of pocket expenditure to cover the indirect costs of accessing care and cost of out of stock commodities and supplies
Existence of donors/ partners who directly support the county mental health services with financial resources	Very poor	poor	-	-	• There is none funding mental health services
Existence of donors/ partners who collaborate with county government to promote mental health programme and services.	Poor	Poor	-	-	• World Vision, USP and Caritas used to support both mental health programming and services but have since closed out. At the point of conducting this exercise only HERAF was actively involved in mental health programming. There exist huge gaps in community mental health services following exit of partner supported programmes for instance PM+ training by World Vision targeting HCWs and CHVs of stress management, referral and linkage for mental health services.
The Kenya Essential Drug List includes essential psychotropic drugs in adequate quantities and varieties	Good	Average	-	-	• Initially only 1st generation psychotropics were on the list now some 2nd generation drugs have been included albeit being expensive they are more effective, have less side effects and more specific to particular mental health cases.

INDICATOR	CHMT/ HMT	HCWS	CHVS	SERVICE USERS/ PATIENT SUPPORT	REASONS/COMMENTS
Essential psychotropic drugs available at all levels of mental health system –community, levels 2&3; County level 4, County referral level 5 and national referral level 6 in sufficient quantities and varieties at all times	Good	Good	Average	Average	• Most common are: modecate (fluphenazine decanoate), chloropromazine (CPZ), and artane • Other drugs are bought from private chemists and other drug stores. • Inconsistent supply of psychotropic drugs within the health facilities. • There is no stand-alone budget line for psychotropic drugs within the healthcare facility. Commodities and supplies at county budget level have one budget line at facility level the service providers have leeway to order against the relevant workload (except for PHC facilities post KEML 2019) within their drawing rights.
Mental health services and basic medicines for mental disorder included in health insurance schemes – NHIF, UHC	Good	Average	Average	Average	• Most drugs are missing in the health facilities so patient buy from out-of-pocket in private drug stores. • UHC used to support mental health services especially on the psychotropic drugs. UHC removed user fees at hospital level this meant that all available services at that level were free both outpatient and inpatient. The drugs and substance rehabilitative services were free but clients were expected to pay Ksh. 15,000 for food and supplies for the 3 month programme. • NHIF will pay for available services and basic medicines at hospital level (terms and conditions apply)

2.3.1 Finding on mental health financing

2.3.1.1. Mental Health Plan

Availability of a costed mental health work plan can help determine resource requirements for drugs, commodities, equipment, human resource, finances as well as technical resources. This is the guide on cost of implementing for instance the Kenya Mental Health Policy (KMHP) or county specific mental health work plans. The costed estimates help planners determine resource needs, financing gaps and determine resource mobilization strategies to bridge the gap. According to table 2.3, the outstanding finding on the mental health financing was that there was no costed mental health plan at the county level to support implementation of mental health initiatives.

2.3.1.2 Budgeting for Mental Health

In regards to budgeting for mental health, there was no separate budget line for mental health services in the broader County government approved budget and at the healthcare facility levels. All mental health budgets were integrated within the main budget in terms of human resource, drugs and commodities. At facility level there were vote heads for commodities (rarely sufficient to meet facility specific demands) depending on facility workload the service provider prioritizes the commodities to order. However the high cost of psychotropic drugs against limiting drawing rights may lead to low prioritization of some psychotropic commodities. For instance modecate single dose costs about Ksh. 150, one client may use 3 or more doses in a month on the other hand a pack of Amoxil 500s may cost Ksh. 1,500 for a least 30 doses the service provider may be inclined to order the later and provide to more clients.

According to the CHMT, mental health was integrated in planning and budgeting under the Non Communicable Diseases (NCDs) sub programme. Lack of clear resource distribution mechanisms within the sub programme seemingly leads to low prioritization of mental health funding in the County. To ensure that mental health is equitably funded within the health sector it is important to establish a mental health programme with clear KPIs, targets and costing to inform mental health specific vote heads in the budget.

2.3.1.3 County Government Planning and Mental Health

The community report card sought to establish whether mental health was included in County Integrated Development Plan and Annual Development Plans. The results showed that mental health was not explicitly included in either of the documents. However, mental health is domiciled in the Preventive and Promotive Health Programme under the NCD Sub Programme. It was also identified as a cross sectoral programme under the Curative and Rehabilitative Health Programme for implementation with support and collaboration with the national government institutions such as the Ministry of National Security and Coordination, NACADA and civil society organisations to create awareness on drugs and substance abuse. There were no Key Priority Indicators (KPIs) or targets specific to mental health in either programme which may influence aligning of budgets to mental health.

Despite having mental health being clustered under the NCD, the community report card sought to vividly understand if there was a separate budget line for mental health services in County government approved budgets. The finding showed that there was neither separate budget line for mental health at the county level nor at the facility level. In addition, there was no department of mental health at the county government level.

2.3.1.4 Health Insurance and Mental Health Services

Universal Health Coverage (UHC) aimed at ensuring all Kenyans access quality health services without suffering financial ruin. The national roll out of UHC was premised on mandatory prepayment to and managed by a reformed NHIF. The government would enhance the social protection for vulnerable households. The available social protection covers include free maternity cover "linda mama", PWD cover for persons with severe disabilities, OVC and the elderly persons cover "Inua jamii". This package should cover outpatient and inpatient services, communicable and non-communicable disease management, maternity, dialysis, radiology, mental health, minor and major surgery, substance abuse rehabilitation, emergency services and cancer treatment among others.

It emerged from the persons with cognitive and mental health disabilities that NHIF catered for mental health treatment at the level 5 and 4 facilities. However there was no evidence of using the cover for rehabilitative services. For example, at Karia rehabilitation center as the facility had not been NHIF accredited. However, all healthcare services at the primary healthcare level were free of charge.

One of the major challenges noted was individuals with psychosocial, intellectual or cognitive disability had not registered for NHIF. Hence, for specialized treatment they heavily relied on the out-of-pocket payments that impoverished the family more. Most of those who had registered with NHIF upon the introduction of pilot UHC programme in Nyeri County defaulted on their monthly premiums. Most of them upon the close of the pilot phase of the programme were not up-to-date with their payment as a result, could not access services.

On the other hand most persons with psychosocial disability are highly dependent and live in abject poverty due to stigma and discrimination associated with mental illness that limits their access to gainful employment. It was unclear if any had benefited from any of the social protection covers highlighted above. There was call on the need to improve transparency in mapping and registration of indigent populations while endeavoring to socially and economically empower vulnerable households through established support groups of persons with psychosocial disabilities.

2.3.1.5 Mental Health Disability Assessment and Registration

This community report card also sought to find out if people with psychosocial, intellectual or cognitive disabilities had benefited in any way from disability assessment and registration under social protection cover by the National Council for Persons with Disability (NCPWD). It was revealed that persons with psychosocial, intellectual and cognitive disability were eligible for disability assessment. In Nyeri County these assessments were conducted in selected hospitals at an average cost of Ksh 400 per person. This was the cost of hospital charges for disability assessment. NCPWD provided free registration services including the first print out for issuance of disability cards. When a client lost the NCPWD disability card they were required to pay Ksh. 100 to the NCPWD for replacement. However, this information was not clearly understood among service users and charges were seen as exploitative despite their socioeconomic vulnerabilities. Periodically NCPWD and Department of Health conducted mass mobilization exercises for PWD disability assessment and registration often at local health facilities or chief's camp. During these mass exercises disability assessment was free of charge.

It nonetheless emerged that disability mapping exercises were largely irregular characterized with miscommunication. There were too many actors without clear messaging at community level thereby causing confusions on disability registration. Once in a while the county department of health and department of social services in partnership with NCPWD mobilizes PWDs either for disability assessment, registration or

issuance of assistive devices. There were nonetheless, complaints on the insensitivity of government officers conducting disability mapping exercise to the financial, physical and psychological stress borne by PWDs and their caregivers when conducting the exercise. A participant said “I mobilized PWDs in their support groups, for persons with severe disabilities there was a minimum of Ksh. 400 cost of transport and a day spent in the sun without food or water only to realize we had been grossly misinformed.”

Such complaints are routinely fed back to lead departments and NCPWD. There exist ample county and national government structures to support identification and registration of PWDs at household level. This according to community members pointed to a lack of people centered approach in implementation of government interventions. In summary, most service users and caregivers indicated that majority of the individuals with mental health challenges were not presented for disability assessment due to:

- Stigma associated with mental health.
- Lack of disability assessment fee.
- Lack of information on the assessment day.
- Ignorance and illiteracy.
- Lack of support system due to family rejection and neglect.
- Poor mobilization for registration exercises. They were characterized by inadequate coordination. Such mapping and registration should endeavor to involve all stakeholders and be done as close as possible to the target population.

Upon the assessment, it was established that people with psychosocial, intellectual or cognitive disabilities were formally registered as persons with disability under the title ‘mental’. A number of them had received their disability cards as well. Nonetheless, it emerged from the discussions with service users and caregivers that, individuals with mental health disabilities had never been sensitized on the benefits of such registration. They only used their disability card for identification when seeking for health services at the level 4 and 5 facility but they did not understand if there were any health cover, social services, economic benefits or any other advantages that comes with the card. Examples of key benefits missed out or not known included access to government support including skills training, access to tools of trade or grants, access to government procurement opportunities, tax exemptions and access to government safety net programmes e.g. cash transfer programmes for persons with severe disability and education support for learners with disability in Primary, Secondary, Colleges, Vocational Training Schools and University.

2.3.1.6 Donor Support for Mental Health

In terms of donor/partners who directly support mental health in County, the community report revealed that unlike communicable diseases such as HIV/AIDS, MNCH had low donor support for mental health at the community level few donors supporting mental health at the community level. World Vision, Users & Survivors of Psychiatric (USP), Caritas and HERAF were identified as partners that had collaborated with the county government to promote mental health programs. World Vision promoted training on PM+, an intervention strategy for prevention and early detection of mental health issues through stress management, linkage and referral where necessary. Caritas and Users & Survivors of Psychiatric (USP) had established and funded psychosocial support groups such supports groups were linked to primary health care facilities for example, Kiamabara and Bellevue healthcare facilities. However, at the time of carrying out the community report, 3 partner supported programmes had closed out. At CHMT level key partners were identified as HERAF, Red Cross, AMREF Health Africa and Caritas. The other partners noted by the County health department were the media, NCPWD, CBOs of persons with mental disorders and Ministry of Interior and Coordination.

2.3.1.7 Mental Health Drugs, Products and Technology

In terms of mental health products and technologies, this community report established that the commonly funded or budgeted for at the healthcare facilities levels were: modecate (fluphenazine decanoate), chloropromazine (CPZ), and artane. For other essential psychotropic drugs such diazepam, antidepressants, phenobarbitone, etc, patients were buying out-of-pocket in private chemists or they had to travel to Karatina level 4 or CRH referral hospital in Nyeri. Challenge of psychotropic drugs running out was very eminent in several primary healthcare facilities which were highly emphasized by the HCWs as a major hindrance for people with psychosocial, intellectual or cognitive disabilities.

At facility level, shortage of psychotropic drugs was attributed to lack of stand-alone budget for mental health, delays in supply of medical products by the county, and over prioritization of other illness such as diabetes and hypertension while overlooking mental health services. The county pharmacist clarified that under the Kenya Essential Medicines List (KEML) 2019 psychotropic drugs supply was limited to hospital level. This is probably because the specialization required to diagnose, treat and periodically review clients was only available at hospital level, consultant psychiatric services were available in 2 of the 5 county hospitals. The question arises of how consultative the process of reviewing and updating the KEML was to factor in the perspective of health planners and service providers at county level, limiting access to psychotropic drugs at PHC level curtails integration and access of mental health services in rural settings.

2.4 Mental Health Service Delivery

WHO[19] elaborated that health systems service delivery should be people-centered. People-centered care is primarily focused on service delivery that is deeply entrenched around the health needs and expectation of people and communities, rather than on the disease. Indeed mental health treatments have largely focused on biomedical approach neglecting the aspect of the psychosocial and social support to the patients.

In consideration of mental health service delivery like other health service delivery, four main principles must be taken into account: Availability, accessibility, acceptability and quality. The availability of mental health service takes into consideration the presence of the healthcare facilities (outpatient or inpatient mental health facilities), community based mental health services including outreach services, homecare, support groups, and emergency care availability, counseling, awareness, screening referral, contact tracing, treatment and rehabilitation services for people with substance use disorder SUD, among other services. Table 2.4 shows the distribution responses by various respondents during the community FGD on the status of mental health service delivery.

19. WHO (2010).Monitoring the building blocks of health systems: A handbook of indicators and their measurements strategies. https://www.who.int

Table 2.4 shows the distribution responses by various respondents during the community FGD on the status of mental health service delivery.

Table: 2.4 Mental Health services Delivery

INDICATOR	CHMT/ HMT	HCWS	CHVS	SERVICE USERS/ PATIENT SUPPORT	REASONS/COMMENTS
County has put in place community mental health workers – Psychologist to work with special or vulnerable populations	Good	Average	-	-	• Psychiatrists, Psychiatrist nurses are available at CRH and Karatina level 4. • 3psychologist available at CRH for referral cases • No mental health specialist at primary levels
County has in-service training on mental health for all health care workers	Average	Poor	-	-	• HCWs at level 4 and 5 HCWs were given study leaves for personal development unlike HCWs at the PHC. • No training at the primary healthcare levels
HCWs at the primary health facilities are trained on component of mental health	Poor	Very poor	Very poor	-	• There were no training for HCWs at primary level facilities; however some HCWs have made some personal effort to seek personal development and training on some components of mental health.
There exists good working conditions, financial remuneration and career progression opportunities for mental health professionals	Poor	Very poor	-	-	• No career progression opportunities, poor financial remuneration out overworking due to few mental health staffs.
Outpatient mental health services provided in all public health facilities in Nyeri County	Good	Average	Average	Average	• Outpatient services available in all county facilities these may include assessment and referral, prescription refill, outreach services or diagnosis, treatment and access to consultant clinics at hospital level
In patient mental health unit/ward available in-patient public health facilities	Very good	Average	average	Average	• In-patients are only available at CRH which has a capacity of 20 beds. • Sometimes it is difficult to quickly get in-patient services because CRH is some distance away from the community therefore ambulances are not readily available for psychiatric patients to transport them to CRH for admission.
All level 4, 5 and 6 health facilities have outpatient units /consultation rooms for mental health services with adequate space and in good conditions	Good	Average	Average	Average	• There are outpatient services at level 4,5, and 6 however, there were some challenges with the some consultations room which lacked enough space, and some are under dilapidated conditions.

INDICATOR	CHMT/ HMT	HCWS	CHVS	SERVICE USERS/ PATIENT SUPPORT	REASONS/COMMENTS
All level 4, 5 and 6 health facilities have inpatient wards for mental health services with adequate space and in good conditions	Average	Average	Poor	Poor	• Only at CRH has inpatient service. • Karatina sub-county usually admit patient in the general wards for other conditions but closely monitored by the psychiatrist
Community based mental health services including outreach services, homecare and support, emergency care available /provided	Average	Very poor	Very poor	Very poor	• Not available • CHVs only do referrals
Mental health included in curriculum/training modules/tool kit for Community Health Volunteers (CHVs)	Average	Poor	Poor	-	• CHVs not been trained in module 13. The mental health component was recently added. • CHVs were trained on PM+ but it is not comprehensive on mental health. PM+ is an intervention strategy for prevention and early detection of mental health issues through stress management, linkage and referral where necessary.
Community health volunteers (CHVs) report on mental health	Very poor	Very poor	Very poor	Very poor	• Do not report on mental health. There is a section under “other” on MOH 514 where a CHV can report anything else not captured on the reporting tool including mental health cases; it would appear this information is not uniformly disseminated in all community health units.
Community health volunteers (CHVs) report on alcohol and substance use and rehabilitation	Very poor	Very poor	Very poor	Very poor	• Not available or sometimes added under others. There is a section under “other” on MOH 514 where a CHV can report anything else not captured on the reporting tool including alcohol and substance use.
Mental health information is integrated into disease specific programme – HIV/AIDS, MNCH, Family Planning, etc. facility, community and home based outreach services	Average	Very poor	Very poor	Very poor	• The integration is not coherent. It is very difficult to determine the level of integration because rarely do HCWs in other disease specific program share about mental health with their patients.

INDICATOR	CHMT/ HMT	HCWS	CHVS	SERVICE USERS/ PATIENT SUPPORT	REASONS/COMMENTS
Mental health services are reported in general KDHIS	Average	Poor	-	-	• Under the mental health, HCWs only indicate the numbers new and old attendees who sought mental health services.
Existence of complaints and reporting procedures known and utilised by persons with mental health disabilities, care givers or family members.	Average	Very poor	Very poor	Very poor	• Most facilities have suggestion box placed in public spaces affecting privacy. Fear identification by management for victimized. Prefer channelling their complaints to local administrations such as the MCAs or chiefs. • Psychiatric patients not informed conditions suffering from, side effect of the drug, or the duration of taking their drugs.
Treatment and rehabilitation services of alcohol and substance use are available in county public health services	Average	Average	Average	Poor	• Only one available for men located in Nyeri town. • Currently the county has one operational inpatient rehab facility for men. A second facility has been constructed but is yet to be commissioned.

2.4.1 Finding on Mental Health Services

2.4.1.1 Mental Health Services

In Nyeri County it emerged from the discussions that mental health services were offered in all the 125 public health facilities, the 5 hospitals (level 4 and 5), 31 health centers (level 3) and 89 dispensaries (Level 2). There were a total of 251 community units (Level 1), and one drugs and substances rehabilitation Centre (Karia). A broad range of mental health services are offered at hospital level, these included mental health diagnosis, treatment and counseling, rehabilitation services are provided at a standalone facility. Primary health care facilities evaluate and make referrals for specialized mental health services and disability assessment for registration. The psychiatric clinic at CRH provides specialized services (complemented by Karatina Level IV), organizes community out/in reaches and manages in patient services at the only psychiatric unit in the county.

Most users of mental health services preferred accessing services at the nearest PHC facility because services were free they were also familiar with service providers and less likely to face negative labeling. Shortage of human resource for mental health results in delays in access to health services; at times clients may seek private services.

Private medical practitioners were singled out in “fleecing” care givers through high cost of care. For example, psychiatric services were said to cost at least Ksh. 5,000 in a private psychiatric clinic while the cost of similar treatment (purchase of 2nd line generic drugs and commodities) was said to cost Ksh 1,200 in a public facility. Improving access to quality mental health services in public health facilities would greatly reduce the out of pocket expenditure.

2.4.1.2 Mental Health Specialists and other HCWs

According to Nyeri county department of health, the county has a handful of skilled mental health workforce the workforce had slightly improved from 8 HCWs in 2019 to 14 as at January 2021. There was ongoing mental health specific capacity building for healthcare providers to enhance service delivery. Below is the distribution of skilled mental health workforce

Table 2.4.1 Number Of mental Health Workers

YEAR	PSYCHIATRISTS	CLINICAL OFFICERS	NURSES	PSYCHOLOGISTS
2019	1	1	6	0
2021	2	3	6	3
Total	3	4	12	3

- Availability of a psychiatrist at Karatina Level 4 hospital had not only increased the number of mental health workers but also resulted in access to weekly psychiatric clinics available every Thursday.
- Psychologists were now an available cadre in public hospitals
- In-service training and study leave was available but HCWs in primary health care (PHC) facilities had yet to benefit.
- Mental health as a career was poorly motivated without career progression opportunities; poor financial remuneration and high workload due to staff shortage were cited.
- There is an untapped 2,510 CHVs strong human resource for community mental health services. However, only 451 had received mental health training on PM+. The remaining numbers were yet to be trained on mental health as part of their training modules.

2.4.1.3 Mental Health Infrastructure

In terms of the availability of the mental health infrastructure, the community report showed that besides Karatina level 4 hospital and Nyeri County Referral Hospital - level 5, the other healthcare facilities did not have designated psychiatric consultation rooms. The primary healthcare facilities had to do with the general consultation rooms some of which were not in line with psychiatric standards. For example, in Kiamabara healthcare facility, the consultation room was very small and the sitting arrangement between the HCW and the patient possessed a major risk to the HCW because there was neither an exit door nor an open window for sufficient lighting and air circulation. To maintain social distance due to Covid-19, the patient sat almost at the entrance whilst the HCWs sat at the corner of the consultation room. Moreover, the waiting bay at Kiamabara was one being shared by all the service seekers including individuals with psychosocial, intellectual or cognitive disabilities. The challenge with sharing waiting bay was reported to facilitate cases of disruption and conflict between psychiatric patients with severe mental health problems and other patients.

The community report showed that inpatient mental health services were only available at Nyeri CRH level 5 Hospital which had a 20 bed capacity. Feedback given indicated that there was a wait list for admissions as demand exceeds bed capacity additionally patients were refused admission over the weekend and at night denying them their need for quick service delivery. This was due to an adaptive measure to put in

check arbitrary admissions. Service users realized that the consultant psychiatrist does not cover night and weekend shifts while most medical officers on duty at these times were more inclined to admit. This was identified as one of the reasons for undue congestion in the psychiatric unit.

HCWs in the mental health unit noted that community members or care givers prefer admissions to managing clients at home. However, service providers (clinician/psychiatrist) reserved the right of admission subject to review, diagnosis and the best management strategy. Service providers reported that most clients need interventions like counseling or to be stabilized and put on medication or coping mechanisms that they can adhere to from home. Interestingly caregiver initiated requests for admission were said to peak during festive seasons when people may wish to celebrate in peace and quiet as such admission is seen to remove "the nuisance" and associated stigma of caring for the mentally ill.

2.4.1.4 Community based mental health services

Community mental health services refer to comprehensive, integrated and responsive mental health and social care services delivered through community platforms. WHO identified priority actions for community mental health are determining the optimal mix of services, building capacity among non-specialist health workers to deliver essential mental health care, advocating for a recovery-oriented model of care, scaling-up low intensity psychological interventions, innovating through digital health, and integrating mental health into Universal Health Coverage (UHC) and primary health care (PHC). Community-based services can lead to early intervention and limit the stigma of treatment.

The MOH mental health unit has five sub units: community mental health, substance use, mental health promotion, health care and health management systems. If this was to inform community mental health services at county level then there would be need for better programming so that the capacity and mandate of CHVs goes beyond linkage and referral to provision of primary interventions with technical supervision. The cross sectoral collaboration between county departments and national actors would also need a coordination mechanism at community level complete with a financing plan.

Community mental health services were pinned on community health strategy. The county had a pool of 2,510 CHVs. Community mental health services were affected by lack of strong community level strategies on mental health. Most of the CHVs had not been trained on the component of mental health which was recently added in their curriculum/training/modules/tool kits. However, 451 had been trained on Problem Management Plus (PM+). PM+ is an early mental health intervention strategy in stress management. CHVs would monitor mental health situation, link and make follow up with clients to enhance adherence to treatment or coping strategies. The department of health in FY2019/20 piloted a community mental health program with one CHU in Nyeri Town. The pilot model established an intervention centre at Nyeri Town Health Centre for treatment, a porridge programme incentivized compliance among the targeted mentally ill persons living on the streets. CHVs would promote access to services, make follow up and promote reintegration of rehabilitated clients.

The report also showed that healthcare facilities did not have or promote community support groups. For example, FGDs with the patient support and service users, it was mentioned that at Kiamabara healthcare facility there used to exist a community support group which had 17 to 22 members supported by USP. The support group also included members from Karindundu Dispensary however, the group became inactive once the funding organization USP ended their program. It was noted that USP used to refund people with psychosocial, intellectual or cognitive disabilities ksh. 100 for attending community support group meetings as a transport reimbursement but when they ended the program, people stopped coming for the meetings.

In a nutshell it emerged that there were no community peer support groups of users, consumers, and care givers of mental health services at the facility or at the community levels. Also, the community report established that there were no community based mental health outreach services, homecare and support and emergency care services.

2.4.1.5 Mental Health Integration

There was no coherent integration of mental health information into specific disease programs such as HIV, MNCH, FP, etc. at the facility or during community and home based outreach services. Specifically, it was very difficult to determine the level of integration because rarely did HCWs in other disease specific program share about mental health with their patients. This showed that mental health services were neglected within the health system despite mental health cutting across in most of the disease base programs. For example, in MNCH, young mothers were likely to experience postpartum depression, in HIV/AIDS issues of stress, depression, suicide related to the disease are common but they were rarely addressed within such specific programs. Integration of mental health services in other health programmes was unclear as there is no guidance on measurable mental health components for integration however in PHC facilities of Kiamabara and Karaba, where there were no specialized mental healthcare workers patients relied on the general clinical officers or the nurse in-charge for their routine observation and drug dispensing or refill.

2.4.1.6 Mental Health Data

On the data and information related to mental health services, it was noted that information related to mental health patients were not effectively captured. The only information being captured within KDHIS was the number of new and old mental health patients who had attended the healthcare facility but neither the kind of mental health orders, nor patient's important demographics.

Facility data therefore, as reported on KDHIS had limited indicators of new clients and old (repeat) clients to inform data analysis for planning while available CHV reporting tools are not mental health specific to input KHIS reporting. Comparative analysis by the department of health on utilization of hospital services indicated a significant drop in service utilization for psychiatric visits, rehabilitative services and referral for mental health services. In 2020 the numbers dropped to 9,534, 1,042 and 624 respectively compared to 11,051, 3,722 and 3,521 in 2019. The decline was attributed to Covid-19 pandemic and stigmatization of health facilities as points of infection, initial government advisory against hospital visits unless seeking essential services may have contributed to this stigma.

The incidence of suicide in the county was reportedly high provisional statistics[20] indicate that 56 of the 61 suicide cases of individuals aged 25-35 reported in 2018, were male and largely farmers or casual laborers. Of the 61 reported cases 44.3% were from Mathira East Sub County. Nonetheless, no study has been conducted to understand the driving forces behind suicidal ideations and suicide. Drowning and poisoning were the most prevalent methods of committing suicide.

It was also noted that CHVs rarely report on mental health or on alcohol and substance use rehabilitation making data related to mental healthcare unavailable for effective planning and quality enhancement. They could only report something concerning mental health or drug and alcoholism under the indicator 'other' in MOH 514.

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20. Nyeri County department of health, disease surveillance unit

2.4.1.7 Feedback Mechanism

As narrated by the caregivers and service users, it was revealed that persons with psychosocial, intellectual or cognitive disabilities were never informed of their mental health condition(s) they were suffering from, never notified of some of the side effects of the drugs they were taking, or the duration of drug consumption. They were only informed of the drugs to take but they could not understand why they were taking such drugs. This approach was contrary to medical and psychological ethics of patient right to information and informed consent. In relation to promotion of user autonomy, dignity, and right to self-determination, the community report established that most of the individuals with psychosocial, intellectual or cognitive disabilities were never consulted on the decisions made on their behalf by the healthcare workers or caregivers.

Despite some of the unacceptable treatments meted to mental health patients, feedback and complaint mechanism within the health facilities were not adequate. The community report established that there were no effective complaint and reporting mechanism known and utilized by persons with mental health disabilities, care givers or family members within several health facilities. It was clarified that most of the health facilities had suggestion box which were placed in public spaces that made it difficult for people to put in their comments for lack of privacy. People feared that they could be easily identified by the HCF management which might result to them being targeted or victimized. Therefore most community members preferred channeling their complaints to local administrations such as the MCAs or chiefs. If the persistent shortage of psychotropic drugs the complaints made are largely ignored.

2.4.1.8 Drugs and substance abuse services

Substance use disorders have co-morbidity with mental health disorders due to common risk factors that can contribute to both mental illness and substance use and addiction. Mental illness may contribute to substance use and addiction and substance use and addiction can contribute to the development of mental illness[21]

Nyeri County had 1 drug and substance abuse rehabilitation centre at Karia in Nyeri Town Sub County. This was an inpatient facility for men only. Despite, substance and alcohol abuse being considered a major contributor to mental health problems in Nyeri County by most of the community respondents. There was a second rehabilitation centre at Ihururu that is yet to be commissioned that could admit female clients too who were left out in the current arrangements.

Care givers expressed their frustration over proliferation of bars that were fuelling alcohol and substance abuse. Alcohol, drugs and substance use predisposed some people to mental health issues and exacerbated mental illness. The loose enforcement of “Mututho laws” limiting drinking hours and regulating consumption of alcohol or exploitation of gaps therein saw many alcoholic selling points operating during proscribed hours. For example, most pubs opened 24 hours some within the proximity of the schools and learning institutions. Easily accessible brews and narcotics worsened the addiction crisis in the county despite stringent national policies and laws limiting distribution and sale of alcohol. Multi stakeholder engagement was necessary to enforce such laws and promote sobriety.

21. https://www.drugabuse.gov/

3.0 CONCLUSION

Despite the existence of legal framework and policies around mental health services at the international, regional and national level, these policy documents were not well known or disseminated among HCWs or the community members. As a result stigma, discrimination, and human right violation still existed towards people with psychosocial, intellectual or cognitive disabilities. Biases, stigma and discrimination related to denial of legal services such as right to marriage, ownership of properties, voting and right of free association were rampant in Nyeri County. Moreover, derogative labeling of persons with mental disabilities as mad people with no socioeconomic value was eminent within the communities. It was evident that cases of individuals with psychosocial, intellectual or cognitive disabilities still continues to increase within the county. Despite this increase, mental health financing under the county government was still a challenge due to lack of costed mental health plan, low prioritization at the CIDP, or ADP level including lack of clear KPIs, targets or stand-alone budget line for mental health at the county health department or at the health facilities level. Lack of clear budgetary allocation for mental health resulted to poor prioritization of mental health services at the county level. The impact of such actions has brought about inconsistent supply of mental health product and commodities, poor mental health infrastructure, and inadequate human resource.

On mental health service delivery, access to mental health specialists was only at the referral levels. Lack of mental health professional at the primary health facilities increases the waiting time for seeking mental health services of which resulted to apathy and neglect due to financial implications and stigma associated with mental health. Insufficient mental health inpatient and outpatient services, poor mental health infrastructure, poor working conditions, lack of good remuneration, and lack of in-service training were some of the factors that hindered mental health service delivery in Nyeri County. Moreover, mental health suffered neglect by having mental health information not effectively captured within the DHIS or reported the CHVs.

In terms of mental health promotion, there were no clear channels to prove the manner of integration of mental health services in other health programs including community outreach programs despite mental health being a problem that cuts across most of the disease-based programs. Also there were no public media channels for promoting mental health service within the community. Limited number of CSOs working in mental health service delivery was another challenge within the county because it increased the mental health burden on the County government budgetary allocation.

4.0 RECOMMENDATION

The following recommendations are based on the finding of the community report.

1. Non-state actors should come in to support community mental health support groups.
2. The county government should enhance the integration of mental health service in other health programs within the healthcare facilities.
3. Continuous in-service training for HCWs on the components of mental health services should be expedited.
4. Awareness creation and public sensitization on mental health disabilities in order to reduce discrimination and stigma associated with the mental illness.
5. In order to increase mental health promotion and prevention at the community level, CHVS, and CHA must be trained on the basic mental health within their curriculum.
6. Non-state actors should increase their advocacy on the mental health financing at the county planning and budgetary levels such as during the CIDP, ADP and budgeting processes.
7. Advocacy for additional mental HCWs in all level 4 health facilities to support outreach clinics and increase mental health service delivery within the County.
8. The County government should increase engagement and participation of different stakeholders in mental health promotion and prevention preferably establish a multidisciplinary, multi-sectoral steering committee or technical working group.
9. National level advocacy for provision of psychotropic drugs at PHC level at a minimum for prescription refill or treatment where the mental health personnel is available
10. There is need to promote access to legal aid for vulnerable populations; mental health stakeholders should identify and strengthen the capacity of community human rights defenders and linkage to pro bono legal services that can fill the redress gap due to the compromised financial and mental acuity of persons with lived experience of mental health.

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