

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



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## LIST OF ABBREVIATIONS

ADP	Annual Development Plan
CCPR	Convention of Civil and Political Rights
CHMT	County Health Management Team
CHV	Community Health Volunteer
CIDP	County Integrated Development Plan
COVID-19	Coronavirus Disease 2019
CRPD	Convention on the Right of Persons with Disability
CSO	Civil Society Organization
KHIS	Kenya Health Information System
FGD	Focus Group Discussion
FP	Family Planning
HCW	Health Care Worker
HIV	Human Immunodeficiency Viruses
KNCHR	Kenya National Commission on Human Rights
MNCH	Maternal, Neonatal and Child Health
NCD	Non-Communicable Disease
NCPD	National Commission for People with Disability
NHIF	National Hospital Insurance Fund
CRH	County Referral Hospital
SUD	Substance Use Disorder
TOR	Terms of Reference
TWG	Technical Working Group
WHO	World Health Organization

## 1.0 INTRODUCTION

### 1.1 Background

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

Mental health is conceptualized as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

In Kenya, the Ministry of Health<sup>3</sup> estimates that 1 in every 4 Kenyans suffers from mental ill health in their lifetime, which translates to 12 million of 48 million Kenyans who will need medical attention. It is estimated that up to 25% of outpatients and up to 40% of in-patients in health facilities suffer from mental health conditions. Further, the probable prevalence of psychosis in Kenya is at an average of 1 % of the population. According to WHO (2017)<sup>4</sup>, Kenya is ranked as the sixth among African countries with high rates of depression. Additionally, KNCHR estimated that six million people in Kenya are suffering from common mental conditions such as depression, substance abuse, stress and anxiety<sup>5</sup>. Subsequently presence of these mental health challenges in Kenya, and the emergence of COVID-19 has seriously escalated mental health challenges in Kenya subjecting individuals to depression, anxiety, and stress among other mental health conditions.

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

### 1.2 Objective of the study

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

### 1.3 Methodology

HERAF with the financial support of OSIEA rolled out an 18 month project aimed at "Improving Mental Health Legislation, Financial Investments and Accountability in Kenya". The project was implemented in Nyeri, Embu and Nairobi Counties from June 2019 to March 2021. Primarily the project would promote the participation of CSOs and organizations of people with lived experience of mental health problems in improving mental health law, financial investments and social accountability in Kenya. Other key targets of the project were Civil Society Organizations, County Government of Embu, National Government, Ministry of Health and other actors in mental health including public and private service providers, religious institutions.

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1. World Health organization (2001). The world health report 2001: Mental Disorders affect one in four people. [www.who.int](http://www.who.int)

2. WHO.(2013).Mental health action plan 2013-2015

3. Ministry of Health. (2020). Taskforce report on mental health.

4. WHO.(2017).Depression and other common mental health disorders: Global health estimates.[www.who.int](http://www.who.int)

5. Kenya National Commission on Human Right. (2011). Silenced minds: The systemic neglect of the mental health systems in Kenya. [www.knchr.org](http://www.knchr.org)

The key objectives were:

- To promote participation of civil society and organizations of people with lived experience of mental health problems in review and development of new mental health legislation in Kenya
- To empower CSOs of people with lived experience of mental health to participate in planning and budgeting for mental health at MOH, national and county levels
- To track government's accountability to international and national commitments, policy and budget implementation for improved mental health services in Kenya

The project held inception meetings with the CHMT to foster buy in and partnership in project implementation, paid a courtesy call to the offices of the governor and the speaker of the county assembly to deliberate on the progress of the project and sustainable financing for mental health. Follow up engagements targeted CSOs network in Embu to strategize on mental health policy and budget advocacy, conduct capacity training workshops and engage in the county planning and budgeting processes. Round table engagement with CSOs network, service providers and county officials yielded a TWG. TORs developed by CSOs were adopted by the department of Health and have been used in guiding the engagement of the TWG as the department pointed out that they talked to the gaps in the County. To track government's accountability to international and national commitments, policy and budget implementation for improved mental health services in Embu County, the project trained stakeholders on social accountability and oriented a lead team comprising of project staff, community members and CSOs on social accountability tools.

In this community report, five public health facilities were selected. The health facilities were County Referral Hospital, Runyenjes Sub County Referral Hospital, Ishiara sub-county Referral hospital, Siakago Sub County Referral Hospital and Kianjokoma Sub County Referral Hospital. For data collection, focus group discussion (FGD) was adopted in collection of the qualitative data. There were a total of twenty FGDs conducted with four FGDs being carried out in each health facility. The participants for the FGDs consisted of HCWs, CHVs, care givers and users of mental health services, Hospital Boards / Health Management Teams and the CHMT at the County level.

## 2.0 STATUS OF MENTAL HEALTH IN EMBU COUNTY

### 2.1 Embu County

Embu County is one of the 47 counties in Kenya located in the Eastern Kenya. The County borders Tharaka Nithi to the North, Kitui to the East, Machakos to the South, Muranga County to the South West, Kirinyaga to the West, and Meru county to the North West. By 2015, Embu County had a total of 173<sup>6</sup> health facilities of which 93 were public health facility, 2 were nongovernmental, 4 faith-based and 53 private health facilities.

### 2.2 Mental Health Situation in Embu

**Table 2.1 Finding on Situation of Mental Health**

INDICATOR	CHMT	HCWS	CHVS	SERVICE USERS/PATIENT SUPPORT	REASONS/COMMENTS
How is the situation of mental health (people with psychosocial, intellectual or cognitive disabilities) in community? Give examples of mental health cases- rank from high to low.	Very poor	Very poor	Very poor	Very poor	<ul style="list-style-type: none"> <li>Many cases in the healthcare facilities and within the community</li> <li>High unreported cases of domestic violence within the community</li> <li>Increase in number of youths abusing drugs and alcohol</li> </ul>
How are people with psychosocial, intellectual or cognitive disabilities often perceived by society? ( <i>What are some common labels or abusive words used in relation to people with psychosocial, intellectual or cognitive disabilities?</i> )	Very bad	Very bad	Very bad	Very bad	<ul style="list-style-type: none"> <li>Associated with witchcraft, curse, and theft</li> <li>They are related to drug and alcohol abuse</li> <li>They are mad people: Mwenda wazimu, aguruki, mundu wa ngoma</li> </ul>
People with psychosocial, intellectual or cognitive disabilities face many barriers and forms of discrimination which prevent them from participating in society (give examples of physical, attitudinal, communication, social, practices –violence, coercion and abuse -or legal barriers barriers)	Very bad	Very bad	Very bad	Very bad	<ul style="list-style-type: none"> <li>They lack basic need provision such as shelter, food &amp; clothing</li> <li>Seen as less of human being</li> <li>They are tied with ropes which normally cause some physical injuries/wounds on the body especially around the wrists, legs, or ribs</li> <li>Beaten and chased away in social gatherings</li> <li>Sexual violations such rape</li> <li>Denied inheritance of properties such as land</li> <li>Discriminated against when comes to marriage:- considered unable to take care of the family, should not have children.</li> </ul>

6. Master Facility List, <https://www.ehealth.go.ke>

## 2.2.1 Situation of Mental Health

Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.<sup>7</sup> The mental health taskforce (July 7, 2020) estimated that in Kenya, one in every 10 people suffer from a common mental disorder. The number increases to one in every four people among patients attending routine outpatient services. Depression, anxiety and substance use disorders are the leading mental illnesses diagnosed in Kenya. Alcohol is the commonly abused substance especially among youth 18-29 years old.

According to information from the Embu County NCD coordinator <sup>8</sup> Mental Health has become a severe health issue in Embu County. This has led to an increase in number of clients seeking mental health support to a range of 30 to 45 persons per day, which is approximately 210 patients per week, translating to around 550- 660 per month. The report also added that there had been an increased case of suicides and a high number of youth and students who have developed mental health disorders.

On the status of people living with psychosocial, intellectual or cognitive disabilities in Embu, this community report card showed unanimous agreement among the respondents that numbers of persons with psychosocial, intellectual or cognitive disabilities had tremendously increased over the years in Embu County. This could be witnessed by the number of patients seeking mental health services within the healthcare facilities. Through observation, the numbers of people with psychosis walking about in the markets places and in the community had also increased over the last few years. Importantly, the number of youths engaging in antisocial behaviors, substance abuse and alcoholism was reported by the community members to have risen.

## 2.2.2 Community Perception of Persons with Mental Health Disabilities

The perception of the society in relation to the etiology of mental health disorders was that mental health illness in Embu County emanates from over use of drugs such as miraa, marijuana and alcoholism; witchcraft; poverty and economic hardships; and being cursed for being against societal norms; among other factors. Moreover, community members perceived people with mental health disabilities as mad people or wendawazimu, muguruki, mundu-wa-ngoma, kithao, kirimu or kiaa in the local dialects. By extension, the labeling was also associated to mental HCW who were discriminated as being mad because they were dealing with mad people. Individuals with mental health disabilities were considered to have been bewitched as a result of stealing from someone or going against the societal norms. Others were perceived as mere drunkards and individuals with no economic value to the society, violent, and persons who deserve to die in order to alleviate the family from the burden of taking care of them, among other derogative labeling.

## 2.2.3 Barriers and Discriminations

Persons with psychosocial and cognitive disabilities face multiple barriers. WHO defines barriers as factors in a person's environment that, through their absence or presence, limit functioning and result to disability. These include aspects such as physical inaccessibility, lack of relevant assistive technology (assistive, adaptive, and rehabilitative devices), negative attitudes of people towards disability, services, systems and policies that are either nonexistent or that hinder the involvement of all people with a health condition in all areas of life."<sup>9</sup> This community report clearly established that there were several physical abuses and communication barrier meted against persons with mental health disabilities. The following were some of the violations established:

7. WHO: 2018

8. As presented by the Embu County NCD Coordinator

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

### 2.2.3.1 Social Barriers

#### a) Stigma and Discrimination:

Stigma and discrimination in mental health refers to negative perception and negative treatment because of mental illness, it can worsen mental health problems and prevent people from seeking help when needed. Stigma may result from lack of awareness and the nature or complications of the mental illness. At household level persons with psychosocial and cognitive disabilities are often bullied, verbally and physically assaulted; this is manifested in isolation, denial of basic needs and neglect. As a result persons with mental disorders often suffer shame, hopelessness that may also result in self-stigma. This negative perception and treatment permeates to community settings leading to further isolation and exclusion from normal social activities.

#### b) Lack of social protection

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

#### c) Limited support systems for care givers

Support systems for persons with lived experiences and their care givers should entail access to community services and support that promote debriefing and stress management, provide insights and plug in points for access to opportunities, care and support. Ideally psychosocial support groups may be formed out of the initiative of beneficiaries or by a third party to align support through community networks.

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

### 2.2.3.2 Legal Barriers

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

1. **Disinheritance.** Both at the family and community level, the ability of persons with psychosocial and cognitive disabilities to utilize or safeguard inherited resources is always in question and a basis for disinheritance. This leads to destitution of persons with mental illness upon the demise of the care giver usually the parent.
2. **Lack of satisfactory legal redress from law enforcers.** Complaints raised by persons with psychosocial and cognitive disabilities especially on physical abuse, disinheritance and neglect were often disregarded and considered as “not true”. Besides, all the facilities that participated in the data collection exercise never had structured complaints redress mechanisms which were clearly spelt out and understood by the community
3. **Right to establish a family.** It was revealed that there were negative perceptions marrying or getting married to a person with lived mental health experiences would transmit the illness to the other family. Hence, few were willing to encourage such relationships. Families worried that they may carry the

burden of the new family including bringing up and educating their children. It was assumed parents with psychosocial and cognitive disabilities were more likely to miss out in access to gainfully employment. Where persons with psychosocial and cognitive disabilities went ahead to establish families and were self-reliant, biases in distribution of family property were reported. Discriminatory laws like the Matrimonial Clauses Act, Cap. 152 that cites unsound mind as a basis for dissolution of marriage was often quoted as a basis for discouraging marriage.

4. **National registration.** It was revealed that most of the persons with psychosocial and cognitive disabilities were not registered by the national government. Hence, they did not have national identity card other than those that developed mental health disabilities in their adulthood. Many missed out on the opportunity for registration due to unmanaged mental illness and neglect. Destitution was also highlighted as a reason for failure to register due to inadequate tracing of the background of persons with psychosocial and cognitive disabilities living in the streets. Though there existed delegated legal capacity in the form of primary care givers, it was at their discretion to ensure persons with psychosocial and cognitive disabilities not registered are duly registered. Such care givers should be empowered to ensure they actually facilitate registration to all at all times.
5. **Right to vote.** Persons with psychosocial and cognitive disabilities were rarely registered for voting. This was partly attributed to lack of national identity cards a prerequisite document for voter registration. In addition, the legal requirement that one “be of sound mind” is deterrent to the right to vote. However, according to Mental Disability Advocacy Centre publication “Right to Legal Capacity in Kenya” as long as persons with psychosocial and cognitive disabilities “lives in the community (not in a psychiatric facility during voters registration or election day); is interested in politics and is supported by his or her family or an NGO to provide support; the polling station officer does not perceive the person to be of “unsound mind”; and the person can physically access the polling station and can physically write, or have someone else mark an “X” on the ballot paper” can exercise their political rights<sup>10</sup>.
6. **Participation in decision making process including public hearing forums.** It emerged that County government did not include persons with psychosocial and cognitive disabilities in decision making processes. The design of public consultation and hearing forums were massive engagements and not specific to stakeholder category. As such persons with psychosocial and cognitive disabilities felt not comfortable or welcome due to community attitude, stigma to engage in such public forums. In one of the FDGs, a participant pointed out that in deed it was the county that was the first to discriminate these people, that in the vent that they appeared at such forum, the meeting would stop so as to ensure that they are taken away from the meeting venue.

### 2.2.3.3 Physical Abuse against persons with mental health disabilities

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

10. [http://mdac.org/sites/mdac.org/files/mdac\\_kenya\\_legal\\_capacity\\_9apr2014\\_0.pdf](http://mdac.org/sites/mdac.org/files/mdac_kenya_legal_capacity_9apr2014_0.pdf)

11. <http://edition.cnn.com/2011/WORLD/africa/02/25/kenya.forgotten.health/>

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

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

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

#### 2.2.3.4 Violations related to communication:

1. Persons with mental health disabilities were hardly informed on any important events, meetings or gathering at family/household or community levels. Whenever, they were involved their voices and opinions were rarely considered in decision making.
2. Negative attitude from health care workers. It emerged from persons with cognitive and mental health disabilities that they were rarely involved in making their health decisions even when able to. The negative attitude toward the mentally ill and service providers therein was partly attributed to lack of psychiatric training among most nurses and clinical officers, misconceptions or stigma and discrimination associated with mental illness.
3. Not receiving information in an understandable way (for example, use of Braille for people with visual impairments or easy-to-read information for people with learning difficulties).
4. The tone of communication, being spoken to in simplistic language or in a condescending tone.
5. Not being listened to by practitioners, family members or others.
6. Having one's differing opinion, perspective or view considered as a "symptom of illness" or "lack of insight".

### 2.3 Mental Health Policies

Kenya being part of the international community, has signed several treaties which are legally binding within the Kenyan legal system. Some of these treaties in relation to mental health policies include: The convention on the right of the child article 23 which recognizes the right of the mentally or physically disabled child to enjoy full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community. The Convention of civil and political rights (CCPR<sup>12</sup>) article 7 focuses on the ban of torture or cruel, inhuman or degrading treatment of persons. The convention on the right of persons with disability (CRPD<sup>13</sup>) emphasizes on prohibition of discrimination on the basis of disability and guarantee of equal protection to persons with disabilities (article 5), right to employment and to gain a living (article 27), equal rights for persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit (article 12); and right to the full enjoyment of life on an equal basis with others (article 10);among other rights.

12. International Convention on Civic and Political Rights. Retrieved from: [www.ohchr.org](http://www.ohchr.org)

13. United Nations. (2007).Convention on the right of persons with disabilities. [www.un.org](http://www.un.org)

The Kenyan Constitution<sup>14</sup> Article 43 (1) (a) provides that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care. Article 43 (2) also provides that a person shall not be denied emergency medical treatment. Mental health being key part of health the legal bench mark for service provision is entrenched in Article 43. Additionally, all general hospitals are gazetted to treat and admit persons suffering from mental disorders in accordance with section 9 of sub-section 2 of the Mental Health Act 1989<sup>15</sup>; Cap 248 of the Laws of Kenya.

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

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

### 2.3.1 Findings on Mental Health Policy

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

**Table 2.2: Findings on mental health policy in Embu County**

INDICATOR	CHMT	HCWS	CHVS	SERVICE USERS/PATIENT SUPPORT	REASONS/COMMENTS
Existence of a national mental health policy that is in line with international human rights instruments.	Poor	Very poor	Very poor	Very poor	<ul style="list-style-type: none"> <li>CHMT -Policy available though not disseminated.</li> <li>We have heard of it not interacted with it.</li> <li>We have not read it</li> </ul>
Existence of a national mental health law that is in line with international human rights instruments.	Poor	Very poor	Very poor	Very poor	<ul style="list-style-type: none"> <li>The law is not felt within the health structure</li> <li>We do not know the existence of such law</li> <li>It has never been disseminated</li> </ul>
Existence of mental health committee/Technical Working Group at county level that provides technical support / oversight to mental health at county level	Poor	Very poor	Very poor	Very poor	<ul style="list-style-type: none"> <li>Only CHMT and HCWs at CRH were of a TWG presence</li> <li>Coordination is done through health governance structure</li> </ul>

14. The Kenya constitution 2010

15. Mental Health Act (1989) chapter 248. [www.kenyalaw.org](http://www.kenyalaw.org)

### 2.3.1.1 Mental Health Policy

According to table 2.2 in relation to mental health policy showed that most of the HCWs, CHMT, hospital boards, and service users had no knowledge of existence of a national mental health policy. Some of the mental healthcare workers have heard of it but had no knowledge of its content. Similarly, majority of the respondents had no understanding or awareness of existence of national mental health law that is in line with international human rights instruments. Lack of knowledge of the policy documents showed that dissemination of the mental health policies had not been done.

### 2.3.1.2 Leadership and Coordination

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

Feedback on the County stakeholders' involvement in the review of amendment Bill was poor or none. Some of the reasons given for lack of participation included: lack of information or notifications of the meetings; lack of interests from the public on County matters by community members; transportation costs or lack of transport reimbursement after attending the meeting which were always held at the County town halls in Embu.

The TWG existence was unknown to service providers and other stakeholders despite having been established. Mental health leadership, governance and coordination was said to be aligned to the health leadership, governance and management structure from Level I to Level 5. Additionally the coordination of mental health services was undertaken under NCD coordination at programme level.

## 2.4 Mental Health Financing

The World Health Organization<sup>16</sup> estimated that high-income countries allocate about 5.1% of their health budget to mental health whilst many low- and middle-income countries currently allocate less than 2% or even 1% of the health budget to the treatment and prevention of mental disorders. Mental health services are widely underfunded especially in developing countries. However, most of the funds that are allocated to mental health by most governments from low-and middle-income countries are specifically directed to the operational costs. SDG<sup>17</sup> goal 3 focuses on ensuring healthy lives and promoting well-being for all ages. Precisely, by 2030, it targets to reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing. Secondly, to achieve 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. Therefore, in order to achieve mental health financing under UHC, a defined set of mental health conditions and interventions should be explicitly recognized and included in the essential list or package of health benefits offered to all citizens by governments, whether as part of the national tax-based health service or under the provisions of social or private insurance schemes.

16. WHO.(2013).Mental health action plan 2013-2015

17. United Nations. (2015). Sustainable development goals. <https://sdgs.un.org/goals>

Kenya is among the 28% of WHO<sup>18</sup> member states countries that do not have a separate budget for mental health. Evidently, mental health budget is estimated to be around 0.5% of the total national and county budget allocations. Despite, health being a devolved function there are no budget lines for mental health in the county government budget. However, there are other budget lines under the health sector budget that touch on mental health. For example, drugs, non-pharmaceuticals, equipment, human resources and transport but they have no dedicated budget line that can show the amount budgeted for mental health. In most counties, the component of mental health is anchored under the NCDs budget; however, priority is given to aspects such as diabetes, cancers, hypertension among others.

The report sought to explore levels of mental health financing as indicated in Table 2.3

**Table 2.3: Mental Health Financing**

INDICATOR	CHMT/ HMT	HCWS	CHVS	SERVICE USERS/ PATIENT SUPPORT	REASONS/COMMENTS
Existence of costed mental health plan at the county level to support implementation of mental health initiatives.	Very Poor	Very poor	Very poor	Very poor	<ul style="list-style-type: none"> <li>No plan.</li> <li>No priorities.</li> <li>There is no mental health data available for evidence based decision making however mental health service provision is largely integrated in curative and rehabilitative services.</li> </ul>
Mental health included in County Integrated Development Plan and Annual Development Plans	Poor	Very poor	Very poor	Very poor	<ul style="list-style-type: none"> <li>Mental health not included in CIDP and ADP.</li> <li>Mental health is under NCD under the programme based budgeting (PBB) mental health is clustered in the Non Communicable Diseases sub programme under preventive and promotive programme alongside hypertension, diabetes and cancer.</li> </ul>
Existence of a separate budget line for mental health services in County government approved budgets	Very poor	Very poor	Very poor	Very poor	<ul style="list-style-type: none"> <li>There is no department for mental health services at the county</li> <li>No separate budget line for mental health at the county including at the facility level.</li> </ul>
All mental health services at primary, county referral and national teaching and referral hospitals are paid for in full by insurance service providers – National Hospital Insurance Fund (NHIF)	Average	Average	Average	Average	<ul style="list-style-type: none"> <li>Partial payment because of frequent stock out of mental health commodities and drugs.</li> <li>Mental health services like all other services are free at primary health care level. At hospital level service users with NHIF cover enjoy available services within the NHIF terms and conditions. There are still incidences of out of pocket expenditure to cover for the indirect costs and cost of out of stock commodities and supplies.</li> </ul>

18. WHO.(2013).Mental health action plan 2013-2015

INDICATOR	CHMT/ HMT	HCWS	CHVS	SERVICE USERS/ PATIENT SUPPORT	REASONS/COMMENTS
Existence of donors/ partners who directly support the county mental health services with financial resources	Average	Average	-	-	<ul style="list-style-type: none"> <li>Existence of Afya Kamilisha undertaking capacity building to CHVs</li> <li>MSF supporting eleven facilities with mentorship and drugs</li> </ul>
Existence of donors/ partners who collaborate with county government to promote mental health programme and services.	Average	Average	-	-	<ul style="list-style-type: none"> <li>MSF creating awareness to CHVs</li> <li>HERAF is currently involved in mental health programming</li> </ul>
The Kenya Essential Drug List includes essential psychotropic drugs in adequate quantities and varieties	Poor	Poor	-	-	<ul style="list-style-type: none"> <li>There are inadequate due to unsteady supply.</li> <li>Initially only 1st generation psychotropic were on the list now some 2nd generation drugs have been included albeit being expensive they are more effective, have less side effects and more specific to particular mental health cases</li> </ul>
Essential psychotropic drugs available at all levels of mental health system –community, levels 2&3; County level 4, County referral level 5 and national referral level 6 in sufficient quantities and varieties at all times	Good	Good	Average	Average	<ul style="list-style-type: none"> <li>Most common are: modocate (fluphenazine decanoate), chlorpromazine (CPZ), and artane Other drugs are bought from private chemists and other drug stores.</li> <li>Inconsistent supply of psychotropic drugs within the health facilities.</li> <li>There is no stand-alone budget line for psychotropic drugs within the healthcare facility.</li> </ul>
Mental health services and basic medicines for mental disorder included in health insurance schemes – NHIF, UHC	Good	Average	Average	Average	<ul style="list-style-type: none"> <li>Most drugs are missing in the health facilities so patient buy from out-of-pocket in private drug stores.</li> </ul>

## 2.4.1 Finding on mental health financing

### 2.4.1.1 Mental Health Plan

Availability of a costed mental health work plan can help determine resource requirements for drugs, commodities, equipment, human resource, finances as well as technical resources. This is the guide on cost of implementing for instance the Kenya Mental Health Policy (KMHP) or county specific mental health work plans. The costed estimates help planners determine resource needs, financing gaps and determine resource mobilization strategies to bridge the gap.

The community report card on the status of mental health financing in Embu County showed that majority of the respondents especially the CHMT and the HCWs did not know if there existed of a costed mental health plan at the county level to support the implementation of mental health initiatives.

### 2.4.1.2 Budgeting for Mental Health

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

### 2.4.1.3 County Government Planning and Mental Health

The community report card sought to establish whether mental health was included in County Integrated Development Plan and Annual Development Plans, the respondents mentioned that there was no allocation. Project analysis showed that mental health and rehabilitation for drugs and substance use were identified as distinct sub programmes in the Preventive and Promotive Health Services Programme with specific Key Performance Indicators (KPIs) and targets. Mental health had an allocation of Ksh. 20 million in the CIDP to increase uptake of mental health services while rehabilitation had an allocation of Ksh. 30 million for identification of users of drugs and substances for the FY 2018-2022. However this did not trickle down to the ADP and therefore could not be traced in the budgets<sup>19</sup>.

### 2.4.1.4 Health Insurance and Mental Health Services

For health insurance provision, it was indicated that NHIF catered for mental health treatment at the level 5 facility only. This was also associated with a policy at NHIF where members were often asked to pick their facility of choice for outpatient services, therefore clients who picked the level 5 facility were able to receive services at the facilities, however those who had picked other facilities were disadvantaged since the services were not offered at the 'lower' level facilities. A major challenge that was noted was that most of the individuals with psychosocial, intellectual or cognitive disability had not registered for NHIF hence, for specialized treatment they heavily relied on the out-of-pocket financing. For those who had registered, most of them were not up-to-date with their payment. This made it a challenge in accessing services using the NHIF card.

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19. Embu Approved CIDP 2018-22

### 2.4.1.5 Mental Health Disability Assessment and Registration

The community report card also sought to find out if people with psychosocial, intellectual or cognitive disabilities were under social protection covered by the National Council for People with Disability (NCPWD). The findings revealed that in all of the facilities under study in Embu County, people with psychosocial, intellectual or cognitive disability were never taken for any disability assessment; and they were not registered under persons with disability. Ideally, most of the respondents did not understand or doubted whether people with mental disorders were disabled. It was easier for people with physical disability be grouped under persons with disability as compared with individuals with psychosocial, intellectual or cognitive disabilities. Therefore, they are denied any form of economic, social or health services related to their mental disabilities. However, at the Embu referral hospital, the APDK representative pointed out that assessment of persons with psychosocial and cognitive disabilities were assessed and were issued with cards. One challenge was the fact that the assessment reports needed to be accompanied by a report from a psychiatrist however this was not possible because there was none in the county as at the time of the exercise. This saw most of the applications rejected as they lacked the merit.

### 2.4.1.6 Donor Support for Mental Health

In terms of donor/partners who directly support mental health in Embu County, Afya Kamilisha and MSF were mentioned. MSF was involved in mentorship of health care workers and procurement of commodities for eleven selected facilities in the county. They were also conducting sensitization of CHVs. HERAF was mentioned to be working with the department of health on advocacy around policies and investment on mental health. This was not uniformly known to all respondents.

### 2.4.1.7 Mental Health Drugs, Products and Technology

In terms of mental health products and technologies, the community report established that the County Referral hospital had essential psychotropic drugs in adequate quantities. However, in other levels of health facility in Embu the major psychotropic drugs that were commonly available were: modicate (fluphenazine decanoate), chlorpromazine (CPZ), and artane. For other essential psychotropic drugs such as diazepam, antidepressants, phenobarbitone, etc, patients were buying from out-of-pocket in private chemists. Additionally, at other times service users revealed that even the three common psychotropic drugs were sometimes missing in public health facility especially the injectable modicate forcing them to buy it from private chemists. It was also revealed that mental health products and technologies were generally included in the healthcare facility budget alongside other departmental needs thereby making it not a priority during budgeting.

## 2.5 Mental Health Service Delivery

WHO elaborated that health systems service delivery should be people-centered<sup>20</sup>. People-centered care is primarily focused on service delivery that is deeply entrenched around the health needs and expectation of people and communities, rather than on the disease. Indeed mental health treatments have largely focused on biomedical approach neglecting the aspect of the psychosocial and social support to the patients. In consideration of mental health service delivery like other health service delivery, four main principles must be taken into account: Availability, accessibility, acceptability and quality. The availability of mental health service takes into consideration the presence of the healthcare facilities (outpatient or inpatient mental health facilities), community based mental health services including outreach services, homecare, support groups, and emergency care availability, counseling, awareness, screening referral, contact tracing, treatment

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

and rehabilitation services for people with substance use disorder (SUD), among other services. In addition, there has to be presence of essential psychotropic drugs and basic medicines for mental disorders.

It is not only justifiable to have available mental health services, but they must be accessible. Accessibility entails the ease of having the available mental health services without discrimination, and without physical, economic, socio-cultural or information barriers. In terms of the healthcare workers, there has to be equitable distribution without any demographic or political biases. In relation to mental health service delivery, acceptability is determined by the social and cultural distance between mental health services and their user. Mental health services in health facilities must be respectful of medical & psychological ethics and should be culturally appropriate and sensitive to the demographics of the service users. In addition, acceptability must consider the aspect of respect, confidentiality, and should be geared towards treating all patients with dignity, create trust and promote demand for services. Quality in service delivery requires that health facilities, goods, and services must be scientifically and medically approved and of good quality. Therefore mental health services would be considered of high quality if there are effective, safe, centered on the patient’s needs and given in a timely fashion. Mental healthcare workers must be technically qualified and highly motivated to undertake their duties. The relationship between the mental health provider and the client should respect informed choices, privacy and confidentiality, and client preferences and needs.

Table 2.4 provides the summary of mental health service delivery in Embu County.

**Table: 2.4: Mental Health services Delivery**

INDICATOR	CHMT/HMT	HCWS	CHVS	SERVICE USERS/PATIENT SUPPORT	REASONS/COMMENTS
<b>Mental Health Service Delivery</b>					
County has in-service training on mental health for all health care workers	Poor	Very poor	-	-	<ul style="list-style-type: none"> <li>Not structured</li> <li>Does not exist within the healthcare facility levels</li> </ul>
County has put in place community mental health workers – Psychologist to work with special or vulnerable populations	Good	Average	-	-	<ul style="list-style-type: none"> <li>Psychiatrist is there at Embu referral.</li> <li>5 psychiatrist nurses exist: 2 at CRH, 1 at each of these facilities Ishiara &amp; Siakago level 4 hospitals and Kithimu health centre. No psychologist, counsellors, social workers, etc</li> </ul>
HCWs at the primary health facilities are trained on component of mental health	Poor	Very poor	Very poor	-	<ul style="list-style-type: none"> <li>There are training but does not focus on mental health.</li> <li>No training for HCWs at primary level facilities</li> </ul>
There exists good working conditions, financial remuneration and career progression opportunities for mental health professionals	Very poor	Very poor	-	-	<ul style="list-style-type: none"> <li>No career progression opportunities, poor remuneration and high workload due to shortage of mental health staff</li> </ul>
Outpatient mental health services provided in all public health facilities in Embu County	Good	Average	Average	Average	<ul style="list-style-type: none"> <li>Patients can get outpatient mental health services but not comprehensive only drug dispensing at level 4.</li> </ul>

INDICATOR	CHMT/ HMT	HCWS	CHVS	SERVICE USERS/ PATIENT SUPPORT	REASONS/COMMENTS
In patient mental health unit/ward available in-patient public health facilities	Poor	Very poor	Very poor	Very poor	<ul style="list-style-type: none"> <li>The inpatient not working at Embu referral. Other facilities sometimes admit patients in general wards.</li> </ul>
Community based mental health services including outreach services, homecare and support, emergency care available /provided	Very poor	Very poor	Very poor	Very poor	<ul style="list-style-type: none"> <li>Not available</li> </ul>
Mental health included in curriculum/training modules/ tool kit for Community Health Volunteers (CHVs)	Very poor	Very poor	Very poor	Very poor	<ul style="list-style-type: none"> <li>CHVs had not been trained in module 13. The mental health component was recently added.</li> </ul>
Treatment and rehabilitation services of alcohol and substance use are available in county public health services	Very poor	Very poor	Very poor	Very poor	<ul style="list-style-type: none"> <li>Not available</li> </ul>
Mental health information is integrated into disease specific programme – HIV/AIDS, MNCH, Family Planning, etc. facility, community and home based outreach services	Average	Very poor	Very poor	Very poor	<ul style="list-style-type: none"> <li>No integration</li> <li>But some HCWs sometimes talk about mental health based on their college trainings.</li> </ul>
Existence of complaints and reporting procedures known and utilised by persons with mental health disabilities, care givers or family members.	Very poor	Very poor	Very poor	Very poor	<ul style="list-style-type: none"> <li>Not available</li> </ul>
All level 4, 5 and 6 health facilities have outpatient units /consultation rooms for mental health services with adequate space and in good conditions	Good	Average	Average	Average	<ul style="list-style-type: none"> <li>Level 5, Runyenjes and Siakago are the only health facilities with mental health consultation rooms. However, most of the room are small and very bad conditions.</li> </ul>
All level 4, 5 and 6 health facilities have inpatient wards for mental health services with adequate space and in good conditions	Average	Average	Poor	Poor	<ul style="list-style-type: none"> <li>Only at level 5 but was not in operations</li> </ul>

INDICATOR	CHMT/ HMT	HCWS	CHVS	SERVICE USERS/ PATIENT SUPPORT	REASONS/COMMENTS
Mental health services are reported in general Kenya Health Information System (KHIS)	Average	Poor	-	-	<ul style="list-style-type: none"> <li>Only the numbers new and old attendees are captured.</li> </ul>
Community health volunteers (CHVs) report on mental health	Very poor	Very poor	Very poor	Very poor	<ul style="list-style-type: none"> <li>Do not report on mental health</li> </ul>
Community health volunteers (CHVs) report on alcohol and substance use and rehabilitation	Very poor	Very poor	Very poor	Very poor	<ul style="list-style-type: none"> <li>Not available</li> </ul>

## 2.5.1 Finding on Mental Health Financing

### 2.5.1.1 Mental Health Services

In Embu County, according to the information from the department health, the county health infrastructure includes 1 level 5 hospital, 4 level four hospitals, 12 health centers, 83 dispensaries, 134 CHUs and 2010 CHVs. In line with access to mental health services, data from the department indicated that there has been a fluctuation in the numbers of patients seeking mental health services whereby in 2013 there were total of 5622 patients which increased to 6825 in 2015 but later decreased to 4848 in 2020. The reduction was as a result of the COVID pandemic where clients were afraid of visiting hospitals and HCWs strike that rocked the county.

**Table 2.5: The table below shows access to mental health services in Embu County from the year 2013 – 2020**

YEAR	MH ACCESS TO SERVICES
2013	5,622
2014	6,156
2015	6,825
2016	4,305
2017	4,032
2018	5,996
2019	6,423
2020	4,848

### 2.5.1.2 Mental Health Specialists and other HCWs

The availability of mental health service delivery takes into consideration the presence of trained healthcare workers such as psychiatrists, psychologists, counselors, and other healthcare workers related to mental health services. In Embu County, information on mental health staffing indicated that there were 3 psychologists, 5 psychiatric nurses and 1 psychiatric consultant.

As shown in table 2.4, community report established the following human resource distribution by cadre:

HOSPITAL	Cadre			
	PSYCHIATRIST	PSYCHOLOGIST	PSYCHIATRIC C/O	PSYCHIATRIC NURSE
Embu CRH	1	3	-	2
Siakago	-	-	-	1
Runyenjes	-	-	-	-
Ishara	-	-	-	1
Kianjokoma	-	-	-	-
Kithimu	-	-	-	1

Despite the presence of mental healthcare workers within specific health facilities in Embu County, their accessibility was a major challenge to service users. Most of the respondents indicated that it was difficult to schedule visits with chief psychiatric at Embu level 5. It was reported that most of the time the mental health specialist was away on leave. However, it was reported that recruitment process for a psychiatrist was underway at the time of carrying out this community report. At Siakago and Runyenjes sub-county hospitals work overload experienced by the psychiatric nurse hindered service users from ease of access of mental health services.

The unavailability of other mental health workers such as psychologists, counselors, and community mental health social worker was a major problem at the community and PHC level. This lack of mental health professional at the other levels of health facilities rendered quality of service to be low because it increased service seeking waiting time and patients did not receive the best quality of service from specialists. It was also indicated that mental health services were mostly acceptable to mental health patients in relation to biomedical approach. Persons with psychosocial, intellectual or cognitive disabilities were expected to take their drugs, adhere to medical prescription given by the HCW and regularly attend their clinics. It did not consider that patient's need for autonomy and need to improve their life through psychosocial and other community based support systems. Lack of mental health professionals accelerated mental health stigma and service seeking problem because most individuals with mental health challenges were afraid to seek services away from their local HCF due to fear from the community, and attitudinal discrimination of being labeled as mad. This resulted to a majority staying away from HCF and suffering from discrimination and stigma.

Subsequently, the community report established that HCWs at the PHC level had never received in-service training on components of mental health to improve their quality of service delivery on mental health. Majority of the HCWs at the FGD indicated that there were no good working conditions; there was poor financial remuneration and lack of career progression opportunities for mental health professionals.

### 2.5.1.3 Mental Health Infrastructures

In terms of mental health infrastructure, the community report showed that outpatient mental health services were readily available in four main health facilities which were Embu County referral hospital Level 5, Runyenjes, Ishiara and Siakago sub-county hospitals. The other health facilities heavily relied on the general outpatient services when seeking consultations for mental health services. However, most of the consultation rooms for psychiatric patients were small and not in good condition. For example, at Siakago sub-county hospital, the consultation room was very small and not spacious and it lacked the required protocol for a psychiatric consultation room requirement. Mental health service users had also to share the waiting bay with patients visiting the MNCH services and this posed a safety risks to both psychiatric patients and the MNCH patients. Conflicts and misunderstanding between the two groups of patients had been reported with one case of a psychiatric patient who took away a child from the MNCH claiming that the child was hers.

For inpatient services, only Embu County referral hospital had inpatient services with a bed capacity of 16 beds. However, inpatient services were not available at the time of undertaking this community report. The reason for lack of inpatient services was because; there was no available psychiatrist to support the patients once they had been admitted in the wards. Therefore, patients with psychosocial, intellectual or cognitive disabilities were admitted in the general wards depending on the status of their psychological conditions. In other healthcare facilities, such as Siakago sub-county hospital, psychiatric patients were at other times admitted in the general wards depending on their condition. In addition, admittance of psychiatric patients was not done at night or during the weekends especially at the Embu referral hospital which hindered effective mental health service delivery. It was also difficult to quickly get in-patient services because Embu County Referral hospital was some distance away from the community and ambulances were not readily available for psychiatric patients to transport them to the facility for admission.

### 2.5.1.4 Community based mental health services

Poor quality of mental health services was evident in lack of strong community level strategies on mental health. All the CHVs at the FGDs reported that they had not been trained on the component of mental health which was recently added in their curriculum/training modules/tool kits. It was also noted that CHVs never report on mental health or on alcohol and substance use rehabilitation making data related to mental healthcare unavailable for effective planning and quality enhancement. They could only report something concerning mental health or drug and alcoholism under the indicator 'other' in MOH 514. Furthermore, there was no coherent integration of mental health information into specific disease programs such as HIV, MNCH, FP, etc. at the facility or during community and home based outreach services. Specifically, it was very difficult to determine the nature or the level of integration because rarely did HCWs in other disease specific program shared about mental health with their patients. This showed that mental health services have been neglected within the health system despite mental health cutting across in most of the disease base programs. For example, in MNCH, young mothers were likely to experience postpartum depression, in HIV/AIDS issues of stress, depression, suicide related to the disease were common but they were rarely addressed within such specific programs. The community report also established that there were no community based mental health services including outreach services, homecare and support, emergency care available.

The report also showed that healthcare facilities did not have or promote community support groups. There was no community support group, consumers, and care givers of mental health services at the facility or at the community levels in Embu County. Moreover, there was no public government led/supported media awareness campaigns to increase public knowledge and understanding of mental health issues. The only known media station was Inooro Television which is a private radio station. Hence, mental health programs were left out in community programs, and social media promotions.

### 2.5.1.5 Mental Health Integration

There was no coherent integration of mental health information into specific disease programs such as HIV, MNCH, FP, etc. at the facility or during community and home based outreach services. Specifically, it was very difficult to determine the level of integration because rarely did HCWs in other disease specific program share about mental health with their patients. This showed that mental health services have been neglected within the health system despite mental health cutting across in most of the disease base programs. For example, in MNCH, young mothers were likely to experience postpartum depression, in HIV/AIDS issues of stress, depression, suicide related to the disease are common but they were rarely addressed within such specific programs. The community report also established that there were no community based mental health services including outreach services, homecare and support, emergency care available.

### 2.5.1.6 Mental Health Data

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

### 2.5.1.7 Feedback Mechanism

As narrated by the caregivers and service users, it was revealed that persons with psychosocial, intellectual or cognitive disabilities were never informed of the nature of mental health condition(s) suffered or never notified of some of the side effects of the drugs they were taking, or the duration of drug consumption. They were only informed of the drugs to take but they could not understand why they were taking such drugs. This approach was contrary to medical and psychological ethics of patient right to information and informed consent. In relation to promotion of user autonomy, dignity, and right to self-determination, the community report established that most of the individuals with psychosocial, intellectual or cognitive disabilities were never consulted on the decisions made on their behalf by the healthcare workers or caregivers. In some cases healthcare workers were identified to be biased and discriminative against people with psychosocial, intellectual or cognitive disabilities especially in healthcare facility where they share consultation room with other populations. For example, one of the service users testified that they were usually served last or were made to wait for longer hours than other patients or dismissed by the HCW as bothersome and disruptive. Despite some of the unacceptable approaches experienced by mental health patients, feedback and complaint mechanism within the health facilities were not adequate. The community report established that there were no effective complaint and reporting mechanism known and utilized by persons with mental health disabilities, care givers or family members within several health facilities. It was clarified that most of the health facilities had suggestion box which were placed in public spaces that made it difficult for people to put in their comments for lack of privacy. People fear that they could be easily identified by the HCF management which might result to them being targeted or victimized. Therefore most community members preferred channeling their complaints to local administrations such as the MCAs or chiefs

### 2.5.1.8 Drugs and Substance Abuse Services

Despite, substance abuse and alcohol being considered a major contributor to mental health problems in Embu, public facility for treatment and rehabilitation services of alcohol and substance use were not available within the five sample health facilities and also there was no known available facility for treatment and rehabilitation for SUDs in Embu County.

### 3.0 CONCLUSION

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

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

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

## 4.0 RECOMMENDATION

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

1. The county government should enhance the integration of mental health service in other health programs within the healthcare facilities.
2. In-service training for HCWs on the components of mental health services should be expedited.
3. Creation of awareness and public sensitization on mental health disabilities in order to reduce discrimination and stigma associated with the mental illness.
4. In order to increase mental health promotion and prevention at the community level, CHVS, and CHA must be trained on the basic mental health orders within their curriculum.
5. Non-state actors should increase their advocacy on the mental health financing at the county budgetary levels such as during the CIDP and ADP budget cycles.
6. Advocacy for the increase of mental HCWs in all level 4 health facilities increase mental health service delivery within the County.
7. The County government should increase engagement and participation of different stakeholders in mental health promotion and prevention





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