



NYERI COUNTY COSTED MENTAL HEALTH ACTION PLAN: 2023-2027

Achieving Optimal Mental Health Status
of Each Individual in the County

April 2023

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LIST OF ACRONYMS

ADP	Annual Development Plan
AWP	Annual Work Plan
CHAs	Community Health Assistants
CHC	Community Health Committee
CHU	Community Health Unit
CHD	County Health Department
CHMT	County Health Management Team
CHVs	Community Health Volunteers
CIDP	County Integrated Development Plan
CME	Continuous Medical Education
COVID-19	Corona Virus Disease 2019
CSOs	Civil Society Organizations
CTRH	County Teaching and Referral Hospital
ECT	Electroconvulsive Therapy
EEG	Electroencephalogram
IEC	Information, Education and Communication
ICT	Information, Communication and Technology
KEPH	Kenya Essential Package for Health
KES	Kenya Shilling
HCW	Health care Worker
HIS	Health Information System
M&E	Monitoring and Evaluation
MH	Mental Health
MNS	Mental Health, Neurological and Substance Use
MOE	Ministry of Education
NCPWD	National Council for Persons with Disability
NHIF	National Health Insurance Fund
QITs	Quality Improvement Teams
SDG	Sustainable Development Goal
SGBV	Sexual Gender Based Violence
TWG	Technical Working Group
UHC	Universal Health Coverage
UN	United Nations
WHO	World Health Organization

FOREWARD

The five-year Nyeri County Mental Health Action Plan 2023-2027 is the first comprehensive strategy document the health department has developed to guide the health sector in implementing mental health activity in the county. The plan is a commitment to pursuing strategies for achieving the optimal mental health status of each individual in the county.

The Action Plan was developed under the leadership of the County Department of Health through a consultative process of key stakeholders. It takes cognizant of the fact that the mental health system is under-resourced, resulting in gaps in the provision of quality and comprehensive mental health interventions at all levels of care.

Anchored on the Constitution of Kenya, 2010, Vision 2030, Kenya Mental Health Policy (2015-2030), and Kenya Mental Health Action Plan 2021-2025, the Nyeri Mental Health Action Plan envisions a county where mental health is valued and promoted, mental health conditions are prevented and persons affected treated without stigmatization and discrimination, and affected persons are given equal opportunities.

A multi-sectoral approach will be applied to achieve the set strategic objective of the action plan. All actors in the mental health space under the leadership of the County Department of Health will have opportunities to meaningfully participate in all mental health processes at the county, sub-county, and community levels.

It is, therefore, my belief that together we can make a difference in the mental health system in Nyeri County. For effectiveness and efficiency, I urge all of us to embrace the multi-sectoral approach to addressing mental health conditions in our communities.

Signed:



Robert Thuo Mwangi,
Ag. County Executive Committee Member (CECM),
Department of Health Services

ACKNOWLEDGMENT

The Nyeri County Mental Health Action Plan 2023-2027 has been developed through a consultative and inclusive process involving the Department of Health, Civil Societies, and Community Groups. We wish to acknowledge the financial and technical assistance provided by Health Rights Advocacy Forum (HERAF) with support from a co-funding partnership between Comic Relief and the UK Government's Department for International Development (DFID) through UK aid for the development of this Mental Health Action Plan. Special gratitude to the County Department of Health whose leadership and guidance ensured that all the necessary resources and technical inputs were provided for the effective planning and development of the Action Plan.

We sincerely thank the technical team under the leadership of the County Director in the Department of Health. We acknowledge the commitment, dedication, and technical inputs by the various units and hospitals in the Department in developing the Action plan.

The contributions from Caritas, St. Joseph Community Based Organisation, National Council for Persons with Disability, Cerebral Palsy Warriors Family, Differently Talented Society of Kenya, Nyeri Disability Network, Maisha Youth, Mental Health Support Groups, Afya Yetu Initiative, Nyeri County Budget Coalition and the Department of Children Services thus promoting the multi-sectoral approach and commitment to partnership and collaboration are highly appreciated. The Action Plan would not have been as enriched without your meaningful participation. The principle of inclusiveness would also not have been realized.

To all stakeholders and partners, we call upon you to embrace the multi-sectoral approach as you implement the action plan. Your investment and collaboration will be of paramount importance in the achievement of the set strategic objectives by the year 2027.

Signed:



Ibrahim Adan,
Chief Officer,
Department of Health Services

EXECUTIVE SUMMARY

The Nyeri County Mental Health Action Plan, 2023-2027 goal is “To attain the highest standard of mental health.” Effective implementation of the plan under the leadership of the health department will result in the provision of quality and comprehensive mental health interventions at all levels of care. The plan identifies four strategic objectives and actions appertaining to each that are informed by the county’s mental health priorities listed below and will be realized through evidence-based interventions.

Strategic Objective 1: Strengthen effective leadership and governance for mental health.

Strategic Actions:

- Establish leadership structures for mental health and mental disability at all levels
- Promote the development and implementation of responsive policies and legislation.
- Mainstream mental health across sectors (stakeholder collaboration).

Strategic Objective 2: Implement strategies for the promotion of mental health and prevention of mental and substance use disorders.

Strategic Actions:

- Establish support groups for people with lived experience and families/ caregivers.
- Create awareness of existing laws and regulations on alcohol, drug, and substance use and empower champions, community leaders and members to advocate for their enforcement.
- Improve health education on mental health.
- Prevent suicide.

Strategic Objective 3: Ensure access to comprehensive, integrated, and high-quality, promotive, preventive, curative, and rehabilitative mental health services at all levels of healthcare

Strategic Actions:

- Improve access to curative and rehabilitative mental health services.
- Improve access to preventive mental health services.
- Improve the quality of promotive, preventive, curative, and rehabilitative mental health services.

Strategic Objective 4: Strengthen the mental health system, including information system and research

Strategic Actions:

- Infrastructure improvement for mental health.
- Mental health information system.
- Access to essential medicines, equipment, and technologies.
- Increased financing for mental health.
- Mental health research.
- Human resource for mental health.

The action plan advocates for a multi-sectoral approach and, once effected, will contribute towards making progress in achieving the optimal mental health status of each individual in the county.

1.0 BACKGROUND

1.1 Definition of mental health

The World Health Organization (WHO) defines mental health as a state of well-being in which every individual realizes their potential, can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape our world. Mental health is a fundamental human right, and it is crucial to personal, community, and socio-economic development.

1.2 Global Perspective for Mental Health

1.2.1 Prevalence of Mental Health Conditions and Behavioral Disorders and Consequences

According to WHO World Health Report 2001, factors associated with the prevalence, onset, and course of mental health conditions and behavioral disorders include poverty; sex; age; conflicts and disasters; major physical diseases; the family, and; social environment. The report further states that mental health conditions and behavioral disorders affect more than 25% of all people at some time during their lives. They have an economic impact on societies and the quality of life of individuals and families.

Globally, an estimated 450 million people suffer from mental health conditions or behavioral disorders. Mental health conditions, neurological and substance use disorders exact a high toll, accounting for 13% of the total global burden of disease. Depression alone accounts for 4.3% of the global disease burden and is among the most significant causes of disability worldwide (11 % of all years lived with disability globally). This notwithstanding, the gap between the need for treatment and its provision is considerable worldwide. Between 76% and 85% of people with severe mental disorders receive no treatment in low-income and middle-income countries; the range for high-income countries is also high: between 35% and 50%.

Access to mental health treatment is further compounded by stigma and discrimination suffered by persons with mental health conditions and their family members. According to the WHO Mental Health Action Plan (2013-2020), the failure of society to acknowledge the burden of mental health conditions

on affected families means that very little support is available to them. The family often bears expenses for treating mental health conditions because they are generally not covered by the State or insurance. In addition, persons with mental health conditions often suffer a wide range of human rights violations. They are denied the most basic human rights, and issues concerning consent for admission and treatment are often ignored.

1.3 Mental Health Situation in Kenya

There is inadequate data and information on the prevalence of mental health, neurological, and substance use (MNS) in Kenya. However, it is estimated that up to 25% of outpatients and 40% of in-patients in health facilities suffer from mental health conditions. Further, the prevalence of probable psychosis in Kenya averages 1 % of the population. The most frequent diagnoses of mental health conditions in general hospital settings are depression, substance abuse, stress, and anxiety disorders. The persistent reported traumatic events, such as violence, disasters, and conflicts, as well as unemployment and poverty, may play a significant role in the development of rising trends of post-traumatic disorders, anxiety, depression, and suicide among those affected.

Nationally, the mental health system gaps are similar to the elaborated global situation of low- and middle-income countries. The WHO Mental Health 2017 Member State Profile reported that the Kenya government's total expenditure on mental health as a percentage of total government health expenditure was 0.01%. The same report showed that most persons with mental health conditions pay mostly or entirely out of pocket for services and medicines.

The Kenya Mental Health Policy, 2015-2030 notes that Kenya is among the 28% of WHO member states without a separate mental health budget. Notably, Kenya spends 15 cents on mental health compared to the recommended KES 150 per capita. The low expenditure has been a significant impediment to developing quality mental health services in the country. The policy states that there should be equitable resource sourcing and allocation for mental health services at all levels. The sources of funds should be from both National and County governments, development partners, and non-state actors. Among the priority actions cited in the mental health policy under financial resources is increasing the budgetary allocation to mental health services; in national and county health sector budgets. On human resources for mental health, the policy acknowledges an acute shortage of skilled mental health personnel.

According to a baseline assessment conducted in 2021 for a project: *Breaking the barriers on access to quality mental health services and support in Kenya*, implemented by Christian Aid (CA) in partnership with Health Rights Advocacy Forum (HERAF), leadership and governance structures were lacking at the national level. The same report noted that mental health service indicators at the national level were only two and integrated into the general health information systems. Civil society organizations were reported as not meaningfully participating in national-level processes related to mental health. The processes include budget-making, development of mental health-related documents, implementation, and monitoring the implementation of mental health-related documents.

1.4 Nyeri County Mental Health System Situation

In the year 2021, the projected county population was 793,210. A total of 7,737 clients were seen in Psychiatry Outpatient Consultants' clinics. A baseline assessment in Nyeri by Christian Aid (CA) in partnership with Health Rights Advocacy Forum (HERAF) in 2021 revealed gaps in the county's mental health system. The assessment revealed an absence of budget allocation specific to mental health at the county level. Human resources for mental health were reported as inadequate in numbers, and distribution was skewed to urban areas. As reported, the total number of human resources for mental health was 37. Regarding continuous professional development for the human resource for mental health, out of the 37 mental health workers, two and six had been trained and sensitized, respectively, in the last two years.

On mental health leadership and governance, there are no standalone leadership and governance structures in the county. The mental health leadership and governance structures are integrated into the governance structures of the Department of Health. A mental health focal person exists under the coordination of the county health management team (CHMT).

In Nyeri County, drugs for mental health conditions were reported as available at all levels of care providing mental health services, including level 5 and some level 4 and 3 facilities. However, the supply of medicines has been reported as inadequate and erratic.

The assessment established no indicators specific to mental health service delivery. Further, no data capture tools for mental health service delivery were noted. As a result of the foregoing, mental health service delivery data is neither collected nor integrated into the health information system. The package of mental health services in Nyeri County also includes outreaches to underserved areas. Mental health services are integrated into other services at lower health facilities and community levels.

On capturing mental health in the County Integrated Development (CIDP), the assessment noted that mental health had not been explicitly stipulated in the CIDP (2018-2022) health sector section. In addition, mental health is inadequately captured in the Annual Development Plan (ADP). Participation of Civil Society Organizations (CSOs) in developing and implementing the CIDP and ADP was reported as inadequate. In addition, there are no technical working groups (TWGs) in the county, and CSOs' participation in the budget-making process is insufficient and, therefore, not impactful. It was also reported by the CSOs respondents that they do not participate in monitoring the implementation of mental health-related documents, utilization of mental health funds, quality, and levels of satisfaction at the county level.

1.5 Gaps and Barriers to access

In Nyeri County, the mental health care system is inadequately resourced as per the baseline assessment, 2021. The budget for Mental health services is integrated into the Departmental budget. There is inadequate community awareness of mental health, a low level of mental health literacy, inadequate promotive and preventive interventions at the community level, no data capture tools for mental health service delivery indicators, lack of community-based mental health services, and inadequate involvement of all major mental health key players.

1.6 Policy & legal framework for Mental Health System

In Kenya, the overarching legal framework that ensures a comprehensive rights-based approach to health services delivery is the Constitution of Kenya, 2010. Health laws and policies, including those related to mental health, should be anchored on the Constitution of Kenya, 2010. The Kenya Government, through the Ministry of Health at the national level, takes leadership in developing all health policies, legislations, and sector strategic plans. In this regard, Kenya has developed policies and legal frameworks to create a supportive environment for the provision of mental health services.

1.6.1 Policies and Action/Strategic Plans

The legal framework concerning mental health in Kenya is premised on the Mental Health (Amendment) Act 2022. The purpose of the Act 2022, as stipulated, is to provide a framework:

- To promote the mental health and well-being of all persons, including reducing the incidences of mental illness.
- Co-ordinate the prevention of mental illness, access to mental health care, treatment, and rehabilitation services of persons with mental illness.
- Reduce the impact of mental illness, including the effects of stigma on individuals, families, and the community.
- Promote recovery from mental illness and enhance rehabilitation and integration of persons with mental illness into the community.
- Ensure that the rights of a person with mental illness are protected and safeguarded.
- Adopt a holistic approach to community-based mental health services.
- Promote the provision of mental health services in primary health facilities.

The Act obligates the county to:

- Provide mental health care, treatment and rehabilitation services within the county health facilities; in particular, ensure that levels 2, 3, 4 and 5 county health facilities set aside dedicated clinics to offer outpatient services for persons with mental illness.
- Provide community-based care and treatment for persons with mental illness, including initiating and organizing community or family-based programs for the care of persons suffering from mental illness.
- Implement the national policy and strategies relating to mental illness and mental health care.
- Allocate funds necessary for the provision of mental health care in the county budgets.
- Provide appropriate resources, facilities, services and personnel capable of dealing with mental illness at the community level.
- Formulate rehabilitation programs suitable for persons with mental illness and provide access to after-care service by persons with mental illness after discharge from mental health facilities.
- Formulate and implement county-specific programs to deal with the stigma associated with mental illness.

- Ensure mental health interventions at the county level:
 - ▶ Are comprehensive and include prevention, early intervention, treatment, continuing care and prevention from relapse.
 - ▶ Target persons at risk of developing mental illness, including children, women, youth and elderly persons.
 - ▶ Target persons affected by catastrophic incidences and emergencies Include education, awareness and training on mental health promotion and interventions.

- Provide adequate resources to ensure a person with mental illness lives a dignified life outside the mental health unit by financing efforts towards reintegrating the person into the community. The Act also stipulates that a county mental health council shall be established at each county government.

The rights of people with mental health have been explicitly stipulated in the Mental Health (Amendment) Act, 2022. Under section 3 of the Act, every person with mental illness, among other rights, has the right:

- To mental health services.
- To consent to treatment. However, where the person with mental illness is incapable of making an informed decision on the form of treatment, the supporter or representative (where a supporter has not been appointed) of the person with mental illness shall, when giving consent, comply with the will and preferences of that person. In the case of a minor, the health care provider shall inform the guardian of the right to choose an appropriate form of treatment for the minor. In addition, the health care provider shall obtain written consent from the guardian before administering any treatment.
- To participate in treatment planning.
- To access medical insurance.
- To the protection of persons with mental illness.
- To civil, political and economic rights.
- To access information.
- To confidentiality.
- To appoint a supporter.
- Decision by the supporter.
- Legal capacity.

1.6.2 Mental Health Legal Framework

Among the targets stipulated in the Sustainable Development Goal 3 to be achieved by 2030 is 1) reducing by one-third premature mortality from non-communicable diseases through prevention and treatment and promoting mental health and well-being 2) achieving universal health coverage (UHC), including financial risk protection, access to quality essential health care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all. Kenya, a signatory member of the UN, is committed to achieving SDG 3 on ensuring good health and well-being for all, including people with mental disorders, by 2030. Kenya has also put in place mechanisms for the attainment of universal health coverage.

The Kenya Mental Health Policy 2015-2030 development was informed by the need to reform the mental health system in Kenya, and the goal is attaining the highest standard of mental health. The policy is also a commitment to pursuing policy measures and strategies for achieving each individual's optimal health status and capacity.

The policy seeks to: 1) Align the mental health services with the Constitution of Kenya, Vision 2030, the Kenya Health Policy (2014-2030), and the global health commitments 2) Address the mental health systemic challenges, emerging trends, and mitigate the burden of mental disorders 3) Integrate the mental health services within the Kenya Essential Package for Health (KEPH) 4) Promote, respect and observe the rights of persons with mental disorders per national and international laws.

The Mental Health Action Plan (2021-2025) provides a framework for National and County Governments and stakeholders to implement the Mental Health Policy through strategic objectives with specified priority targets and indicators. It also guides the implementation of strategic actions and investments to bring transformative reforms in the following: 1) Mental Health Leadership and Governance 2) Preventive and Promotive Mental Health 3) Access to Quality Mental Health Services 4) Strengthening of Mental Health Systems.

The Kenya Community Health Policy 2020-2030; is based on provisions of the Constitution 2010, Kenya Health Policy 2014 – 2030, Universal Health Coverage, and principles of Primary Health Care. The policy stipulates that counties shall ensure the community health workforce is enabled to:

1. Discuss and counsel community members on the importance of knowing the risks factors, signs, and symptoms of mental illness.
2. Increase awareness on how to prevent mental illness and avoid using harmful substances such as alcohol, drugs and tobacco.
3. Screen for common disorders and refer appropriately.
4. Referral for rehabilitative and counseling services for drug and substance abuse.
5. Maintain close contact with members of the community with mental health conditions to ensure adherence to therapy and treatment protocols.

The Community Health Strategy 2020-2025 aims to provide a framework for all stakeholders to implement Community Health Services in a standardized manner. The strategy intends to build the capacity of individuals and households to know and progressively realize their rights to equitable, good quality health care and demand services as provided for in the constitution 2010.

A mental health unit in the Facilitator’s Manual: “Community Health Volunteers (CHVs), NCD Module 13”, serves to build the capacity of community health volunteers on mental health, The purpose of the unit is to equip community health volunteers with the appropriate knowledge, skills and attitudes that will enable them to respond to the mental health needs of the communities they serve. It presents key community based mental health care concepts and practical approaches for community health volunteers to develop the competences required for community mental health care awareness, promotion, identification, referral and follow-up.

1.7 SWOT analysis of existing Mental Health systems in Nyeri County

Table 1: SWOT Analysis

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • Integration of MH services into other services at some facilities and community level. • Availability of human resources for MH at the facility and community level who can be trained on MH. • Availability of MH drugs. • MH leadership integrated into the leadership structures for the Department of Health. • Outreaches conducted at the community level. • Linkages established between primary health facilities and the community. • Functional MH Unit in place • SGBV Centre at CTRH. • Collaboration between CHD with other sectors, e.g. Ministry of Interior and Coordination of National Government, Children’s Department, Education, Social services. • Partnership with the local churches in place for community mobilization and awareness creation. • Collaboration with local FM for community mobilization and awareness creation. 	<ul style="list-style-type: none"> • No specific budgetary allocation for mental health services. • Inadequate number of skilled MH human resources at both facility and community level. • Inadequate community awareness of MH. • Low level of mental health literacy. • Inadequate promotive and preventive interventions at the community level. • Lack of mental health-specific governance structures in the county • Lack of MH TWG. • Inadequate/erratic supplies of MH drugs. • Inadequate funding for community outreaches. • Lack of community-based MH services. • Insufficient data on mental health services. • Inadequate involvement of all significant MH key players.

OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> • Existence of national MH legislation, policies, and action plan. • Presence of a national Integrated Health Information System (HIS) • Availability of technologies e.g. telemedicine. • Availability of social media platforms • Political good will at the national level. • Inclusion of mental healthcare in the enhanced medical scheme offered by the National Hospital Insurance Fund (NHIF). 	<ul style="list-style-type: none"> • Poor enforcement of the regulations and rules that govern the alcoholic and illicit drinks and substances industry. • High cost of treatment. • Discrimination by the health insurance industry against persons with MNS disorders in accessing insurance policies. • Stigma and discrimination of persons with mental health conditions at the community and facility level. • Negative socio-cultural beliefs and practices. • Lack of political will at the county level. • Global pandemics e.g. Covid-19. • Social determinants of mental health in a changing world; conflicts, trauma, humanitarian emergencies, population movements, urbanization, socioeconomic and sociocultural disadvantages, climate change, and technological advancement.

2.0. STRATEGIC FOCUS

2.1. County's Vision on mental health, Goal and Strategic Objectives

2.1.1. Vision

A county where mental health is valued and promoted, mental health conditions and disabilities are prevented, persons affected by mental disorders and disabilities are treated without stigmatization and discrimination, and affected persons are given equal opportunities.

2.1.2 Goal

To attain the highest standard of mental health

2.1.3 Strategic objectives

1. Strengthen effective leadership and governance for mental health.
2. Implement strategies for the promotion of mental health, prevention of mental health conditions and substance use disorders.
3. Ensure access to comprehensive, integrated and high-quality, promotive, preventive, curative, and rehabilitative mental health services at all levels of healthcare.
4. Strengthen the mental health system, including information system and research.

2.2 Cross-cutting principles and approaches

Informed by the Kenya Health Policy 2014-2030, the Kenya Mental Health Policy 2015-2030, and the WHO Comprehensive Mental Health Action Plan 2013-2030, the cross-cutting approaches that guided the development of the Costed Nyeri County Mental Health Action Plan will also direct its implementation. The cross-cutting approaches are as follows:

1. **Universal health coverage.** Regardless of age, sex, socioeconomic status, race, ethnicity, religious affiliation, or any other status and following the principle of equity, persons with mental health conditions should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.

2. Human rights. Mental health strategies, actions, and interventions for treatment, prevention, and promotion must be compliant with the Constitution of Kenya, 2010; Kenya Health Act, 2017; Mental Health (Amendment) Act, 2022; Convention on the Rights of Persons with Disabilities, and other international and regional human rights instruments.

3. Evidence-based practice. Mental health strategies and interventions for treatment, prevention, and promotion need to be based on scientific evidence and/or best practice, considering cultural considerations.

4. Life-course approach. Mental health conditions and behavioral disorders affect individuals of all ages. Therefore, policies, plans, and services for mental health need to consider health and social needs at all life course stages, including infancy, childhood, adolescence, adulthood, and older age.

5. Multi-sectoral approach. The use of a multi-sectoral approach is based on recognising the importance of factoring the social determinants of mental health into efforts to achieve overall county mental health goals. Mental health-related issues shall, therefore, be included in policies that relate to other sectors, such as education, labor, security, correctional services, children services, planning, finance, the legal justice system, industrialization, agriculture, social services, environment, and other relevant sectors as well as the private sector, as appropriate to the county's situation.

6. Empowerment of persons with mental disorders and psychosocial disabilities and caregivers. Persons with mental health conditions and psychosocial disabilities and caregivers should be empowered and involved in mental health advocacy, promotion and prevention of mental health conditions, provision of psychosocial support, policy, planning, legislation, service provision, monitoring, research, and evaluation.

7. People-centered approach to mental health interventions. A people-centred approach should ensure that health and mental health interventions are organized around people's legitimate needs and expectations. This calls for community involvement and participation in deciding, implementing, and monitoring interventions.

8. Participatory approach to the delivery of interventions. The various actors involved in mental health service provision shall participate in designing and delivering interventions to achieve the best possible outcomes. The private sector shall be seen as complementary to the public sector to increase the geographical coverage, scale, and scope of the health services provided.

9. Efficiency in the application of health technologies. Health technologies, including e-health and specialized mental health equipment, are integral in delivering mental health services. Health technologies should maximize the use of existing resources and build capacity. This is in the selection of technologies that are appropriate, accessible, affordable, feasible, and culturally acceptable to the community for addressing mental health challenges and in the application of such technologies.

10. Social accountability. The constitution of Kenya obligates all institutions to be accountable to the public directly and through their representatives. Realization of the highest standards of mental health can only be achieved by bridging public perceptions and their needs through assessments, performance reporting, public awareness, transparency, and public participation in decision-making on mental health-related matters.

11. Community-based approach. Empowerment of relevant community structures to provide mental health care services appropriate for the level of care, community mobilization, advocacy, and participation in community dialogues and action days, policy formulation, planning, legislation, monitoring, evaluation, and research.

3.0. STRATEGIC ACTIONS AND PRIORITY INVESTMENT AREAS

To achieve the strategic objectives of the action plan, all actors in the mental health space will be expected to implement the following strategic actions and priority investment areas under each of them.

3.1. Strategic objective 1: Strengthen effective leadership and governance for mental health

3.1.1. Strategic Action 1.1: Establish leadership structures for mental health and mental disability at all levels.

Priority Investments under strategic action 1.1

- Establish a county mental health council
- Establish a multi-sectoral coordination committee at the county level
- Establish a multi-sectoral coordination committee at the sub-county level
- Establish subcommittees for mental health at the sub-county level
- Appoint a mental health focal person at the county and sub-county level
- Integrate mental health into the community health committees

3.1.2. Strategic Action 1.2: Promote the development and implementation of responsive policies and legislation

Priority Investments under strategic action 1.2

- Integrate mental health into all county government development plans, including County Health Plan, County Integrated Development Plan (CIDP) and Annual Development Plans (ADP).
- Disseminate the national-level policies and legislation on mental health conditions.
- Develop county-level policies and legislation on mental health conditions.

3.1.3. Strategic Action 1.3: Mainstreaming Mental Health across Sectors (Stakeholder collaboration)

Priority Investments under strategic action 1.3

- Establish TWGs at the county and sub-county levels.
- Disseminate county mental health action plan.
- Coordinate utilization of multi-stakeholder funding for mental health programs and services to avoid funding duplication.

3.2. Strategic objective 2: Implement strategies for the promotion of mental health, prevention of mental and substance use disorders.

3.2.1. Strategic Action 2.1: Establish support groups for people with lived experience and families/caregivers.

Priority Investments under strategic action 2.1

- Establish and nurture psychosocial support groups for promotion and prevention of MH and substance use.
- Enhance capacity for support group to provide psychosocial support to clients with mental health and substance use lived experiences.
- Link members of the support groups to social-economic development programs.
- Formation and strengthening of psychosocial support groups for the families/Caregivers of persons with lived experiences.
- Train members of the support groups for families/Caregivers to provide psychosocial support to families/caregivers of clients with lived experiences

3.2.2. Strategic Action 2.2: Create awareness of existing laws and regulations on alcohol, drug, and substance use and empower champions, community leaders and members to advocate for their enforcement.

Priority Investments under strategic action 2.2

- Disseminate existing laws, polices and regulations on alcohol, drugs, and substance use.
- Sensitize mental health champions on existing laws and regulations on alcohol, drugs, and substance use to advocate for enforcement.
- Sensitize community leaders and members on existing laws and regulations on alcohol, drugs, and substance use to advocate for enforcement.
- Empower the champions, community leaders and members to advocate for the enforcement of existing laws and regulations on alcohol, drugs and substance use.

3.2.3. Strategic Action 2.3: Action 2.3: Improve mental health education

Priority Investments under strategic action 2.3

- Empower members of the people with lived experience support groups with knowledge on withdrawal of addiction from drug abuse, alcoholism, and stigma.
- Train health promotion officers in mental health.
- Conduct health education outreaches to communities, and learning institutions, including schools, prisons, police stations, and, support groups, among others
- Develop and distribute mental health-targeted IEC materials for different special population segments.
- Collaborate with other stakeholders such as the Ministry of Education (MOE), Department for Trade, Department for Gender and Social Services, Prisons Department, National Police Service, Religious Organizations, the Business Community, Civil Society Organizations, Youth and Women Organizations and Community Gatekeepers to reach special populations with mental health promotion and prevention messages.
- Integrate mental health messages into topical national and globally celebrated health days.
- Integrate mental health messages in community dialogue meetings and community action days.
- Sensitize stakeholders to identify and refer the affected for better management.
- Identify and train men and women champions in positive behavior change and positive parenting.
- Develop and disseminate a MNS Communication Strategy.

3.2.4. Strategic Action 2.4: Preventing Suicide

Priority Investments under strategic action 2.4

- Train gatekeepers in suicide prevention.
- Conduct community dialogue days on the prevention of suicide.
- Sensitize CHAs and CHVs on suicide prevention and referral at community level.

3.3. Strategic objective 3: Ensure access to comprehensive, integrated and high-quality, promotive, preventive, curative, and rehabilitative mental health services at all levels of healthcare

3.3.1. Strategic Action 3.1. Improve Access to Curative and Rehabilitative Mental Health Services

Priority Investments under strategic action 3.1

- Integrate mental health services at all levels of care: community, dispensary, health centre, and county referral levels.
- Adopt the national mental health training module for health care workers in the county.
- Train service providers at all levels of care in mental health.
- Integrate mental health referral tools into the health facilities referral system.
- Integrate mental health into the community referral tool.
- Avail psychosocial services at all health facilities providing mental health services.

3.3.2. Strategic Action 3.2: 3.3.2. Strategic Action 3.2: Improve access to preventive mental health services

Priority Investments under strategic action 3.2

- Develop a community-based mental health screening tool.
- Train CHVs in community-based mental health screening.
- Conduct community outreaches for rehabilitative and facilitative therapy for persons with mental health conditions.
- Sensitize the community members on existing mental health rehabilitation services.
- Develop a facility-based mental health screening tool.
- Train HCWs in facility-based mental health screening.
- Hold debriefing sessions on mental health for health workers.
- Collaborate with stakeholders in establishing community-based clients' re-integration programs.

3.3.3. Strategic Action 3.3: Improve the quality of promotive, preventive, curative, and rehabilitative mental health services.

- Develop and integrate mental health support supervision tools into existing support supervision programs.
- Conduct integrated mental health support supervision.
- Provide in-service training in mental health for all healthcare workers
- Provide mentorship to service providers (HCWs) providing mental health services.
- Integrate mental health into the existing quality improvement teams (QITs) activities.
- Disseminate and distribute existing mental health clinical guidelines, protocols, norms, and standards.
- Monitor and evaluate mental health activities bi-annually.
- Train healthcare workers on Quality Rights.

3.4. Strategic objective 4: Strengthen mental health systems, including information system and research.

3.4.1. Strategic Action 4.1: Infrastructure Improvement for Mental Health.

Priority Investments under strategic action 4.1

- Avail essential ICT technologies to all facilities providing mental health services as appropriate for the level of care.
- Integrate mental health in-patient services into general wards in all major hospitals.
- Construct a modern in-patient mental health unit at the County Teaching and Referral Hospital to replace ward 10.

3.4.2. Strategic Action 4.2: Mental Health Information System.

Priority Investments under strategic action 4.2

- Develop county data capture and reporting tools for adequate data collection that enables informed decision-making at the county level.
- Train health care workers in capturing and reporting mental health data.
- Present analyzed mental health data during County Health Management Team (CHMT) meetings to aid informed decision-making.

3.4.3. Strategic Action 4.3: Access to essential medicines, equipment and technologies.

Priority Investments under strategic action 4.3

- Avail essential mental health drugs at all facilities providing mental health services.
- Avail essential occupational therapy equipment to the three facilities providing in-patient and rehabilitation services.
- Equip all major hospitals providing mental health services with essential treatment technologies.

Strategic Action 4.4: Increased financing for mental health

Priority Investments under strategic action 4.4

- Develop unit-costed annual work plans.
- Liasise with National Health Insurance Fund (NHIF) to accredit all rehabilitation centers.
- Conduct bi-annual registration drive events for enrollment of Vulnerable and Most at-Risk Populations, including persons with lived mental health experience, into social protection services such as NHIF, Disability registration with the National Council for Persons with Disability (NCPWD) and UHC, among others.
- Train civil society organizations in mental health space on advocacy for increased mental health investments.
- Establish partnerships and collaboration platforms for all stakeholders in the mental health space to pool financial resources.
- Establish public-private sector partnerships to address mental health.

3.4.5. Strategic Action 4.5. Mental Health Research

Priority Investment under strategic action 4.5

- Map and segment regions by type of drugs and substances used to inform interventions.
- Map stakeholders in the county, including mental health areas of focus and geographical coverage.
- Conduct a baseline survey to quantify the burden of mental health to inform mental health investments.
- Conduct research to establish the root cause of drugs and substance use.
- Hold scientific conferences and support the presentation of scientific papers.

3.4.6. Strategic Action 4.6. Human Resource for Mental Health

Priority Investment under strategic action 4.6

- Conduct training needs assessment of existing mental health service providers.
- Train existing mental health service providers as per the findings of the training needs assessment.
- Recruit mental health-human resources, i.e. nurses, clinical officers, psychologists and medical social workers.
- Conduct continuous medical education (CME) for healthcare workers to keep them updated on new technologies and the management of mental health conditions.

4.0 IMPLEMENTATION FRAMEWORK

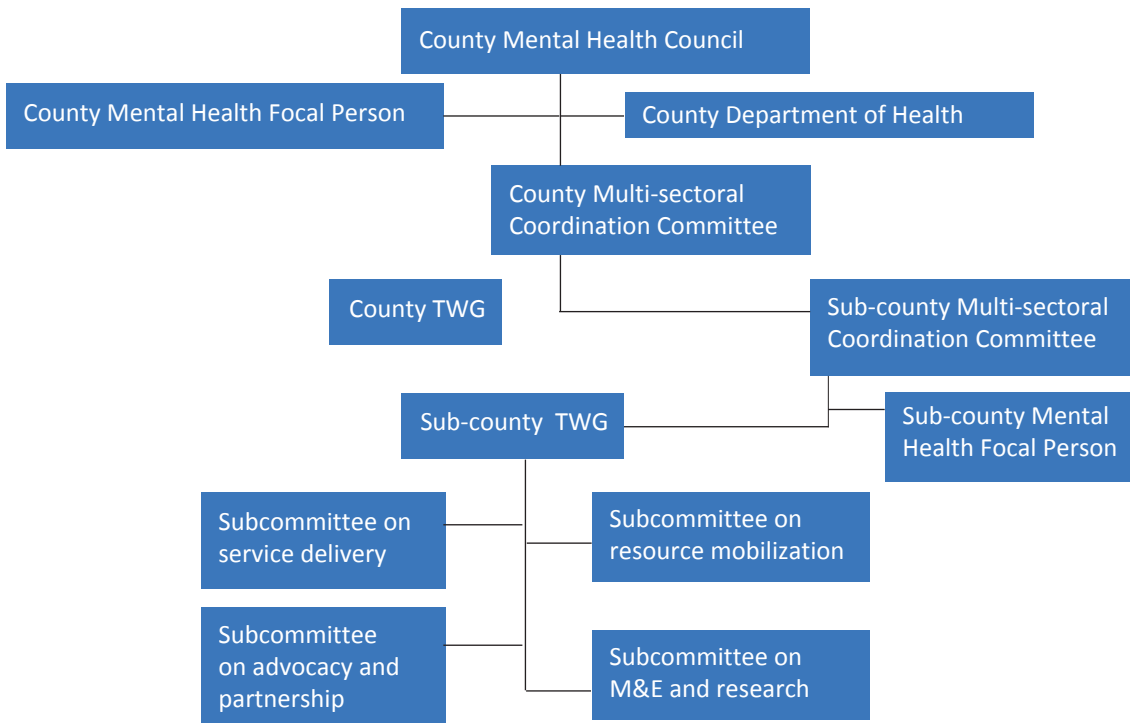
4.1 Coordination Framework

To effectively implement this costed action plan, Nyeri County will implement multi-sectoral coordination mechanisms; guided by the principles stipulated in the Kenya Health Sector Partnership and Coordination Framework 2018 – 2030. Coordinating and harmonizing the investments and actions of all partners in the mental health space is critical to ensure that the best use of all available resources is made to address identified priorities and achieve results. An effective partnership will, among others,

1. Facilitate coordination and harmonization of investments and actions between partners through joint consultative, planning, budgeting, monitoring, and review processes to eliminate duplication in efforts and to identify critical gaps that need to be addressed.
2. Promote and facilitate mutual accountability for results.

The figure below presents the envisioned coordination structure that will encourage the participation of all players.

Figure 1: County Mental Health Coordination Structures



Roles and Responsibilities

County Mental Health Council

The County Mental Health Council established by the Nyeri County Government shall oversee mental health at the county level.

County Department for Health

Through the County Department for Health, Nyeri County Government Will:

1. Provide leadership in the implementation, management, and coordination of mental health multi-sectoral coordination committee that include non-state actors such as the private health sector, faith-based and civil society organizations.
2. Ensure that national mental health policy, strategic plans, and legislation are integrated and mainstreamed in all county health policies, strategic plans, and legislations.
3. Ensure mental health is included in the County Integrated Development Plan (CIDP), Strategic Plan, and Annual Implementation Plans.
4. Provide leadership in planning, implementing, and monitoring the mental health annual work plans.
5. Establish and convene joint annual planning, budgeting, and monitoring processes and forums to ensure all available resources are aligned and reflected in annual plans and budgets.
6. Establish and convene joint annual review processes and forums to review the implementation of the mental health work plan.
7. Provide guidance and reporting formats to mental health partners to report on planned investments at county levels.
8. Identify areas where capacity strengthening is required to achieve mental health set objectives.
9. Build the capacity and offer technical assistance to state and non-state actors to effectively implement mental health policies, legislation, and annual work plans.

Multi-sectoral Coordination Committee stakeholders at County Level will

- Advocate and actively participate in the integration and mainstreaming of the national mental health policy, strategic plans, and legislation issues in all county health policies, strategic plans, and legislation.
- Develop terms of reference for the multi-sectoral TWGs, sub-county multisectoral coordination committee, and sub-county sub-committees.

- Provide support to county mental health process, including annual forums and conferences.
- Share information on mental health programs, geographical coverage, and the support provided to guide each stakeholder’s prioritization of investment areas and support.
- Provide regular reports on planned investment areas using the county-provided reporting formats for mental health.
- Annual review processes to review the implementation of the mental health work plan. Actively participate in joint annual planning and budgeting forums to ensure all available resources are aligned and reflected in annual plans and budgets.
- Actively participate in implementing and monitoring the mental health annual work plans.
- Align their agency’s mental health review processes to the joint mental health annual review processes and forums as per the terms of the multi-sectoral coordination committee.
- Contribute to need-based capacity building of stakeholders to actively engage and participate in mental health processes (planning, budgeting, implementation, monitoring, and evaluation) and annual review forums.

4.2 Framework for Monitoring and Evaluation

The defined indicators in this costed five years mental health action plan shall be continuously monitored and evaluated throughout the implementation process. Data will be systematically generated, captured, and used to inform decision-making, evidence-based advocacy, and programming improvements to achieve the set goal and strategic objectives of the action plan. The county government, through the health department, is responsible for the overall monitoring and evaluation of the plan. The county health department will coordinate with mental health stakeholders to capture data using the county-approved formats and submission deadlines to ensure data availability. The county health department will submit mental health data to the national level per the requirements of the prevailing health information management system. MH data will be analyzed and processed quarterly into reports for presentation during CHMT meetings for informed decision-making. Annually a status report on progress made in implementing the annual work plan will be prepared, gaps thereof and challenges encountered. The report will be presented during the annual work plan implementation review forums, and stakeholders will propose recommendations for action by management.

4.3 Mobilization of Financial Resource

4.3.1 Financial resource mobilization approaches

Effective implementation of the action plan to attain the set objectives requires adequate and sustained mental health funding. Different approaches to secure mental health funding will be applied and include: the exchequer, user fees, partners' funds, health insurance, and public-private partnership.

4.3.2 Priority interventions for sustainable funding in the implementation of this 5-year action plan

In this 5-year action plan, priority interventions geared toward ensuring sustainable funding for mental health have been identified. The priority interventions are as follows:

- Include mental health services in all health plans-CIDP, ADP and AWP.
- Coordinate utilization of multi-stakeholder funding for mental health conditions programs and services to avoid funding duplication.
- Develop mental health costed annual work plans.
- Liaise with NHIF to accredit all mental health substance and drug use rehabilitation centers.
- Conduct bi-annual registration drive events to enrol vulnerable persons with lived experience into NHIF and other social protection programs.
- Train the members in the support groups of those with lived mental health experiences and the caregivers to advocate for an increased mental health budget.
- Establish partnerships with stakeholders in the mental health space to pool financial resources.
- Establish public-private sector partnerships.

5.0 COSTED MONITORING AND EVALUATION MATRIX

This section outlines the various strategic actions against their output indicators and the estimated cost over the five years of implementation.

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
Strategic Objective 1: To strengthen effective leadership and governance for mental health										
Strategic Action 1.1: Establish leadership structures for mental health and mental disability at all levels										
1.1.1. Establish a county MH council	MH Council established	Number of MH councils established	1	Conference package and transport allowance for 7 pax. Meeting quarterly	5,000	140,000	140,000	140,000	140,000	140,000
1.1.2. Establish a multi-sectoral coordination committee at the county level.	Multi-sectoral coordination committee established at the county level	Number of multi-sectoral coordination committees established at the county level	1	Conference package and transport allowance for 15 pax. Meeting quarterly	4,000	240,000	240,000	240,000	240,000	240,000

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
1.1.3. Establish multi-sectoral coordination committees at the sub-county level	Multi-sectoral coordination committees established at the sub-county level	Number of multi-sectoral coordination committees established at the sub-county level	8 (one per sub-county)	Conference package, facilitation, and transport allowance for 56 pax and 3 facilitators. Meeting twice a year		452,800	452,800	452,800	452,800	452,800
1.1.4. Establish subcommittees for Mental Health at the sub-county	Sub-committees for mental health at the sub-county level established	Number of sub-committees for mental health established at the sub-county level	32(4 per sub-county)	Conference package, facilitation, and transport allowance for 56 pax and 3 facilitators. Meeting twice a year		452,800	452,800	452,800	452,800	452,800
1.1.5. Appoint a mental health focal person at the county and sub-county level	Mental health focal person at the county and sub-county level appointed	Number of Mental health focal persons at the county and sub-county level appointed	9 (one at county level and 1 per sub-county)	No budget requirement	-	-	-	-	-	-

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
1.1.6. Integrate MH into the community health committees	Mental health integrated into community health committee	Number of community health committees in which MH is integrated	120 CHCs (4 per ward)	Hall hire, stationary, lunch, tea, snacks facilitation, transport, coordination airtime.		1,141,000	1,426,250	855,750		
1.2. Promote development and implementation of responsive policies and legislation										
1.2.1. Integrate mental health into all county government development plans, including County Health Plan, County Integrated Development Plan (CIDP) and Annual Development Plans (ADP).	Mental health integrated into all health plans	Number of health plans in which MH is integrated	11 (one CIDP in the 1st yr, 1 county health plan and 1 ADP per year for 5 years)	Hall hire, stationary, lunch, tea, snacks facilitation, transport, coordination airtime		678,394	339,197	339,197	339,197	339,197

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
1.2.2. Disseminate the national-level policies and legislation on mental health	National-level policies and legislation on mental health and MNS disseminated	Number of national-level policies and legislation on mental health and MNS disseminated	As disseminated from the national level	Hall hire, stationary, lunch, tea, snacks facilitation, transport, coordination airtime		687,200	687,200	687,200	687,200	687,200
1.2.3. Develop county-level policies and legislation on mental health conditions	County level policies and legislation on mental health conditions developed	Number of county level policies and legislation on mental health conditions developed	As deemed necessary	Hall hire, stationary, lunch, tea, snacks facilitation, transport, coordination airtime		53,900	53,900	53,900	53,900	53,900
Strategic Action 1.3. Mainstreaming Mental Health across Sectors (Stakeholder collaboration)										
1.3.1. Establish TWG at county and sub-county level	MH TWG established at county and sub-county level	Number of MH TWG established at county and sub-county level	9 (one at county level and 1 per sub-county)	Hall hire, stationary, lunch, tea, snacks facilitation, transport, coordination airtime		770,400	770,400	770,400	770,400	770,400

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
1.3.2. Disseminate county mental health action plan	County mental health action plan disseminated	Number of county mental health action plans disseminated	1	Hall hire, stationery, lunch, tea, snacks facilitation, transport, coordination airtime		262,800				
1.3.3. Coordinate utilization of multistakeholder funding for MH programs and services to avoid funding duplication	Utilization of multi-sectoral stakeholders funding for MH coordinated	Number of coordination meetings for multi-sectoral stakeholders' funding for MH held	5 (one per year)	Hall hire, stationery, lunch, tea, snacks facilitation, transport, coordination airtime		262,800	262,800	262,800	262,800	262,800

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
Strategic Objective 2: To implement strategies for the promotion of mental health, prevention of mental and substance use disorders										
Strategic Action 2.1. Establish support groups for people with lived experience and families/caregivers										
2.1.1 Establish and nurture psychosocial support groups for people with lived experience to promote and prevent MH and substance use	Psychosocial support groups for people with lived experience to promote and prevent MH and substance use established and nurtured	Number of psychosocial support groups for people with lived experience to promote and prevent MH and substance use established and nurtured	150 (1 Per Ward with 15 pax) per year	Hall hire, Public address, Stationary, Conference package, facilitation, transport Reimbursement		2,925,000	2,925,000	2,925,000	2,925,000	2,925,000
2.1.2. Enhance capacity for support groups to provide psychosocial support to clients with mental health and substance use lived experiences	Members of psychosocial support groups for people with lived experience trained to promote and prevent MH and substance use	Number of members of psychosocial support groups for people with lived experience trained to promote and prevent MH and substance use	2250 member (15 pax@150 support group) over a period of 5 years	Hall hire, Public address, Stationary, Conference package, facilitation, transport reimbursement		3,900,000	4,875,000	2,925,000	1,950,000	975,000

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
2.1.3 Link members of the psychosocial support groups to social-economic development programs	Psychosocial Support group members linked to trade skills training programs	Number of Psychosocial Support group members linked to trade skills training programs	2250 member (15 pax@150 support group) over a period of 5 years	No budget required						
	Psychosocial Support group members linked to programs providing tools of trade	Number of psychosocial support group members linked to programs providing tools of trade	2250 member (15 pax@150 support group) over a period of 5 years	No budget required						
	psychosocial support group members linked to enterprise development training programs	Number of psychosocial support group members linked to enterprise development training programs	2250 member (15 pax@150 support group) over a period of 5 years	No budget required						

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
2.1.4. Formation and strengthening of psychosocial support groups for the families/caregivers of persons with lived experiences.	Families / caregivers' psychosocial support groups of persons with lived experiences formed and strengthened	Number of families/caregivers' psychosocial support groups for the families/caregivers of persons with lived experiences Support groups Formed and strengthened	150 (1 per ward with 15 pax) per year	Hall hire, Public address,		2,925,000	2,925,000	2,925,000	2,925,000	2,925,000
2.1.5. Train members of the psychosocial support groups for families/caregivers to provide psychosocial support to families/caregivers of clients with lived experiences	Members of Psychosocial support groups for families/caregivers trained to provide psychosocial support to families/caregivers of clients with lived experiences	Number of members of Psychosocial support groups for families/caregivers trained to provide psychosocial support to families/caregivers of clients with lived experiences	2250 (15 pax @ 150 support group) over 5 years)	Hall hire, Public address, Stationary, Conference package, facilitation, transport reimbursement		3,900,000	4,875,000	2,925,000	1,950,000	975,000

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
2.1.6. Establish community-based alcoholic and substance use anonymous groups	Community-based alcoholic and substance use anonymous groups established	Number of community-based alcoholic and substance use anonymous groups	150(1 per ward per year	Health promotion facilitation, consultant and transport		360,000	360,000	360,000	360,000	360,000
Strategic Action 2.2: Create awareness of existing laws and regulations on alcohol, drug, and substance use and empower champions, community leaders and members to advocate for their enforcement										
2.2.1. Disseminate existing laws and regulations on alcohol, drugs, and substance use	Sessions held to disseminate existing laws and regulations on alcohol, drugs and substance use	Number of dissemination sessions held to disseminate existing laws and regulations on alcohol, drugs and substance use	1 per Year (for 100 pax)	Hall hire, Public address, Stationary, Conference package, facilitation, transport reimbursement		460,000	460,000	460,000	460,000	460,000
2.2.2. Sensitize mental health champions on existing laws and regulations on alcohol, drugs, and substance use to advocate for enforcement	Barazas held to sensitize champions on existing laws and regulations on alcohol, drugs, and substance use to advocate for enforcement	Number of barazas held to sensitize championson existing laws and regulation no alcohol, drugs, and substance use to advocate for enforcement	40 (1 per sub-county for approximately 32 pax) per year). There are 251 CHUs and each CHU will have a champion	Hall hire, Public address, Stationary, Conference package, facilitation, transport reimbursement		515,200	515,200	515,200	515,200	515,200

2.2.3. Sensitize community leaders and members on existing laws and regulations on alcohol, drugs, and substance use to advocate for enforcement	Community outreaches held to sensitize community leaders and members on existing laws and regulations on alcohol, drugs, and substance use to advocate for enforcement	Number of community outreaches held to sensitize community leaders and members on existing laws and regulations on alcohol, drugs, and substance use to advocate for enforcement	150 (1 per ward per year)	Facilitation for health promotion officers, drivers, public address system and fuel (50 litres per ward @ KSH150)	637,500	637,500	637,500	637,500	637,500
2.2.4. Empower the champions and the community members to advocate for enforcement of existing laws and regulations on alcohol, drugs, and substance use	Empowerment workshops held for champions and community members to advocate for enforcement of existing laws and regulations on alcohol, drugs, and substance use	Number of empowerment workshops held for champions and community members to advocate for enforcement of existing laws and regulations on alcohol, drugs, and substance use	40 (1 per Sub-County per year)	Hall hire, Public address, Stationary, Conference package, facilitation, transport reimbursement	1,115,200	1,115,200	1,115,200	1,115,200	1,115,200

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
Strategic Action 2.3: Improve mental health education										
2.3.1. Empower members of the people with lived experience support groups with knowledge on withdrawal of addiction from drug abuse and alcoholism and stigma	Members of the people with lived experience groups empowered with knowledge on withdrawal of addiction from drug abuse and alcoholism and stigma	Number of the people with lived experience support groups empowered with knowledge on withdrawal of addiction from drug abuse and alcoholism and stigma	2250 (15 pax @ 150 support group) over 5 years)	Hall hire, Public address, Stationary, Conference package, facilitation, transport reimbursement		3,900,000	4,875,000	2,925,000	1,950,000	975,000
2.3.2. Train health promotion officers on mental health	Health promotion officer trained on mental health	Number of health promotion officers trained in mental health	150 health promotion officers	Hall hire, Public address, Stationary, Conference package, facilitation, transport reimbursement		173,000	173,000	173,000	173,000	173,000

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
2.3.3. Conduct health education outreaches to communities, learning institutions, prisons, police stations, support groups, etc.	Health education outreaches conducted to communities, learning institutions including schools, prisons, police	Number of Health education outreaches held	1,000 health education outreaches	Facilitation of 3 health promotion officers, public address system, driver ,and fuel		173,000	346,000	259,500	43,250	43,250
2.3.4. Develop and distribute mental health-targeted IEC materials for different special population segments	Targeted IEC materials development workshops held Distribution of the targeted IEC materials sessions/ outreaches held	Number of targeted IEC materials development workshops held Number of distribution of the targeted IEC sessions/ outreaches held	5 (1 per Year) 150 (1 per ward per year)	Conference package, consultant and fuel Facilitation for health promotion officers, public address system, driver and fuel		170,000 82,500	170,000 82,500	170,000 82,500	170,000 82,500	170,000 82,500

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
2.3.5. Collaborate with other stakeholders such as the Ministry of Education (MOE), Department for Trade, Department for Gender and Social Services, Prisons Department, National Police Service, Religious Organizations, the Business Community, Civil Society Organizations, Youth and Women Organizations and Community Gatekeepers to reach special populations	Stakeholders collaboration meetings held	Number of stakeholders collaboration meetings held	40 (1 per sub-county) peryear. For 1600 Participants (40 per sub-county per year)	Hall hire, Public address, Stationary, Conference package, facilitation, transport reimbursement		3,856,000	3,856,000	3,856,000	3,856,000	3,856,000

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
with mental health promotion and prevention messages.										
2.3.6. Integrate mental health messages into topical national and globally celebrated health days	Mental health messages integrated into topical national and globally celebrated health days	Number of mass education sessions held in which mental health messages are integrated into topical national and globally celebrated	40 (1 per sub-County per Year)	Health promotion facilitation, consultant and transport		551,000	551,000	551,000	551,000	551,000
2.3.7. Integrate mental health messages in community dialogue meetings and community action days	Community dialogue meetings held with MH messages included Community action days held with MH messages included	Number of Community dialogue meetings held with MH messages included Number of community action days held with MH messages included	60 (12 per Year) 60 (12 per Year)	Public address system, facilitation for health promotion officers, drivers and fuel		435,000	435,000	435,000	435,000	435,000

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
2.3.8. Sensitize stakeholders to identify and refer the affected for better management	Workshops to sensitize stakeholders (traditional healers, religious leaders and community leaders) on how to identify and refer the affected for better management held	Number of Workshops to sensitize stakeholders (traditional healers, religious leaders and community leaders) on how to identify and refer the affected for better management held	15 (3 Per year)	Hall hire, Public address system, facilitation for health promotion officers, conference package, stationary, transport, driver and fuel		267,650	267,650	267,650	267,650	267,650
2.3.9. Identify and train men and women champions on positive behavior change and positive parenting	Men and women champions identified and trained in positive behavior change and positive parenting	Number of men and women champions identified and trained on positive behavior change and positive parenting	1600 (40 per sub-county per Year)	Hall hire, Public address system, facilitation for health promotion officers, conference packages, stationary, transport, driver and fuel		267,650	267,650	267,650	267,650	267,650

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
2.3.10. Develop and disseminate an MNS communication Strategy	MNS communication strategy developed	Number of MNS communication strategies developed	1	Hall hire, conference package, consultant, transport, coordination airtime		964,800				
Strategic Action 2.4: Preventing Suicide										
2.4.1. Train gatekeepers on suicide prevention	Gatekeepers trained on suicide prevention	Number of gatekeepers trained on suicide prevention	1600 (40 per sub-county per Year)	Hall hire, Public address system, facilitation for health promotion officers, conference packages, stationary, transport, driver and fuel		267,650	267,650	267,650	267,650	267,650
2.4.2. Conduct community dialogue days on the prevention of suicide	Community dialogue days on the prevention of suicide held	Number of Community dialogue days held on the prevention of suicide	480 (96 per Year – 1 per Sub-County per Month)	Facilitation of promotion officers, CHVs, drivers and fuel		275,250	275,250	275,250	275,250	275,250

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
2.4.3. Sensitize CHAs and CHVs on suicide prevention and referral at community levels	CHAs and CHVs sensitized on suicide prevention and referral at community levels	Number of CHAs and CHVs sensitized on suicide prevention and referral at community levels	1600 (320 per year – 40 per Sub-County per year) for 5 years	Hall hire, facilitation for health promotion officer, stationary, conference package, coordination airtime		1,307,000	1,307,000	1,307,000	1,307,000	1,307,000

Strategic Objective 3: Ensure access to comprehensive, integrated and high-quality, promotive, preventive, curative, and rehabilitative mental health services at all levels of health care

Strategic Action 3.1. Improve Access to Curative and Rehabilitative Mental Health Services

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
3.1.1. Integrate mental health services at all levels of care	MH care services integrated at all levels of care.	Number of health facilities integrating MH care service	130	No budget required						
	Provision differentiated scope of MH care services from basic (level1) to comprehensive (level5)	No. of CHUs integrating MH care services No. of level 1 (CHUs) providing MH care services No. of levels 2 and 3 providing MH care services No. of levels 4 & 5 providing MH care services	251 Community health units 251 CHUs 132	No budget required No budget required No budget required No budget required						

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
3.1.2. Adopt the national MH training module for health care workers in the county	National MH facility- based training modules adopted	No. of national MH facility- based modules adopted	1	Design, print and distribute		120,000				
	National MH training community- based modules adopted	Number of MH national community- based training modules adopted	1			120,000				
3.1.3. Train service providers at all levels of care on mental health	Facility-based Service providers trained in mental health	Number of facility-based healthcare workers trained in mental health	2,000	Hall hire, public address system, conference package, facilitators, transport, coordination airtime		2,407,200	2,407,200	2,407,200	2,407,200	2,407,200
	Community based service providers trained in mental health	Number of community- based service providers trained in mental health	2,500	Hall hire, public address system, conference package, facilitators, transport, coordination airtime		296,000	888,000	888,000	592,000	296,000

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
3.1.4. Integrate mental health into the community referral tool	Mental health tool for integrated into the community referral tool designed	Number of community referral tools that have integrated MH referral	1	10 pax to design the integrated tool @1,000	1,000	10,000				
	Integrated tool printed and distributed	Number of community health units with the integrated referral tool	125,500	100 pieces per CHU per year	100	2,510,000	2,510,000	2,510,000	2,510,000	2,510,000
3.1.5. Avail counseling services at all health facilities providing mental health services	Counseling services are provided at all health facilities providing MH service	Number of health facilities providing MH services with counseling services	140 health facilities	No budget required		-	-	-	-	-

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
Strategic Action 3.2. Improve Access to Preventive Mental Health Services										
3.2.1. Develop a community-based mental health screening tool	MH screening tool developed	Number of MH Screening tools developed	1	10 pax to design the screening tool @1,000	1,000	10,000				
	MH screening tool printed and distributed	Number of community based screening tools printed and distributed	125,500	100 tools per CHU per year	100	2,510,000	2,510,000	2,510,000	2,510,000	2,510,000
3.2.2. Train CHVs on the community-based mental health screening	CHVs trained in community based mental health screening	Number of CHVs trained in community based mental health	2,500	Hall hire, public address system, conference package, facilitators, transport, coordination	100	296,000	888,000	888,000	592,000	296,000
	Community outreaches for rehabilitative and facilitative therapy for persons with mental health conditions conducted	Number of community outreaches for rehabilitative and facilitative therapy for persons with mental health conditions conducted	80 (2 per sub-county per year)	Lunch allowance for HCW and driver, public address, fuel, coordination		372,000	372,000	372,000	372,000	372,000
3.2.3 Conduct community outreaches for rehabilitative and facilitative therapy for persons with mental health conditions	Community outreaches for rehabilitative and facilitative therapy for persons with mental health conditions conducted	Number of community outreaches for rehabilitative and facilitative therapy for persons with mental health conditions conducted	80 (2 per sub-county per year)	Lunch allowance for HCW and driver, public address, fuel, coordination		372,000	372,000	372,000	372,000	372,000

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
3.2.4 Sensitize the community members on existing mental health rehabilitation services	Community members sensitized on existing rehabilitation services	Number of radio spot messages broadcasted to sensitize community members on existing rehabilitation services	120(Yr1-48, Yr2-36, Yr3-24 and Yr4-12)			144,000	108,000	72,000	36,000	
3.2.5. Develop a facility-based screening tool	Facility screening tool developed	Number of facility-based screening tools developed	1	10 pax to design the screening tool @1,000	1,000	10,000				
3.2.6. Train HCWs on facility-based mental health screening & preliminary diagnosis	Facility-based screening tool printed & distributed HCWs trained in facility-based MH screening & preliminary diagnosis	Number of facility based screening tools printed and distributed Number of HCWs trained on MH screening & preliminary diagnosis	70,000 2,000	100 tools per facility @140 facilities per year Hall hire, public address system, facilitators, conference package, transport, coordination airtime	100	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000
						2,407,200	9,628,800	7,221,600	2,407,200	2,407,200

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
3.2.7. Hold debriefing sessions on mental health for health workers	Deebriefing sessions on mental well being held	Number of debriefing sessions held	14,000 @140 facilities by end of 5 years	Facilitation of 140 counselors	1,000	140,000	140,000	14,000	140,000	140,000
3.2.8. Collaborate with stakeholders in establishing community-based clients' re-integration programs	Community-based clients reintegration programs established	Number of community-based clients' reintegration programs established	8 (1 per sub-county) over a period of 5 years	Facilitation of 2 Social workers @1,000 per day for 10 days, a driver @ 750 per day for 10 days, fuel @200 per day for 10 days quarterly		118,000	118,000	118,000	118,000	118,000

Strategic Action 3.3. Improve the quality of promotive, preventive, curative and rehabilitative mental health services

3.3.1. Develop and Integrate mental health support supervision tools into existing support supervision program	-Develop a MH supervision tool for the county and sub county MH Supervising teams Print and distribute the MH supervision tool	-Number supervision tool developed & distributed to the county and sub county MH supervising teams Number of MH supervision tools printed and distributed	1 4,500	10 pax to design the tool @1,000 100 for county and per sub-county per year@ KSH 100	1,000 100	10,000 90,000	10,000 90,000	90,000 90,000	90,000 90,000	90,000 90,000
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3.3.2. Conduct integrated mental health support supervision	Integrated MH support supervision conducted	-Number of integrated MH support supervision conducted	2,800	18 pax quarterly (per year) @1,000, 9 drivers quarterly (per year) @750, fuel, 800 litres quarterly (per year@150	219,000	219,000	219,000	219,000	219,000	219,000
3.3.3. Provide in-service training for all healthcare workers on mental health	In-service training for HCWs on mental health provided	Number of HCWs provided with in-service training on MH	2,000	Hall hire, public address system, facilitators, conference package, transport, coordination airtime	2,407,200	9,628,800	7,221,600	2,407,200	2,407,200	2,407,200
3.3.4. Provide mentorship to service providers (HCWs) providing mental health services	Mentorship provided to service providers (HCWs)	Number of HCWs mentored	2,000	18 pax quarterly (per year) @1,000, 9 drivers quarterly (per year) @750, fuel, 800 litres quarterly (per year@150	219,000	219,000	219,000	219,000	219,000	219,000
3.3.5. Integrate mental health into the existing activities of quality improvement teams (QITs)	Mental health integrated into the activities of existing QITs	Number of existing QITs integrating mental health in their activities	16	No budget required	-					

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
3.3.6. Disseminate and distribute existing MH clinical guidelines, protocols, and standards	MH clinical guidelines, protocols, and standards distributed & disseminated	Number of MH clinical guidelines, protocols, norms, and standards distributed & disseminated	2,100	Hallhire, public address, facilitators, conference package, stationery, transport reimbursement, coordination airtime (county and subcounties)		1,881,000	1,881,000	1,881,000	1,881,000	1,881,000
3.3.7. Monitor and evaluate (M&E) mental health bi-annually	M&E conducted	Number of scheduled M&E conducted and reports done	8 Sub-Counties (M&E conducted in each sub-county twice a year)	5 HCWs Lunches for 5 days per county @KES 1,000, one driver for 5 days per county @KES 750, and fuel at KES 1500 (M&E activities will be conducted twice a year in each county)		484,000	484,000	484,000	484,000	484,000

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
3.3.8. Train healthcare workers on Quality Rights	Healthcare workers trained on quality Rights	Number of HCWs trained on quality rights	2,000	Hall hire, public address system, facilitators, conference package, transport, coordination airtime		2,407,200	9,628,800	7,221,600	2,407,200	2,407,200

Strategic Objective 4: To strengthen mental health systems including information systems and research

Strategic Action 4.1 Infrastructure Improvement for Mental Health

4.1.1. Avail essential ICT technologies to all facilities providing mental health services as appropriate for the level of care	All facilities providing MH services are equipped with appropriate ICT technologies	Number of facilities providing mental health services equipped with ICT (phones, internet, computer etc.) appropriate for level of care	140	Computer, APP installation, WIFI connection, monthly payment for WIFI		2,400,000	2,400,000	2,400,000	2,400,000	1,600,000
4.1.2. Integrate MH in-patient services into general wards in all major hospitals	MH in-patient services integrated into general wards in major hospitals	Number of major hospitals integrating MH in-patient services	5 major hospitals	No budget required		-	-	-	-	-

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
4.1.3. Construction of a modern in-patient mental health unit to replace ward 10 at County Referral Hospital	A modern mental health in-patient unit at the County Referral Hospital constructed	Number of modern mental health in-patient wards constructed at the County Referral Hospital	1 modern mental health in-patient ward	Building materials, equipment, and furniture	50 Million		50 Million			
Strategic Action 4.2. Mental Health Information system										
4.2.1. Develop county data capture and reporting tools for adequate data collection that enables informed decision-making at the county level	Mental health data collection and reporting tools developed, printed distributed	Number of data collecting tools developed Number of summary tools developed Number of data capture and summary tools printed and distributed	1 1 28,000	10 pax for 2 days @1,000 10 pax for 2 days @1,000 200(100 data capture tools and 100 summary tools per facility (140) per year		20,000 20,000 2,800,000			2,800,000 2,800,000 2,800,000	

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
4.2.2. Train health care workers on capturing and reporting mental health data	Trained healthcare workers on mental health data capturing and reporting.	Number of healthcare workers trained in mental health data capturing and reporting	2,000 health care workers	Hall hire, public address system, facilitators, conference package, transport, coordination airtime		2,407,200	9,628,800	7,221,600	2,407,200	2,407,200
4.2.3. Present analyzed mental health data during CHMT meetings to aid informed decision making	MH data presented during CHMT meetings	Number of CHMT meetings during which mental health data was presented	20 (4 CHMT meetings per year) for 5years	Tea and snacks for 30pax@200		24,000	24,000	24,000	24,000	24,000

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
Strategic Action 4.3. Access to essential medicines, equipment and technologies										
4.3.1. Avail essential mental health drugs at all facilities providing mental health services	Essential commodities for mental health included into the county supply chain system	Number of health facilities providing mental health services with essential mental health drugs	140	No budget required		-	-	-	-	-
		Train HCWs at facility level on MH drugs quantification and forecasting	420 (2 days training for 70 pax) biannual in years 1,2 and 3	Hall hire, public address system, facilitators, conference package, transport, coordination		683,333	683,333	683,333		
4.3.2. Avail essential occupational therapy equipment to the three facilities providing in-patient and rehabilitation services	Occupational therapy equipment provided	Number of facilities supplied with Occupational therapy equipment	3 main facilitates providing in patients care Namely NCRH, Karia and Ihururu rehabilitation center	Dart Boards, table tennis sets, football sewing machines, and fabric, table games, TV, Radio		132,000	132,000			

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
4.3.3. Equip all major hospitals providing mental health services with essential treatment technologies	Major hospitals providing mental health services equipped with essential treatment technologies	Number of major hospitals providing mental health services equipped with treatment technologies (ECT Machine, EEG Machine)	5	ECT and EEG at KES 2,000,000 Each. Two hospitals will be equipped in year 1 and the other 3 in year 2	2m per Equip.	8,000,000	12,000,000			

Strategic Action 4.4. Increased financing for mental health

4.4.1. Develop unit-costed annual work plans	Annual MH unit costed work plans developed	Number of unit-costed work plans developed	45 costed annual work plans (1 county and 8 sub-county per year) for 5 years	Hall hire, stationery, facilitators, conference package, transport and coordination airtime		951,000	951,000	951,000	951,000	951,000
4.4.2 Liaise with NHIF to accredit all rehabilitation centers	NHIF accreditaed Rehabilitation centers	Number of rehabilitation centers accredited by NHIF	2	Facilitation for 2 pax @1000, driver @750 and fuel (20litres @150)			5,750			

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
4.4.3. Conduct bi-annual registration drive events for enrollment of vulnerable persons with lived experience in social protection services e.g. NHIF, Disability registration (NCPWD), UHC among others	Bi-annual registration drive conducted	Number of bi-annual registration drive events conducted	10	Tent and chairs hire, snacks/soda/water, facilitators facilitation, transport, coordination airtime No budget required		40,800	40,800	40,800	40,800	40,800
4.4.4. Train civil society organizations in mental health space on advocacy for increased mental health investments	Members of civil society organizations in mental health space trained on advocacy for increased mental health investments	Number of members of civil society organizations in mental health space trained on advocacy for increased mental health investments	150 (30 pax per year)	Hall hire, stationery, facilitation, conference package, transport, coordination airtime		448,000	448,000	448,000	448,000	448,000

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
4.4.5. Establish partnerships and collaboration platforms for all stakeholders in the mental health space to pool financial resources	Partnerships and collaboration platforms to pool financial resources established	Number of partners with budgetary provision for mental health	TBD	Hall hire, stationery, facilitation conference package, transport, coordination airtime		191,000	191,000	191,000	191,000	191,000
4.4.6. Establish public-private sector partnerships to address mental health	Public-private partnership established	Number of public-private partnership projects on mental health being implemented in the county	5	Hall hire, stationery, facilitation, conference package, transport, coordination airtime		153,600	153,600	76,800		

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
Strategic Action 4.5. Mental Health Research										
4.5.1. Map and segment regions by type of drugs and substances used to inform interventions	Mapping and segmenting of regions by type of drugs and substance used conducted	Number of mapping and segmentation of regions by type of drugs and substance used conducted	1 in the first year			1,406,000				
	Mapping findings disseminated	Number of dissemination workshops held to disseminate the mapping and segmentation findings	1 in the first year			460,400				
4.5.2. Map stakeholders in the county, including mental health areas of focus and geographical coverage	Fora to map stakeholders including mental health areas of focus and geographical coverage conducted.	Number of fora held to map stakeholders including mental health areas of focus and geographical coverage	27 fora meetings (1 at county 8 levels) held every two years	Hall hire, stationery, facilitator, conference package, transport, coordination airtime		1,278,000		1,278,000		1,278,000

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
4.5.3. Conduct a baseline survey to quantify the burden of MH and MNS to inform MH investments	Baseline survey to determine MH burden conducted	Number of baseline surveys conducted to determine the burden of mental health	1 in the 2nd year	Consultant fee, inception meeting, research assistants, coordination airtime		1,406,000				
	Survey findings disseminated	Number of dissemination workshops held to disseminate the baseline survey findings	1	Hall hire, stationary, consultant fee, conference package, transport coordination airtime		464,000				
4.5.4. Conduct research to establish the root cause of drugs and substance use	Research conducted on root cause of drugs and substance use	Number of researches conducted to establish root cause of drugs and substance use	3 (One every two years).	Consultant fee, inception meeting, research assistants, coordination airtime		1,406,000		1,406,000		1,406,000
	Survey findings disseminated	Number of dissemination workshops held	3 (One every two years)	Hall hire, stationary, consultant fee, conference package, transport coordination airtime		464,000		464,000		464,000

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
4.5.5. Hold scientific conferences and support presentation of scientific papers	Scientific conference held on MH.	No. of scientific conferences held.	5 (1 scientific conference per year)	Hall hire, stationery, facilitators, conference package, transport coordination airtime		32,5000	32,5000	32,5000	32,5000	32,5000
Strategic Action 4.6. Human Resource for Mental Health										
4.6.1. Conduct training needs assessment of existing MH services providers	Training needs assessment on existing MH service providers conducted	Number of training needs assessments on existing MH service providers conducted	3 (1 assessment every two years)	Assessors (Staff) facilitation, stationary, transport, coordination airtime		8,123		8,123		8,123
4.6.2. Train existing MH service providers as per the findings of the training needs assessment	Existing MH service providers trained	Number of existing MH service providers trained	37	Hall hire, facilitator, conference package, transport, coordination airtime		144,892	289,784	101,424		

Activities	Output	Output Indicator	Target	Cost item description	Unit Cost	YR1	YR2	YR3	YR4	YR5
4.6.3. Recruit MH human resource i.e. nurses, clinical officers, psychologists, medical social workers	MH human resource recruited by cadre	Number of MH human resources recruited by cadre	As need arises	No budgetary implication						
4.6.4. Conduct CME for mental health service providers to keep them updated on new technologies and management of mental health	CME conducted for mental health service providers	Number of CME conducted for the services providers	20 (4 CME	Hall hire, public address system, facilitator, conference package, transport, coordination airtime		2,412,000	2,412,000	2,412,000	2,412,000	2,412,000

6.0 THE MONITORING AND EVALUATION FRAMEWORK

Component Area	Indicator	Target	Yr1	Yr2	Yr3	Yr4	Yr5	
To strengthen effective leadership and governance for mental health	Number of MH councils established	1	1					
	Number of multi-sectoral coordination committees established at county level	1	1					
	Number of multi-sectoral coordination committees established at sub-county level	8	8					
	Number of sub-committees for mental health established at the sub-county level	32	32					
	Number of mental health focal point persons at the county and sub-county levels appointed	9	9					
	Number of community health committees in which MH is integrated	120	40	60	20			
	Number of health plans in which MH is integrated	11	3	2	2	2	2	
	Number of national-level policies and legislation on mental health and MNS disseminated	As disseminated from national level						
	Number of county level policies and legislation on mental health conditions develop	As deemed necessary						
	Number of MH TWG established at county and sub-county level	9	9					
Number of county mental health action plans disseminated	1	1						
Number of coordination meetings for multi-sectoral stakeholders' funding for MH held	5	1	1	1	1	1	1	

Component Area	Indicator	Target	Yr1	Yr2	Yr3	Yr4	Yr5
To implement strategies for the promotion of mental health, prevention of mental and substance use disorders	Number of support groups established and nurtured (clients)- one per ward per year	150	30	30	30	30	30
	Number of support groups members (clients) trained to promote and prevent MH and substance use	2,250	600	750	450	300	150
	Number of support group members (clients) linked to trade skills training programs	2,250	600	750	450	300	150
	Number of support group members (clients) linked to programs providing tools of trade	2,250	600	750	450	300	150
	Number of support group members (clients) linked to enterprise development training programs	2,250	600	750	450	300	150
	Number of families/caregivers' support groups formed	150	30	30	30	30	30
	Number of members of family/caregivers support groups trained to provide psychosocial support to families/caregivers of clients with lived experience	2,250	600	750	450	300	150
	Number of community- based alcoholic and substance use anonymous groups	150	30	30	30	30	30
	Number of sessions held to disseminate existing laws and regulations on alcohol, drugs, and substance use and existing mental health rehabilitation centres.	5	1	1	1	1	1
	Number of barazas held to sensitize champions on existing laws and regulations on alcohol, drugs, and substance to advocate for enforcement	40	8	8	8	8	8
Number of community outreaches held to sensitize community leaders and members on existing laws and regulations on alcohol, drugs, and substance to advocate for enforcement	150	30	30	30	30	30	
Number of empowerment workshops held for champions and community members to advocate for enforcement of existing laws and regulations on alcohol, drugs, and substance	40	8	8	8	8	8	

Component Area	Indicator	Target	Yr1	Yr2	Yr3	Yr4	Yr5
	Number of members of the people with lived experience support groups empowered with knowledge on withdrawal of addiction from drug abuse and alcoholism and stigma	2,250	600	750	450	300	150
	Number of health promotion officers trained on mental health	150	30	30	30	30	30
	Number of mental health education outreaches conducted to communities, learning, institutions, including schools, prisons, police stations, support groups, among others held	1,000	200	400	300	50	50
	Number of targeted IEC materials development workshops held	5	1	1	1	1	1
	Number of targeted IEC distribution sessions/ outreaches held	150	30	30	30	30	30
	Number of stakeholders collaboration meetings held	40	8	8	8	8	8
	Number of mass education sessions held in which mental health messages are integrated into topical national and globally celebrated	40	8	8	8	8	8
	Number of community dialogue meetings held with MH messages included	60	12	12	12	12	12
	Number of community action days held with MH messages included	60	12	12	12	12	12
	Number of workshops to sensitize stakeholders (traditional healers, religious leaders and community leaders) on how to identify and refer the affected for better management held	15	3	3	3	3	3
	Number of men and women champions identified and trained on positive behaviour change and positive parenting	1,600	320	320	320	320	320
	Number of MNS communication strategies developed	1	1				
	Number of MNS communication strategy dissemination workshops held	9	9				
	Number of gatekeepers trained on suicide prevention	1,600	320	320	320	320	320
	Number of community dialogues held on the prevention of suicide	480	96	96	96	96	96
	Number of CHAs and CHVs sensitized on suicide prevention and referral at community level	1600	320	320	320	320	320

Component Area	health facilities	Target	Yr1	Yr2	Yr3	Yr4	Yr5
Ensure access to comprehensive, integrated and high quality, promotive, preventive, curative and rehabilitative mental health services at all levels of health care	Number of healthcare facilities integrating MH care services.	140	30	30	30	30	20
	Number of CHUs integrating MH care services	251	51	50	50	50	50
	Number of MH national facility based training modules adopted	1	1				
	Number of facility-based healthcare workers trained in mental health	2,000	200	800	600	200	200
	Number of MH national community- based training modules adopted	1	1				
	Number of community-based service providers trained in mental health	2,500	250	750	750	500	250
	MH care referral system integrated & distributed to the county & the sub-county health facilities	140 health facilities	30	30	30	30	20
	Number of health facilities providing MH services with counselling services	140	30	30	30	30	20
	Number of community-based mental health screening tool developed	1					
	Number of community based screening tools printed and distributed	125,500	25,100	25,100	25,100	25,100	25,100
	Number of CHVs trained on community-based mental health screening	2,500	250	750	750	500	250
	Number of community outreaches for rehabilitative and facilitative therapy for persons with mental health conditions conducted	80	16	16	16	16	16
	Number of radio spot messages broadcasted to sensitize community members on existing rehabilitation services	120	48	36	24	12	
Number of facility-based MH screening tools developed	1	1					
Number of family based screening tools printed and distributed	70,000	14,000	14,000	14,000	14,000	14,000	
Number of HCWs trained in facility-based mental health screening	2,000	200	800	600	200	200	
Number of debriefing sessions on mental health for health workers held	14,000	3,000	3,000	3,000	3,000	2,000	
Number of community-based clients reintegration programs	8	1	1	2	2	2	

Component Area	health facilities	Target	Yr1	Yr2	Yr3	Yr4	Yr5
To strengthen mental health systems, including information and research	Number of supervision tools developed	1	1				
	Number of MH supervision tools printed and distributed	4,500	900	900	900	900	900
	Number of integrated MH support supervision conducted by county and sub-county	180	36	36	36	36	36
	Number of HCWs providing mental health services provided with in-service training on mental health	2,000	200	800	600	200	200
	Number of HCWs providing mental health care services mentored .	2,000	400	400	400	400	400
	Number of existing QITs integrating mental health in their activities	16	8	8			
	Number of MH clinical guidelines, protocols, norms, and standards disseminated & distributed	2,100	420	420	420	420	420
	Number of scheduled M&E conducted and reports done	80	16	16	16	16	16
	Number of HCWs providing mental health services trained in Quality Rights	2,000	200	800	600	200	200
	Number of facilities providing mental health services equipped with ICT (phones, internet, computer etc.) appropriate for the level of care	140	30	30	30	30	20
	Number of major hospitals integrating MH in-patient services	5	3	2			
	Number of modern in-patient mental health units constructed at the County Teaching and Referral Hospital to replace ward 10	1	1				
	Number of data capture and summary tools printed and distributed (1 for data apture and 1 for summary reporting)	2	2				
Number of data capture and summary tools printed and distributed (1 for data capture and 1 for summary reporting)	28,000	6,000	6,000	6,000	6,000	4,000	
Number of data capture and summary tools printed and distributed	28,000	6,000	6,000	6,000	6,000	4,000	
Number of HCWs trained in capturing and reporting mental health data	2,000	800	600	200	200	200	
Number of CHMT meetings during which mental health data was presented	20	4	4	4	4	4	

Component Area	health facilities	Target	Yr1	Yr2	Yr3	Yr4	Yr5
	Number of health facilities providing mental health services with essential mental health medicine	140	30	30	30	30	20
	Number of HCWs at the facility level trained in MH drugs quantification and forecasting	420	90	90	90	90	60
	Number of major hospitals providing mental health services equipped with treatment technologies (ECT Machine, EEG Machine)	5	2	3			
	Number of unit-costed work plans developed	45	9	9	9	9	9
	Number of rehabilitation centers accredited by NHIF	2	2				
	Number of bi-annual registration drive events conducted for enrollment of vulnerable and Most at-Risk Populations, including persons with lived mental health experience for social security	10	2	2	2	2	2
	Number of of vulnerable and Most at-Risk Populations, including persons with lived mental health experience enrolled for social security	10,000	2,000	2,000	2,000	2,000	2,000
	Number of members of civil society organizations in mental health space trained on advocacy for increased mental health investments.	150	30	30	30	30	30
	Number of partners with budgetary provision for mental health	TBD					
	Number of public-private partnership projects on mental health being implemented in the county	5	2	2	1		
	Number of mappings and segmentation of areas by type of drugs and substances used to inform interventions	1	1				
	Number of workshops held to disseminate findings of the mapping and segmentation of areas by type of drugs and substances used to inform interventions	1	1				
	Number of fora held to map stakeholders in the county, including mental health areas of focus and geographical coverage	27	9		9		9
	Number of baseline surveys conducted to quantify the burden of mental health	1		1			

Component Area	health facilities	Target	Yr1	Yr2	Yr3	Yr4	Yr5
	Number of workshops held to disseminate findings of the baseline survey to quantify the burden of mental health	1	1	1			
	Number of research conducted to establish the root cause of drugs and substance use	3	1		1		1
	Number of workshops held to disseminate findings of the root cause of drugs and substance use	3	1		1		1
	Number of scientific conferences held.	5	1	1	1	1	1
	Number of training needs assessments for existing MH service providers conducted	3	1		1		1
	Number of existing MH service providers trained based on the training needs assessment	37	10	20	7		
	Number of human resources for MH recruited by cadre	As need arises					

7.0 ANNEXES

7.1 References

- CA. (2021). Baseline Assessment Report: Breaking The Barriers to Access to Quality Mental Health Services and Support in Kenya. Nairobi: Christian Aid Kena.
- GOK. (2022). The Mental Health (Amendment) Act, 2022. Nairobi: Government Printer.
- KLR. (2010). The Constitution of Kenya. Nairobi: The National Council for Law Reporting.
- MOH. (2015). Kenya Mental Health Policy 2015-2030: Towards Attaining the Highest Standard of Mental Health. Nairobi: Ministry of Health.
- MOH. (n.d.). Kenya Community Health Policy 2020-2030. Nairobi: Ministry of Health.
- MOH. (n.d.). Kenya Community Health Strategy 2020-2025. Nairobi: Ministry of Health.
- MOH. (n.d.). Kenya Health Sector Partnership & Coordination Framework 2018-2030. Nairobi: Ministry of Health.
- MOH. (n.d.). Kenya Mental Health Action Plan 2021-2025: Towards attainment of the highest standards of mental health. Nairobi: Ministry of Health.
- UN. (2015). Transforming our World: The 2030 Agenda for Sustainable Development A/RES/70/1. New York: United Nations.
- WHO. (2001). The World Health Report 2001: Mental Health: New Understanding, New Hope. Geneva: World Health Organization.
- WHO. (2003). Investing in Mental Health. Geneva: World Health Organization.
- WHO. (2018). Mental Health Atlas 2017. Geneva: World Health Organization.
- WHO. (2021). Comprehensive Mental Health Action Plan 2013-2030. Geneva: World Health Organization.

7.2 List of Contributors

Name	Stakeholder Group	Organization/Department
Agnes Mwendia	County Government	Department of Health
Agnes Wangechi	Support Group	Mental Health
Amos Rono	National Government	NCPWD
Anita Njeri	Civil Society	Nyeri County Budget Coalition
Ann Nduta Wanjiku	County Government	Department of Health
Boniface Macharia	County Government	Department of Health
Caroline W. Kariuki	County Government	Mt. Kenya Hospital
Charles Weru	Civil Society	Afya Yetu Initiative
Christine Ajulu	Civil Society	HERAF
Edward Munene	Civil Society	HERAF
Esther Kariuki	Support Group	Cerebral Palsy Warriors Family
Faith Gatere	Support Group	Differently Talented Society of Kenya (DTSK)
Ivy Mbinya	National Government	National Council of Persons with Disability
Jane Gatimu	County Government	Department of Health
Jemimah Muthoni	Civil Society	HERAF
John Namu	Civil Society	Imarisha Kenya
John Ngugi	County Government	Department of Health
John W. Kabatha	Civil Society	Nyeri Disability Network
Joseph Maina	Civil Society	Maisha Youth
Lawrence King'ori	County Government	Department of Health
Lawrence Kinyua	County Government	Department of Health
Lucy Mwati	Civil Society	HERAF
Lydia Njaramba	County Government	Department of Health
Margaret Makumi	Technical Advisor	HERAF
Mary Wachira	County Government	Department of Health
Michael Ndegwa	Civil Society	Nyeri County Budget Coalition
Ndegwa John	County Government	Department of Health
Nelly Muiruri	County Government	Department of Health
Paul Gatitu	Civil Society	St. Joseph CBO
Peter M. Munyua	County Government	Department of Health
Rahab Ngatia	County Government	Department of Health
Rosemary Mbuthia	National Government	Children's Department
Stephen Kimotho	County Government	Nyeri County Referral Hospital
Yvonne Njeri	County Government	Mukurwe-ini Hospital

7.3 List of Reviewers

Dr. Nasri Omar	Ministry of Health	Focal person Mental Health System and Policy
Dr. Nelson Muriu	County government	Director, Department of Health
Oscar Agoro	County government	Department of Health
Martin Kamau	County government	Department of Health
Sarah Njoroge	County government	Department of Health
Caroline Wambui	County government	Department of Health

Office of the Director, Health Department,
P.O. Box 110-10100, Nyeri
Telephone: 0758563121
Emergency Operations Centre: 0800721019
Email: nyericountyhealth@yahoo.com

